

Invisible rights: Barriers and facilitators to access and use of interpreter services in health care settings by Polish migrants in Norway

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Abstract

Aims: Polish migration to Norway is a relatively new phenomenon. Many Polish migrants do not speak Norwegian or have insufficient knowledge of the language, which makes it difficult or impossible to communicate with health personnel. The main aim of the study was to identify barriers and facilitators to Polish migrants' access and use of interpreter services in health care settings in Norway.

Methods: 19 semi-structured interviews with Polish migrants were carried out in 2013 and 2014. Thematic analysis was performed to identify barriers and facilitators related to the use of interpreter services.

Results: Participants often received information regarding their health condition and treatment in a language they did not fully understand. They reported that their access to interpretation services was limited or denied for a variety of reasons, such as reluctance of health personnel to book an interpreter and overestimation of patient's language skills. In many cases, using friends, relatives or bilingual staff instead of professional interpreters compromised the quality of interpretation.

Conclusions: Even though migrants are entitled to free interpreter services, Polish migrants experience several barriers accessing interpreters in health care settings. A variety of practices such as selective use and use of unqualified and ad hoc interpreters reveals a failure to meet recommended standards of interpretation services. Not involving professional interpreters in language discordant consultations constitutes a serious threat to practitioners' ability to work as competent professionals, potentially risking the quality and safety of healthcare for these patients.

Key words: Polish migrants, interpreter services, health care setting

Introduction

Polish migrants constitute the largest foreign population group in Norway, with nearly 100 000 registered as of January 1, 2017 [1]. With a small outflow and high family reunification [2], a significant number are predicted to stay. Due to the characteristics of the labour market, Norway attracts more Polish men than women (2013 – M: 50 658, F: 26 004; 2018: M: 63 576, F: 35 636), [3]. 76% of Polish migrants work full time in Norway but it is not known whether they have permanent positions or not [4].

Polish migration to Norway is a relatively new phenomenon, and existing research shows that many Poles in Norway do not speak Norwegian or their language competence is not sufficient for communicating with health personnel [5, 6].

Lack of a common language between a migrant and the health personnel in the new country delays or even prevents contact with the health care system [6]. Studies from a variety of countries on various migrant groups confirm that a lack of language competence may prevent migrants from using health services [7]. The anticipation of language difficulties was cited as the main reason why Polish migrants in the UK prefer to delay care in order to see a doctor in Poland [8]. Poles in the UK who spoke English fluently reported feeling discomfort due to the more subtle levels of communication they could not control [8]. Other studies from UK show that migrants perceive language and communication difficulties as the main barrier to receiving effective health care [9, 8]. Indeed, it is widely recognized that a language barrier between the migrant and health personnel can create poor communication and constitutes a serious risk to patient safety [10, 11, 12, 13].

Equity in health care means equal access to health services, equal utilization for equal needs and equal quality of care [14]. Communication barriers jeopardise such equity [15]:

patients who speak a minority language will not have the same opportunity to communicate with a health care provider as patients who speak the **majority** language do. For example, equal access and quality of care is compromised if doctors and patients cannot communicate sufficiently to effectively diagnose the patient's problem, make a decision regarding how to address it, and formulate a plan for how to treat it.

In medical settings, the negative effects of language barriers are mitigated by providing professional interpreter services. Both the patient and the doctor can speak in their mother tongue, and a professional medical interpreter can translate in real time. However, in European countries, access to such interpreter services is inconsistent [16], depending on national policies rather than international or European law [17]. Unfortunately, access to professional interpreter services is not sufficient for their regular use: Research shows that health personnel prefer using ad hoc (i.e., non-professional, untrained) interpreters, even if professional interpreter services are widely available [18,19,20] and even if medical personnel are aware that ad hoc interpreters compromise the quality of care and can risk patient safety [21].

