MASTER'S THESIS

Course code: SO330S Name: Christian Tesfahun Alemayehu

"Alienated from the care process and outcomes…"

A qualitative study of language barriers in cross-cultural provision of healthcare to people with immigrant background.

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Abstract

Effective communication between patients and health professionals is a core component of healthcare quality since patient participation, collection of accurate and comprehensive patient-specific data that are necessary in providing patient-entered and evidence based practice depends on the communication comprehended by both patients and clinicians.

The objective of the research is to identify and analyse challenges of language barriers in the provision cross-cultural healthcare to patients with limited Norwegian language proficiency based on empirical data collected from patients, healthcare professionals and language interpreters, and in the context of relevant theories and earlier studies. Top this end, the research aims at presenting and discussing challenges of language barriers in the provisions of cross-cultural healthcare to patients with limited language proficiency from the perspectives of patients, healthcare professionals and language interpreters, and their implication for providing patient-centered and culturally congruent healthcare. Besides, the research aims expanding a thoughtful discourse and adding to the existing knowledge.

The findings of the research shows challenges of language barriers are multidimensional and includes hampering impairs the quality of the healthcare process and outcomes by negatively influencing patients, health professionals and interpreters. The research also points suggestions and recommendations with the view to address and the challenges and point a move toward a more inclusive and responsive healthcare system.

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Language barriers in cross-cultural provision of healthcare to people with immigrant background

Chapter 1 Introduction

Over the last few decades, migration has dramatically increased and becoming more continues than ever before. According to the international organization for migration (IOM) report, the number of international migrants worldwide increased from 174 million in 2000 to 221 million in 2010 and nearly 272 million in 2019 (McAuliffe et al., 2020). Thus, international migrants comprise 3.5 per cent of the global population as of today (McAuliffe et al., 2020). Of this number, more than half of all international migrants lived in Europe (82 million) or Northern America (59 million) (McAuliffe et al., 2020). Accordingly, migrants account for more than ten per cent of the total population in Europe, Northern America and Oceania. This in turn leads to creation of sizable populations with linguistic and cultural background in the host countries.

With regard to migration to Norway, there were 765 100 immigrants and 179 300 Norwegian-born to immigrant parents in Norway at the beginning of 2019 (Statistics Norway, 2019). Accordingly, immigrants accounted for 14.4 % of the total population in Norway as per 2018, while Norwegian-born to immigrant parents accounted for 3.4 per cent (Statistics Norway, 2018). These two groups have a background from 221 different countries and independent regions (Statistics Norway, 2018). Owing to this continued trend of migration, Norway has become multilingual, and a multicultural state. For example, in the last 50 years, the capital city of Oslo has gone from being an almost linguistically homogeneous city to being a multi-ethnic, multicultural and multilingual capital (Lee, 2013).

The ever-increasing trend of global migration and the resulting cultural and linguistic diversity brings challenges to healthcare systems like the Norwegian, which is originally designed and intended to serve an almost culturally and linguistically homogenous society. The challenge to the healthcare systems is even more tense since a good number of people with immigrant background have difficulty in using Norwegian in direct communication with their physicians in medical communication settings. A study shows, for instance, that only 7% of adult non-western immigrants have good reading skills in Norwegian, whereas 60% of people with immigrant background who have lived in the country for five years have difficulty understanding simple texts in Norwegian (Lee, 2013). Accordingly, a significant number of patients with immigrant background face language barriers in accessing healthcare.

This in turn has huge implications with regard to the provision of language concordant, patient-centered and culturally appropriate healthcare. Furthermore, language barriers pose also new challenges for health professionals, professional language interpreters and the healthcare system in general in provision of high quality and patient-centered care, as it demands extra skills like cultural competency and structural adjustment to accommodate the new demands(Eriksen & Sajjad, 2015; Jacobs & Diamond, 2017). In doing so, the challenge of language barriers in cross-cultural provision of healthcare is multifaceted as it adversely affect central components of healthcare quality, like patients utilization of healthcare, patient participation in the care process and outcome, and thus affects the quality of the care and contributes to health inequalities between these patients subgroup and the overall population. In this thesis, I will identify and analyse challenges of language barriers in cross-cultural provision of healthcare to patients with immigrant background whose Norwegian language proficiency is low. Throughout the research paper, I will use the term 'patient' more often than the term 'user' since the research's target group is patients with immigrant background with limited Norwegian language proficiency and challenges of language barriers in cross-cultural provision of healthcare.

1.1. Research problem and research questions

The main research question is;

- What are the challenges of language barriers in the provision of cross-cultural healthcare to adult patients with limited-Norwegian language proficiency?

To address the main research question, the research will also address the following related questions:

- What are the communication challenges caused by language barriers in medical communication settings, seen from patients`, health professionals` and language interpreters' perspectives respectively?
- What are the consequences of the language barriers as described by patients, health professionals and interpreters?

1.2. Background for choice of research topic and researchers stand point

My interest in studying language barriers in healthcare goes both to my personal experience and the literature survey I have done. Since I came to Norway as immigrant myself and started working, I have always been interested in doing research on areas concerning immigrants, migration health and challenges facing immigrants in the post-migration phase. I have worked in different private and governmental organizations on different positions both

here in Norway and in Ethiopia as a lawyer, teacher, nurse and language interpreter among others. In Norway, I have worked, among others as a language interpreter in different places like the refugee camps, schools, hospitals and municipalities refugee office translating different languages, Amharic, Afan Oromo and English. This gave me the chance to notice challenge of language barriers in both capacities as service user and language interpreter. While working as language interpreter I have experienced and noticed that language barriers are a challenge for immigrants with limited language proficiency– in getting access to high quality, patient-centered and culturally congruent healthcare owing to myriads of problems pertaining to patient themselves, healthcare professionals, language interpreters and limitations of relevant laws and the healthcare system in general. Yet, my academic background as a lawyer, nurse and social worker also gave me the chance to observe and understand challenges of language barriers from perspectives of various disciplines. This led to my interest in finding out how problematic and widespread challenges of language barriers are in cross-cultural provision of healthcare to patients with limited language proficiency. Yet, the fact that I myself have been through these challenges adds to my curiosity. In addition, I have explored literature on the subject and found that language barriers in healthcare settings is understudied at least in the context of Norway in general and cross-cultural provision of healthcare to people with immigrant background in particular. Beside my personal experience, the research is based on solid survey of literature and studies done on the subject matter as reviewed below.

1.3. Literature review

As mentioned earlier, the aim of the research is to identify and explore challenges of language barriers in cross-cultural provision of healthcare, thereby gaining a deeper understanding of the problem, approached from patients, healthcare professionals and language interpreters' perspective. The research is done based on empirical data collected through qualitative interviews and review of the existing literature on challenges of language barriers inherent to medical communication involving patients with limited language proficiency.

Effective communication between patients and their clinicians is a core component of health care as it determines collection of accurate and comprehensive patient-specific data that are basis for proper diagnosis and prognosis (Jacobs & Diamond, 2017; Schyve, 2007). Effective communication in turn requires language concordance between healthcare providers and patients. Several studies have shown positive associations between language concordance and better quality of care for patients with limited language proficiency (De Moissac & Bowen,

2019; Jacobs & Diamond, 2017; Lee, 2013). Accordingly, language concordant healthcare is directly associated with improved healthcare quality and outcomes. It leads, among other things to better patient satisfaction with care, and patients receiving language concordant care are less likely to have question about their care (Jacobs & Diamond, 2017). However, patients with limited Norwegian language proficiency cannot use directly communicate with health professionals due to language problem.

A study shows that Only 7% of adult non-western immigrants have good reading skills in Norwegian whereas 60% of people with immigrant background who have lived in the country for five years have difficulty understanding simple texts in Norwegian(Lee, 2013). Accordingly, a significant number of patients with immigrant background face language barriers in accessing healthcare. In addition, according to one study, health professionals have trouble understanding between 36% and 43% of the patients who do not speak Norwegian (Kale & Syed, 2010). This in turn has huge implications for the provision of language concordant healthcare. Several studies show that failure to handle language barriers in effective way can result in reduced quality of and access to health services(De Moissac & Bowen, 2019; Kale & Syed, 2010). Language barriers lead to communication problems between healthcare workers and patients, which in turn leads to reduced access to health services, poorer quality and under consumption of care services, reduced access to preventive health care, greater risk of misdiagnosis, greater risk of incorrect treatment, difficulty understanding one's own illness, inadequate follow-up of recommended treatment, unnecessary readmissions with medical and financial consequences, less satisfaction, increased frustration and insecurity among patients and relatives, low trust in healthcare personnel and in the healthcare services (Direktoratet, 2011; Lee, 2013). For instance, studies have shown that immigrants in Norway utilize the health care services differently than native Norwegians (Abebe et al., 2017; Sandvik et al., 2012; Straiton et al., 2014; Syed et al., 2006). These studies demonstrates, for instance, that immigrants utilize primary health care services less than the overall population. For instance, according to studies by Esperanza Diaz and Hogne Sandvik, immigrants utilized both their general practitioner and emergency primary health care services less than native Norwegians (Sandvik et al., 2012). These studies depicted also that one of the primary factors of underutilization of the healthcare system by patients with immigrant background is their Norwegian language proficiency. However, other factors like duration of stay in Norway, country of origin, reason for immigration to Norway, and their health literacy, are also mentioned (Sandvik et al., 2012). When it comes to specialist mental healthcare services, a study indicates that immigrants in Norway have lower utilization

rates of specialist mental healthcare than ethnic Norwegians (Abebe et al., 2017). However, there are also considerable variations among immigrants in Norway in terms of country of origin, age, reasons for migration and length of stay (Abebe et al., 2017).

Beside underutilization of healthcare, unaddressed challenges of language barriers also negatively affects quality of care throughout the healthcare continuum from patient's data collection, patient assessment, examinations, testing, diagnosis, and prescribed treatment (De Moissac & Bowen, 2019; Lee, 2013). That is, language- discrepant medical communication have adverse impact on patients' participation in healthcare process and outcomes, patient experience, clinical effectiveness thereby affecting the quality of care and patient safety. Yet, multiple studies have demonstrated that patients with language barriers are at the risk of disparities in healthcare processes and outcomes (De Moissac & Bowen, 2019; Jacobs & Diamond, 2017; Lee, 2013). For instance, in case of language discordant healthcare patient understanding of diagnoses and treatment is worse, medication adherence declines and patients are more likely to miss an appointment and go to emergency rooms that those with language- concordant care (Jacobs & Diamond, 2017; Lee, 2013). Therefore, patients with limited Norwegian language proficiency are at risk of health disparities, and receiving low quality healthcare at the risk of their safety.

In what follows, it is logical to ask, what are available mechanisms to provide cross-cultural healthcare to patients with limited Norwegian language proficiency overcoming challenges of language barriers?

The Norwegian healthcare system is founded on the principles of *universalism;* i.e. universal access entitling every legal resident in Norway the right to essential medical and care services by virtue of which immigrants with a residence permit have the same rights as citizens regarding securing a general practitioner and receiving highly subsidized primary healthcare (brukerrettighetsloven, 1999; Pierson & Castles, 2006). However, mere allowance of access to healthcare is not enough to ensure effective utilization of high quality healthcare for patients with limited language proficiency, as demonstrated by multiple studies mentioned earlier. In this regard, Norwegian health authorities have recognized that linguistic barriers are challenge for the principle of equal health service (Regjering, 2013). To address the challenges of faced by linguistic and cultural minority groups, laws and reports considering the unique needs and challenges these groups are incorporated in various healthcare laws (brukerrettighetsloven, 1999; Spesialisthelsetjenesteloven, 2001). For instance; the Patient Rights Act requires adapting health information to patients' individual and cultural background(brukerrettighetsloven, 1999). To this end, the law states under § 3-5 that

"All patients have the right to participation and the right to information, and; information must be adapted to the recipient's individual conditions, such as age, maturity, experience and cultural and language background."

The requirement of adaptation pertains both to physical accessibility and accessibility related to cultural and linguistic understanding. The law also requires the information to be given in a considerate manner and that the healthcare professional must ensure that the patient has understood the content and meaning of the information (brukerrettighetsloven, 1999). This means patients with limited Norwegian language proficiency, have legally recognized right to receive all the necessary help in getting access to quality healthcare in the manner and language they understand. Although such legislations are important, provision of patient centered and culturally competent healthcare for linguistic minority communities needs more measures beside the legal remedy. One of the challenges of language barriers in this regard is the one in relation to assessing patients' language proficiency and the need for interpreter (Kale et al., 2010; Lee, 2013; Sagli, 2015).

By virtue of the aforementioned legislation, patients with limited language proficiency have rights to healthcare service that is adapted to their linguistic barriers. One of way of adapting health information to recipient's individual cultural and language background is by providing of language service through professional language interpreters. In a language-discrepant medical communication setting the use of professional interpreters among effective ways of bridging language barriers (Jacobs & Diamond, 2017; Karliner et al., 2007).

The decision as to whether to use language interpreter in turn demand assessment of patient's language proficiency. Yet, the challenge remains to be how can one establish standards of language fluency for patients? That is, how can one identify whether a patient needs language interpreter or not? When can we say that a patients Norwegian language proficiency is good enough to comprehend the dialog with healthcare professionals without the need for language interpreter? What is good enough? Are there objective ways of assessing and measuring patient's language proficiency in order to determine the need for language interpreter?

In the Norwegian healthcare system, the assessment and decision as to whether to use language interpreters or not is entirely up to healthcare professionals discretionary power (Direktoratet, 2011). Although relevant laws and guidelines leave the assessment and decision as to whether to use language interpreters or not entirely to healthcare workers, it fails to provide detailed guidelines as to when and how healthcare workers should use professional language interpreters. This in turn makes the work of assessing the need for language interpreter difficult for health professionals because the task of assessing patients language

proficiency and deciding whether a patient needs language interpreter is complicated due to various reasons (Kale et al., 2010; Sagli, 2015). First, the level of patients' language proficiency varies from context to context (Jacobs & Diamond, 2017; Sajjad, 2000). This for instance, means, being skilful at Norwegian in social context does not necessarily implicate proficiency in complicated medical conversation with healthcare professionals at the time the patients' health is at issue. Moreover, some patients may miss their fluency in language other than their native language in certain situations like when they are sick. Secondly, there is limitation with regard to accuracy of patient's self-assessment of their language proficiency level. That is even if patients say that they can communicate directly, their level of their language proficiency may not be enough to comprehend medical communication. All these in turn paves way for various challenges like overestimation of the patient's Norwegian skills by healthcare professionals in several cases and under-consumption of professional interpreters (Kale & Syed, 2010; Lee, 2013). For instance studies conducted in 2011 at Norwegian Centre for Minority Health Research (NAKMI) shows that health personnel participants in a focus group interview overestimated the patient's Norwegian skills in several cases (Lee, 2013). In addition, the task of assessing patients' language proficiency is challenging for healthcare workers who normally lack professional competency in language assessment (Jacobs & Diamond, 2017; Sagli, 2015).

Although, the task of establishing objective standards for assessing language fluency of patients is a difficult and complex task, experts of the field have come up with suggestions and approaches to consider in the task of establishing standards of language fluency for patients.

In assessing patients level of proficiency in either English or Norwegian one can use language tests, self-reported metrics of fluency, or hospital data as to patient language, if any (Jacobs & Diamond, 2017; Kale & Syed, 2010). Hence, every health system requires a systematic method for identifying those patients with language barriers. In this regard, in the US, information as to patient's language data has been identified at the time of registration for healthcare and entered into the demographic section of the medical record(Jacobs & Diamond, 2017). As far as my research is concerned, in the Norwegian healthcare system patient language data is found out by asking the patient and is not part of the patients' medical record. As such, there is limitation with regard to collecting patients language data (so as) to be used as a source in the decision as to whether to use professional interpreter or not.

The other challenge with regard to establishing standards of language fluency is that patient's language proficiency is context driven, as mentioned earlier. What is considered enough

Norwegian language proficiency to enable patients with limited language proficiency to communicate directly with their healthcare providers? In other words, when can we say that a patient has sufficient Norwegian or English language proficiency to comprehend the dialog with healthcare professionals?

According to Kale patients' Norwegian proficiency can be considered deficient when; You are unsure whether the patient understands your questions, questions must be repeated several times, you have problems understanding what the patient is saying, the patient does not explain himself adequately in Norwegian (Kale & Syed, 2010). In this regard, the US Interagency Language Roundtable provides a way that could potentially also be used in Norway that;

> *Speakers who can give straightforward instructions in a language but use awkward or incorrect phrasing, together with speakers who can communicate effectively in most social and professional situations but have difficulty communicating some abstract topics, constitute the middle of ILR range (Jacobs & Diamond, 2017)*

Yet, another indicator can be difficulty in `word finding" on the part of the patient. That is, if the patient finds it difficult to find the right word to describe his or her situation, and rephrasing in which a patient displays lack of comprehension during teach-back communication with the physician and "emotional disconnect," in which a patient displays an emotional response that seems discordant with the conversation (Jacobs & Diamond, 2017). These indicators can be used as a benchmark in the assessment of patients' language proficiency level, and in decision whether to use language interpreter. The other relevant point worth mentioning when it comes to the task of establishing standards of language fluency for patients is the importance of setting absolute minimum standard when the use of an interpreter become critical. Studies show also the importance of setting absolute minimum standard when the use of an interpreter is mandatory depending on how high-risk the encounter is for the patients' health. These encounters include end of life (palliative care), advanced care planning discussions, high stakes genetic counselling and trauma, physical or sexual assault (Jacobs & Diamond, 2017).

To stablish standards of language fluency, it is therefore important to work out some details, which might help the healthcare professional care professional to assess patient's language fluency. These include collecting patients' language data and making it part of patients medical record and developing some indicators to patients language proficiency among other things.

Using language interpreters

Once healthcare professionals establish that patient's level of Norwegian language proficiency, the next step is finding the means to overcome the challenge. One of the conventional and effective way to bridge communication problem due to language barrier between patients and their clinicians are the use of language interpreter. Interpreters whether formal, trained and professional interpreters or informal, untrained or ad-hoc interpreters like family members and bilingual healthcare staff are commonly used to bridge the language barrier between patients and their clinicians in language-discrepant medical communication settings (Jacobs & Diamond, 2017; Kale & Syed, 2010).

The use of professional language interpreters in communication between patients with low proficient language skill and their clinicians is beneficial in many ways including collection of accurate and comprehensive patient-specific data that are the basis for proper diagnosis and treatment (Jacobs & Diamond, 2017; Schyve, 2007). Yet, studies demonstrate that the use of professional interpreters enhance communication and healthcare outcomes for patients with limited language proficiency including decreasing clinical errors and readmission (Flores & Abreu; Flores et al., 2012; Jacobs & Diamond, 2017; Kale & Syed, 2010; Karliner et al., 2007; Lee, 2013). Professional interpreters, in addition to their positive impact on process and clinical outcomes, also contribute to higher satisfaction with communication and the perceived quality of medical care for patients and physicians alike. Multiples studies have demonstrated that compared to ad-hoc-untrained interpreters like family and friends, the error rate for professional interpreters is considerably lower – and when errors are made, they are less likely to be clinically significant (Flores & Abreu; Flores et al., 2012; Jacobs & Diamond, 2017; Jacobs et al., 2004).. In addition, when professional interpreters are used to assist communication between patients with limited language proficiency and their clinicians the risk of malpractice concerns is lower, leading to healthcare that is more cost effective (Jacobs & Diamond, 2017; Jacobs et al., 2004). Hence, using professional language interpreters in language discrepant medical communication setting leads to better quality of care and outcomes. As such, provisions of professional language interpreter services should be considered part of high-value care for patients with limited language proficiency. However, multiple studies have also demonstrated under-utilization of professional language interpreters in healthcare in Norway (Direktoratet, 2011; Kale, 2006; Kale & Syed, 2010; Karliner et al., 2007; Lee, 2013).

Competency of language interpreters

The interpreter's task is demanding, and requires having the necessary competence as an interpreter to be able to provide effective language service thereby ensuring equal access to high quality healthcare services for patients with limited Norwegian language proficiency. Several studies reveal that safety of patients with low Norwegian language proficiency is compromised due to incompetent and inadequate interpretation (Direktoratet, 2011; Kale & Syed, 2010; Lee, 2013). A study conducted in Norway shows that, almost 50% of health professionals participated in the research expressed the need for increased professional competency among the interpreters (Kale & Syed, 2010).

Professional interpreters are required to possess certain skills to bridge language barrier, to reduce potential errors in interpretation and perform their job in the quality and standard expected of them. The skills an interpreter expected to have include linguistic fluency and knowledge of professional words and concepts in both languages. Standard of professionalism for interpreters include; important component of language access service; accuracy, accessibility and respect for confidentiality (Jacobs & Diamond, 2017). Possession of these skills leads to differences between professional interpreters and ad-hoc interpreters in the effective delivery of language service (Flores et al., 2012; Jacobs & Diamond, 2017; Karliner et al., 2007).

In relation to competency of interpreters, one point worth mentioning is the practical effect of biomedical model in healthcare service. That is, stakeholders including language interpreters who have different professional background than health profession must understand and use biomedical terminology in order to communicate effectively in these practice domains (Healy, 2014). This in turn means, professional language interpreters are expected be competent and be familiar with medical terminologies in both language in order provide quality language translation service. This might be challenging for language interpreter coming from different professional background than the biomedical discourse. In fact, interpreters are prohibited not to take task of interpreting for which they lack competency (Direktoratet, 2011; Tolkeforbundets, 2017).

Having reviewed relevant literature regarding challenges of language barriers in cross-cultural provision of healthcare to patients with low Norwegian language proficiency, I have found two limitations. First, there is a very limited number of research done on challenges of language barriers in cross-cultural provision of healthcare in the context of healthcare in Norway. Secondly, the few studies conducted on the subject matter depicted language barriers as a challenge in limiting, for instance, access to healthcare by these patients subgroup,

however, these studies fail to show how language barrier in creating the challenges, and consequences of challenges from the perspectives of various stakeholders like patients, medical professionals and language interpreters.

In this research, I will identify and analyse challenges of language barriers in cross-cultural provision of healthcare from the perspective of patients, language interpreters, healthcare professionals, and the healthcare system in general. Thus, the research aimed at providing a more comprehensive knowledge on how language barriers give rise to challenges in cross-cultural provision of healthcare and the consequences thereto in the provision of patient-centered and culturally competent healthcare for patients with limited Norwegian proficiency thereby producing more information and creating a deeper understanding of the problem from multiple perspectives. Moreover, I am genuinely interested in initiating and expanding a thoughtful discourse on the issue through findings of the research and to bring attention to the need to create a more inclusive and responsive healthcare system.

1.4. Scope and limitations of the research

The focus group of the research is adult patients with immigrant background who do not speak Norwegian in their direct communication to health professionals, and who are 18 years of age or above. In doing so, communication challenges due to language barrier faced by younger first or second-generation immigrants or immigrant children who do not speak Norwegian is beyond the scope of the dissertation. In addition, challenges of language barriers in cross-cultural healthcare faced by immigrants from western countries is not in the main focus of the research. Yet, language barriers that prevent individuals from effective communication include dialectical differences and physical language disabilities that cause language barriers like stuttering, dysphonia or an articulation disorder and hearing loss, language barriers arising from dialects and language disability is beyond the reach of the paper

Furthermore, cofounding factors effecting a minority linguistic community's access to healthcare like cultural barriers, socio-economic status, legal status, lack of awareness or knowledge of health care services, discrimination, poverty, and social isolation is not the primary focus.

Finally, the analysis of the research is devoted more to a micro-level analysis laying greater emphasis on challenges of language barriers between patients and clinicians medical communication settings. However, challenges of language barriers in cross-cultural provision of healthcare that are systemic or structural will also be discussed, albeit not the primary focus.

1.5. Organization of the research

With regard to the organization, the thesis is divided into five main chapters.

The first chapter of the dissertation begins by giving general introduction of the topic, the research problem and background for choice of research problem followed by brief presentation of literature review and scope and limitations of the research.

In the second chapter, the theoretical framework of the research will be presented. Hereinunder, relevant theoretical background necessary to depict challenges arising from language barriers in cross-cultural healthcare settings will be presented. The chapter begins with a brief summary of Norwegian healthcare system`s characteristics features. Then, various theoretical perspectives on disease and illness with particular emphasis on the biomedical discourse and the social constructionist view and their implication for the understanding of cross-cultural provision of healthcare will be presented. In what follows, I will present relevant communication theories like Communication Accommodation Theory (CAT), theoretical approaches considering semantic barriers and theory on the conversational dynamics of patient-doctor interactions. In addition, relevant theories like cultural capital theory, Anti-oppressive theory, patient-participation, empowerment and cultural competency among others, will be presented.

Chapter three is devoted entirely to presentation of the methodologies employed in conducting the research. This chapter outlines the research design and methodology chosen for conducting the research. To this end, present respondents demographics, followed by the presentation and justification of the research methodology and design as well as describe the research process, data collection and data analysis methods. Research evaluation pertaining to the research validity and reliability will also be discussed. In the end of this chapter, ethical aspects of the research will be presented.

Chapter four, which is the main part of the thesis, is devoted to the presentation, discussion and analysis of the findings of the empirical data, as to challenges of language barriers in the provision of cross-cultural healthcare. The chapter begins with the presentation and discussion of challenges of language barriers as related to the healthcare process and outcomes. Thereafter challenges of language barriers as described by various stakeholders, like patients, health professionals and language interpreters will be presented and discussed respectively.

In the last chapter of the research, a brief summary and reflection will be given.

Chapter 2 Theoretical framework for language barriers in the provision of cross-cultural healthcare

2.1. Introduction

Challenges of language barriers in healthcare settings can be encountered under different circumstances, and systematic review of these challenges demand theoretical approach and putting the challenges in theoretical context.

In this chapter, I will present theories that are relevant to understand challenges of language barriers in cross-cultural provision of healthcare. These theories are not only important in understanding what challenges of language barriers are, but also why communication problems arise in language-discrepant medical communication settings and their implications. To this end, the chapter begins with brief presentation of the Norwegian healthcare system`s characteristics features followed by presentation of various perspectives on diseases and illness. In what follows, I will present communication theories like a) Communication Accommodation Theory (CAT), b) a theoretical approach considering semantic barriers and c) a theory on the conversational dynamics of patient-doctor interactions. In addition, I will also present theories like Cultural capital theory, Anti-oppressive theory, Patient-participation, Empowerment and Cultural competency.

2.2. The Norwegian healthcare system - characteristics features

In order to gain a comprehensive understanding of challenges faced by patients with limited Norwegian language proficiency in the healthcare, it is important get acquainted with general background information about the healthcare system. To this end, I will present a brief summary of the Norwegian healthcare system in the context of cross-cultural provision of healthcare, as doing so is also important for later analyses and discussions as well as for readers not overtly familiar with the Norwegian healthcare system.

The Norwegian health care system is part of the Norwegian welfare state, which in turn can be categorized as the Nordic welfare model, or the social democratic welfare model. This especially due to service delivery with regard to delivery of social and health care service is run by the public sector (Greve, 2007). The Nordic welfare state model is the universal welfare arrangement and social-security scheme developed after the Second World War based on Keynesian economic policies and combining features of capitalism, such as a market

economy and economic efficiency, with social benefits (Castles et al., 2014). The Nordic welfare model shares certain characteristic features such as the principle of universalism and universal welfare policies, high level of decommodification, which means survival of a person is not dependent on the labour market, and higher levels of wage and taxation, among other things (Castles et al., 2014; Greve, 2007).

Universalism and universal welfare policies, which is one of the main distinctive aspects of the Nordic model, entitles individuals and families access to benefits like healthcare solely on the basis of citizenship or being legally resident in the territory of the states (Bengt et al., 2007; Castles et al., 2014; Greve, 2007). As such, every legal resident of the states have equal access to healthcare irrespective of their immigrant or employment status. In doing so, universalism and universal welfare policies are often contrasted with the liberal welfare model where benefits is given on selective bases targeting the poor and as a last resort (Castles et al., 2014). Since, the Norwegian welfare system is based on universal principles with a comprehensive social policy and social rights, it offers a full range of universal benefits, including the right free healthcare, pension and unemployment benefits among other things to all legal residents irrespective of their immigrants status. Hence, residents with immigrant background have the same rights as citizens regarding access to a general practitioner and receiving highly subsidized primary and specialist healthcare (brukerrettighetsloven, 1999; Regulation, 2011). That is, they have equal rights regarding access to both primary healthcare run by the municipalities and the specialist health care sectors like hospitals governed by the national health directorate. Residents receive primary health care through their general practitioner, who then refers the patient to a specialist if needed (brukerrettighetsloven, 1999). Nevertheless, provision of cross-cultural healthcare to people with immigrant background and especially to patients with limited Norwegian language proficiency require more than allowing access to healthcare. To provide high quality and culturally competent healthcare, it is of particular significance for a given healthcare system to understand and endeavor to meet the different needs of its immigrant population (Flores et al., 2012; Karliner et al., 2007). In this regard, various policies, laws and programs have been adapted to meet the different needs of the immigrant population in Norway. The measures includes ensuring the immigrant populations right to health as recognized under international treaties signed by Norway such as the International Covenant of Social Economic and Cultural Rights of 1966 (ICESCR) which is directly implemented by the Norwegian Human Rights Act (Aall, 1999§ 2(1) & 2(2)). Further, Norwegian health authorities have also recognized that language barriers

challenge the principle of equivalent health service. Yet, various laws, regulations and guidelines have been enacted to ensure effective delivery of language service in provision cross-cultural healthcare to patients with limited language proficiency. Healthcare professionals are for instance, required to adapt healthcare information to the individual need of a patient which include using professional language interpreter (brukerrettighetsloven, 1999; helseinformasjon & Norge, 2006; Spesialisthelsetjenesteloven, 2001). Moreover, the Health Directorate guideline mandates health personnel to only use professional language interpreters. In other words, it is prohibited to use ad-hoc or untrained interpreters like family members in communication with patients with limited Norwegian language proficiency (Direktoratet, 2011). Although the generous *universalist* policies in general and laws and programs in particular significantly important to adapt the healthcare system to need of people with diverse cultural and linguistic backgrounds thereby empowering this group, studies show the continued persistence of health inequalities even in the highly developed 'welfare states' like Norway, between citizens with a higher and a lower socioeconomic position (Mackenbach, 2012).

2.3. Various approaches to and perspectives on disease and illness

Disease and illness have various components and their perception and experience differs across cultures, societies and among various theoretical perspectives. That is, what is perceived as illness or abnormality in one culture or place does not need to be classified as such elsewhere. Yet, the biomedical discourse perception and explanation of disease differs from the social constructionist view of disease or illness (Blaxter, 2004; Eriksen & Sajjad, 2015; Healy, 2014). This in turn has huge impact and implication for patients with immigrant background who normally come from different cultural and linguistic backgrounds, and possibly have different perception and experience of illness than the western biomedical explanation. Below, I will present a brief summary of different theoretical perspectives on disease and illness, with particular emphasis on the biomedical discourse and the social constructionist view and their implication for cross-cultural provision of healthcare.

2.3.1. The biomedical discourse

The biomedical model is the most dominant discourse in shaping practice contexts in healthcare institutions in the western world. As such, it plays a dominant role, in the Norwegian healthcare system in defining what is perceived as disease or illness and the treatment there to, who is considered as expert (Blaxter, 2004; Eriksen & Sajjad, 2015; Healy, 2014). This discourse shapes practice contexts in Norwegian healthcare systems, including

health services at hospitals, rehabilitation and mental health services (Eriksen & Sajjad, 2015). As such, central values of healthcare in Norway including perception of disease, diagnosis and treatment models and who is expert, is based on this discourse (Eriksen & Sajjad, 2015). Although very limited, there are also other medical treatment traditions than biomedicine in Norway. Medical systems other than western or biomedicine, also called non-scientific medicine, is alternative medicine or complementary medicine in Norwegian contexts, and includes very different forms of treatment, from homeopathy to reflexology and healing. From 1 January 2004, the so-called Kvakksalverloven was repealed and replaced by the Act on Alternative Treatment of Disease (Eriksen & Sajjad, 2015).

The biomedical model assumes and rests on four key tenants or principles.

The first principle is what is called the doctrine of specific etiology. That is the idea that all disease is caused by theoretically identifiable agents such as germs, viruses, bacteria or parasites (Blaxter, 2004). As such, the model explains disease purely in terms of biological factors, and asserts that diseases are caused by specific biological agents or processes (Healy, 2014).

The second principle is the assumption of generic disease. That is, the idea that each disease has its own distinguishing features that are universal. Accordingly, disease is universal in nature regardless of culture, time and place and the assumption that medicine is a scientifically neutral enterprise (Blaxter, 2004; Conrad & Barker, 2010; Healy, 2014).

The third principle of the discourse is biological explanations of disease. i.e. illness is considered as deviation from the normal range of measurable biological variables (Blaxter, 2004). Accordingly, diseases and other malaises, such as disabilities, are deviations from normal biological functioning and diagnosis, and treatment as such focus on addressing deviations and bringing back to their normal biological functioning(Blaxter, 2004; Healy, 2014). In doing so, the model undermines other factors like psychological, environmental, cultural and social influences.

The fourth postulates of the discourse is the principle of scientific neutrality of medicine. The biomedical discourse assumes neutrality of medicine, and asserts that reliable knowledge is the evidence obtained by scientific means and one which is unbiased by the prejudices of the scientists and medical practitioners(Blaxter, 2004; Healy, 2014). In biomedical model expertise is associated with knowledge of the biological basis of health and illness and, this in turn confers power on the biomedical experts, particularly medical scientists and practitioners, for defining and leading intervention efforts (Healy, 2014). Although the objective nature of evidence obtained by scientific means cannot be disputed, at least in cases of somatic

diseases where objective evidence can be found through for example blood or urine tests, but it is highly limited in cases like experience and expression of pain or mental health issues where the experience, perception and diagnosis of patients problem is highly subjective and different from culture to culture (Eriksen & Sajjad, 2015).

Despite its significant contribution to the understanding, assessment, diagnosis and treatment intervention of many diseases, the biomedical model has also limitations which is significant in cross –cultural provision of healthcare. In purely focusing on biological explanation of disease, the biomedical discourse fails to take a comprehensive and systemic approaches including cultural and social aspects of disease and illness (Blaxter, 2004; Conrad & Barker, 2010; Healy, 2014). For instance, the discourse tends to undermine cultural values that affect people's understanding and experience of a given disease, as has been asserted by the social constructionist approach. Peoples experiences and explanations of illness are also descriptions of the world as it is perceived and interpreted by the patient and will be affected by ones cultural and linguistic background among other thing (Blaxter, 2004; Conrad & Barker, 2010; Healy, 2014). Patients with immigrant background can have very different experiences with illness and treatment depending on gender, age, economy, religion, state of health, where and how they have lived. In Norway, they may encounter other ways of interpreting symptoms and expressing and explaining illness. Both healthcare workers and patients may also encounter specific types of diseases that may be completely unknown and difficult to integrate into biomedical explanatory models (Blaxter, 2004; Eriksen & Sajjad, 2015). For instance, there is no primary health care program that includes mental health in Somalia, and as such mental health illness are largely unknown to patients from Somalia (Rivelli, 2010). This in turn means that patients from this country may not understand or may not even have vocabularies or language to express mental health problems. Research have revealed that various cultures have different ways of expressing pain and our cultural background influences the way we express pain (Østfold & Bjørkli, 2019). That is, our cultural background provide guidelines for how we communicate our own pain experience to others. Norms, traditions and worldviews affect how each of us perceives the pain as phenomenon (Blaxter, 2004; Conrad & Barker, 2010; Østfold & Bjørkli, 2019). Thus, the western biomedicine assertion that disease is universal suffers limitations as people interpret illness differently.

Finally, although the biomedical model assumes that medicine is a scientifically neutral enterprise and based on scientific principles and rationality, the western biomedical discourse itself is conditioned by the cultural and social context in which it is developed (Blaxter, 2004;

Conrad & Barker, 2010; Eriksen & Sajjad, 2015). The justification is that a medical system does not exist in a cultural vacuum since medical knowledge is conditioned by the social context in which it is developed and especially in explaining that what qualifies as biological disease or biomedical evidence is often socially negotiated and interpreted (Conrad & Barker, 2010). Yet, practice of medicine cannot be neutral, whatever its theory, is always deeply embedded in the larger society, and there are wider social political and cultural forces dictating how it works and how patients are dealt with (Blaxter, 2004). For instance, healthcare workers are affected by the cultural background in their communication, perception and treatment of a given patient. A diagnosis says not only the identification of the nature of an illness or other problem by examination of the symptoms, but also the clinician's categorization and understanding of reality. That is what makes a difference between Norwegian and Ethiopian medical doctor for instance. Therefore, biomedical concepts and explanation of disease are also cultural constructions (Eriksen & Sajjad, 2015). Biomedicine can thus not be said to be independent of culture. It is rather characterized by various socio-cultural, political and economic conditions in which it is developed (Blaxter, 2004; Eriksen & Sajjad, 2015).

2.3.2. The social constructionist approach

Social constructionism is a conceptual framework that emphasizes the cultural and historical aspects of phenomena like disease or illness widely thought to be exclusively natural (Blaxter, 2004; Conrad & Barker, 2010). The social Construction of illness is another perspective on illness and is a major research perspective in medical sociology. It emphasis on how meanings of phenomena develop through interaction in a social context. That is how individuals and groups contribute to producing perceived social reality and knowledge (Knoblauch & Wilke, 2016). The approach has made significant contributions to our understanding of the dimensions of illness that the biomedical discourse fails to take into consideration. In contrast to the biomedical biological explanation of disease, the social construction of illness, explains how illness is shaped by social interactions, shared cultural traditions (Blaxter, 2004; Conrad & Barker, 2010). In doing so, the model brought shift in frameworks of knowledge, and relations of power.

The social constructionist approach to illness is based on three key findings; the cultural meaning of illness, the illness experience as socially constructed, and medical knowledge as socially constructed (Blaxter, 2004; Conrad & Barker, 2010).

First, some illnesses are particularly embedded with cultural meaning—which is not directly derived from the nature of the condition—that shapes how society responds to those afflicted and influences the experience of that illness. According to the social constructionist approach, illnesses have both a biological and an experiential dimensions (Blaxter, 2004; Conrad & Barker, 2010). Hence, one of the key tenants of the social constructionist perspective is cultural meanings of illness. According to this approach, some illnesses have cultural meanings that are not reducible to biology, and these cultural meanings further burden the patient. Moreover, cultural meanings have an impact on the way the illness is experienced, how the illness is depicted, and the social response to the illness among other things (Blaxter, 2004; Conrad & Barker, 2010).

Besides, cultural dimensions, another key insight of social constructionist approach is the subjective experience of illness. Building on this tradition, Conrad (1987) elaborates the approach stating:

> *"[A] sociology of illness experience must consider people's everyday lives living with and in spite of illness. It needs to be based on systematically collected and analysed data from a sufficient number and variety of people with an illness. Such a perspective necessarily focuses on the meaning of illness, the social organization of the sufferer's world, and strategies used in adaptation." (Conrad, 1987, pp. 4–5)*

As such, it is important to note that illnesses are socially constructed at the experiential level, based on how individuals come to understand and live with their illness. In terms of constructing the illness experience, culture and individual personality both play a significant role. A social constructionist approach to illness is rooted in conceptual distinction between disease (the biological condition) and illness (the social meaning of the condition) (Blaxter, 2004; Conrad & Barker, 2010).In contrast to the biomedical model, which asserts that diseases are universal and invariant to time or place, social constructionists emphasize how the meaning and experience of illness is shaped by cultural and social systems. According to the social constructionist approach, although there are bio-physiological bodily conditions not all illness are disease and vice versa, and what is labelled a disease or qualifies as biological is often socially negotiated (Blaxter, 2004). Hence, the social constructionist approach differs from the biomedical discourse in that medical knowledge about illness and disease is not necessarily given by nature but is constructed and developed by claims-makers and interested parties (Conrad & Barker, 2010).

Taken together one can understand from the aforementioned perspectives that disease and illness must be seen as relative concepts and in connection with the socio-cultural, religious, political and economic contexts in which they happen. Provision of culturally competent healthcare to patients with limited Norwegian language proficiency demands a comprehensive approach taking into various dimensions and components of disease. For instance, medical professionals need to have cultural competency to realize the impact of cultural meanings d dimensions embedded in illness.

2.4. Communication theories

2.4.1. Communication Accommodation Theory

Communication Accommodation Theory, hereinafter referred to as CAT, states that in intercultural communication, people have to often make a choice about which language to use and how much to accommodate each other and therefore adjust (or accommodate) their style of speech and behaviour to one another. Accordingly, in cross-cultural communication settings, people use language in different ways to achieve different goals, like gaining approval from the other partner, increasing efficiency in communication between both parties, and helping the sender maintain a positive social identity (Dragojevic et al., 2015; Gallois et al., 1995; Giles, 2016)

The basis of the theory lies in the idea that each of us often accommodates verbally and nonverbally to others, and is aware of others accommodating to us or not, on multiple levels of communication. Adjustment of speech or manner of communication are common in different settings, including communication in healthcare settings. Experts even argue that there are no occasions in which we do not adjust our language style to take into account what we believe to be the perspective of the person with whom we are interacting (Gallois et al., 1995). In doing so, a Norwegian health professional may use a standard Norwegian accent and manner of speech while talking with a fellow Norwegian, whereas she may opt to use simpler version of the language or a dialect while communicating with a patient with immigrant background with low-language proficiency. Accordingly, the main tenets of CAT is the style of speech or behavioural changes that people make to adjust their communication to the person with whom they are interacting and, the extent to which people perceive their partner are adjusting their communication to them (Gallois et al., 1995)

According to CAT, there are many kinds of accommodative acts, with various reasons for accommodating, and the resulting consequences arising from accommodation. In this regard,

the theory introduce two acts of accommodation, named convergence and divergence as its core concepts of accommodation. Accordingly, communicator may accommodate each other through convergence and divergence. Convergence is a strategy through which individuals adapt their communicative behaviours on one or a number of linguistic, paralinguistic, and nonverbal features with the intention to reduce social differences and become more similar to the other party in the communication. Thus, motives for converging vary widely and includes the desire to improve the effectiveness of communication and the desire to gain approval from ones interlocutor (Gallois et al., 1995; Giles, 2016). In medical communication settings, health professionals adjusting their communication –for example using simpler medical terminologies that the language interpreter or the patient can understand lower uncertainty, interpersonal anxiety, and heightened mutual understanding. In doing so, convergence is significantly important in mitigating, if not alleviating, the challenges of language barriers in cross-cultural provision of healthcare to people who is low-proficient in the Norwegian language.

An individual can converge his communication behaviour through different ways like using linguistic, paralinguistic, and nonverbal features and characteristics found within language groups, like pronunciation; speech rate, and message content, languages and dialects, pauses, utterance length, phonological variants, smiling, and gaze. In addition to English language, studies have depicted convergence on temporal, phonological, or language switching dimensions in many different languages, including Dutch, Hebrew, Mandarin, Japanese, and Cantonese among others (Gallois et al., 1995; Giles, 2016).

Divergence refers to the way in which speakers accentuate the speech and non-verbal differences between themselves and their interlocutors with the intention to emphasize distinctiveness from one's interlocutor, usually based on group membership. A phenomenon similar to divergence is maintenance, the speaker continues in his or her original speech style, in spite of the convergence or divergence of the interlocutor. Maintenance is often evaluated in the same way as divergence (Giles, 2016)

Accommodation is not a one-way process, rather it is multifaceted. According to CAT, accommodation can be symmetrical or asymmetrical (Gallois et al., 1995). Note that convergence and divergence are complementary concepts, they can both occur in a communication episode and in different ways for each interactant. According to CAT, convergence and divergence can take place to varying direction, degree and mutuality of accommodation. For instance, in a given conversation, one partner to the communication can converge, diverge, or maintain, although not necessarily to the same extent as the other

partner. When accommodation is approximately equal for both partners, it is said to be symmetrical. At other times one partner may converge or diverge to the greater or lesser extent, or fail to react (i.e., maintain), or behave in a contrasting manner. This is called asymmetrical accommodation. CAT also identifies objective, Subjective, and Psychological accommodation. Objective accommodation is accommodation that is, actual communicative behaviour, as assessed through direct observation of linguistic exchanges in an interaction. As such, it is accommodation at behavioural level. Psychological accommodation is accommodation related to an examination of the intentions of speakers, whereas subjective accommodation is accommodation related to the perceptions of listeners. Subjective accommodation refers to the listener's interpretation of the speaker's act. Like psychological accommodation, subjective accommodation does not necessarily correspond with objective behaviour (Gallois et al., 1995; Giles, 2016). For example, a Norwegian doctor may decide to adopt Arabic accent in order to accommodate an Arabic speaking patient. However, the Arabic language speaker may not be familiar enough with Norwegian language to notice that the Norwegian health professional has altered his or her language or may not recognize the change as a shift to Arabic accent. In addition, even if the patient perceive the Norwegian health professional change in behaviour, the Arabic speaking patient's interpretation may not be consistent with the Norwegian health care professional speaker's intention. For instance, the Arabic speaking patient may see the change of communication manner or accent by the Norwegian health professional as disrespect or a rude joke, as mimicry of his or her imperfect Norwegian.

Finally, the theory outlines factors that influence convergence or divergence namely stereotypes about outgroup members and norms for intergroup interactions and situationally acceptable behaviour. In cross-cultural communication, speakers and listeners have beliefs and expectations that act as guidelines for what is appropriate and acceptable accommodation behaviour. Two of such guidelines are stereotypes regarding outgroup members (and their level of communicative competence) and beliefs about the appropriate norms regarding language use.(Gallois et al., 1995; Giles, 2016)

CAT, thus, provides a useful framework for examining the dynamics of patient-practitioner communication, especially where challenges of language barriers exist. In language-discrepant medical communication settings, inability to achieve convergence (i.e. to appear more similar in speech) can affect how the patient and health professionals perceive not only each other, but also the quality of the healthcare and working relationship between them (Meuter et al., 2015).