All persons residing in Norway have the right to access health services [22]. Registered migrants from Poland have the same entitlements as Norwegians and are subject to the same cost-sharing regulations. The Health Personnel Act § 10 states that health- and care providers are to give information to the person entitled to it, in accordance with the regulations in the Health & Rights Act Chapter §§ 3-2 to 3-4 [23]. The Health & Rights Act Chapter 3 (Pasient- og bruker- rettighetsloven) underlines that *'a patient has the right to receive information necessary to gain insight in his/her health condition, the content of the medical treatment, in addition to information about possible risks and side effects and of any inflicted injuries or serious complications'*, cf. §§ 3-1 and 3-2 [24]. The act further states that the information is to be *adjusted* to the recipients' individual premises, such as age, maturity, experience, education, culture and language background. Moreover, the personnel are, as far as possible, to secure that

the recipient has understood the content and the meaning of the information, cf. § 3-5 [23]. The chapter further states that patients have the right to information adjusted to their language background even if they speak Norwegian on a daily basis. One might say that the use of professional interpreters is only implied in these acts, as the way to implement the Health Personnel Act; that is, even though immigrants' right to have professional interpreters is not clearly stated, access to interpreting services is a prerequisite in realizing patients' rights.

The increased significance and legal strengthening of patient's rights have important implications for the communication in health care settings [18]. According to the Interpreting Services Review Committee, an advisory body set up by the Ministry of Children, Equality and Social Inclusion, professional staff employed in the public services, including health personnel, must be able to communicate with all users [25]. Therefore, according to the committee, communication through an interpreter should be included in the education of relevant professions, inter alia, doctors and nurses [25]. The Directorate of Integration and Diversity (IMDi), which is the national authority on interpreting in the public sector in Norway, recommends using authorized interpreters to ensure the best quality service [26]. According to report published in 2014 by IMDi, due to the high number of Polish interpreters available, requests for interpretation between Norwegian and Polish was amongst the easiest to fulfil [27].

Access to cost-free interpretation helps to ensure that underserved patients have equal access to health care regardless of language. This is in line with the Universal Declaration of Human Rights, paragraph 25 [28] and with the Norwegian National Strategy Document on Immigrant Health, which argues for equitable access to health care services for migrants in Norway [29]. However, studies show that Polish migrants in Norway may not be aware of the availability of cost-free interpreting services [8,9]. Further, relatives are often asked to interpret on behalf of the patients [8,9], even though the guidelines on communication via interpreter for

health personnel underlines that children, family members or health personnel should not be used as interpreters [30]. An absolute ban on using children as interpreters came into force in Norway in 2016 [31].

Patients' lack of awareness of their rights to professional interpreters, combined with the use of unauthorized (ad-hoc) interpreters, suggests that these rights may not always be put into practice. The present article is part of a larger study on Polish migrants' access to Norwegian health care services [6]; access to interpreting services emerged spontaneously as particularly salient for participants in the study. The main aim for this part of the study is therefore to identify barriers and facilitators to interpretation services among Polish migrants.

Materials and methods

Study setting and participants

The data that are presented in this article derive from a qualitative study conducted among Polish migrants in Oslo and its vicinities from November 2013 to July 2014. Oslo was chosen as the sampling site as it has the largest population of Polish migrants among Norwegian cities [2].

The first author, a Polish migrant herself, approached 3 key participants within the Polish community who had different characteristics in terms of age, education level, and type of work. She applied a snowball sampling method, asking these three participants to recruit other informants who varied in age, gender, education level, work-situation, and length of stay in Norway, thus seeking to obtain a sample with maximum variation according to certain socio-demographic characteristics [32]. All informants received an information letter that included the following information: study aims (their experiences accessing health services in Norway), methods used, confidentiality, voluntary participation, freedom to withdraw and researcher's contact details. Note that study aims did not refer to interpreter services specifically. Five

people declined to participate, stating that they believed that their experience with the Norwegian health services was too limited to be of interest or that they had no time to participate in the study. The recruitment of interviewees continued until data saturation was reached at 19 participants (Table 1). Ultimately, the sample consisted of eight males and eleven females, ranging in age from 30-60 years and with an educational background varying from basic vocational to university degree. Some of the participants were living permanently in Norway with a permanent job. Others had a more unstable living-situation without a permanent job and traveling back and forth to Poland. They did not know whether they would bring their families to Norway or if they eventually would go back to Poland. All male participants reported migrating to Norway for economic reasons, while most female participants had come to Oslo for family reunification. All participants were registered migrants and had experience with Norwegian health care services. Eight participants reported having only basic knowledge of Norwegian despite having spent from 5.5 to 7 years in Norway.

Individual semi-structured in-depth interviews

We chose individual semi-structured, in-depth interviews in order to focus on individual health patterns. The interview guide was based on the results of previous studies. It explored broad themes (e.g., barriers and facilitators experienced by Polish migrants when accessing Norwegian health care services, experiences with health services in Norway, health seeking behaviour both in Poland and Norway) and did not focus on access or use of interpretation services directly. Rather, this topic emerged spontaneously as participants answered questions about their experiences with the Norwegian health care system.

The interviews took place at a time and place convenient for the interviewees (cafes, interviewer's or interviewee's flat, work place), lasted between 30-70 minutes, and were tape recorded. They were conducted by the first author in Polish, enabling the participants to convey

their experiences in their mother tongue. Sharing the language and the cultural background was also valuable for building trust between the researcher and participants. However, this “insider position” [33] could introduce bias, and to avoid reproduction of methodological nationalism [34] and to reduce the influence of assumptions and prejudices introduced by the researcher, self-reflexivity was particularly important [35]. When interviewing, reflecting on the need to maintain her position as a researcher, she refrained as much as possible from responding to informants’ attempts to involve her in a more familiar, conversational manner (i.e., as one would speak to a friend or acquaintance). For example, sometimes informants invited a comparison of experiences or perspectives, such as saying “you know Polish doctors” or “you know how it is here”. During analysis, any potential bias was mitigated by the involvement of the last author, who was Norwegian and who participated in the whole process of data analysis.

Analysis

The recordings were listened to immediately after the interview and transcribed verbatim within the following day. Descriptive and analytical notes were systematically taken throughout the research process.

The first author extracted and translated into English all excerpts concerning interpreter services from the interviews. These excerpts were coded manually, categorized, and analyzed, applying the following six-phase approach to thematic analysis [36]. The first and the third author conducted these phases of analysis by consensus. (1) They read the transcribed excerpts several times in order to obtain a thorough overview of the data. (2) They assigned initial codes to the text and (3) clustered them into themes. (4) They reviewed initial themes to assure the coherence of the data within each theme and a clear distinction between the themes. (5) They identified subthemes within each theme and (6) merged the content of themes and subthemes into generalized descriptions. Throughout this process, the first author interpreted several of

the topics from a Polish frame of reference, while the last author viewed and interpreted the findings from a Norwegian frame, based on her experience with Norwegian society and the Norwegian health care system. Thus, the analytical process produced a thorough and negotiated representation of the findings, increasing the validity of the study.

Ethics

The project was considered to be outside the remit of the Act on Medical and Health Research and could therefore be implemented without the approval of the REK (the Regional Committees for Medical and Health Research Ethics). The study was approved by the Data Protection Officer (Personvernombudet) at Oslo University Hospital. All participants gave written and informed consent.

Results

12 of the 19 study participants addressed access to interpretation services during the interviews without being directly asked about it. Although most of them mentioned awareness of the right to interpretation services and one explicitly told that he had no problems accessing these services, the results show that a large group of the participants experienced several barriers to accessing interpretation services. We identified two broad themes related to the topic of interpretation: facilitators to accessing interpreter services and barriers to accessing interpreter services. Two subthemes were identified from the first theme: the right to access interpreter services and the services being free of charge. Four subthemes were generated from the second theme: limited availability/accessibility of authorized interpreters, insufficient knowledge or awareness among staff, lack of integration of interpretation services in organisational routines, and varied quality of interpreters.

Facilitators for accessing interpreter services

The existence of the right to cost-free interpretation services in Norwegian medical settings is, if implemented, a potentially huge facilitator on the systemic level. Below, one of the male participants told how he managed to communicate without problems due to the availability of an interpreter:

I manage with my Norwegian when I visit the emergency room or my GP. In hospital, when more advanced medical vocabulary is needed, there is usually interpreter present. No problem. (M1)

The participant underlined that he needed an interpreter only in encounters in which he felt that his Norwegian vocabulary was insufficient, and he had not experienced any problems related to such considerations.