2.4.2. Theoretical approaches considering semantic barriers

As mentioned earlier, language barriers in cross-cultural communication can be encountered under various circumstances. One of the conditions under which language barriers arise in intercultural communication is as related cross-language semantic differences. As such, understanding challenges of language barriers in cross-cultural provision of healthcare presuppose perception of conditions under which language barriers arise in cross-cultural communication by looking at cross-language semantic differences (Segalowitz & Kehayia, 2011). Semantic barriers can simply be defined as misunderstanding between communicators due to the different meanings of words, and other symbols used in the communication (Lunenburg, 2010). Studies have revealed cross-language similarities and differences in how words and their translation 'equivalents' are used. Accordingly, there are differences among languages, not only with regard to how different words and descriptors are used but also how two seemingly similar words may mean entirely different things in different languages (Eriksen & Sajjad, 2015). It is very important to get cognizance of semantic differences in interpreter mediated healthcare encounters, because healthcare communication language is used to represent other highly subjective experiences relevant to health. Thus, literal translations of one word or concept in one language to the other may lead to erroneous conclusion and risk to patients safety and wellbeing.

There are various approaches and techniques to analyse potential cross-language semantic barriers or semantic mismatches between sender and receiver of communication, including linguistic approaches using lexico-grammatical functional analysis, cognitive semantics, natural semantic meta-language (NMS), and psycholinguistic approaches using factor analysis, multidimensional scaling, and other cognitive psychological techniques (Segalowitz & Kehayia, 2011). Below, I will present two examples illustrating cross-language semantic barriers.

First, the meaning of a particular word or concept depends on its use in the respective language. Hence, people with different backgrounds may have different understandings of similar words. In this regard, the literal translation of a word can result in a very different meaning in the translated language than in the originally intended message. That is, there is difference in the meaning of the words and phrase even if it is understood both by the patient and healthcare professional (Eriksen & Sajjad, 2015).

Secondly, words or concepts have cultural scripts, and understanding their correct meaning presuppose understanding of the cultural context in which the concerned language is spoken. In this regard, Wierzbicka (2008) has argued that cultures can be characterized by different

linguistic scripts underlying the meanings of certain concepts that are said to be key to understanding aspects of the culture. She points out that certain words and concepts have meanings that are rather unique to the speakers of the language community (Segalowitz & Kehayia, 2011). For instance, patients with immigrant background may understand `lett mat` differently than the correct meaning of the words in the context of Norwegian food culture (Eriksen & Sajjad, 2015).The other useful example in this regard is pain and its expression. Pain is a profoundly private experience, and has a social dimension and, therefore, is subject to cultural variation in its expression and all of these considerations are reflected in the way a given patient express pain (Segalowitz & Kehayia, 2011). Research show that various cultures have different ways of expressing pain and our cultural background influences the way we express pain. That is, our cultural background provide guidelines for how we communicate our own pain experience to others. Norms, traditions and worldviews affect how each of us perceives the pain as phenomenon (Østfold & Bjørkli, 2019). In doing so, there are cross-language differences in how pain is represented at the conceptual and semantic levels and communicated through language. This in turn create a language barrier and has implication for cross-cultural healthcare in that health professionals may to miss the deeper meaning of patients' messages about pain even in interpreter mediated medical encounters (Segalowitz & Kehayia, 2011).

The aforementioned cross-language semantic differences and barriers may even be greater among languages that do not belong to the same language family. As for example between Norwegian and Arabic or Afan Oromo. In intercultural communication involving these languages, direct or literal translation of words and sentences by the interpreter may lead to erroneous perception. As a result, in cross-cultural communication, interpreters cannot simply resort to exact translations to convey the same nuanced meanings since such differences have implication for cross-cultural healthcare, as health professionals may not be able to handle all the subtleties of meaning to which a patient would be sensitive. This results in miscommunication with possibly serious consequences to patients' safety.

2.4.3. Theoretical approaches considering the conversational dynamics of patient-doctor interactions

The other theoretical approach to communication problem due to language barriers in healthcare settings is the ones that considers the conversational dynamics of patient-doctor interactions. These theoretical approaches focus on the power relation differences between healthcare professionals and patients, and how language-use both reflects these relationships and serves as a tool for manipulating them (Maynard & Heritage, 2005). Techniques to analyse the dynamics of conversation, including process analysis, microanalysis, and conversational analysis.

2.4.4. Non-verbal communication

As stated earlier, intercultural communication is multi-faceted and involve exchange of language, gestures and body language between healthcare worker and patient who have different cultural and linguistic backgrounds. Non-verbal communication is communication through our physical presence and behaviour, including facial expressions, posture, nonvocal cues, such as pitch and tone of voice, nonverbal cues such as nodding, and distance to other persons (Healy, 2012). Studies on communication have indicated that up to 85% of communication is conveyed through nonverbal communication (Healy, 2012). Hence, nonverbal communication is a highly influential form of communication with huge implications for cross-cultural healthcare to be provided. Yet, non-verbal expressions, like facial expressions and posture may have different meanings in different cultures and contexts. For instance, saying 'yes', or nodding head is a gesture, which conventionally in many cultures is interpreted to indicate agreement, acceptance, or acknowledgement. However, in some cultures or instances it may also connote the opposite meaning (Eriksen & Sajjad, 2015). Understanding non-verbal aspects of communication in intercultural communication as such demands competency to understand different elements of communication, both verbal and nonverbal in their cultural and social context in order to have a meaningful communication. To bridge communication challenges owing to language barriers, it is therefore important that healthcare professionals have competency to understand non-verbal communication as much as that of verbal communication. In addition, awareness of nonverbal communication is vital beginning to address the fear, distress and resistance that many patients feel towards healthcare professionals. Congruence in nonverbal communication between service provider and client is significant in building professional relationships (Healy, 2012). To this end, healthcare professionals need to be able to

understand and reflect on their nonverbal behaviour and adjust this behaviour to the communication needs of patients with limited language proficiency. One of the most well-known models of nonverbal communication for health and social work professionals is SOLER. The acronym SOLER stands for sitting squarely, leaning towards the other, eye contact and relaxed. This model is developed by Gerard Egan (2010) for counsellors and case workers, but can also be used as a framework for reviewing our nonverbal behaviour in other contexts (Healy, 2012). This in turn means, healthcare professionals can use SOLER to enhance and bridge challenges of language barrier in their communication with patients with diverse cultural and linguistic backgrounds.

With regard to Non-verbal communication, cultures or languages can be categorized into high context cultures or languages and low-context cultures or languages depending on how important the non-verbal aspects of communication, like facial expressions, gestures and context in affecting and understanding the meaning of the content, is (Eriksen & Sajjad, 2015).

In high-context languages the non-verbal or implicit aspect of the languages are significant for understanding the meaning of the content. That is, the way something is said and other non-verbal expressions are important in defining the content of what is said. In such languages, taking literal meaning of words and sentences may lead to error. For example, saying "yes" for patient with immigrant background does not necessarily mean what a Norwegian healthcare professional associate with "yes". That is, YES/NO do not mean exactly the same thing in the high and low context language. Hence, while communicating with patients with immigrant background, the correct meaning of Yes/No depends not only on the meaning of the word, but also on factors like whether the patient comes from high or low context culture, how the yes/no is messaged, the facial expression, the tonality of the voice and the body language, among other things. Whereas in low-context cultures, the patients expression of yes/no can be taken literary with little or no regard to the context. Examples of high-context languages include Arabic, Spanish, and Italian (Eriksen & Sajjad, 2015).

In contrast, low-context languages rely heavily on explicit verbal communication, and the context has little effect on the meaning of the content of what is being said. That is, the message lies in the wording of the language, not in the non-verbal context. In such languages,

one can safely take literal meanings of words or sentences. Scandinavian languages fall under this category (Eriksen & Sajjad, 2015).

2.5. Theories in relation to access to healthcare, patient participation and patient centredness

2.5.1. Cultural capital theory

Cultural capital theory is developed by Pierre Bourdieu, and explains how power in society is transferred and social classes maintained. According to the theory, cultural capital form the foundation of social life and dictates one's position within the social order. Differing from the class theory of Karl Marx, according to which economic capital dictated ones position in a society, Bourdieu believed that cultural capital play a significant role in defining ones position and status in a given society. However, for both Marx and Bourdieu the more capital one has, either economic or cultural, the more powerful the person is (Bourdieu et al., 1995). The theory define cultural capital as 'familiarity with the legitimate culture within a society'; called According to Bourdieu's these cultural capital includes symbolic elements such as skills, tastes, posture, clothing, mannerisms, material belongings and credentials that one acquires through being part of a particular social class. Sharing similar forms of cultural capital with others, for instance the same taste in movies, creates a sense of collective identity and group position. Bourdieu grouped these cultural capitals into three distinct categories: embodied, objectified and institutionalised capital. Embodied cultural capital comprises the knowledge that is consciously acquired and passively inherited, by socialization to culture and tradition of a given society. This includes, for instance, language, mannerisms and preferences that a person acquire from the national culture. Objectified cultural capital, on the other hand, refers to cultural properties like cultural goods, books and works of art that can be transmitted for economic profit (Bourdieu et al., 1995).

Institutionalized cultural capital refers to an institution's formal recognition of a person's cultural capital, like education credentials or professional qualifications thereby facilitating the conversion of cultural capital into economic capital by creating opportunity in the labour market. According to the theory, these capitals are acquired over time, as it is impressed upon the person's habitus and some of these cultural capital passes down to generations. Families, for example, pass on cultural capital to their children by introducing them to dance and music, taking them to theatres, galleries and historic sites (Bourdieu et al., 1995)

The theory explains how possession of these capitals define position of a person in a society and creates opportunity. On the other hand, Bourdieu also points out that cultural capital is a major source of social inequality. Certain forms of cultural capital are valued over others, and can help or hinder one's social mobility just as much as income or wealth. Those with low overall capital are unable to access a higher volume of cultural capital because they lack the necessary means to do (Bourdieu et al., 1995). In this regard, the theory of cultural capital is also compatible with the assertion of the concept of "sense of coherence" as developed by Antonovsky. Accordingly, individuals capacity to cope with situations, maintain their health, and display a psychic resistance depends on the extent to which individuals perceived the world as comprehensible (ordered, making sense , structured, predictable, manageable with the resource available and meaningful, i.e. making emotional sense (Blaxter, 2004).
In case of target group of this research, patients with limited Norwegian language proficiency they lack cultural capitals like language and education. This in turn leads to low-socioeconomic status, low health literacy and health inequalities as revealed by multiple studies (Abebe et al., 2017; Diaz et al., 2015; Mackenbach, 2012). For instance, research has shown the continued persistence of health inequalities - even in the highly developed 'welfare states' like Norway - between citizens with a higher and a lower socioeconomic position, as indicated by education, occupation, income or wealth (Mackenbach, 2012).

2.5.2. Anti-oppressive practice

Anti-oppressive practice is multidisciplined theoretical framework, based on critical social work theories, humanistic and social justice values taking into account experiences and views of oppressed people (Healy, 2014). The theory asserts there are multiple levels, forms and sources of oppression, including personal or psychological, cultural and structural oppression. The complex nature of oppression is witnessed in the lives of people who are marginalised a society (Burke & Harrison, 1998). The personal sources of oppression is the one that emanates from the personal feelings and attitude of the service user, as well as the interpersonal relationship established between service provider and service user. Whereas the cultural sources of oppression is the one that emanates from the interest and influence of society as reflected in societal values and cultural norms we internalize via process of socialization. The systemic or structural form of oppression is the one that come from the system or structure itself (Healy, 2014). The theory places greater emphasis on recognition of the structural origins of service user's problems and seek to change structural arrangements and transform power relations in practice to deal with the problem.

Anti-oppressive theory also emphases that various forms of oppression interact with one another, and an individual may experience multiple forms of oppression. Making links between oppressions therefore will require the recognition of both commonalities and specificities across different forms and experiences of oppression. For instance, the personal and cultural base of oppression must be integrated within structural analysis of oppression and its recognition of interpersonal and statutory works as legitimate sites of anti-oppressive practice (Healy, 2014).

Anti-oppressive theory operates on certain core assumptions, like existence of multiple forms, levels and sources of oppression at various levels and contexts, and that oppression arise from unequal power across social division (Healy, 2014). For instance, a study shows that power differences are one of the key factors in affecting communication and contact between immigrants and Norwegians. In most cases of communication between immigrants and Norwegians, it is the Norwegian who has comparative power advantage (Eriksen & Sajjad, 2015). Yet, the theory urges social workers to be constantly alert to the social divisions affecting service user's life (Healy, 2014).

There are five key principles of anti-oppressive practice; i) critical reflection on self in practice, ii) critical assessment of service user's experience of oppression, iii) empowering service users, iv) working in partnership, and v) minimal intervention (Healy, 2014). One of the principles of anti-oppressive practice is maintaining an open and critical stance towards one's own practice. This in turn demands awareness of how ones culture or our membership in particular social divisions shape our practice relationships. For instance, how being health professional trained in western medicine or the biomedical discourse shape our practice with patients with non-western immigrant background. The principle of critical reflection also extend to reflection on how the language one uses in assessment is shaped by dominant ideologies that convey and sustain oppressive power relations. In this regard, it is important to be aware of the way in which language can reflect power relations and have impact on the people with whom we are working (Healy, 2014).

The other principle is critical assessment of service user's experience of oppression. That is, consideration of the social divisions affecting service user's experience of using the intended service. In addressing oppression experienced by service users, be it personal, cultural or structural oppression, the theory requires us to consider how the service users membership in a particular social division and their historical and geographical context shape their experience and the options for actions available to them. Here one might consider factors like race, gender, immigrant background, competency in language and socio-economic status

among other aspects (Healy, 2014). For instance, being a patient with immigrant background, and with low level of competency in Norwegian language, affects patient's experience of the healthcare service (Kale & Syed, 2010). Yet one might also consider how the biomedical discourse might shape various professional assessments of patients in cross-cultural provision of healthcare as mentioned earlier (Conrad & Barker, 2010). Finally, the anti-oppressive theory insists that, to tackle oppression, whether it comes from the personal, cultural or the system - it is crucial that service providers have opportunities to learn about and maximize their potential for, anti-oppressive practice (Healy, 2014). Medical professionals, as such, need to have competency to understand and respond to the complexity of the experience of oppression that can potentially be experienced by patients with limited language proficiency. Below, I will present theoretical approaches considering patient-participation and empowerment.

2.5.3. Patient-participation

Patient participation in healthcare means involvement of the patient in decision-making processes at all levels of healthcare services including assessment, diagnosis and treatment, by sharing information about their experience of their disease, feelings, signs or expressing opinions about different treatment methods and decision (Longtin et al., 2010).

In the international literature, patient participation is used interchangeably with terminologies and concepts like user-participation, empowerment, engagement, involvement, participation; collaboration and partnership. In this dissertation, I use patient participation instead of user participation because the term patient is more comprehensive in relation to the fact that this study focuses on the language barrier in cross-cultural provision of patients with limited language proficiency.

Patient-participation as a value is based on human rights like the right to self-determination, individual autonomy and equality. Patient participation brings about paradigm shifts in terms of democratization of the health care system and recognition of nonprofessional's (patients) knowledge (Longtin et al., 2010). It signalled transformation from the paternalistic model of the doctor-patient relationship, in which the clinician has dominant role in decision making in terms of choosing the necessary interventions and treatments to a more patient-centered healthcare. In the new model of patient participation, patients and clinics represent different sources and types of knowledge. That is, the patient contributes with his subjective experience whereas the clinician's contribution is the objective interpretation of the disease. As such, in

patient participation model patient's subjective experience is considered as valid knowledge in contrast to the paternalistic and expert-led decision-making model (Longtin et al., 2010). Patient-participation is also in line with an underlying principle of evidence-based medicine that all relevant and accessible information should contribute to the decision-making process (Longtin et al., 2010). Here, it is important to note that in our modern time what is conventionally used to be considered as expert and objective knowledge about healthcare is no more exclusive to health professionals and internet bring this knowledge to the public. For instance, study demonstrates that more than 80 % of Norwegian use the internet to search for information about health or for other health-related activities (Kummervold & Wynn, 2012). Patient-participation has huge significance in promoting patient-centered and culturally competent healthcare (Organization, 2013). First, it puts the patient at the centre and is given explicit decision-making authority. In doing so, it gives the patient opportunity to control and receive the healthcare on their own terms and condition by contributing their own expertise. Yet, it empowers patients since involvement in the decision making let them to be seen and respected by virtue of their basic dignity. Hence, it has implication both for patients and healthcare professionals. For the patient, it means being taken seriously and met with respect, whereas for clinicians it means recognizing that patients role and patients side of the information based on the patient's own experience of the disease.

Patient participation is a core concept and one of the central values of the Norwegian healthcare system as enshrined in the law. The Patient and User Rights Act, § 3-1, stipulates that patients have the right to participate actively in choices concerning their own health and treatment, and health professionals, on the other hand, have a duty to facilitate participation (brukerrettighetsloven, 1999).

In spite of all the aforementioned relevance, involving patient in healthcare decision-making is challenging. According to WHO factors that support or deter patients from being willing and able to participate actively in the provision of healthcare including patients demographic characteristics and health literacy, patients health conditions like severity of illness, health care professionals knowledge and attitudes, compatibility between tasks to be performed by the clinicians and clinicians abilities and health care setting (Organization, 2016). Yet, according to anti-oppressive theory, the potential for user partnership in decision making process is constrained by various factors like by power relation, the stigma of service use, vested power interest held by professionals and service provider agencies, social control roles of service agencies, agency accountabilities for third parties such as funding bodies rather than primarily to service users themselves (Healy, 2014).

The other important factor with regard to patient-participation is the patient's perception of their role and status as subordinate to clinicians. In this regard, WHO pointed out that one of the important factors with regard to patient-participation is the patient's perception of their role and status as subordinate to clinicians. For example, patients may fear being labelled as difficult or non-compliant (Organization, 2016). As mentioned earlier, the language barrier generates negative emotional and cognitive responses, and therefore participation in healthcare decision-making is especially challenging in language discrepant medical communication setting and for patient with low-language proficient as borne out by findings of researches. According to anti-oppressive practice working in partnership means service users must be included as far as possible in the decision making process which affect their lives. This in turn demands overcoming potential challenges that users may face at three different levels, individual, service and system level (Healy, 2014). However, what it takes to overcome these challenges and endure effective and meaningful patient participation? According to WHO, the starting point for engaging patients in healthcare decision making is collecting information about the patient experience and outcomes of care (Organization, 2016). Ensuring, meaningful participation in healthcare decision-making process has implication both for patient and the health professional. Hence, the patient and the doctor must understand the new patient role, the patient should have information understanding and knowledge of health information, how the information is to be used and how to make good healthcare decisions (Longtin et al., 2010). In addition, effective participation requires a facilitative environment, that is the environment must be adapted to enable and encourage patient participation. This may include ensuring access to information about treatment choices in the language and level they understand. For instance; giving patients access to their own electronic health records thereby allowing them to monitor and update their medication or treatment plans has the potential to increase treatment concordance, as well as enabling health care providers to review and intervene, if needed (Organization, 2016). Yet patients must get the support needed in making informed decision. As such, patient participation in practice requires competence from both health professionals, user representatives and users. It is about having sufficient knowledge of what user participation is, why it is important and how to exercise it. In addition to knowledge, it is necessary to have sufficient skills in facilitating participation. The attitude of professionals towards participation is also of great importance for how it is practiced.

2.5.4. Empowerment

Empowerment is a concept closely related to user participation because meaningful and effective user participation presupposes empowerment of the service user (Healy, 2014; Organization, 2013). The world health organization defined patient empowerment as "a process through which people gain greater control over decisions and actions affecting their health" (Organization, 2009). According to the guideline, patient Empowerment as a process has four fundamental components, namely; understanding by the patient of his/her role, acquisition by patients of sufficient knowledge to be able to engage with their healthcare provider, patient skills, and the presence of a facilitating environment. As such, empowering a patient requires, among other things, understanding by the patients of their role in the healthcare provision and health professionals has to inform and equip the patients with the view to enable and encourages patient participation (Organization, 2009).

As mentioned earlier patient empowerment, patient participation and patient-centeredness as a concept have been introduced as part of the trend towards creating a more participatory healthcare (Longtin et al., 2010).

Empowering patients has of huge significance in ensuring meaningful participation of patient at different levels of healthcare and therefore in the provision of culturally competent and patient centered healthcare. In doing so, empowering patients has multiple significance. Studies show that empowered patients have better health outcomes than those non-empowered patients since; empowered patients are more likely know about their health situations, proactive, to be involved with and follow through with their care plan (Jacobs & Diamond, 2017). However, empowering patients demand identification of patient's situation and barriers to empowerment. For instance, since, effective patient participation presuppose empowering the patient in a way patient can participate in disseminating relevant information about their health situation and make an informed decision, empowerment I case of patients with immigrant background who do not speak Norwegian may mean empowering the patient by providing language concordant healthcare.

In this regard, anti-oppressive theory states that service users may face various barriers at cultural, institutional or structural and personal levels, and asserts that an endeavour to empower service users so that clients are taking greater control of their lives should seek to overcome these obstacles (Healy, 2014). Empowering patients so that they participate in healthcare decision-making requires, for instance, ensuring that their views are incorporated into the assessment process, especially where the service provider and service user disagree. This is because, when patients feel heard and understood by their clinicians, they want to play

an active role in their healthcare to be provided. Yet, empowering patients with the aim of involving the patients in the decision making process and thereby providing patient-centered and culturally competent healthcare, demands partnership and effective communication between the patient and healthcare professional. According to anti-oppressive theorists, partnership with service users in turn demands genuine sharing of power and commitment to collaboration at interpersonal and institutional levels, that service providers value the individual by, for example, showing respect for their perspectives and their lives knowledge and by maximizing service users' opportunities for participation in the decisions affecting them. Accordingly, service users' opportunities for participation can be maximized through establishing mechanisms for redressing a lack of opportunity to participate and allocation of resources, such as support stuff, to ensure that service users can truly participate in decision-making (Healy, 2014).

Furthermore, effective participation depends on patients having access to reliable health information and the competence to acquire this information. Therefore, empowering patient in this sense demands developing effective measures to equip the patient with relevant health information and knowledge. As such, measures that are intended to empower and promote participation include increased knowledge and better communication and that the decisions are to a greater extent in accordance with the patient's preferences and values.

2.5.5. Cultural competency

In the today's wave of migration and the ever-increasing cultural diversity, healthcare providers face individual ethical and epistemological predicaments in providing cross-cultural healthcare and approaching patients with diverse cultural and linguistic background (Kirmayer, 2012). Provision of cross-cultural healthcare that is patient centred and culturally competent, requires culturally competent communication among other things. As such, healthcare professionals are required to possess certain professional skills in communicating with patients with diverse linguistic and cultural background such as cultural sensitivity and cultural competence. Before proceeding to the presentation of cultural competency and its significance in bridging and overcoming challenges arising out of language barrier, it is vital define concepts and terms relevant to the presentation including culture, intercultural communication and cultural competency.