Another facilitator on the systemic level is that interpreters are free of charge, and that Polish interpreters are highly available [27]. One of the female participants highlighted that interpreter services can be reached without costs, thus “*everyone can ask for an interpreter if necessary*” (F4). No other participants mentioned successfully accessing services, let alone the conditions that facilitated the process.

Limited availability/accessibility of interpreters

Most migrants who mentioned interpretation were aware of their right to access cost-free interpretation services. However, all of them except for one reported that they had experienced limited access to interpreters or that their access was denied for the following reasons: health personnel did not offer the service, they claimed they did not have access to or have resources for interpreter services, they asked the patient to pay him/herself, or they forgot to order an interpreter when the patient had asked for one. One of the male participants reported that even though he was at the hospital regularly due to injuries caused by a traffic accident, he

always had to ask the hospital staff for an interpreter. He described how the lack of an interpreter affected his consultation:

Each time I had to ask for the interpreter. Once they forgot to arrange an interpreter for me. I did not know that I was going to be on my own so I did not get a chance to prepare for this visit. I didn't prepare the right terminology, the stuff that I wanted to say, the medical stuff... after 2 minutes we both gave up because there was no way I could explain my problem. (M8)

This participant felt helpless because he could not communicate with the doctor, thus it was impossible to present his current health problem. Participants reported a variety of strategies for managing when the staff had failed to arrange for a professional interpreter. Some asked a friend to translate for them by phone, others cancelled the visit. Some would attempt to secure an interpreter by claiming that they spoke less Norwegian than they actually did, while others tried to communicate with the doctor in English.

Insufficient knowledge or awareness of staff

In Norway, a patient can call and ask for an interpreter before the consultation, and health services have the duty to provide one. Some participants mentioned that when attempting to book one in advance, they were persuaded not to because the staff members deemed their Norwegian sufficient for communicating with a doctor. A female who was fluent in English attempted to book an English (instead of Polish) interpreter because her English-speaking husband would be attending the visit with her. She described her struggles trying to convince the medical secretary that she needed an interpreter:

I used a dictionary and tried to ask for an interpreter over the phone. At the beginning, the receptionist told me that it wasn't necessary but I asked if the

interpreter could come anyway. I repeatedly had to ask her but she told me that the doctor could speak English. When I actually went there later on, it turned out that we had nothing to talk about. She [the doctor] was able to say only 'hello' and 'goodbye' and that was all...The visit was over. My doctor is Russian and maybe that is why she doesn't speak English. (F13)

In the case above, both the patient and the doctor had to use English as their lingua franca, which, because of the doctor's lack of proficiency, made communication impossible. In other cases, a lack of shared vocabulary or syntax would confuse discussion of symptoms, diagnosis, tests, and treatment plans. More importantly, the above quote illustrates that, for some reason, the medical secretary actively discouraged this patient from booking interpreting services, something that other participants who had moderate Norwegian language skills also reported. One of the participants declared that he spoke Norwegian fairly well in the context of his everyday interactions but not well enough to feel safe in communication with health personnel preparing for an operation. He found it very difficult to convince the nurse that he needed the interpreter:

It was in (X hospital)... And there, you could say, it turned into a fight. The nurse said that I couldn't (get an interpreter) and I said that I needed one. She was stubborn but she finally called for an interpreter. There is a way of doing it. When she (nurse) says something and I understand it, I can always say that I can't understand her. No matter what she is saying I can always reply: 'I don't understand, I don't understand'. (M1)

In this case, the participant knew that he was entitled to interpreting services. Due to difficulties with executing his rights, he felt forced to pretend that he understood far less Norwegian than he actually did.

Lack of integration of interpreting services in organisational routines

For some of the participants, gaps in hospitals' organisational routines created barriers to accessing interpreters. One female participant being prepared for a gynaecological operation described having to arrange an ad hoc interpreter at the last minute:

When I went for the operation at the arranged time, it turned out that there was no interpreter. I said: 'where is the interpreter'? And they were surprised... I was saying that the form [hospital admission form] says that there must be an interpreter. Because I need to have an interview with anaesthesiologist and the doctor before the operation. A friend of mine who is a translator made a break at work, and she went to the toilet and interpreted over the phone. This is how I made it. (F7)

In this case, the institutional routine for requesting an interpreter had failed. The patient recognized the risk to her safety and called her friend at the last minute. The hospital personnel approved this ad hoc solution, despite being unable to verify her friend's credibility and qualifications.

Other participants told about similar gaps, when formal requests for interpreters were not fulfilled, generating a need for last minute, ad hoc solutions. Whether these gaps were due to a lack of proper routines or a lack of awareness of those routines was unclear.

Quality of interpreting

Many participants experienced using ad hoc interpreters such as friends, children, or bilingual employees, compromising the quality of the interpretation. One male participant described being taken to the hospital after a car accident. It was an emergency, and a Polish doctor who worked there was asked to interpret for him during his first conversation with the health personnel. However, after this first, hastily-arranged consultation, the health personnel did not

ask the patient whether he needed “*a normal interpreter*” (M8), and, as a result, he had to manage all subsequent interactions with health personnel with his limited Norwegian language skills. Another participant reported interpreting for her friend during visits to the GP:

This is how it is here. Sometimes they provided her (friend) with an interpreter and other times they would say that they are very sorry, but they couldn't get her an interpreter because it is too expensive for them to organize one, and she has to bring her own interpreter along to the visit. (F12)

The above quote suggests more than the inconsistent availability of interpreters, it suggests that health personnel may directly deny access to interpretation services, thus placing the responsibility for providing adjusted information on the patient. There was also one example of using a child as an interpreter, even though this clearly conflicts with the law. The participant reported that her 14-year old son interpreted for her and her sister when they visited the doctor. Despite being illegal, the participant found this solution practical and was proud of her child's language skills, demonstrating the complexity of protecting patients and their families as they try to navigate the encounters with health personnel.

Sometimes, even though a professional interpreter was present, the quality was not always sufficient to safeguard good communication between doctor and patient. One participant described trying to prepare the appropriate medical terminology before the visits to the GP and the neurologist:

I knew that not all the interpreters that I was offered knew Norwegian perfectly. I repeatedly had to correct the interpreter when it came to the use of medical terminology because he could not say that (right)... Apparently, this (interpreter services) company won the tender... But not all the interpreters

who came there were so skilled ... I just knew that before the visit itself I had to prepare the medical terminology. (M8)

In the above case the participant had to make efforts to secure the quality of the consultation himself, an example illustrative also for some of the other participants' experiences with interpreters.

Discussion

Earlier studies on post-accession Polish migrants have reported that the most often mentioned barriers to accessing health care were lack of language competence and lack of adjusted health information [37, 9, 8, 6]. Access to cost-free interpretation services for migrants in Norway can help to address these barriers, helping to achieve equity in health care. In addition, a high number of Polish interpreters are available in Norway, and, as mentioned in the introduction, requests for interpretation between Norwegian and Polish are, reportedly, amongst the easiest to fill [27]. Our results show that entitlement to equitable health care is not enough without effective implementation. The Polish migrants who we interviewed experienced several problems regarding access to and use of interpretation services in Norway, and by extension, access to health information adjusted to their language background.

Health services often failed to meet recommended standards of interpretation services, providing them inconsistently or selectively. Health care personnel also seemed to overestimate patients' language competence, even when patients themselves (arguably the experts on their own level of proficiency) had emphasized their need of such services. A patient who can use Norwegian fairly well in the context of small talk (or even their everyday life) may not necessarily have the skills to manage the specific vocabulary and concepts needed to discuss health care (e.g., the symptoms they are experiencing, physiology, medications, risks, side-effects, treatment options). These findings are in line with other studies on different migrant

groups from Norway [5, 18] and from other countries [8]. In addition, it seemed that health care personnel may deem unqualified, ad hoc interpreters (e.g. friends, family members) an acceptable solution, suggesting a lack of understanding regarding the specialized skills and knowledge that professional medical interpreters bring to the health care consultation.

Access to interpretation services may be particularly important in situations in which effective communication between health personnel and patient may be a matter of life and death. Our findings indicate that hospitals do not always provide interpreters for patients who request them, even in situations that put patients' safety at risk. A review of effective interventions regarding caring for migrants in hospitals in Europe shows that patients who do not speak the language of the health staff in hospitals are more exposed to health risks and are at double risk of receiving insufficient care [38].