Although the term culture is defined differently by different groups and experts, it refers to refers to set of attitudes, values, norms and beliefs shared by a group and which may have their foundations in a particular geographical or historical location (Healy, 2012). As such,

members of a culture can be identified by the fact that they share some similarity in terms of language, religion, geography, race or ethnicity among other things. As stated earlier, peoples understanding and experience of disease is affected by cultural values and perception (Conrad & Barker, 2010; Healy, 2012). Moreover, disease, its experience and manifestation is not only biological and universal as asserted by biomedical discourses but also cultural aspects to (Conrad & Barker, 2010; Eriksen & Sajjad, 2015). Hence, it is immensely important for healthcare professionals to understand the cultural platforms and contexts in from which a patient explains and experiences a disease, and present treatment options according to patient explanatory model, and understand patients concern about specific medication in cultural context. That is, a holistic approach that seeks to understand patients with immigrant background in their cultural and social context presuppose cultural competency.

The term cross-cultural communication may be used in reference to communication between people who have differences regarding age, nationality, ethnicity, race, gender, and sexual orientation to exchange, negotiate and mediate cultural differences by means of language, gestures and body language (Eriksen & Sajjad, 2015). For the purpose of this research, I would like to limit the scope of cross-cultural communication to communication between a Norwegian healthcare professionals and patients who come from different linguistic and cultural backgrounds.

Cultural competence as related to healthcare professional refers to an ability of a medical provider to possess the cultural awareness, knowledge, and skills to interact effectively with patients of different cultures and socio-economic backgrounds (Campinha-Bacote, 2011). It refers to combination of knowledge of other culture, right attitude towards other cultures and the skill to adapt your medical knowledge to patient's cultural values and beliefs. Hence, its requires cultural sensitivity which in turn presuppose awareness of cultural diversity, including how culture may influence patients' values, beliefs and attitudes, and involves acknowledging and respecting individual differences (Crawley et al., 2002). In order to be culturally competent caregiver and provide culturally competent communication clinicians should first be aware of one's own cultural beliefs, values, attitudes and practices. Following awareness of once own culture, clinicians should also be aware of rules of interactions within a specific cultural group, such as communication patterns and customs, division of roles in the family unit, and spirituality, and how they influences the patients behaviour and thinking. This enables healthcare professionals to get acquainted with the patient's own explanatory model or belief system - how the individual person thinks about illness and treatment (Eriksen & Sajjad, 2015).

Cultural competence and being a culturally competent caregiver is significantly important in bridging and overcoming challenges arising out of language barriers and in the provision of optimal health care for patients with diverse cultural background. First, culturally competent clinicians understand how culture may influence patients' values, beliefs and attitudes, and involves acknowledging and respecting individual differences (Crawley et al., 2002). This in turn enables him/her to understand the entrenched cultural sensitivity and the complexity involved in providing cross-cultural healthcare to clients with diverse linguistic and cultural background. Secondly, since individual healthcare preferences are influenced among other things by cultural diversity, it is of significant importance that clinicians are cognisant of cultural competence and the importance of cross cultural communication to ensuring safety and equity in the provision of healthcare (Bellamy & Gott, 2013). As mentioned earlier, one of the key tenants of the social constructionist perspective is cultural meanings of illness. According to this approach, illnesses have both biomedical and experiential dimensions. And cultural meanings have an impact on the way the illness is experienced, how the illness is depicted, and the social response to the illness among other things. As such, it requires to be cultural competent to realize the impact of cultural meanings embedded in illness (Conrad & Barker, 2010). Yet, patient –centered healthcare demands, among other things, individual healthcare preferences that are influenced by cultural diversity, and communication skills to ensure safe and equitable healthcare (Bellamy & Gott, 2013). On the other hand, lack of cultural competence can create myriads of challenges in the provision of cross-cultural healthcare. Lack of cultural competence on the part of clinicians who may not know how to communicate with persons from culturally diverse backgrounds may result in lack of cultural sensitivity. And when communication is not culturally sensitive, there is a potential for it to negatively impact the care provided, and patient and family satisfaction (Williamson & Harrison, 2010).

Chapter 3 Research methodology

In this chapter, I will outline the research methodology and design chosen for conducting the research. To this end, I will present and justify the research methodology and design as well as describe the research process such as interview guide and planning and conducting interviews, data collection methods like qualitative research method and qualitative interviews and data analysis methods like transcribing data, coding and categorizing data and respondents' demographics. Research evaluation pertaining to the research validity and reliability will also be discussed. In the end of this chapter, ethical aspects and other related facets of the research will be presented.

3.1. Research method, strategy and approach

As mentioned earlier, the aim of the research is to identify and explore challenges of language barrier in cross-cultural provision of healthcare thereby gaining a deeper understanding of the challenges, approached from the patient's, the healthcare professionals and interpreter's perspectives. Hence, analysis and findings of the research is based on empirical data collected through qualitative interviews and review of the existing literature on challenges of language barrier inherent to communication with low-language proficient patients. The empirical part of collecting relevant data for identification and analysis of challenges language barrier is conducted by using qualitative interviews of patients, healthcare professionals and language interpreters as the primary data gathering method. Thus, relevant empirical data are collected through qualitative interviews of various stakeholders in the provision of cross-cultural healthcare.

3.2. Respondents' demographics

The main target group of the research, patients with limited Norwegian language proficiency, are a diverse group who share a set of common experiences, motivations, and assumptions about challenges of language barriers in the provision of cross-cultural healthcare. Identification of challenges of language barriers in cross-cultural healthcare requires understanding the challenges from different stakeholders; patient perspective, health personnel and professional interpreter's side, in order to gain multiple perspectives and a comprehensive or holistic understanding on the subject matter. That is understanding the multifaceted and interrelated nature of challenges of language barrier in its totality. As such, I have interviewed healthcare professional, interpreters and people with immigrant background who do not speak Norwegian or English.

A total of 12 participants have participated in the qualitative interviews which include three healthcare professionals, three interpreters and six patients. As such, a larger proportion of participants were patients with immigrant background, with little or no educational background from their home country. Four of the patient informants have lived in Norway for more than five years, are married and have children. All of the participants among the patient group came to Norway either as an asylum seeker or through family reunification. Although about 2 to 3 of the informants in this group felt they could understand and communicate to some extent conversation in Norwegian, they cannot express their situation or understand the Norwegian or English language at a level that permits them to interact effectively with healthcare providers or during a medical consultation without aid of interpreters, whereas five out of six of the patient participants cannot speak, read, write properly either Norwegian or English. Four of the participants from the patient group in this very group cannot read or write their native languages.

Almost all of the in total six participants from the healthcare professionals and interpreters are either bilingual or multilingual. The majority of participants in this group have experienced the challenges of language barriers in healthcare setting in different capacities and from different perspectives.

The healthcare professional informants work in different positions, both in primary and secondary healthcare, as physicians in hospitals, general practitioners (doctor), nurse assistants, nurses and bioengineers. Two of the healthcare professionals are born outside of Norway and are bilingual /multilingual. Among the healthcare professionals who are born outside of Norway, one of them came to Norway as asylum seeker whereas the other came as skilled worker immigrant. The health professional participants who came to Norway as asylum seeker have also attended university education in Norway.

Among language interpreters whom I interviewed, all of the three participants begun their career as interpreter in the healthcare while being in Norway for under five years Two of the language interpreters have attended college education in their home country. However, all three interpreters have no health related educational background. All the three participants from language interpreters speak three or more languages.

3.3. Data Collection

3.3.1. Qualitative research method

In conducting the research, I have used a qualitative research design to develop a comprehensive understanding of challenges of language barriers in cross-cultural provision of healthcare, and depicts how language barriers are creating challenges in cross-cultural healthcare for patients with low Norwegian language proficiency and the implications thereto. The quest for answering the research main question; "What are the challenges of language barriers in the provision of cross-cultural healthcare to adult patients with immigrant background with limited Norwegian language proficiency?" demands detailed understanding of the problem from the perspectives of different stakeholders. The very explorative and subjective nature of my research question demands research methodology which is explorative and descriptive in nature. To this end, qualitative research is a beneficial methodology as it provides a flexible approach as both research questions, data collection and data analysis can continually be adjusted to new findings (Berg & Lune, 2012). Yet, qualitative method is descriptive in its nature in the sense that it offers opportunity for participants to describe the subject of the study in their own words and condition (Boeije, 2010). That is, in qualitative research methodology like qualitative interviews, participants are allowed to describe their situation and experiences as they think fit. Thus, the qualitative method is a rewarding tool to explain complex phenomenon like challenges of language barriers, in which the understanding of the research questions comes from examining the context in which the phenomenon is experienced.

As aforementioned, the attempt to get comprehensive understanding of the challenges of language barriers in cross-cultural healthcare requires approaching the subject matter from different perspectives. As such, I will conduct semi –structured qualitative interview with three key informants; healthcare professionals, professional language interpreters and patients. In addition to qualitative interviews as a primary source of collecting data, secondary sources like earlier published researches will be consulted to enrich and complement the empirical data. To this end, secondary sources like studies published on related topic, and publications of stakeholders affiliated with a Norwegian organization, like the Norwegian Centre for Minority Health Research (NAKMI), which are dedicated to producing research in order to achieve healthcare equity for immigrants in Norway and have background in researching immigrants' pattern of health care utilization in Norway will be examined.

3.3.2. Qualitative interviews

Interviews can be unstructured or free, semi or half structured, structured or standardized, depending on their content and target group (Berg & Lune, 2012). For the purpose of my research, I will use semi structured in depth interviews, which is a popular form of collecting data in qualitative research. This type of interview has the main objective of creating a more relaxing environment so that participants reflect on their experience and opinion on the subject matter (Tjora, 2017). Thus, it provides me with a useful tool to explore, the research problem. This interview type also allows participants to describe their experience in their own words and ways, while at the same time giving opportunity for the interviewer to probe far beyond the answers to their prepared standardized questions (Berg & Lune, 2012). This in turn gives me, as a researcher, a better opportunity to navigate the different perspectives and experience of the participants regarding the challenges of language barriers in different healthcare settings and contexts, thereby answering the research question. Therefore, semi or half-structured interviews have advantages of both formality and flexibility (Berg & Lune, 2012).

3.5. Research Process

3.5.1. Planning and conducting the interview

Collection of empirical data relevant for answering the research question presuppose plan and preparation for identification of data type and data collection methods among others (Blaikie, 2010). Planning and conducting a research further requires a systematic approach involving diligent planning of different components of the research like the interview guide, predefined components such as aims, population, and conduct/technique among other things (Blaikie, 2010).

To identify challenges of language barriers as happened in different language-discrepant medical communication settings and from perspectives of various stakeholders, I have conducted qualitative interview different participants comprising patients, health professionals and language interpreters. To this end, I have prepared different interview questions depending on whether the interviewee is a patient, healthcare professional or language interpreter. The interview guides are attached to the appendix.

3.5.2. The interview guide

The success and outcome of an interview largely depends on the preparation and planning the interview in advance. In this regard, a well prepared interview guide is often necessary for semi structured in depth interview (Tjora, 2017). Given the subjective, explorative and descriptive nature of the research question, I have prepared the interview guides containing questions that provoke and offers opportunity to the interviewees to describe their subjective experience and situations in the face of language barriers in medical communication settings.

In the beginning, I had written around 20 questions without any categorization. However, given the fact that I will interview different stakeholders with different experience and perspectives on the subject matter in order to gain multiple perspectives and holistic understanding on the subject matter, I found that some of the question did not fit to all the respondents. For instance, questions regarding level of proficiency (skills) in Norwegian language may not be relevant for health professional informants whereas question regarding cultural competency may not be relevant for patients. Accordingly, the interview guide is divided in to three main parts namely interview questions for patients, health professionals and for language interpreters and in a way that enable to ask relevant questions to the right respondents and produce relevant empirical data. Grouping the interview guide into different topics is important both for the interviewer and informant to keep track of the questions (Tjora, 2017). Yet, I have also used a flexible approach to the questions in the interview guide, and ask follow-up questions during the interview, as I deem necessary for the outcome of the interview, albeit not written in the interview guide. This is in turn important to avoid the chance of losing track and missing relevant data.

3.5.3. Conducting the interview

In conducting the interview, I have planned and tried to make the interview situation as relaxing as possible since the interview environment has huge impact for the outcomes (Tjora, 2017). To this end, I have left the preference as to the place and time of the interview to the interviewee and informed them that I could come at their place and time of convenience. In fact, Tjora states that conducting the interview at the place, time and convenience of the interviewee contribute to a more relaxing environment since participants feel safe and comfortable at their place of choice. This can be their home or work place (Tjora, 2017). In my case, a location convenient for the most of the participants happen to be public library in in the town, called Stormen, and therefore most of the interviews took place there. Each

interview lasted approximately 45-60 minutes on average. In addition, using semi-structured in depth interviews help me in creating a more relaxing environment as there is no fixed standard to follow or objective answer to expect. Thus, it gave the respondents opening to reflect on their experience and opinion on the subject matter while at the same time giving me opportunity to navigate the experience of the participants about challenges of language barriers in cross-cultural healthcare thereby answering the research question (Tjora, 2017). Finally, having secured both written and oral consent from the participants, I have recorded the whole interview. Recording and full transcription of the interview is recommended (Tjora, 2017). In fact, audio recoding the whole interview has many advantages as it allows the researcher to focus on the interview without having to worry about taking notes, avoid the chance of missing valuable data as everything will be recorded. Audio recording also provide a more detailed insight in the experience of the interviewee as both questions and answers are registered. Yet, it gives chance to go back to refer to data as the situation demands, since I may find some of the answer relevant on the latter process.

3.5.4. Transcribing data

Transcribing is converting the audio recording to its equivalent text format. Hence, transcribing is hugely important part of the analysis as it lays foundation for one to perform analysis (Nilssen, 2012). Transcribing audio text is a time taking process since one has to transcribe the whole interview word by word.

Having finished the interviews, I have transcribed them into text documents on the same date while I have fresh memory of the whole process. Transcribing the first interview on the same date also gave me a better insight and experience, which helped me to prepare better for the consecutive interviews. Transcribing the interview gave me also the chance to review the whole interview data and gain better insight into a more detailed aspect of the respondents experience. To this end, recorded audio helped me to transcribe every word and sentences of the participants as it gave me the chance to play and stop whenever I needed it. Yet, the recording provides me with detailed information on the experience of the interviewee as both questions and answers are registered. Yet, it gives chance to go back to refer to data as the situation demands, since I found some of the answer relevant while transcribing it.

Finally, one thing worth mentioning is that all the interviews are conducted in Norwegian, Amharic and Afan Oromo languages, all of which I speak well. Nonetheless, in the process of transcribing the audio text, I have to translate the respondents answer to English language since I am writing the dissertation in English. However, I have tried my best to use synonymous English terminologies and take into consideration linguistic equivalence, functional equivalence, cultural equivalence, and metric equivalence so that the translated English version of the interview transcript carries the same intended meaning or message that the participants languages carry, and thereby also avoiding alteration or omission of the original idea of the respondents, a phenomenon called lost in translation (Peña, 2007).

3.6. Data analysis

Qualitative data analysis involves the process of systematically searching and arranging the interview transcript, with the view to come up with findings (Nilssen, 2012). As such, it differs from data interpretation which refers to developing ideas about the research findings and relating them to the literature and to broader concerns and concepts (Nilssen, 2012). Data analysis involves, among other things coding and categorizing of empirical data collected through interview, which is presented below.

3.6.1. Coding and categorizing data

After transcribing all interviews, the next task was coding and developing domains, or general topic areas. Coding is the first step in the process of identifying and reducing a large amount of data to a few themes, dimensions or categories that capture the essence of the material (Nilssen, 2012). In the context of qualitative data a 'code' can be a word or a short phrase that represents a theme or an idea. Further coding can take various forms like open coding, axial coding and selective coding, each type with it is own strengths and shortcomings (Tjora, 2017).

Although, phrases and sentences in the transcribed interview can be coded using qualitative data analysis software such as NVivo (Nilssen, 2012), I have done the coding manually. I began to code the interview transcript using open coding technique which took its inspiration from Grounded theory. Grounded theory based analysis do not start from a defined point (for example a defined hypothesis) unlike content analysis. Rather, the primary center of focus is the collected data and allowing the data to 'speak for itself', with themes emerging in to coding and categorizing (Nilssen, 2012). Hence, the coding process started with open coding,

which refers to identifying codes, classifying and giving name to the most important patterns in the interview transcript (Nilssen, 2012). In doing so, I have read through all of the interview transcripts multiple times to identify patterns and phrases or sentences which all related to a specific topic in the transcript and assigned pattern a code by using a colour-coding system. That is, I have highlighted phrases, sentences, and lines of transcribed text. I used red colour to highlight codes that are most relevant to the research question whereas blue colour to identify patterns, which is less important data to the research question and deleted (removed) the rest of the transcript. However, I have saved copies of the interview transcript to go back and refer to the data in case I need them in the latter process.

Having done with coding the phrases, sentences and patterns in the transcribed text, I end up with many highlighted phrases and sentences, all depicting challenges of language barriers in healthcare settings and showing different aspects and sources of the challenges emanating from language barriers. This include patients difficulty in expressing their situations and understanding treatments and diagnosis, low satisfaction with the care given, challenges of assessing patients language proficiency and the need for language interpreter, limitations of relevant healthcare laws and codes of ethics, problems related to competency of interpreters and low awareness of clinicians about risks associated with language barriers, lack of competency to overcome the challenges among other things.

The next challenge is how to classify all these coded units in some categories. Here my objective is to fewer (reduce the number of) categories, patterns, topics and dimensions that can give an answer to my research problem (Nilssen, 2012). After coding the transcribed data, I proceeded to categorize the coded data through text based coding, as this approach is consistent with inductive analysis. Then I selected the coding unit and highlighted and categorized the units by their content and ended up with five categories of challenges as related to healthcare quality, process and outcome, challenges of language barriers in relation to patients, the clinicians, the interpreters and challenges of language barriers as related to limitations of the relevant healthcare laws. However, I latter reduce the five categories into four main categories and used challenges identified in relation limitations of the relevant laws under the four different categories as it fits. My overall, driving guide in the process of coding and categorising is the quest to answer my research problem while at the same time focusing primarily on the transcribed data itself. Since, I have focused primarily on the transcribed text (text based coding) not on the interview guide in refining and developing the categorization,

the categories I have come up with from interview transcript is somehow different from the main classifications and sequence of questions in the interview guide. However, since the whole interview is conducted based on the interview guide; categorization of the interview question into main parts and the flow in the interview guide helps a lot to discover patterns and categories. In this regard, categorization of the interview questions for each category of participants; i.e. interview questions for patients, health professionals and language interpreters, are important in giving insight to the coding and categorization of the empirical data. However, the final work of the categorization differs to some extent from the original categorization done in the interview guide as I end up with four main categories of challenges of language barriers namely; i) challenges of language barriers as related to healthcare quality, process and outcomes, ii) challenges of language barriers as related to the patients themselves, ii) challenges of language barriers related to healthcare professionals and iv) challenges of language barriers related to language interpreters and language interpreting. As such, the domains in the categorization differs to some degree from the original pattern of categorization of the interview questions in the interview guide.

After the categorization, I started to sense the relevancy of the transcribed text to the forthcoming discussion and to answering the research problem. The categories gave me a clearer picture of the challenges of language barriers seen from various perspectives. One thing worth noting in relation to the process of coding is that the coding of the data is subjective to the researcher`s individual perception of the whole transcribed data and patterns that exist within it. In this regard doing the research and the coding alone gave me the flexibility of doing it in my own terms and judgement of as to which unit to code and how to categorise the coded unit in to the categories with the view to make sense out of the data and answer the research question.

3.7. Key findings of the research

Though there are no universally applicable data analysis techniques that can be applied to generate findings in qualitative research, key findings can be developed from the aforementioned process including from the interview transcript, coding and categorizing through which one can identify common themes, patterns and relationships. In this regard, Tjora underlines the need to use ones intellectual and creative skills (Tjora, 2017). Thus, analytical and critical thinking skills of the researcher is extremely important in the analysis and findings of qualitative research. In fact, there could not be qualitative research that can be

repeated to generate the same results(Nilssen, 2012). In general, the key findings of the research include challenges of language barriers with regard to healthcare quality, process and outcomes like challenges in patient participation and patient centredness, patient assessment, data collection, and diagnosis. It also leads to delay of treatment, and low satisfaction among patients and healthcare professionals. In relation patients, language barriers caused patients' poor understanding of diagnosis or treatment, and difficulty in expressing their health situations, and the feeling of loss of control due to inability to participate in the care process by the patients and contributes to poorer quality of care and endangers patient safety. Challenges of language barriers in relation health professionals, as demonstrated by the empirical data include difficulty in assessing patients language proficiency level and the need for language interpreter, lack of cultural competency, low awareness of risks of language impediments and lack knowledge on how to use interpreters during interview, and challenges related to non-compliance with relevant legislations requiring the use of professionals language interpreters. The last categories of , challenges of language barrier which relates to interpreters and language interpreting include issues related to competency, neutrality and availability professionals interpreters and semantic barriers among other things.

3.8. Ethics

With regard to the ethical aspect of the research, one of the most important aspects of research process is securing informed consent of the research participants so that informants participate in the research willingly and knowing the purpose of the research (Nilssen, 2012). To this end, the participants were informed about the purpose of the research and requested to give informed consent by reading and signing on the consent form. I handed out the consent letter to be read and signed in advance and asked for their consent, not only regarding the interview, but also concerning permission to record the session. I have also made clear that they may stop the interview at any time if needed. Thus, necessary information are given and informed consent of the participants are obtained from the respondents in advance. In addition, the participants are informed orally about the fact that the research will not include patient-sensitive information, and information collected during the interview will be used for the sole purpose of this very research. Yet, private information regarding the participant will be kept confidential. In addition, respondents are informed that all the information is analysed with confidentiality with no name or any specific information that may potentially reveal the identity of the participants. In doing so, any data which can potentially reveal sensitive information or identity of the interviewee will not be revealed. In this regard, data that could

potentially be used for identifying participants or their institutions have either been deleted or recoded into broad categories, as stipulated by the Norwegian Data Protection Authority. The research project is also notified to and approved by the Norwegian Center for research data (NSD). As such, all the necessary legal and ethical requirements to conduct the research and collecting the necessary data is met.

3.9. Research evaluation

When it comes to research evaluation, one of the most important components of a research process in a qualitative research is reliability of the data, the research process and research findings (Nilssen, 2012).

3.9.1. Reliability

Reliability of a research is about the consistency, dependability and replicability of the findings of a piece of research (Nilssen, 2012). As such, reliability measures the extent to which the findings of a given research can be repeated (Nilssen, 2012). However, there could not be qualitative research that can be repeated to generate the same results since qualitative research cannot be repeated in exactly the same way, which is called dependability and the findings of the research depends on the subjective experience of the participants and the context in which the research is conducted. Therefore, the question in qualitative research is rather whether the findings of the research is consistent with the data collection process and empirical data collected from the informants (Nilssen, 2012). In this research, reliability of the findings should thus be measured in light of the collected data, and all the research process that I have aforementioned. In this regard, although it is difficult to draw a general conclusion about the findings of the research due to the limited number of participants, and variation among informants in terms of length of stay in Norway and experiences with regard to challenges of language barriers, the findings of the research is reliable in the contexts in which the research is conducted.

Chapter 4. Results and Discussion

Introduction

Medical communication comprehended by both patients and healthcare professionals is at the heart of high quality, patient centred and culturally congruent healthcare. Language barriers and thus impaired communication results in provision of poor quality healthcare, and risks to patient safety since it has negative impacts on collection of accurate and comprehensive patient-specific data that are the basis for proper diagnosis and treatment, and involving the patient in treatment planning, process, education and decision making (Direktoratet, 2011; Jacobs & Diamond, 2017; Schyve, 2007).

In this chapter, I will present the findings of the research based on the empirical data collected from participants through qualitative interviews and discuss and analyse the findings in light of theories and literature presented under chapter two. To this end, I will discuss a) challenges of language barriers in cross-cultural healthcare as related to healthcare quality, process and outcome, b) challenges of language barriers as related to patients, c) challenges of language barriers related to healthcare professionals and d) challenges of language barriers in relation to language interpreters and interpreting. At the end of the chapter, brief summary of the analysis will be presented.

4.1. Challenges of language-barriers as related to healthcare quality, process and outcomes

In the context of language barriers, healthcare quality often focuses on differences in healthcare provision between those who are proficient in the dominant language, which is Norwegian in our case, and those who are not in terms of appropriateness, continuity, patient safety, participation, patient-centredness, accessibility and patient satisfaction (Schyve, 2007). Below, I will present challenges of language barrier as related to important components of healthcare quality including a) language barrier in patient assessment, data collection, and diagnosis, b) challenge of language barriers in patient participation and patient centredness, c) delayed treatment caused by language barriers, language barriers as a cause for patients and healthcare professionals low satisfaction and d) Language barriers as impediment to access to healthcare, with brief summary at the end.

4.1.1. Challenges of language barriers with regard to healthcare quality, patient assessment, data collection, and diagnosis

World health organization define quality of care as the extent to which healthcare services provided to individuals and patient populations to improve health outcomes and in the way that is safe, effective, timely, efficient, equitable and people-centred (Organization, 2018). Empirical data collected from the informants demonstrate that one of the challenges of language impediments faced in language discrepant medical communication settings is the one in relation to patient assessment, data collection and reaching correct diagnosis. In this regard, a healthcare professional stated during the interview;

> *In interpreter-mediated medical communication, there is a good chance that the healthcare professional can miss important facts about the patient's situation and this creates uncertainty regarding the diagnosis and treatment to be given. In some instances, I am not even sure if the interpreter is getting across the message between me and the patient because the translation is taking place in the patients native language which I have no clue about. Sometimes I have to order extra investigation like CT-scan or X-ray to get more and reliable information about the patient situation. However, the risk of miscommunication is always there.*

This informant underlines that, in a medical communication involving patients with limited language proficiency there is often potentials for miscommunication between patients and health professionals due to various factors including competency of language interpreters to correctly translate the message. What makes the matter more complicated, according to this clinician, is the fact that there are very limited control mechanism at the disposal of medical professionals to verify the accuracy of the information exchanged since the latter do not normally speak patient's native languages. Here it is important to note that it is the patient safety and life which is at stake, and what seems so be a minor error or misunderstanding can potentially be life threatening and risky to patient safety.

Another medical professional interviewee said;

> *Sometimes, I see uncertainty on the face of the patient. There are occasions where I repeated the message multiple times to just make sure that the patient is getting the right information. There are also occasions where the patient keep on asking the same question again and again while I am giving the same answer repeatedly. In such situation I am really doubtful if the patient is getting the right answer to his/her questions.*

This medical professionals also mentioned her experience with interpreter mediated communications which create doubt as to whether the patient is understanding what the clinician is saying. One thing worth notice in such situation is that, the risk of miscommunication in such communication settings are goes both ways. Just as patient can get

wrong information, health professionals may also miscommunicated owing to various factors including cultural differences, or factors related to language interpreters, patient or health professionals themselves thereby leading to errors, poor healthcare quality, and risks to patient safety.

In this regard, studies show that absence of shared language between patients and health professionals make collection of accurate patient data difficult thereby contributing to medical professionals' incomplete understanding of patients' situations, poor patient assessment, increasing the potential risks for malpractice and misdiagnosis and incomplete prescribed treatment (De Moissac & Bowen, 2019; Jacobs & Diamond, 2017). For instance, a study conducted in Norway indicated that, health professionals have trouble understanding between 36% and 43% of the patients who do not speak the local language (Kale & Syed, 2010).

All of the aforementioned data and studies show that language barriers have unfavourable impact on data patient collection, assessment, diagnosis and thus affects the delivery of high quality, patient-centred and culturally congruent healthcare. Although less is known as to how many patients from cultural and linguistic minority groups in Norway experienced harm in hospital due to language barriers, it has been demonstrated language barriers between healthcare workers and patients contribute to poorer quality of care and patient safety (Lee, 2013).

4.1.2. Language barrier as a cause for poor patient participation and patient centredness in the healthcare process and outcomes

Poor patient participation in the healthcare process were described both by patients and clinicians participants in the interview. In response to the interview question on how absence of common language between patients and healthcare providers affect healthcare quality, process and outcomes in cross-cultural healthcare settings, a health professional interviewee said;

> *When I communicate with a patient with low Norwegian language proficiency through interpreter, it is difficult to establish a common platform and involve the patient in patient assessment, and decision as relevant examinations, and prescribed treatment. The fact of communicating with the patient through third party, the interpreter has blocking effect by itself.*

According to this informant, inability to directly communicate with the patient by itself has a blocking effect in participating the patient in the process and outcome of the care. As presented under the theoretical framework, patient participation aims at making the focal point and thus giving patients explicit decision making. Therefore, in medical communication

through language interpreter, it is important that both patients and clinicians should be conscious not to focus their attention on the interpreter rather than each other. As mentioned in statement quoted above, the fact of communicating with a patient through third part, the interpreter, makes it challenging to establish direct contact between the parties to the communication. Unless care is taken, this may leads to the loss of important components of communication, including body language. In the most extreme of cases, the healthcare provider may even miss important facts about the diagnosis, such as constant lip-licking or facial expression of pain by the patient. Moreover, unless care is taken, interpreter mediated medical communications may lead to the loss of an opportunity of the healthcare provider and the patient to connect on a level beyond the spoken words, where nonverbal communications like smiles and warm gestures which in turn helps to establish trust between the two (Wolz, 2015)

In describing the challenge of taking part in the healthcare process in the face of language barriers, a patient stated during the interview that;

> *I do not feel part of the process and I am rather on the receiving end. I do not dare to ask what the diagnosis means, why the treatment is ordered and if there is any alternative treatments. I am reserved and do not want to burden the clinicians with my poor Norwegian language. Even, the fact of talking to the clinicians through third party, or though interpreters, I feel disconnected and that feeling has a negative influence on describing my situation and asking questions about the healthcare services and treatment prescribed.*

According to this patient language barriers has inhibiting effect to meaningfully participate in the healthcare process and outcome by hindering patients both not to reveal important information about their health situations and also not to ask questions about the process and prescribed treatments. Thus, language problem alienated the patient from the care process. This may in turn lead to omission by the patients of important facts that is significant for the healthcare. A study conducted in Norway indicated that 37% of healthcare professionals felt that patients hide some information because of language barriers (Kale & Syed, 2010). That is, language barriers is causing patients not to disseminate relevant information that is important for quality and outcome of healthcare. A study also demonstrates that patient perception of patient-centredness is higher among patient receiving language-concordant care. Whereas, patient receiving language discordant care report worse interpersonal care and give lower ratings to their provider (Jacobs & Diamond, 2017). Yet, challenges of involving patients with limited language proficiency in healthcare process and outcomes, as mentioned by the informants, are also consistent with findings of multiple studies revealing that language

problems pose challenges with regard to involving patients with limited language proficiency in decision making since patient preference for treatment can be difficult to assess in the presence of language barriers (Williamson & Harrison, 2010). Therefore, language barriers makes it challenging to involve patients with limited Norwegian language proficiency in healthcare processes like treatment planning; eliciting informed consent; providing explanations, instructions, and education to the patient as to assessment and important healthcare decisions. Thus, in face of language barriers it is challenging to provide patient centred healthcare that is respectful and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.

4.1.3. Delayed treatment caused by language barriers

One of the most important aspects of quality of healthcare is provision of the treatment on time when the patient needed the care (Organization, 2018). In this regard, the empirical data collected from the participants show that one of the challenges related to the healthcare quality emanating from language barriers is the one related to delay of treatment. A healthcare worker informant mentioned, in this regard, that;

> *In some instances, I am not even sure if the interpreter is getting across the message between me and the patient because the translation is taking place in the patients native language which I have no clue about. Sometimes I have to order extra investigation like CT-scan or X-ray to get more and reliable information about the patient situation.*

This means, language barriers may cause delay in care or treatment in various ways like by creating uncertainty between patients and health professionals. The informant mentioned that absence of shared language between patients and clinicians, creates, at least sometimes, doubt as to accuracy of the health information exchanged between the parties thereby making clinicians to order extra-investigation to get a more accurate and reliable information as to the patients' health situation. That is, due to uncertainties and challenges in understanding patients due to language barriers, health professionals are more likely to order extra tests, or ask for consultant opinions to avoid malpractice. These extra-investigation, which would have not been necessary had the patient and clinician have common language, in turn prolong the assessment process and the time when the patient receive the intended care thereby resulting in delayed treatment.

A patient interviewees stated during the interview that;

> *Once, I tried to talk to my doctor without the aid of professional interpreters. However, the conversation is difficult to comprehend and I have to repeat words and struggled to find the correct terms. However, we could not understand each other properly and the appointment is postponed to take place in the presence of language interpreter.*

Accordingly, patient's inability to directly communicate with his physician due to his limited language proficiency resulted in postponement of the consultation and thus delay of the intended care.

The collected data also revealed that delay in healthcare may also be caused by unavailability of interpreter and related problems. One participant explained during the interview that;

> *I waited for several hours for an interpreter, on multiple occasion and even at times when language interpreters show up, I still have problems to use interpreters communicate with health professionals due to the gender of the interpreter or because the interpreter is someone she already knows.*

This means, for patients who do not speak Norwegian directly with their clinicians, delays in treatment might be caused either due to inability to provide the language interpretation service on timely fashion due to distance/travelling time between interpreters' place of residence and healthcare institutions. Yet, even when the language interpreter is present on time, delay in care may still be caused due patients to religious beliefs about the gender of the interpreter or issues related to confidentiality as mentioned by the language interpreter participants.

4.1.4. Low satisfaction among patients and healthcare professionals

Patient satisfaction is a core component and indicator of quality care (Organization, 2018). The empirical data collected from patient and health professional participants demonstrate that language barriers have also adverse impact on aspects of healthcare quality and outcomes related to patients and clinicians' satisfaction with care given. According to data collected from informants, the main reasons for low patient satisfaction include delay in treatment caused by uncertainties related to language barriers, patients inability to directly communicate with their physician, feeling of loss of control over their own health situation, feeling of not being part of the healthcare process, patients' low health literacy, limitation in understanding the healthcare process and diagnosis, and low confidence on the competency of interpreters, all of which related to language impediments. For instance, a patient informant stated;

> *I am not even sure if the healthcare professional understood my situation and if the prescribed treatment is can improve my health situation because I use to take much more medications in my home country which my doctor never ordered for me here.*

Accordingly, this informant felt not to be understood by his physician, and he is doubtful as to the prescribed treatment and thus not satisfied with the care. In this regard, his inability to directly communicate with his physicians and explain his doubt or ask for justification due to language problem left him with questions and doubt about the care given.

Another informant said;

> *Speaking in my native language to healthcare worker who understand the language is important in so many ways. When I speak in my own native language with my physicians, I explain my situation without thinking about language barrier. I am not use to speak to my physician or somebody else through interpreter. This is nothing to do with the problems with the interpreters but I just do not used to it. It is something new for me. When I talk to healthcare workers though interpreters, I feel disconnected. I sometimes doubt if the interpreter is telling the healthcare professional all what I am saying and also whether the healthcare professional is understanding my situation and what I am experiencing.*

For this patient inability to communicate with his native language with his health professionals is by itself is problematic and he feels alienated from the healthcare process and outcomes. Beside, all of the patient interviewees reported that they had difficulty communicating directly with medical professionals and therefore experienced decreased satisfaction with their healthcare. In fact, patients receiving language concordant care are less likely to have questions about their care than those receiving language discordant care. In doing so, language barriers between patients and clinicians leads among other things to; decreased patient satisfaction with care since patients with limited language proficiency are more likely to have to have question about their care as they do not receive or understand much information about their diagnosis and treatment plan (Jacobs & Diamond, 2017). In this regard, studies show that patients who do not speak the local language will have less satisfaction with their healthcare and therefore language barriers is impediment to the delivery of high quality healthcare and positively associated with lower satisfaction among medical providers (Fiabane et al., 2012). When it comes to medical professionals, all of the medical professionals interviewee mentioned, directly or indirectly, low satisfaction with the quality of healthcare owing to various reasons, like limitations in understanding patient needs, feeling satisfaction, and trust in competency of language interpreters, inability to participate the patient effectively in the healthcare process and decisions thereto, lack of cultural competency and training among others. In describing his concern about competency of interpreters a health professional explained;

Let for example say we are talking about pregnancy complication like preeclampsia. If the interpreter do not know anything about pregnancy complication or preeclampsia, how do I, some healthcare professional, know that he is translating correctly to the patient's native language. For example, the interpreter is a man that came from a culture where man is not involved in breastfeeding or pregnancy issues how can you be sure that he is interpreting what you are saying correctly.

Another clinician mentioned that in medical communication involving patients with limited Norwegian proficiency there is always risk for miscommunication and that he often doubt if he had missed important information about patients health situation that could have changed the whole outcome. Therefore, absence of shared language between patients and medical professionals are associated with poor communication, patient involvement in the care given and thus decreased satisfaction among patients and healthcare workers. And when medical communication is not culturally sensitive, it potential impact the care provided, and patient and family satisfaction negatively (Williamson & Harrison, 2010; Wolz, 2015).

4.1.5. Language barriers as impediment to access to healthcare

The empirical data collected through the qualitative interviews, show language barriers are also impediments to access healthcare. According to these data, low language proficient patients access to healthcare service affected by various factors associated with absence of shared language between patients and clinicians. For example, patients with limited language proficiency may experience longer waiting time to see their physicians due to either unavailability of interpreters or inability to get the language service on time. In addition, low health literacy rate and length of stay in Norway all of which is associated with patients language proficiency are also mentioned by the participants. In describing challenges of accessing the healthcare service, an informant said;

Often times I have to wait long time until the language interpreter come, and there are occasions when her appointment is cancelled due to unavailability of interpreters.

Accordingly, this patient's inability to communicate directly with health professionals, and thus reliance on language interpreters limited the accessibility of the healthcare since it can, sometimes, be difficult to get language translation service on time. Other factors like length of stay in Norway is also associated with patients language proficiency since it is normally assumed that the longer a patient stay in Norway, the better her or his language proficiency be and thus decreasing reliance on language interpreters. Another participant said,

The only situation I visit my private doctor is when I am sick.

This means, at some of patients with limited Norwegian language proficiency do not consult health professionals about preventive treatment or make any check-ups to follow their health status due to language problem. Moreover, some of patient informants said language barriers limits their understanding of any other written health materials since it is often in English or Norwegian, both of which language they do not speak. In this regard, one can find brochures with health information written in various languages in different health institutions. Although these health information are in their native languages, it is of no help for these patients subgroup since they are uneducated and do not read or write even in their native language. Therefore, unaddressed problems of language barriers can lead to reduced access to health services and thus reduced quality of healthcare since accessibility is an important aspect of high quality healthcare (Jacobs & Diamond, 2017; Lee, 2013). Language barrier, as such leads to different patterns of health care utilization and thus health disparities between linguistic minorities and native local population, Norwegians in our case as demonstrated by both Norwegian and international studies (Flores et al., 2012; Lee, 2013; Mackenbach, 2012; Sandvik et al., 2012; Straiton et al., 2014; Syed et al., 2006). For instance, studies by Esperanza Diaz and Hogne Sandvik demonstrated that people with immigrant background utilize both their general practitioner and emergency primary health care services less than native Norwegians, and language barrier is mentioned as one factor (Diaz et al., 2015). Yet, studies revealed that patients who do not speak the local language are disadvantaged in terms of access to healthcare services (Lee, 2013; Sandvik et al., 2012). However, it is worth noting that there are also other cofounding factors to language barriers that hinders patients with limited language proficiency access to healthcare. Besides, the degree of the challenges resulted from language barriers in accessing healthcare varied among immigrants depending, among other things on the immigrant's country of origin and reasons for migration (Diaz et al., 2015).

All the aforementioned empirical data and studies show that language barriers pose challenges on the healthcare quality, process and outcomes in various ways like making the collection of patient specific data and assessment difficult, and potentially leading to misdiagnosis. It also influences the quality of healthcare process and outcomes by hampering patients' access to and participation in the healthcare, delaying the timely provision of the care, and thus leading to low satisfaction among patients and health professionals.

4.2. Challenges of language-barriers as related to patients

As aforementioned, language barriers coupled with other cofactors like low socio-economic status indicated in terms of lack of education and low health literacy leads to myriads of challenges for patients with limited Norwegian proficiency. Empirical data collected from informants show that, in relation to patients, challenges inherent to communication in language-discrepant healthcare setting include a) poor understanding of diagnosis or treatment, b) difficulty in expressing one's health situation, c) the resulting feeling of loss of control due to inability to participate in the care process and d) challenges of limited language proficiency as related to patients` low- socioeconomic status and cultural capital**.** Below, I will discuss these challenges.

4.2.1. Poor understanding of diagnosis or treatment caused by language barriers

Data collected from participants reveal, patients with limited language proficiency have difficulty in understanding the diagnosis or treatment even in interpreter – mediated health encounters. One interviewee stated during the interview;

> *Often times, I do not understand what my health problem is. This is the case even if the interpreter is telling me the diagnosis in my own language. For instance, I do not know what it means to have pregnancy complications. I mean, I need more than telling me the name of the disease, in the way and level I understand. Here, health information translated by the interpreter is my only source of health information because I cannot read myself about my diagnosis and learn from other sources. In addition, when the doctor asks me whether I understand, I usually say yes even if I did not properly understand because I am embarrassed to admit that I do not. That is actually my problem not theirs.*

This patient demonstrates well what it means, and how it feels to be, a patient in the language discrepant medical communication settings. She has difficulty in understanding the information exchanged due to language problem. Besides, she is afraid of asking questions and rather confirms whatever the clinician said. This, I turn can be dangerous since clinicians normally assume that patients understood when they give confirmation to that effect.
Her answer also indicate that the challenge of language barriers in the provision iof healthcare to this patient groups should be seen in conjunction with, and context of, other socioeconomic and cultural capital elements, like education or health literacy, as stated by the theory of cultural capital (Bourdieu et al., 1995). She states that, the problem even goes beyond knowing the name of her diagnosis in her native language. That is, even in interpreter – mediated health encounters she has difficulty in understanding her diagnoses. Poor

understanding of diagnosis and prescribed treatment in turn also leads to patient confusion, resulting in failure to follow treatment instructions. Another informant stated;

> *I only understand what the healthcare professional is saying and the whole process through language interpreter. For example, during my pregnancy I have missed multiple appointments at the hospital because I did not understand the information written in the appointment letter from the hospital since I do not have someone who can translate for me at home.*

This means, patient's understanding of healthcare information is severely limited, and the only instances these patients understand information as to healthcare process and outcome is during interpreter assisted medical conversations. As such, any written communication concerning health information, including electronic patient journal, appointment letter for patients, or patient discharge summary report is difficult to understand for these patient subgroups. Limitation in accessing and understanding health information due to language problem in turn leads to lower health literacy. Moreover, poor understanding of diagnosis and treatment caused by language barriers leads also to decline in medication adherence, increased medication complications and increase the likelihood of missing appointments and going to emergency rooms among other things (Jacobs & Diamond, 2017). Hence, low-language proficient patients have limited capacity to obtain, process, and understand basic health information due to language problems. Studies have also revealed that patients with limited language proficiency understands diagnosis or treatment poorly, compared to language proficient patients given language-concordant care (Jacobs & Diamond, 2017).

The empirical data collected from informants also pointed that poor understanding of diagnosis and treatment by these patients is also caused by factors beyond patients own language limitations like poor quality of the language service due to incompetence of interpreters and inability by health workers to adapt the health information to patients level. In this regard, an interpreter said;

> *It is also difficult for me as a translator to understand professional terms that the healthcare professional take it for granted without regard to whether I understand it or not. I have also experienced difficulty in understand some of the dialects.*

The interpreter underlines that, there are instances where language interpreters themselves do not understand the content of the message they are supposed to translate owing to various reasons including the use of medical jargons and dialectical differences. Interpreters' failure to understand the health information has huge implications for patients understanding of the diagnosis and treatment since these patients rely on interpreters, as mentioned by patients themselves in the statement quoted above. Effort to help patients with limited language

proficiency to understand diagnosis and treatment, therefore, requires adapting the healthcare communication to the needs and level of the patients and empowering the patients among other things. Adapting the healthcare communication requires, among others, accommodative communication as asserted by communication accommodation theory (Gallois et al., 1995). Medical professionals may use communication accommodation like convergence to adapt their communicative behaviours and message to reduce gaps created. Doing so, will significantly improve the effectiveness of the medical communication to some extent (Gallois et al., 1995; Giles, 2016). For instance, health professionals may give simple explanation about the disease in the way and level both the patient and the language interpreter gaps. Studies show, in medical communication settings, health professionals adjusting their communication – for example using simpler medical terminologies that the language interpreter or the patient can understand - lower uncertainty, interpersonal anxiety, and heightened mutual understanding (Gallois et al., 1995; Meuter et al., 2015). In doing so, convergence is significantly important in mitigating, if not alleviating, the challenges of language barriers in cross-cultural provision of healthcare to low language proficient patients. In fact, the need for adapting health information to the level and needs of patients' linguistic and cultural background is explicitly enshrined in the Patients' rights act (brukerrettighetsloven, 1999, § 3-5). Accordingly, patients are entitled to choose from available examination and treatment methods while at the same time clinicians are required to facilitate for the patient's ability to make decisions, by adapting the information to the patient's age, maturity, experience, cultural background and language, and that health-care workers should ensure, to the best of their ability, patient comprehension of the information (brukerrettighetsloven, 1999,§ 3). Such legislation is significantly important in, at least, minimizing problems related with understanding the care process and outcomes, and also challenges arising from language barriers in healthcare communication involving patients with limited language proficiency.