When migrants do not know the language at all, the quality of the interpreting services is particularly important for understanding essential information about symptoms, diagnosis, tests, and the type and course of treatment. However, the findings show that the quality of interpretation is often compromised, and there were several examples of patients being forced to choose between having a family member or friend interpret and having no interpreter at all. Patients being allowed or encouraged to ask friends or family members to translate infringes upon the policy, which implies that, except for emergencies, only qualified interpreters are to be used [31]. Our findings are in line with the results of the Norwegian study on health personnel's experiences with language barriers and the use of interpreters during medical encounters [18]. This study showed that more than half of the doctors and nurses surveyed declared that they often used migrants' family and friends to facilitate the communication [18]. The common practice of using bilingual health staff is not recommended either, because the employees are not trained interpreters [39]. Furthermore, according to the guidelines at Norwegian hospitals (i.e. not allowing other than treating health personnel to have insight into

case history), this practice may infringe upon protecting the confidentiality of the patient. Our findings indicate that in Norway, as in many other European countries where there is access to interpreter services in healthcare [18,19,20], health personnel still tend to prefer using ad hoc interpreters.

According to previous studies on European migrants in Sweden, migrants usually prefer a professional interpreter [40, 41], but they tend to accept family members interpreting for them, especially in emergencies when a professional interpreter is not available [40]. A practical handbook for health care professionals in Norway states that in acute situations (e.g. at the emergency department), health professionals with multilingual skills or, as the last resort, the relatives and friends can be used [42]. Research in Norway showed that in acute situations, 33% of health care professionals reported that they tried to communicate with the patient without any interpreter, 38% used family members or acquaintances, and 12% tried to find an employee who spoke the patient's language [18].

As illustrated in our findings, there were cases in which patients had to cancel, interrupt, or endure a consultation during which little was understood. Indeed, some doctors seemed to persist on continuing the consultation, even when communication was clearly inadequate. These findings are consistent with a Norwegian study presenting a detailed analysis of a consultation between a doctor and patient, neither of whom spoke Norwegian as the native language. The doctor was attempting to secure the patient's understanding and agreement about a recommended diagnostic test. For over ten minutes, he repeated and rephrased this recommendation while the patient responded only minimally. Finally the doctor decided to suspend the decision until a future appointment that would include an interpreter [43]. Even when a decision has been reached, if the patient has not understood the plan, he or she may unintentionally not adhere to it.

According to our findings, at least in 2013-2014, children can still be used as ad hoc interpreters, contradicting existing policy and generating ethical and social problems. Using children affects not only the quality of doctor-patient communication but also the children involved [44]. Operating in an adult situation can interfere with the roles in the family, and besides potentially introducing errors, it places an unacceptable amount of responsibility on the child [44].

In Norway, the service provider is responsible for covering the cost of interpreter services, which is an important facilitator for migrants to access those services. Indeed, in interviews with Norwegian health care professionals, only 4% stated financial reasons for not ordering an interpreter; more often, they did not order one because they felt it was time consuming and impractical (26%) or they had poor access themselves to the services (21%) [18]. However, our findings indicate that this expense may be a contributing factor, as some of the patients were frequently told about high expenses associated with interpreter services. While medical secretaries may be considered as being positioned rather low in the institutional hierarchy, they represent an authority to those who do not know the system, may be unclear on their rights, and are not fluent speakers of the majority language. Thus, our findings suggest that interventions aimed at increasing access to interpreter services might start with creating awareness among those who schedule appointments and facilitating their ability (and willingness) to book interpreters.

At the system level, using interpreter services may help to avoid unnecessary human and economic expenses. Access to qualified interpreters may prevent situations in which patients delay medical consultations due to anticipated language barriers, a situation that often results in higher costs to the health care system downstream. Research from the US has shown that access to professional interpreters in medical settings results in a greater use of primary care and less frequent use of emergency visits [45]. A study from Switzerland on asylum

seekers showed that providing interpreters resulted in higher use of health services (generating higher initial costs) while preventing the escalation of long-term costs [12]. Thus, to ensure adequate communication during the consultations and strengthen the equity in health care, interpreter services need to be more actively offered to all migrant patients, including those that are not aware of their rights.