4.2.2. **Challenges of expressing one`s health situation due to language** barriers

The other challenge inherent language discrepant medical communication setting demonstrated by the collected data is that patients with limited Norwegian language proficiency have difficulty in communicating effectively and expressing their health situations due to language problem. In this regard, an informant explained;

> *It is difficult for me to describe the symptoms even in my own language because I am not good in describing my health issues. I do not have much knowledge and the vocabulary about different diseases and related symptoms. For example, I can say I am having pain in my stomach. However, if the physician ask me to describe more, I cannot explain it properly.*

This means, the patient cannot describe his experience of the disease even in his native language. This in turn has significant implication for the healthcare process and outcome since the patient cannot either directly communicate with health professionals to explain his problem in Norwegian nor can he explains it in his native language thereby making it difficult for interpreters who only translate description of patients health situation presented to them. Another participant described her situation as;

> *I can only feel and experience my health problem, I cannot describe it. Whenever, I have to describe it I struggle to find correct terms and statements that can nearly describe my situation*.

That means this the patient lacks vocabulary to describe her experience of the disease. In response to the question to whether, there are situations in which language barriers become more prominent, an informant explains;

> *Usually when I am sick I do not want to talk much because, when I am sick I do not have energy to talk. I just use to answer to the healthcare professionals questions shortly. When I am sick, it is difficult for me to explain something, especially emotion1al, even in my own native language*.

Accordingly, her language barriers become more prominent when she is sick because the disease makes it difficult to explain her situation. Language barriers as such have an emotional impact on patients. That is, when one is sick inability of patients to express their health situation due to language barriers becomes even worse. In fact, discussing and explaining health is challenging for patients as such discussion frequently merges into their accounts of the cause of illness (Blaxter, 2004). Experts state that for those who are experiencing illness, their primary and basic concern is to understand the cause of their illness, and patients' belief about cause can affect their interpretation of their symptoms and how they express them to give an accurate description of one's health condition.

to health professionals (Blaxter, 2004). Therefore, if it is normally difficult to describe health conditions between patients and clinicians who share common language, it can be more difficult for patients with limited language proficiency when you talk to somebody from other cultures, in the presence of language barriers and through interpreter. Further, it becomes more challenging when one is sick and in a state of emotional distress.

Inability of patients to describe their situation and subjective experience of the disease has in turn huge negative implications for the whole process and outcome of the healthcare since it impairs collection of data pertinent to patients' health. The concept of patient participation, which brought about a paradigm shift in the role of patients in terms of choosing the necessary interventions and treatments requires the patient to contribute with his subjective experience of the disease, which is limited in case of the researches target group due to language impediments (Organization, 2013).

The limited language proficiency and the resulting challenge of expressing their subjective experience of their health condition by the patients have significant clinical significance for the care given since it limits effective patient participation in the healthcare process and outcome. In addition, the challenge of collecting comprehensive patient specific data may lead to extra investigation, thus prolonging the assessment process and delaying the treatment. Moreover, patient's inability to express their health situation due to language barriers may also result in withholding health important information about their situation. A study conducted in Norway demonstrated that 37% of physicians indicated that they felt that patients hide some information because of language barriers (Kale & Syed, 2010). Withholding health information caused by language problems may also further lead to disinformation, and wrong diagnosis.

4.2.3. Feeling of loss of control over their own health situation caused by language barrier

Another challenge of language barriers faced by patients, indicated by the empirical data, is the feeling of loss of control over their own health situation, healthcare process and outcome, due to language problem. Most of the patients who participated in the interviews expressed that they do not feel that they have control over their own health and the healthcare due to various reasons, including impaired communication with their healthcare providers caused by language barriers and their low health literacy. One patient interviewee mentioned;

> *I do not understand what is going on and I do not know what to expect. I am not even sure whether what I am telling the interpreter is important for healthcare process and outcome*.

The patients make clear that, the patient has no feeling of control over the healthcare process and outcome due to limited understanding caused by language barriers. Yet, perceived barriers, like low self-confidence on the relevance of his information about his health and on their ability to influence the outcome of the healthcare is also mentioned by the patient. Patients feeling of loss of control are also mentioned by patient participants during the interview. One informant mentioned,

> *I do not feel part of the process and I am rather on the receiving end. I do not dare to ask what the diagnosis means, why the treatment is ordered and if there is any alternative treatments. Even the fact of talking to clinicians through third party, or interpreter makes me feel disconnected. I am on the receiving end and conforms whatever the medical professionals said and whichever treatment is provided.*

For this patient inability to communicate directly with their clinician due to language problem disconnect her from the process and makes the whole process alien and somethings she cannot take part in or control. She mentioned, among other things that, communication through interpreter has a negative influence on describing her situation and asking questions about the healthcare services and treatment prescribed. Therefore, inability of the patients to communicate directly to the healthcare professionals due to language impediments, leads to limitation in expressing one's health situation, and in understanding the treatment process and outcomes all of which may eventually lead to feeling of loss of control over one important aspect of life, health. In addition, there are also perceived barriers by these patient groups, which have inhibiting effect and impacts unfavourably patients' ability to use their resources and coping mechanisms to overcome the disease and its effects. According to the concept of "sense of coherence" developed by Antonovsky, the extent to which individuals perceived the world as comprehensible (ordered, making sense, structured, predictable, rather than disordered, random and chaotic), manageable (with the resource available) and meaningful (making emotional sense) is directly associated with health because those who has high measures of these qualities are more likely to cope with situations, maintain their health, and display a psychic "resistance" somewhat like immunological resistance (Blaxter, 2004). This is in fact consistent with the theory of cultural capital as well (Bourdieu et al., 1995). Therefore, considering these challenges and empowering the patient has significant importance, both in terms of enabling patients to get control of their health situation and increasing the quality of healthcare process and outcome for these patient subgroups.

4.2.4. Challenges of language barrier as related to patients` low- socioeconomic status and lack cultural capital

The findings of empirical data collected from participants demonstrate also that these patient subgroups` low- socioeconomic status and cultural capital is related to language problem. The collected data shows that in relation to language barriers, the most relevant socioeconomic and cultural capital is education and health literacy. To this end, all of patient interviewees have no educational background and their health literacy is very low. The patient subgroups lack of education in turn negatively influences these group opportunities to learn a new language, and patient's ability to seek receive, interpret and use healthcare information. Furthermore, inability to learn the language has in turn its own negative implications. A health professionals stated during the interview that;

> *For me language barriers in healthcare setting is part of the bigger problem. What I mean by that is that, for someone who do not speak Norwegian or English it is often difficult to understand the culture here in Norway, how the system works, the mentality, expectation, your rights and role as a patient.*

According to this informant, patients low language proficiency makes it difficult to understand the wider culture and system in Norway and challenges of language barriers in healthcare is part of the bigger problem. For instance, the aforementioned challenge related to patient's inability to express their health situation even in her own native language is partly due patients' lack of education and thus limited capacity to access health information resulting in lack of health information. One patient mentioned during the interview that;

> *The only chance for me to understand what the healthcare professional is saying and the whole process is through language interpreter.*

The patient revealed that her opportunity to seek and understand health information on her own is severely diminished due to her limited language proficiency which in this context is closely related to lack of education as well. Health literacy which comprises, among other things individuals the ability to seek, obtain and understand health information and to participate and influence health processes and outcomes (Schyve, 2007) is therefore low among these group due to their limited language proficiency.

Patients limited language proficiency and thus limited health information leads also to poorer access to and quality of healthcare care and risks to patients safety as demonstrated by this research and other studies. In this regard, Bourdieu's classical theory on cultural capital, underlines among other things that individuals knowledge of language and language proficiency, which Bourdieu called embodied capital, determines ones opportunity within a

society, which include opportunity to get access to and use the healthcare (Bourdieu et al., 1995). In addition, the importance of education and health literacy in quality of healthcare process and outcome is demonstrated both by Norwegian and international studies (Diaz et al., 2015; Lee, 2013; Mackenbach, 2012). Studies show, for instance that, there is a significant difference between Norwegian and people with immigrant background concerning degree of utilization of healthcare and language barriers and low socioeconomic status are among key contributing factors (Diaz et al., 2015; Mackenbach, 2012). That is individuals who have more education and are fluent in Norwegian have better access to services than those with less education and limited language proficiency. Therefore, it is important to examine challenges of language barriers in healthcare within in context of related socioeconomic and cultural elements to gain comprehensive understanding of the issue. Therefore, challenges of language barriers as related patients range from difficulty in understanding treatments and diagnosis, to challenge in expressing one's health condition, and the feeling of loss control over the care process and their own health. Comprehensive understanding of challenges of language barriers as related to patients demands also consideration of the impact of these patients' low socioeconomic status and lack of cultural capital as stated by various theories and concepts like cultural capital (Bourdieu et al., 1995), and the sense of coherence(Blaxter, 2004).

4.3.Challenges of language barriers in relation to healthcare professionals

The findings of empirical data collected from participants demonstrate that patients with limited Norwegian language proficiency seem to share common characteristics features that differentiate them from the general population. They often times to have low cultural capital and low socioeconomic status indicated by lack of education, limited language proficiency, low health literacy and thus very limited resources to get access to and use the healthcare as normally expected. For instance, all the patient informants cannot directly communicate with medical professionals due to language barriers, and thus have to use interpreter mediated medical communication. In this regard a patient informant stated during the interview that;

> *Although I had been to language course for almost two years through the introduction program, my Norwegian language is still very limited. I can speak and understand some simple conversation but when it comes to important things at school, refugee office, kindergarten or healthcare institution I use interpreter.*

The interviewee explains that her Norwegian language proficiency is so low to allow her direct communication in what she calls important things of her life including medical

conversation. This is in fact the case for all of the patient informants. As such, these patient subgroups are in much disadvantageous position compared to the general population, which is also demonstrated both by Norwegian and international literature and studies (Diaz et al., 2015; Mackenbach, 2012). On the other hand, both the Norwegian healthcare system and the healthcare professionals are originally organized and trained to serve a monolingual society, the exception being the Sami People of Norway who can use the Sami language in the healthcare institutions (Regjeringen, 2019). Therefore, patients with immigrant background who do not speak Norwegian in the level that allow them to communicate directly with their clinicians deviate from the conventional wisdom and expectation. These unique features characterizing patients with limited Norwegian proficiency have huge implication for health professionals working with these patients and in the provision of cross-cultural healthcare involving this group. Below, I will present and discuss challenges faced by health professionals in language discrepant medical communication settings as mentioned by informants during the interviews and in light of relevant theories. To this end, I will present discuss a) challenges with regard to assessing patient's language proficiency and the need for interpreter, b) healthcare professionals lack of cultural competence as a challenge to bridge language barriers, c) low awareness of risks of language barriers among health professionals d) challenges in relation to how to use interpreters during interview e) non-compliance with legislations as to the use of language services and provide brief summary at the end.

4.3.1. Challenges with regard to assessing patient's language proficiency and the need for language interpreter

Professional interpreters plays an important role to bridge communication gap caused by language barriers in medical communication that involve patients with limited language proficiency (Jacobs & Diamond, 2017; Karliner et al., 2007; Lee, 2013).The use of language interpreter in turn demands identification of whether the patient's Norwegian language proficiency is enough to allow her or him to communicate directly and comprehend dialog with their clinicians. However, the challenge remains regarding how to establish standards of language fluency for patients. That is, how can one identify whether a patient need language interpreter or not? When can we say that a patient has enough Norwegian or English language proficiency to comprehend the dialog with healthcare professionals without the need for language interpreter? What is good enough? Are there objective ways of assessing and measuring patient's language proficiency to determine the need for language interpreter?

In a response to the interview question how do you assess whether a patient need language interpreter or not, a health professionals participant answered;

> *In working with people who do not speak or speak little Norwegian this is one of the challenges. I usually use to ask patients whether they need language interpreter before they come. In this way, it is up to the patient's self-assessment as to whether to use professional language interpreter or not. However, I have instances where a patient says she can speak Norwegian and does not need interpreter. However, in the midst of the conversation with this patient we found out that she understands much less of what is being said than she taught. So we cancelled the meeting and we have to have a new appointment with her in the presence of a professional language interpreter since we are not sure if we are getting all the necessary information and also whether she is understanding what we are saying. So to answer your question, the decision as to whether to use a professional language interpreter or not depends solely on health professionals assessment and partly patients self-assessment of their level of language proficiency*.

This illustrates that assessment of patients language proficiency is challenging for health professionals. Although one may ask the patient in advance as to the need for language interpreter, the patient's self-assessment can also be erroneous, as mentioned by the informant. That is, patients may overestimate the level of their language skill to later find comprehension of medical communication without presence of interpreter difficult, thereby prolonging the whole process and delaying the treatment.

In the Norwegian healthcare system, the assessment and decision as to whether to use language interpreters or not, is entirely left up to healthcare workers discretionary power (Direktoratet, 2011). Thus, it is the health professional who assess patients' language proficiency and decide whether to use professional interpreters not. However, the task of assessing patient's language proficiency is challenging for healthcare workers who normally lack professional competency in language assessment(Sagli, 2015). In fact one study shows that health personnel participants in a focus group interview overestimated the patient's Norwegian skills in several cases (Kale & Syed, 2010). Assessment of patients' language proficiency is a difficult task due to various factors. First, the level of patients' language proficiency varies from context to context (Sajjad, 2000). In this regard, a patient informant mentioned;

> *Although I can speak and understand some simple conversation but when it comes to important things at school, refugee office, kindergarten or healthcare institution I use interpreter.*

The informant underlines that although she can speak Norwegian and comprehend simple conversation in social contexts, her language proficiency is not enough to directly communicate in medical communication with her clinicians. This means, being good at

Norwegian in social contexts does not necessarily implicate proficiency in complicated medical conversation with healthcare professional at time patients health is at issue. Secondly, there is limitations with regard to the accuracy of patient's self-assessment of their language proficiency level. As one can see from the statement quoted above; even if the patient said she can speak Norwegian and does not need interpreter, the healthcare worker later on found out that she is not comprehending the conversation and has to cancel the appointment.
In addition, absence of patients' language data, in the patient registry record or journal is also a contributing factor to challenges of medical professionals in assessing patient's language proficiency. In response to the interview question; how do you assess patients' language proficiency and decide whether to use interpreter or not, a healthcare professional participant said;

> *Unless language interpreter is appointed in advance through patients' general practitioners or at some earlier point, we use to ask patients up on arrival whether they need language interpreter or not. This is challenging specially for new patients, whom we do not know their language fluency level and whether they need interpreter or not. However, most of the time patients who do not speak Norwegian come with family member or friends who can help them with the translation.*

The informant explains that unless language interpreter is arranged before the patient come to the institution, the need for language interpreter is assessed up on patient's arrival. He pointed also that there is no prior mechanisms, or information, for instance in the patient journal as to patient's language fluency. In this regard, a Norwegian study shows that 25.3% of health professionals indicated that they often conduct the initial medical consultation with patients without knowing whether the patient's Norwegian language skills were adequate, and language interpreter may be arranged only after this initial consultation (Kale & Syed, 2010). That is one among four patients with limited Norwegian proficiency make the initial medical communication without any prior assessment as to whether the patient need language interpreter or not. This in turn leads, among other things, to delay of treatment as happened in the case of the aforementioned informant who fails to understand the communication although she thought and said can. One way of addressing this challenge is developing objective standards and indicators as to patients' language proficiency including making patients language data part of patients' journal. However, there are limitations of existing laws, in this regard concerning the absence of objective standards and indicators as to patients' language proficiency.

4.3.2. Healthcare professionals lack of cultural competence as a challenge to bridge language barriers

As mentioned earlier, the findings of empirical data pointed that patients with limited Norwegian language proficiency seem to share unique characteristics, and thus deviate from the general population, therefore demand extraordinary skills to adapt the healthcare to their unique situation. In an answer to the interview question, "how important is understanding or knowledge of other cultures (cultural competency) for the healthcare professionals?" A healthcare professional participant said;

> *In giving healthcare to people who come from a different culture than yours, knowledge and understanding of their culture is definitely important. It is important that healthcare professionals are in concordance with their patients in order to help them. Though most of the diseases can be defined objectively from a biological perspective, how people understand their situation and express them depends much on their cultural background. For instance people with different cultures express pain differently. I mean how the patient manifest or express pain. In addition, knowledge of other cultures is crucial in prophylactic or prevention care or treatment. The importance of cultural competency also varies depending on the disease or illness at stake. I mean some of the diseases like pain manifestation and management is strongly tied and affected by culture while others are more biological and their diagnosis can be objectively established.*

The healthcare professional underlines provision of healthcare to patients with diverse cultural and linguistic background, demands additional competency in addition to the conventional medical knowledge and skills required in providing healthcare to the general population. This shows that meeting the unique demands of these patient subgroups goes beyond the normally expected medical knowledge patients` understanding, experience and manifestation of illness is culturally tied, which clinicians may not be aware of. In this regard, it worth nothing that, communication gap between healthcare worker and patients due to absence of shared language between the two is not limited to lack of shared language. Rather it has also cultural aspects and context to it. To this end, social constructionists emphasize how the meaning and experience of illness is shaped by cultural and social systems (Blaxter, 2004; Conrad & Barker, 2010; Eriksen & Sajjad, 2015). Patients subjective experience in turn has huge clinical significance (Blaxter, 2004).

Challenges of language barriers is also related to ones' perception, experience and expression of his or her health condition, since patients' individual healthcare preferences are influenced among other things by cultural diversity (Bellamy & Gott, 2013; Eriksen & Sajjad, 2015). Cultural meanings have an impact on the way the illness is experienced, how the illness is depicted (Blaxter, 2004; Conrad & Barker, 2010; Eriksen & Sajjad, 2015). As such,

communication in language-discrepant medical setting should also be seen in light of other related factors like difference in culture, value, beliefs and clinicians' cultural competence and awareness in this regard. For instance, there is different perceptions of disease, treatment and how one express one's health situation in different cultures. There are also differences in understandings of how health is defined, as health and disease can be defined, perceived and expressed differently in different cultures albeit the biomedicine biological explanation (Blaxter, 2004; Eriksen & Sajjad, 2015).

Moreover, the target group of this research come from high context culture or language, which means understanding the correct meaning of their expression, depends not only in the meaning of the word but also on factors like how the word or sentence is messaged, the facial expression, the tonality of the voice and the body language among other things. As such, their culture differs from low-context languages, like Norwegian which rely heavily on verbal communication, and the context has little effect on the meaning of the content of what is being said (Eriksen & Sajjad, 2015). This in turn pose challenge for the health workers in correctly understanding the patients' situation. Health professionals need to have professional communication skill in nonverbal communication, cultural sensitivity and competency to overcome the challenges and provide culturally appropriate healthcare that is responsive to the patients' unique need (Eriksen & Sajjad, 2015; Healy, 2012). Yet, most of medical professional participants in the interview rated their culturally competency as low and mentioned they have never been to courses on cultural competency or related subject. Furthermore, a medical professional participant mentioned*;*

> *Although knowledge of the culture to which the patient belong is important, we have to be careful not to understand or treat the patient as a part of their culture than as an individual. Each patient should be treated individually. For example, if a pregnant woman from Syria behave in some particular way it does mean that all woman from Syria is the same or her way of expression are Syrians culture.*

That is, the informant explains, there is also differences in communication manner even among individuals belonging to the same cultural identity. It means that clinicians' cultural competency is also important to differentiate between patients' individual experience and their cultural identity as one patient way of communication may not necessarily indicate cultural elements, as revealed by the health professional. It is thus important that health professionals have competency to recognize differences yet avoid stereotyping patients and denying their individual experiences or expression of cultural identity (Healy, 2012). Therefore, health professionals cultural knowledge is important in drawing proper balance between the two thereby avoiding stereotyping a patient. However, given the culturally

diverse nature of the today's Norwegian society comprising people from different cultural and linguistic background, it is impractical for a clinician to get to know all this culture. Nonetheless, one can be selective of which culture to know depending on the demographics of the patients in the location of the healthcare institution. For instance, if there are more people with immigrant background from Somalia or Eritrea in a given geographical area, knowledge of these cultures are important in the delivery of cross cultural healthcare to patients from these countries.

As indicated by the empirical data and discussed in the research, one of the challenges in language discrepant medical communication is clinicians lack of cultural competency which in turn have negative bearing on central components of healthcare quality like patient centredness and the healthcare's responsiveness to individual patient preferences, needs and values. Clinicians' cultural competency, thus, plays significant role in ensuring efficient cross-cultural healthcare communication thereby helping to reach correct diagnoses and high-quality healthcare. On the other hand, lack of cultural competence can create myriads of challenges in the provision of cross-cultural healthcare, and when communication is not culturally sensitive, there is a potential for it to negatively impact the care provided (Williamson & Harrison, 2010). Culturally competency comprises, therefore, not only understanding patients' linguistic and cultural identity, which may have bearing on the healthcare communication but also competency to adapt ones healthcare knowledge and communication to the unique need and situation of a patient.

4.3.3. Low awareness of risks of language barriers among health professionals

As demonstrated by findings of the empirical data and discussed earlier, language problem affects, among others, patients' expression of their health condition, understanding of the diagnosis or treatment, leads to poor patient participation in the healthcare process and outcomes and thus risks to patients' safety. It is, therefore of huge significance that healthcare workers are aware of the risks involved in the provision of healthcare to low-language proficient patients.

In an answer to the question; to what extent are you aware of risks and complexities of language barriers, one healthcare professional mentioned;

> *To be honest, as long as a language interpreter is present, I normally assume that the patient understands the conversation.*

It is in fact true that, under normal circumstances, the use of interpreter is the most effective way to bridge communication barrier caused by language problem (Jacobs & Diamond, 2017). However, such belief may lead to mistakes as it undermines potentials for

miscommunications that may arise due to other factors like incompetency of interpreters or cultural differences. Thus, it is important to be aware of the fact that even in interpreter mediated medical communication there are still various factors affecting healthcare communication with low-language proficiency including competency of interpreters and patients health literacy. For instance, even if professional interpreter is present, the interpreter himself may not understand what the clinicians is saying due to dialect that the clinician speak or medical terminologies used by the clinician. In this regard, one language interpreter explained during the interview

> *In some instances, it is also difficult for me as a translator to understand professional terms that the healthcare professional take for granted without regard to whether I understands it or not. I have also experienced difficulty in understanding some of the dialects. I have lived around also and speak the Oslo dialect. However when I moved here five years ago it was challenging for me to understand some of the words and the sentences. I have also experienced a situation where I could not understand what is being said by the healthcare professional from the western part of Norway while translating through telephone.*

This interpreter is telling that the competency of the interpreters should not be taken for granted as there are chances that interpreters may fail to grasp the message due to various reasons, like professionals jargons used or dialectical differences. This may further leads to miscommunication between the patient and the clinician, misdiagnosis and poses risks to patient safety. Thus, communication challenges between healthcare professional and patients due to language barriers might be aggravated due to lack of awareness of risks involved and lack of effort on the parts of healthcare professionals to mitigate the problem thereby having negative implications for the health and wellbeing of the patient.

Awareness of risks involved in language-discordant communication is the first and crucial step to initiate the effort to mitigate the risks to a patient safety (Eriksen & Sajjad, 2015; Healy, 2012). Being aware of risks involved in language barriers healthcare workers can make effort to adapt the information about the healthcare to be understandable by the interpreter and the patient. Adapting the healthcare communication requires, among others, accommodative communication as described by communication accommodation theory (Gallois et al., 1995; Giles, 2016). Healthcare workers may adjust their communication –for example using simpler medical terminologies that the language interpreter or the patient can understand thereby lowering uncertainties, and potential risks of miscommunication due to overtly use of professionals terminologies and jargons or dialectical differences (Gallois et al., 1995). For instance, some of the professional words and jargons might be replaced by ordinary language that the interpreter can easily understand. Yet, sometimes the healthcare professionals might

have to speak simpler dialect to make things understandable. As explained by a healthcare professional during the interview; the use of repetition and simpler and common words with fewer syllables to convey a message can make a significant change.

4.3.4. Challenges of health professionals in relation to how to use interpreters during interview

Another challenge of language barrier as related to clinicians, that is mentioned by the healthcare worker informants during the interview is the one related to competency of medical professionals in using interpreters during interview. All of healthcare professional participated in the interview mentioned that they have not taken any additional training on how to use language interpreters during interview. This is in fact consistent with a finding of a study conducted in Norway in which 69% of healthcare professionals who are asked about their competency in using language interpreters expressed dissatisfaction with the opportunities the their institution provides to increase competence when it comes to the use of interpreters (Kale, 2006; Lee, 2013). As such, one of the challenge interpreter mediated medical communication is clinicians' low competence on how to use interpreters during interview. This in turn has significant implication for the quality of the language service and eventually for the process and outcome of the healthcare. This is because health professionals` knowledge of how to use language interpreter is significant role in adapting the healthcare information to the needs and situation of patients as required by the laws (brukerrettighetsloven, 1999; Spesialisthelsetjenesteloven, 2001). In providing patient centered and culturally competent healthcare, language interpreter paly significant role not only as a language interpreter but also as a cultural mediators as they normally have knowledge of the cultures represented by the patients' native languages. Hence, it is important to increase competency of health workers with the view to address challenges language barriers in this regard.

4.3.5. Challenges with regard to health professionals non-compliance with legislations as to the use of professional language interpreters

One of the challenges of language barriers related to medical professionals, identified based on the collected data, is non-compliance with relevant laws and regulations as to the use of professionals interpreters in communication with patients with limited language proficiency. In an answer to the interview question; how often do you use professional interpreters in communication with patients with limited language proficiency, a healthcare professional stated;

> *Under normal circumstances, we often use professional interpreter, as there are problems in using patient's family members as an interpreter. However, sometimes-family member has the only option we have at that time because sometimes these women come to give birth in the night and under emergency. This makes it difficult to find an interpreter because it is mid night and you do not have time to go through the bureaucracy to call the interpreters agency and order interpreter. Sometimes, it is also difficult to find an interpreter who speaks the patient's native language. In such cases, we often use their family members or someone who is with them to get the immediate information we need and then we will use professionally trained interpreters during daytime to get a more detail information about the patient's situation.*

The healthcare professional explains that, although it is prohibited to use untrained interpreters in contact with patients with limited Norwegian proficiency like family members, there are various factors that hinders the use of professional interpreters including clinical scenarios like patients admitted to the institution at night time, or emergency situations during which, it is impractical to get access to professional interpreters and unavailability of professional interpreters in some languages. According to the informant, the only option in such circumstances, is using family members or friends who accompanied the patient to the hospital. However, relevant laws clearly require health personnel to only use professional language interpreters during interview (Direktoratet, 2011; Tolkeforbundets, 2017). In other words, it is prohibited to use ad-hoc or untrained interpreters like family members in communication with patients with limited Norwegian language proficiency (Direktoratet, 2011). Hence, on one hand, the practice of using family members as an interpreter is in breach of guidelines which prohibits the use of untrained interpreters to assist communication between a patient and healthcare professional (Direktoratet, 2011; Tolkeforbundets, 2017). Thus, using untrained interpreters during interview violates the laws and have its own drawbacks as it poses risks to patients' safety. On the other hand, there are scenarios that are unavoidable deterrent to using professional interpreters, since emergency care must be provided for the best interest of the patient whether or not professional interpreter is available

(Jacobs & Diamond, 2017). Therefore, there are clinical scenarios, as those mentioned by the informant, that put medical workers in ethical dilemma as to whether to use untrained interpreters like family members to respond to the immediate need of a patient in violation of the laws or wait for professionals interpreters to comply with the law at the cost of patients immediate need for help.

With regard to the use of untrained family members during interview, an informant stated that;

> *I use my family member including my children on multiple occasion to assist me in communication with health professionals, and I only use professional interpreter in a matter I or healthcare professionals deemed important*.

Accordingly, this patient uses family members more often than professional language interpreter. In this regard, studies have depicted both underutilization of professional interpreters, and the extensive use of ad-hoc or untrained interpreters in the Norwegian healthcare ((Direktoratet, 2011; Kale, 2006; Kale & Syed, 2010). The underuse of professional interpreters in the healthcare implicates two possible scenarios. Either, the healthcare providers are using ad-hoc or untrained interpreters, like family members to bridge language barriers between patients and their clinicians, or interpreter whether trained or untrained is not being used even if the patient language proficiency is low and therefore cannot communicate with their clinicians directly.

The use of untrained interpreters to bridge language barriers has in turn has its own drawbacks since these interpreters lack skills and training required to bridge language barriers and perform their job in the quality and standard expected. The task of interpreting is a huge responsibility, which requires maturity, broad knowledge and specific skills. Situations where there is a need for an interpreter can also deal with serious matters that untrained interpreter like family member or children should not have to decide on - or hear about (Direktoratet, 2011). Interpreters' professional ethical guidelines prohibits even professional interpreters not to take on assignments without having the necessary competence (Direktoratet, 2011; Tolkeforbundets, 2017).

In describing problems associated with the use of untrained interpreters; a health professionals said;

> *The use of family members, for example, husband is not correct as it raises the issue of neutrality in the conversation between his wife and her physicians. Because we do not know the nature of their relationship. Their relationship in the marriage can be one of conflict, disagreement or mistrust. In such situation, the husband can be biased and might change some important detail of the message from the physician. For example, the wife can be a woman who needs psychosocial support because she is traumatized*

> *but the husband might perceive this as something unimportant or humiliating. Let's, for example, say the wife has a mental health problem like depression, which the husband is not willing to mention due to some personal beliefs or because he does not want other people including healthcare professional to know about it. Under such circumstances, the husband might interpreter only half of the truth.*

According to this informant, the use of family members as an interpreter is problematic in many ways as it compromise neutrality, and potentially alter the content of the message to be translated thereby leading to miscommunication between the patient and the clinicians. In addition to leading to important information being altered or withheld and thereby having adverse impact on the provision of necessary healthcare, the use of untrained interpreters, like family members entails also an unclear role and access to patient's private information by the untrained interpreter illegally (Direktoratet, 2011). One of justification for prohibition of ad-hoc interpreters can be the fact that they are not under any ethical or legal duties while performing the task of interpreting. Moreover, according to the Norwegian Directorate of Health guideline, it is the responsibility of healthcare professionals to ensure that children or other family members are not used as interpreters, even in situations where the individual patient expresses a wish (Direktoratet, 2011). In addition to clinical scenarios, another cause for not using or underutilizing professional interpreters during interview, as revealed by the empirical data collected from participants, is the absence of objective guideline to assess patients' language proficiency and the need for a language interpreter. In this regard, a health professional informant said;

> *Unless language interpreter is appointed at some earlier point before arrival of the patient at the institution, we do not know if the patient needs language interpreter or not as information about patients' language skill is not written on patient's health journal.*

The informant explains that there is no routines or no prior mechanisms, including information to patient's language fluency in the patient journal, which guide health workers to know s patients' language proficiency level in advance and decide up on the need for language interpreter.

Another clinician stated;

> *I usually use to ask patients whether they need language interpreter before they come. In this way, it is up to the patient's self-assessment as to whether to use professional language interpreter or not. However, I have instances where a patient says she can speak Norwegian and does not need interpreter. However, in the midst of the conversation with this patient we found out that she understands much less of what is being said than she taught. So we cancelled the meeting and we have to have a new appointment with her in the presence of a professional language interpreter.*

Accordingly, even if health professional avoid to use professional interpreter based on patients self-assessment as to her language proficiency level, there are constraints to rely on patients' self-assessment. All of the aforementioned problems relate partly to absence of standardized routine that is applicable across the board in all healthcare institutions. Although the power assess and decide up patients need for professional interpreters is conferred up on clinicians by the law (Direktoratet, 2011), the task is challenging for clinicians who normally lack expertise on the task and partly because the laws fail to provide detailed guideline as to when and how healthcare workers should use professional language interpreters (Sagli, 2015). Absence of standardized guideline in assessing patients' language proficiency level and deciding the need for interpreter is thus another factor why healthcare professionals fail to use professional language interpreter and thereby failing to comply with the requirement of relevant laws. Absence of standardized guidelines in turn leave the decision to as to whether to use professional interpreter or not to the subjective assessment of health professionals. Leaving the decision as to when to use professional interpreter entirely to the subjective and discretionary power of clinicians, in turn creates gap in observance of laws requiring the use of professionals interpreter as healthcare workers often lack expertise in language assessment (Kale et al., 2010; Sagli, 2015). For instance, research shows that healthcare professionals often overestimate patients' language proficiency level (Kale, 2006; Kale & Syed, 2010). As such, absence of standardized routines and enforced regulation as to when to use professional interpreters has also its role to play in non-compliance to the relevant laws by healthcare providers.

Others factors for non-adherence to the laws include lack of awareness on the part of healthcare professionals as to the complexities and issues associated with using untrained interpreters, clinicians own time constraints, and challenges in finding an interpreter frequently (Jacobs & Diamond, 2017; Kale et al., 2010; Kale & Syed, 2010).

As revealed by empirical data and relevant studies and discussed above, challenges associated with lack of common language in cross-cultural provision of healthcare include difficulty in assessing patients language proficiency level and the need for language interpreter, lack of cultural competency, low awareness of risks of language impediments and how to use interpreters during interview, and challenges related to non-compliance with relevant legislations requiring the use of professionals language interpreters.

4.4. Challenges of language-barriers as related to interpreters and interpreting

The results from the interviews show that there are several challenges associated with interpreters and interpreter-mediated health encounters. The most prominent challenges underlined by the interviewees and presented below are a) problems related to competency of interpreters, b) neutrality of interpreters, c) cultural, language and value differences and d) unavailability of professional interpreters among other things.

4.4.1. Challenges of language barriers as related to competency of interpreters

Findings of data collected from informants showed that among challenges of language barriers associated with interpreters is the problem of incompetency of interpreters. The task of interpreting is complex and multi-faceted, and requires possession of certain skills like bilingual fluency to bridge language barriers as required, to reduce potential errors in interpretation and perform their job in the quality and standard expected of them (Jacobs & Diamond, 2017). Association of professional Interpreters ethical guidelines adopted in 2017 define competence to mean knowledge, skills and experience necessary to perform interpreters' task (Tolkeforbundets, 2017). In explaining challenges in relation to competency of interpreters, interpreter participants stated during the interview,

> *In some instances, it is also difficult for me as a translator to understand professional terms that the healthcare professional take it for granted without regard to whether I understand it or not. I have also experienced difficulty in understand some of the Norwegian dialects.*

The interpreter underpins that problems of competency of interpreters is not limited to ad-hoc or untrained interpreters but also include professional interpreters since the latter may also unable to grasp properly the message sought to be translated due to professional jargons used by clinicians or dialectical differences. Besides, all of the professional interpreters I have interviewed come from different educational background than health disciplines. This in turn makes it difficult for some of the interpreters to grasp medical words and concepts necessary for enhancing the communication between patients and their clinicians. In doing so, the fact that most of interpreters come from background other disciplines or discourses other than the medical discourse can be a contributing factor. One of the limitation of regarding practical effect of biomedical discourse in this regard is that one must understand and use biomedical terminology in order to communicate effectively in these practice domains (Healy, 2014). In expressing his concern about competency of language interpreters in some clinical scenarios, a healthcare professionals mentioned that;

> *Let for example say we are talking about pregnancy complication like preeclampsia. If the interpreter do not know anything about pregnancy complication or preeclampsia, how do I, as healthcare professional, know that he is translating correctly in patient's native language? In addition, if the interpreter is, for example, a man that came from a culture where man is not involved in breastfeeding or pregnancy issues how can you be sure that he is interpreting what you are saying correctly. The challenge in such situation might be that what is being said by the healthcare professional or the patient may be culturally filtered and translated by the interpreter.*

Here, the informant enunciate that competency of interpreters to perform their job depends also on familiarity of with health concepts and issue underlying the communication, and some of interpreters may lack such competency due to differences culture and experience. Further, another medical professional participant said that there are instances she doubt whether what she is saying is being correctly translated to the patients native language because she sometimes observed uncertainty on the face of the patient. For instance, there are occasions when patient keep on asking the same question again and again while she is giving the same answer repeatedly. In such circumstances, although repetitive questions from patients can mean different things like patients need for confirmation, one cannot exclude the potentials for failure of the interpreters to properly convey the message from the clinicians. In response to the interview question how do you rate or describe your Norwegian language proficiency, an interpreter informant said;

> *Now it is very good but at the time i began to work as an interpreter in healthcare institutions my Norwegian language proficiency is not that good, and I use to ask for repetition from the clinicians to understand the message properly and to avoid translating what I myself do not grasp.*

According to this participant, at the time she begin to work as an interpreter in the healthcare institutions she has difficulty understanding some of the content of the medical conversation due to her language proficiency level. That is, interpreters' level of Norwegian language proficiency has significance for their competency to perform the job.

Problems related to incompetency of interpreters have serious implications for the whole process and outcome of the healthcare since interpreters serve as a bridge between patients and their clinicians. What seems to be a minor error during translation can potentially be life threatening consequences for the patient. Interpreters' professional ethical guidelines, therefore, prohibits even professional interpreters not to take on assignments without having the necessary competence (Tolkeforbundets, 2017). In response to the interview question "Is there safety mechanism to make sure that the conversation between healthcare worker and patients is being translated correctly, a medical professional informant said,

> *Since the translation is taking place in the patients native language which the healthcare worker has no clue about. However, I follow the body language and ask some follow up questions in addition. Yet, medical history of the patient is also important in this regard. Sometimes you have to order extra investigation in to the patient situation like CT-scan or X-ray. However, the risk of miscommunication is always there.*

That is, if medical communication happen to be beyond the competency of the interpreter, health professionals need to follow accuracy of the translation. However, this informant underlines that it can be difficult for both patients and health professionals to verify the accuracy of the translation. That is health professionals have little control mechanism as to whether the patient is getting the right information while at the same time what the patient is saying is being translated correctly because the translation is taking place in the patients' native language, which the healthcare worker do not speak. This informant, nonetheless, pointed out some of the mechanisms that may minimize risks of miscommunication like following patients' body language and asking some follow up questions, cross –checking patients' medical history and sometimes ordering extra investigation to get more reliable information about patients' health. In such scenarios, in order to understand patients' body languages clinicians needs communication skill in non-verbal behaviour including facial expressions, posture, nonvocal cues, such as pitch and tone of voice, nonverbal cues such as nodding as described in relation to nonverbal communication under the chapter dealing theoretical framework (Healy, 2012).

Generally, results of the empirical data show that, there are various factors in explaining problems of competency of interpreters like lack of formal training, good knowledge of Norwegian language, lack of experience, cultural difference and the fact that professional interpreters come from different discourse or educational background than health education. Challenges related to competency of interpreters are even worse when one use ad-hoc or untrained interpreters, like family members as they lack formal education and training.

4.4.2. Challenges of language barriers as related to interpreters` neutrality and impartiality

The empirical data from participants shows, one of the challenges in relation interpreter mediated medical communication is the one related to the neutrality and impartiality of interpreters.

The ethical guideline for interpreters require, among other things, that the interpreter to be impartial or neutral between the parties (Direktoratet, 2011; Tolkeforbundets, 2017). Neutrality of interpreters requires among other things the interpreter to be an impartial facilitator of communication and not to alter the original intent by the parties to the conversation by adding interpreters own thoughts and opinion into the exchange (Direktoratet, 2011; Tolkeforbundets, 2017). Neutrality or impartiality of an interpreter is important in many aspects like a patient withhold no information, and the clinician will get the chance to get the intended patient information without alteration or omission from the interpreter. However, empirical data collected demonstrates that, upholding the ethical requirement of neutrality is sometimes difficult in medical communication involving patients with limited language proficiency and low health literacy. A patient participant said for example;

> *I do not understand what my health problem is even if the interpreter is telling me the diagnosis in my own language. I mean, I need more than telling me the name of the disease, in the way and level I understand.*

According to this patient, she does not understand word to word translation by the interpreter. Thus, this patient need more explanation of the information in order to properly understand it. Doing so in turn violates the requirement of neutrality and impartiality. The requirement of impartiality and neutrality in the ethical guideline rest on the very assumption that patients and healthcare professional are there to talk to each other and understand the content and implication of the information. However, given the fact that most of patients with limited language proficiency have low education and socio-economic status, the role of an interpreter sometimes goes far beyond that mere facilitator of the conversation to assist patients to understand the content of the message being interpreted. In substantiating the challenge, an interpreter stated during the interview;

> *Due to differences between the two languages, a thing which you can explain in just one word in Norwegian may require long explanation when you translate it to Arabic and vice versa. In addition, some of the medical terminologies do not even exist in my native language. For example, names like CT-scan or X-ray do not exist in my native language and it is difficult to translate it in the way the patient understands it. On the other hand, some of the words and expression in Arabic do not exist or it is difficult to find their equivalent Norwegian version.*

This patient explains some of the factors that makes observing the requirement of neutrality which require interpreters to only translate what is being said by the parties. She mentioned factors like differences in word meanings, and difficulty of translating some of the medical terminologies. Another challenge to neutrality and impartiality of interpreters mentioned during the interview is the smaller nature of linguistic and cultural communities in which interpreters and patients may know each other. In this regard, an interpreter informant mentioned;

> *In almost all time, I showed up physically to interpret at medical encounter I know the patient or it is somebody I have close relation with. This makes it challenging to be impartial and professional as required. In addition, when the patient is someone you know or have close relationship with, they do not understand or do not care about neutrality or professionalism*.

This means, the smaller nature of immigrants community in which a patient and the interpreter knows each other or might even be friends or family members may lead to impairment of the ethical requirement of neutrality or impartiality. One important thing to mention in relation to using family member as an interpreter is that even if the interpreter is professional the fact of being an interpreter for a close family member raises the question of neutrality and impartiality. In this regard, one of the healthcare professional stated during an interview that one of the limitation in using family members, as an interpreter is that we do not know the relationship between the interpreter and the concerned family member. There is a likelihood of controlling or manipulative dynamic between the family member who is acting as an interpreter and the patient thereby having negative implications on patient's privacy and autonomy. In some situations, the use of telephone interpreter might be a good solution address challenges and risks associated with neutrality of interpreters (Jacobs & Diamond, 2017).

Challenges and risks associated with neutrality of interpreters is even worse when it comes to untrained interpreters since they do not have formal education and necessary skills mentioned above. Yet, they do not understand the complexities involved and they are not under any legal or ethical duty as to their service. As such, untrained interpreters like family members are not impartial and also lack the necessary qualifications as interpreters even if they have good command of the Norwegian language.

4.4.3. Challenges in relation to availability of professional interpreters

In a response to an interview question, what are challenges of using professional interpreters, a healthcare professional answered;

> *One of the challenge we often face in using professional interpreters is the problem of availability of professional interpreters. For instance, it is difficult to get access to professional interpreters on timely fashion especially during night and in relation to some minority languages. I remember once I had a patient from Sudan who do not speak a word of Norwegian. The patient speak minority language in Sudan, for which we could not find professional interpreter even through agencies.*

This shows that it is often challenging for health professionals to get access professional interpreters, although it is required by the law that patients with limited language proficiency has the right to adapted information through the use of professional interpreters, and healthcare professional are under the duty to use professional interpreters in language discrepant medical communication settings (brukerrettighetsloven, 1999; Direktoratet, 2011). As also mentioned in the statement quoted above, the problem of availability of interpreter also related to availability of trained and professional language interpreter in certain minority language. However further data is needed to identify the mismatch between availability of professional interpreters and patient race, ethnicity and language. In the context of Norway, I have searched for data showing the number of professional interpreters in the country vis-a-vi respective professional language interpreter but did not find relevant data.

Yet, the problem of availability of professional interpreter also relates to the temporary nature of the job. In this regard, a professional interpreter explained during an interview that;

> *To work as an interpreter is not dependable job, because I work, for example, five hours one week and two hours next week. Therefore, in terms of income, it is not a job one can depend on. In addition, the job is also seasonal. For instance, when Norway takes, for example, immigrant from Arabic speaking countries it is good opportunity for us since it gives us job. However, as the new comers learn Norwegian over period of time, the need for interpreter decrease.*

According to this interviewee, one of the reason for unavailability of professional interpreter is the seasonal nature of the job which makes it difficult to make career out of interpreting job in minority languages, like native language of the target group of this research. Unavailability of professional interpreters may in turn force health professionals to use ad-hoc interpreters like family members thereby leading to underutilization of professional interpreters. As mentioned earlier, studies have revealed underutilization of professional interpreters in the healthcare. One of the underlying reason for not using professional language interpreters is unavailability of professional language interpreters (Kale, 2006; Kale & Syed, 2010). On the other hand, unavailability of professional interpreters may also lead to health professionals

use of untrained interpreters like family members. Unavailability of professional interpreters and the illegality of using ad-hoc or untrained interpreters, however, put healthcare workers in dilemmatic situation. That is, on one hand, it is mentioned that reliance on untrained interpreters, such as family members has many limitations and lead to compromised patient care, while on the other hand it is difficult to get access to professional language interpreters in some clinical scenarios like patients coming to the hospital during night-time. In this regard, the law stipulates that health institutions can use health personnel with multilingual competence to remedy in demanding situations where a qualified interpreter cannot be found (Direktoratet, 2011). To this end, it is significantly important to make the healthcare staff multicultural by employing more people with diverse linguistic and cultural background. However, the use of healthcare professional as an interpreter has also its own limitation since they have their own work to do and have time constraints as mentioned by an interviewee during the interview.

Another challenge of language barriers in this regard is that unavailability of interpreters often leads to cancellation of appointment thereby delaying the treatment as mentioned earlier.