Good communication between doctor and patient is a prerequisite of safe and effective health care. Good quality communication between patient and health care personnel is also a work protection issue for health care workers as it helps prevent incorrect diagnoses and medical errors. It is important for health personnel to bear in mind that it is not only the patients that need interpreters, but also the health personnel, who are working to provide safe and adequate healthcare. Without understanding the patients (including their case history, experiences of symptoms, emotions, and situation at home), it is difficult for doctors to use their professional skills to provide appropriate treatment and care [23].

There are some limitations of our study: Due to its qualitative nature and the sampling technique, the results cannot be considered representative for the whole population of Polish migrants in Norway. Also, we did not specifically ask about access to interpreters; this topic emerged spontaneously, and participants focused on their negative experiences, which could be distilled into a variety of barriers. Therefore, we could not provide a complete profile of possible facilitators. Future studies should be focused on exploring the details around those situations when migrants were provided with interpreters and felt that they had received the adjusted health care to which they are entitled. The small sample size provides justification for a larger-scale quantitative study among Polish as well as other migrant groups in Norway.

A summary of implications for practice

Our results suggest a need to improve staff awareness on the importance of interpreting when providing treatment and care to migrants with limited proficiency in the national language. It seems essential that this awareness include those that book appointments for patients, such as the health secretaries. Frontline staff are the gatekeepers to these services, and they need to become active agents in providing migrants with the safe treatment and care to which they are entitled. Management and institutional routines of everyday practice can either facilitate or discourage the implementation of guidelines and laws. Thus, to secure that all patients who need interpreters are offered (and receive) one, the hospital management has to create actionable policies. Policies and guidelines should also facilitate access to professional interpreting while deterring the use of unqualified, ad hoc interpreters.

Conclusion

The patients in this study often received information regarding their health condition and treatment in a language they did not fully understand. Thus, their rights enshrined in the Health & Rights Act Chapter 3 were violated (Pasient- og brukerrettighetsloven) [24].

Linguistic diversity poses a challenge to health services. Overcoming language barriers is a prerequisite for effective communication between doctors and migrant patients. Our analysis shows that many Polish migrants seem to be aware of their right to a qualified interpreter during medical encounters, but they experience barriers in their attempts to exercise this right. For various reasons, ranging from costs to overestimating migrants' language skills, health personnel seem reluctant to book interpreters. As a result, effective communication between health care personnel and patient is hindered, putting migrant patients' health at risk. It seems important to raise health personnel's awareness that the need for an interpreter goes both ways, as it is impossible to diagnose and provide appropriate treatment and care without being able to establish mutual understanding with the patient.

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Availability of data

The datasets generated and analysed during the current study are not publicly available due to risk of interviewees' recognition. Additional quotes and examples, that will support the findings, can be provided upon request.

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Table 1. Socio-demographic characteristics of informants

	Sex	Age	Education	Self-declared knowledge of Norwegian	Length of stay in Norway (years)	Type of work
1	M	40-50	Secondary vocational	Basic	7	Construction sector
2	F	30-40	University	Very good	6	Early childhood education
3	M	50-60	Basic vocational	Basic	6,5	Construction sector
4	F	30-40	University	Fluent	7	Public administration
5	F	20-30	University	Basic	1	Cleaning sector
6	F	30-40	Secondary vocational	Basic	8	Private business
7	F	50-60	Secondary vocational	Basic	6	Cleaning sector
8	M	40-50	Secondary vocational	Good	6	Service sector (plumber)
9	F	30-40	University	Basic	5,5	Service sector (receptionist)
10	F	30-40	Vocational	Basic	7	Private business
11	F	30-40	Secondary vocational	Basic	6	Cleaning sector
12	F	30-40	University	Good	5	Cleaning sector
13	F	20-30	University	Basic	1	Research sector
14	M	30-40	University	Good	1,5	Service sector (carpenter)
15	M	30-40	Secondary vocational	None	2	Construction sector
16	F	30-40	University	Good	6	Early childhood education
17	M	30-40	Secondary vocational	None	1	Construction sector
18	M	50-60	Secondary vocational	Very basic	6	Construction sector
19	M	30-40	Secondary vocational	Good	4	Service sector (mechanic)