4.4.4. Challenges of language translation as related to differences between languages, cultures and semantic barriers

Beside challenges related to competency, availability and neutrality of interpreters, results from the empirical data also show that task of interpreting involves challenges related to differences between languages, cultures and values among other things.

An interviewee stated during the interview that

> *In healthcare settings, some of the professional terminologies do not even exist in my native language. For example, names like CT-scan or X-ray do not exist in my native language and it is difficult to translate it in the way the patient understands it. On the other hand, some of the words and expression in Arabic do not exist or it is difficult to find their equivalent Norwegian version.*

This means that some medical terminologies like x-ray do not exist in the patient`s native language or some of words in patients native language do not have their equivalent in Norwegian. Such differences between languages and cultures makes it is challenging for interpreters since the very nature of language translation requires knowledge and possession of vocabularies to translate the intended message in both languages.

Further, the informant adds;

> *In addition, some of the ways in which the patient explain his situation, feeling or emotion is difficult to translate in Norwegian. I mean some of the patients explanation*

> *cannot be directly be translated to Norwegian because the cultural context and the mentality is different.*

Accordingly, some of the ways in which patients from other linguistic and cultural background express their feelings and emotions about their health condition cannot directly be translated into Norwegian without losing its meaning due to the underlying cultural differences.

Another health professional mentioned;

> *People with different culture express pain differently. I mean how the patient manifest or express pain.*

This means, the way people manifest pain depends, among other things on, their cultural background and people interpret and express illness differently. This is in fact shows limitation of the western biomedicine principle that disease is universal and presupposes that the interpretation and meaning aspects of illness are the same all over the world (Blaxter, 2004; Eriksen & Sajjad, 2015; Healy, 2014). As presented under the theoretical framework, the dominant discourse shaping practice context in the Norwegian healthcare,, as part of the broader western medicine, is the biomedical discourse (Healy, 2014). One of the key tenants of this discourse is that the idea that each disease has its own distinguishing features that are universal. That is the universal nature of disease, regardless of culture, time and place and the assumption that medicine is a scientifically neutral enterprise (Blaxter, 2004; Healy, 2014). In doing so, the discourse tends to undermine cultural values that affect people's experience and expression of a given disease, as has been asserted by the social constructionist approach, which underlines that peoples experiences and explanations of illness are also descriptions of the world as it is perceived and interpreted by the patient and will be affected by ones cultural and linguistic background among other things (Conrad & Barker, 2010; Eriksen & Sajjad, 2015; Healy, 2014). Patients with immigrant background can have very different experiences with illness and treatment depending on gender, age, economy, religion, state of health, where and how they have lived. In Norway, health professionals may find patient with immigrant background expression of pain specific types of diseases that may be completely unknown and difficult to integrate into biomedical explanatory models (Eriksen & Sajjad, 2015). All these in turn has huge impact on the work of interpreters who suppose to help patients and clinicians to understand each other as these patients come from different cultural and linguistic backgrounds, and possibly have different perception and experience of illness than the western biomedical discourse model of explanation.

In stating cultural connotation of patients' expression, a medical professional informant stated;

> *Sometimes, I see uncertainty on the face of the patient. There are occasions where I repeated the message multiple times to just make sure that the patient is getting the right information. I mean it might have something to do with the patient culture or way of communicating or patient mechanism of making sure that the message is right*.

Accordingly, the uncertainty on the face of this patient may mean different things depending on the cultural context to it.

With regard to semantic barriers, a language interpreter informant said,

> *In several occasions I have experienced and noticed that, when a patient say something he or she does not mean it. For instance, a patient saying "yes" does not necessarily mean he or she understand or agree with the message. I mean words that seems to have similar meaning in Norwegian and patient`s native language, may not really so*.

This interpreter underlines that similarity in literal meaning of words and sentences between patients` native language and Norwegian does not necessarily indicate the speaker's intention or similarity in cultural meaning of what is being said. As presented under the theoretical framework, semantic barriers, that is, two seemingly similar words may mean entirely different things in different languages thereby leading to misunderstanding (Eriksen & Sajjad, 2015). In this regard, literal translation of a word can result in a very different meaning in the translated language than in the original message. That is, there is difference in the meaning of the words and phrase even if it is understood both by the patient and healthcare professional (Eriksen & Sajjad, 2015). This is because words or concepts have cultural scripts, and understanding their correct meaning presuppose understanding of the cultural context in which the concerned language is spoken. Moreover, certain words and concepts have meanings that are rather unique to the speakers of the language community (Segalowitz & Kehayia, 2011). Therefore, simple translations of one word or concept in one language to the other may lead to erroneous conclusion and risk to patients safety since the correct meaning of patients statement require understanding the nonverbal aspects of the communication as presented under the theoretical framework dealing with nonverbal communication.

As mentioned earlier, the target group of this research belongs to what is classified as high context culture or language which means understanding the correct meaning of their expression, depends not only in the meaning of the word but also on factors like how the word or sentence is messaged, the facial expression, the tonality of the voice and the body

language among other things, as opposed to low-context languages, like Norwegian which rely heavily on verbal communication, and in which context has little effect on the meaning of the content of what is being said (Eriksen & Sajjad, 2015). Hence, both language interpreters and clinicians should pay attention to nonverbal aspects of the patients' communication. In other words, direct and literal translation of patients' expression may lead to wrong perception by the healthcare professional. Thus, the language interpreter may also pay attention to the non-verbal aspects of the patient's communication in finding out the correct translation of the patient's words and sentences.

In summary, empirical data collected from participants indicate that challenges of language barriers are multidimensional and have huge implications for the provision of patient-centered and culturally congruent healthcare to patients with limited language proficiency. As discussed in this chapter, language barriers impairs provision of quality healthcare and have impacts on patients, health professionals and language interpreters in various ways. For instance, language impediments negatively affect important components of healthcare quality including patient participation and patient centredness, patient assessment, data collection, and diagnosis. It also leads to delay of treatment, and low satisfaction among patients and healthcare professionals. Yet, language barriers leads to patients' poor understanding of diagnosis or treatment, and difficulty in expressing their health situations. As shown by the empirical data and discussed above, all these results in feeling of loss of control due to inability to participate in the care process by the patients and contributes to poorer quality of care and endangers patient safety. In language discrepant medical communication settings, clinicians face various challenges related to language barriers including difficulty in assessing patients language proficiency level and the need for language interpreter, lack of cultural competency, low awareness of risks of language impediments and lack knowledge on how to use interpreters during interview, and challenges related to non-compliance with relevant legislations requiring the use of professionals language interpreters. Yet, challenges of language barrier also related to interpreters as raises issues related to competency, neutrality and availability professionals interpreters among other things.

Chapter 5 Summary and reflection

5.1. Introduction

Over the last few decades, migration, has dramatically increased and becoming more continues than ever before with about 272 million people living outside their country of origin in 2019 (McAuliffe et al., 2020). Norway has also become increasingly multicultural, and as of 2018, immigrant population accounted for 14.4 % of the total population in Norway (Satistics Norway, 2018). The continued globalization and migration, which brought about demographic changes and multiculturalization, has increased the likelihood of experiencing language barriers for patients with low language proficiency. This in turn presents new challenges to healthcare systems like Norwegian healthcare system that are originally organized and intended to serve a more or less monolingual and mono-cultural society.

5.2. Summary

In the provision of patient centered and culturally competent care, medical communication comprehended by both patients and clinicians is significant and core component of the healthcare as collection of accurate and comprehensive patient-specific data that are the basis for proper diagnosis; involving patients in healthcare process and outcomes, eliciting informed consent; providing explanations, instructions, and education to a patient requires effective communication. However, unaddressed challenges of language barriers and thus impaired communication leads to low quality healthcare and risks to patient safety. Hence, it constitute challenges for meeting the health-care needs of linguistic and cultural minority groups as identified both in this thesis and other related studies. In this research, I have identified and analysed challenges of language barriers in cross-cultural provision of healthcare to patients with immigrant background whose Norwegian language proficiency is limited. To this end, empirical data is collected from patients, healthcare professionals and language interpreter, among others, and analysed in light of relevant theories in order to gain multiple perspectives, and to answer the main research question; what are challenges of language barriers in the provision of cross-cultural healthcare to adult patients with immigrant background with limited-Norwegian language proficiency.

The results from the empirical data show that there are multiple challenges associated with medical communication involving patients whose Norwegian language proficiency is low, as summarized below. Based on the data collected through qualitative interviews of patients, healthcare professionals and language interpreters, I have identified four main categories of challenges of language barriers in cross-cultural healthcare in relation to a)

healthcare quality, process and outcomes, b) patients, c) healthcare professionals, and d) language interpreters.

The first category is challenges of language barriers as related to *healthcare quality, process and outcomes*. The findings of this research indicate that challenges of language barriers are multifaceted, and language barriers have adverse impact on quality of care throughout the health-care continuum from accessing the healthcare, patient assessment & examinations, testing, diagnosis, and prescribed treatment. The, informants explained challenges of language discrepant medical communication on central component of high quality healthcare like patient-centeredness, understanding the process and outcomes of the healthcare, expressing their situation, patient assessment and data collection, timely provision of the care patient safety and patient satisfaction among others. For instance, language discrepant medical communication may necessitate extra investigation like X-ray to get a more reliable information about the patient situation thereby leading to delayed treatment and low satisfaction with the healthcare among the patients and healthcare professionals. In doing so, challenges of language barriers in this regard compromise central components of healthcare quality like patient-centeredness, timely provision of the intended are and patient satisfaction as described under the theoretical framework (Longtin et al., 2010; Organization, 2013, 2018).

The second area of challenge of language barriers identified in the research is the one related to *patients themselves*. Patients with immigrant background and with limited language proficiency are special and forms exception in many ways to the general population. These patients subgroup inability to speak the local language, which Bourdieu called embodied cultural capital (Bourdieu et al., 1995), often leads to communication problem with their clinicians and poorer quality of care as aforementioned. The empirical data demonstrated, among other things that, these patients have low cultural capital and socioeconomic status indicated by lack of education, limited language proficiency, low health literacy rate and thus very limited resources to get access to and use the healthcare as normally expected.. For instance, they cannot directly communicate with medical professionals due to language barrier and thus have to use interpreter mediated medical communication. Main obstacles identified in the research in this regard include poor understanding of diagnosis or treatment, difficulty in expressing one's health situation, poor participation in the healthcare process and the resulting feeling of loss of control due to inability to participate in the care process, perceived barriers, emotional distress, and cultural barriers among other things. Informants mentioned, for instance, difficulty understanding any written documents including medication

instruction and discharge summary or appointment letter from the health institution. Some of the informants, pointed that some of the challenges extend far beyond communication between the patient healthcare professional, as it also affects patient's capacity to seek necessary health information and language barrier limits capacity of patients with limited language proficient to get access to and understand health information only in the interpreter mediated medical communication. All these, in turn, led to decline in medication adherence, increased medication complications and increase the likelihood of missing appointments and going to emergency rooms, low satisfaction among patients with limited language proficiency among other things (Jacobs & Diamond, 2017).

Third, in relation to *medical professionals*, challenges inherent to communication in language-discrepant healthcare settings, which are identified in the research, include challenges in assessing patients` language proficiency and the need for language interpreter, lack of cultural competency and low awareness of risks associated with language-discordant healthcare and non-compliance with laws and regulations as to the use of professional interpreters and utilization of untrained interpreters like family member among other things. For instance, due to lack of cultural competency and low awareness among medical professionals as to risks involved in medical communications with limited language proficient patients , clinicians often times fails to make the communication accommodative of patients. As presented and discussed above sometimes interpreters and patients face challenges in understanding the communication which would have been avoided had the clinicians adjust their communication by using, for example, simpler medical terminologies that the language interpreter or the patient can understand thereby lowering uncertainty, interpersonal anxiety, and heightened mutual understanding as stated by communication accommodation theory (Gallois et al., 1995; Giles, 2016; Lee, 2013). Yet, the research identifies challenges in relation to limitations of relevant legislations in providing language-concordant healthcare like absence of objective standard that medical professional can use to assess patients language proficiency and decide whether the patient need language interpreter or not. The empirical data demonstrate also the medical professionals' limited competency in terms of meeting the special demands and challenges presented by patients with limited Norwegian language proficiency. For instance, health professionals lack cultural competency to adjust their medical knowledge and the healthcare provision to the unique cultural and individual need of these patient subgroups.

The final category of challenges of language barriers identified in the research is the one in relation to *language interpreters*. Accordingly, challenges identified include lack of

formal training, incompetency of language interpreters, challenges related to neutrality and impartiality of interpreters, unavailability of interpreters and challenges of language translation emanating from cultural, language and value differences. Beside, challenges related to the ethical requirements of neutrality and impartiality of interpreters, which require interpreters to only translate what is being said without any further explanation(Direktoratet, 2011; Tolkeforbundets, 2017), are also identified and analysed. Yet, challenges related to interpreters` different education background and discourse than the health discipline is also identified and discussed.

5.3. Reflections

All of the aforementioned challenges emanating from language barriers be it challenges related to the provision of high quality healthcare, or as related to patients, medical professional, interpreters or limitation of relevant laws are all interrelated. For instance, challenges related to involving patients in healthcare process and decision making is also related to patients difficulty in expressing his health condition and lack of patient empowerment, whereas challenges faced by healthcare workers in assessing the language proficiency of patients and the need for language interpreters should also be seen in light of limitations in relevant laws in providing guidelines and details so as to ease the work of healthcare professionals**.** Therefore, the interrelated and interdependent nature of challenges of language barrier in cross-cultural provision of healthcare, demands holistic and comprehensive approach to address the challenges seen from different perspectives and various factors which have bearing on the issue in one way or another. To this end, the researcher recommends consideration of various intervention measures ranging from rethinking and making the healthcare system accommodative and responsive to the need and conditions of linguistic and cultural minority groups in general and patients with limited language proficiency in particular to overcome the challenges.

Based upon earlier researches and this study, it could be claimed that the systemic nature and parts of challenges of language barriers demands changes to the healthcare system taking into the unique need and experience of this group as stated by the anti-oppressive theory (Healy, 2014). These measures include, making necessary modifications to relevant healthcare policies, laws, values, and the conventional wisdom on which the healthcare systems service provision is founded upon so as to be inclusive and responsive to people with diverse linguistic and cultural background. For instance, challenges of language barriers as related to assessing patients language proficiency level and the need for interpreter can be addressed by

enacting laws and guidelines providing standardized and objective criteria as to assessment of patients language proficiency level and the need for professional interpreter, providing guideline and instruction on absolute minimum standards indicating critical situations where healthcare workers should use professional interpreters, and on how to work with professional interpreters, and making patients language data to be part of the patient care journal with the view to make patients language fluency level available for clinicians in advance among other things. This is also important in minimizing problems related assessing patients language level and overestimation of patients' language proficiency by health personnel and address the widely reported under-utilization of professional language interpreters and the use of untrained interpreters in the healthcare system (Kale, 2006; Kale & Syed, 2010).

With the view to address challenges of language barrier in relation patients themselves various measures can be considered including empowering patients with low language proficiency. As demonstrated by the empirical data, all of the patients informants has no educational background and cannot use Norwegian in their direct communication with their clinicians, thus any effort empower these patients should take in to consideration challenges and situation of these population including lack of education and thus low cultural capital and socioeconomic status in addition to language barriers. Thus, measures should be taken to empower these patients, as empowered patients are in a better position to manage their own health and participate in the healthcare process and outcomes (Organization, 2013).

Meaningful patient-participation in healthcare provision is multifaceted should be approached from the role of various stakeholders and presuppose, empowering the patient with healthcare information among other things. Empowering these patient groups further requires understanding the unique situation of each patient, and equipping them with the necessary health information while at the same time adapting the health information to their level and language they understand to ensure effective patient participation as mentioned under patient empowerment under the theoretical framework. This requires adapting the health information not only to these patient subgroups native language but also to the level they grasp in easy-to-read, low literacy picture and symbol formats. In this regard, all the necessary documents that are component of the healthcare process and outcomes including application forms, patients right statements, consent forms, appointment letters and discharge summaries could be translated in patients native languages so as to bridge the communication gap caused by language barrier in this regard. In addition, it is important to develop health materials and brochures intended for patient education considering specific needs of these cultural and linguistic patient groups.

As indicated by the empirical data and discussed in the research, healthcare providers face individual cultural and epistemological predicaments in approaching patients with limited language proficiency. As such, medical professionals need awareness about risks associated with language barriers, and competency to understand and to empower these patients by adapting the healthcare process and information to the unique need and situation of patients with diverse linguistic and cultural background. Addressing challenges faced by medical professionals in language discrepant medical communication setting can thus, at least be minimized by raising the awareness of medical professionals as knowledge of language barriers in healthcare and associated risks, and equipping them with necessary skill to deliver culturally appropriate healthcare that meet the identified needs of the target population group. This can be done through provision of ongoing in-service staff training aimed at equipping medical professional with cultural competency and raising awareness as knowledge of language barriers in healthcare and associated risks so that health professionals become informed of evidence on cultural differences in communication across cultures and get familiar with communication strategies and styles of cultural communities to which the patient belong (Healy, 2012). This is important to ensure language-concordant healthcare across the healthcare continuum and will ultimately help to improve healthcare outcomes and patients experience. In addition, it is important that healthcare institution facilitates training and courses for healthcare professional on how to use interpreters during interview as such knowledge is significant for the quality of the language service and also for the purpose of adapting healthcare information to the personal need and situation of a patient. Yet, making cultural competence an important component of curriculums in medical education programs is important.

With regard to addressing challenges of language barriers associated with interpreters and achieving best practice standards in interpretation in medical communication settings, the researcher suggest appropriate screening and training of interpreters. In addition, continues trainings for interpreters specifically aimed at increasing competency of interpreters' and awareness raising about risks and complication involved in the cross cultural healthcare among others will help to improve the quality of the language translation service. To alleviate challenges of language barriers in relation to unavailability of language interpreters, the researcher suggest the move towards the legalization and incorporation of online or digital translations tools. In this regard, tools like videoconferencing, also known as Video Medical interpretation (VMI), or Video Remote Interpretation (VRI), is vital as it can be accessed remotely by multiple different health systems and allows access for scheduling, anytime of

the day or night thereby reducing challenges of accessing interpreters in some clinical scenarios like emergency situations when there is no other options or for use briefly while awaiting a professional interpreter as mentioned by health professionals during the interview. In addition, such technologies, has advantage over telephonic interpretation as it allows health professionals to observe body languages of both patients and interpreters (Jacobs & Diamond, 2017). However, the use of online translation tools and internet based applications for smartphones and tablets can useful resource in dealing with challenges of language barriers in healthcare, its practical application and use needs caution and further studies. Moreover, employing health personnel with diverse linguistic and cultural background, or culturally, and linguistically competent workforce and using bilingual clinical in the provision of cross-cultural healthcare can potentially mitigate challenges of language barriers associated with incompetency of health professionals and unavailability of professionals interpreters. With regard to challenges of interpreters concerning the gender of interpreters owing to patients religious and cultural beliefs, the researcher suggest briefing the concerned patients and/or the use of telephonic interpreters to overcome the problem in the short run while working on raising awareness on gender issues in these communities in the long run.

Eventually, while aforementioned findings and suggestions are based on empirical data collected through qualitative interviews and contextual features from the healthcare system, their clinical relevance can, with necessary modification and adjustment**,** have transferable values and be applied in a wider context beyond the healthcare system to other social service areas, like schools and welfare institutions where language barriers create communication challenges and thus impair service delivery. In addition, although the research is done on the basis of data collected and contextual features from healthcare in Norway, the clinical relevance and findings of the research can also be applied in a wider context beyond Norway, especially in western countries whose health system is facing new challenges due to the ever increasing number of people with immigrant background and multicultural nature of the society.

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Appendices

Appendices.1 Consent letter for conducting interview

I am a master student in social science at Nord University and want to conduct an interview to collect data for my master thesis.

The objective of the interview is to collect information for the purpose of doing research on the language barrier in provision of cross-cultural provision of healthcare to people with immigrant background in Norway.

As part of the interview, I will use audio record to record the interview for the purpose of working on the information during the research. However, all the recorded audio of the interview will be deleted eventually.

The participant may, at any time, of the interview, ask a question, comment or stop the interview if necessary.

Information collected during the interview will be used for the sole purpose of this very research and will not be published anywhere.

Private information regarding the participants will be kept confidential. As such, any data which can potential reveal sensitive information or identity of the interviewee will not be revealed. All requirements concerning collection of data is complied with and the necessary permission is obtained from Norwegian center for research data (NSD)

My contact information is written below.

Thank you for your willingness and time for the interview in advance!

Appendices.2 Interview guide for patients

1. Tell me about your education level and how you come to Norway?
2. How do you rate/describe your language proficiency in Norwegian and/or English? How about other languages?
3. Have you experienced language difficulty in communicating with healthcare workers and explaining your health situation? How?
4. Is there situations in your language barrier became more prominent?
5. How do language barriers affect your involvement in the healthcare process and outcomes?
6. How is it to talk to your healthcare providers though language interpreter r?
7. How important is it for you to speak in your native language to healthcare worker?
8. How satisfied are you in the healthcare process and outcomes?

Appendices.3 Interview guide for healthcare professionals

Question 1

- In which capacity do you work in the healthcare institution?
- How problematic is language barrier in the provision of healthcare to patients with limited Norwegian proficiency?
- How absence of common language/direct communication with the patient affect your understanding of the patient's situation?
- What kind of problem or challenges can absence of common language between the patient and healthcare professional create?

Question 2

- Any practical experience?

Question 3

- How do you assess patients' language proficiency and decide whether to use interpreter or not?
- How often do you use professional interpreters in communication with low language proficient patients?
- Is there situations during which you use untrained interpreters like family members to communicate with patients who do not speak Norwegian?
- From your experience to what extent, the use of interpreters solve or mitigate the problem of language barrier in communication patients who not speak Norwegian?
- To what extent healthcare professionals can depend solely on interpreters in terms of quality of the language service or accuracy of the translation?
- Is there safety mechanism to make sure that the conversation between healthcare worker and patients is being translated correctly?
- Do you have training on how to use professional language interpreters during interview?
- Do you make preparation when you go to the interview?

Question 4

- How do you describe your knowledge of other cultures (cultural competency)?

Question 5

- How aware are you of the complexities of language barrier in language discrepant medical conversation setting?

- How aware are you of professional medical terminologies that language interpreters or patients may not understand
- How aware are you about situations and feelings that patients may not tell due to cultural values or religious beliefs?

Question 6

- Any final though?

Appendices.4 Interview guide for language interpreters

1. How do you describe or rate your Norwegian language proficiency?
2. What is your educational background?
3. Do you have formal education in language translation?
4. How long have you been in Norway?
5. How do you describe your knowledge of the Norwegian culture (especially as related the healthcare system)?
6. How language barriers is a problem in the provision of healthcare to people with immigrant background who do not speak Norwegian?
7. What are the challenges of being language interpreter in a medical communication involving patients with low Norwegian language proficiency?
8. Have you experienced or observed challenge due to the differences in cultures involved?
9. What makes it different had these patients communicate directly with healthcare professionals with his native language?