Improving the Quality of Medical Interpreting in Norway

A qualitative study with perspectives from qualified interpreters

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Master Thesis

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Abstract

There have been several studies on the use of interpreters in healthcare in Norway but mostly these have taken the perspectives from healthcare practitioners and patients. The majority of the research has documented that there is an underuse of qualified interpreters in healthcare. As the quality of interpretation in healthcare has been a subject of discussion and debate the last couple of years, this paper aims to capture the views of qualified interpreters. The purpose of the study is to investigate how interpreter services are organized and the barriers and facilitators to the use of qualified interpreters.

My research questions are;

- Why is there an underuse of qualified interpreters in Norwegian health care?
- What are the barriers and facilitators to use of qualified professional interpreters?
- How can the quality of interpreting services be improved?

To investigate these questions, a qualitative method was employed. In-depth qualitative interviews with seven qualified interpreters were carried out.

This research uses the theoretical framework of professionalization to analyze the interpreters' professional system. In particular the concepts of traits and control are utilized. The traits theory involves some traits that are required to enhance occupations to professions. The concept of control is applied to examine an occupations` relation to the labor market. These concepts are used to explore the degree to which the field of interpreting has achieved professionalization in Norway.

My findings suggest that the interpreter market is highly fragmented and comprises an unregulated "profession" which makes it easier to use unqualified interpreters. Anyone with two languages can refer to themselves as interpreters and get paid to work as an interpreter.

According to my findings, there are two reasons why the interpreter services in Norwegian healthcare do not function effectively. Firstly, there exists a market disorder, which makes it difficult to control who takes the interpreting assignments. Private interpreting agencies are used to recruit interpreters, and since these agencies work in a competitive market, they win tenders based on price and not on quality. Secondly, the recruitment of qualified interpreters is compounded by the working conditions, payment and salaries that are insufficient to attract

qualified interpreters to healthcare. The number of qualified interpreters in the market is also low compared to the demand.

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1 Introduction

The growth of a foreign born population is shaping Norway today. Norway has become a multi-cultural society, with over 600,000 immigrants from all over the world. Immigrants in Norway are a large and heterogeneous group, and there is a great variation in their use of health care services, depending on the country of origin and reason for immigrating. Age and length of residence in Norway also explains much of the variation in healthcare use among immigrants from the different countries. But the differences in the utilization of healthcare are not only explained by differences in health and culture, but also by linguistic barriers (Lunde & Taxmon 2013).

In a study done by Blom (2011) on living conditions among migrants, it appears that immigrants have poorer health than the general population. As immigrants come from different socioeconomic backgrounds, their immigration status and limited language proficiency is likely to affect the quality of care they receive (Derose 2007).

Echoing the same sentiments, a report from the Norwegian Medical Association states that the growing language and cultural differences pose a major challenge to health care provision (Legeforeningen 2008). Communication barriers with patients who have insufficient Norwegian language skills make it particularly challenging to provide optimal healthcare.

Studies in health care for minority-language users indicate that language and communication problems have negative consequences for treatment and the flow of information concerning disease or disability. According to a report from the Directorate of Health (2009), communication problems can first and foremost lead to important information being misunderstood, which may in turn affect treatment outcomes. Secondly, communication barriers can also limit access to health care services for those who have difficulties in expressing their needs.

The Norwegian Directorate of Integration and Diversity (IMDi 2007) as well as Karliner (2007) acknowledge the challenges to healthcare resulting from linguistic and cultural diversity and the benefits of using professional interpreters are well established. The use of professional interpreters is important in order to offer quality health care services. In Norway, previous studies have shown an underutilization of professional interpreters in healthcare, and efforts in addressing the need of using professional interpreters have increased.

Objective of the study

The purpose of this study is to investigate how interpreter services are organized with the aim of identifying the barriers and facilitators to the use of qualified interpreters, based on the views of qualified interpreters themselves. Related Studies in the field of medical interpreting are concentrated on the views from patients and health practitioners (e.g Le 2011; IMDi 2007; Kongshavn et.al 2012; Kale 2006). Other authors have discussed the importance of using qualified interpreters (Jareg & Pettersen 2006; Hanssen 2002; Dahl 2001). A recent report from The Equality Project mapped the quality of interpretation in healthcare in the Oslo metropolitan area (Linnestad and Buzungu 2012). However, I have not come across any studies primarily based on the perspectives of qualified interpreters. It is therefore my hope that this paper will help bridge the existing knowledge gap in understanding and consequently improving the quality of interpretation in health care in Norway.

By contributing with knowledge from qualified interpreters, the present study will, hopefully, stimulate more research efforts in this domain and hopefully, better the quality of interpretation services in health care.

Hence, my research questions are;

- Why is there an underuse of qualified interpreters in Norwegian health care?
- What are the barriers and facilitators to use of qualified professional interpreters?
- How can the quality of interpreting services be improved?

Definition of terms

Interpreter and Interpreting

An interpreter is a person who renders a spoken message from one language to another language. In this paper interpreting is not used to mean translating, which is converting written text from one language to another. Interpreting is the process of interpretation. Hence an interpreter provides the oral interpretation (Jareg & pettersen2006).

Professional interpreter

The terms Professional interpreter and qualified interpreter are used interchangeably in this paper referring to a person with qualified interpreter training and skills. According to Jareg &

Pettersen (2006), a professional interpreter demonstrates a high level of proficiency in at least two languages and has appropriate training to interpret. In Norway, the national Authority for interpretation in the public sector, IMDi, defines an interpreter as a person with interpreter training from a university or university college, and or with a license as a certified public interpreter (2012).

Unqualified interpreters

In this paper, unqualified interpreters refer to individuals with no training and certification to work as interpreters.

Interpreter services

In this paper, the term interpreter services refer to mechanisms and processes used to facilitate communication with individuals who do not speak Norwegian. The services include recruitment of interpreters for direct, telephone or video interpreting**.** Interpreters are accessed either directly or through public or private intermediaries.

Tender system

As explained by Valio (2009), in general, health institutions get interpreters by putting interpreter services out on tenders. In this way tenders create competitions and the agency that wins the bid supplies the interpreting services. Private and public agencies compete to get tenders, and thereby supply interpreters to the institutions.

Thesis structure

This paper has seven chapters. The first chapter introduces the topic and the main aim of the study. Chapter two gives a background on immigrants in Norway and discusses the issue of immigration and health. It also describes the legislative aspects connected to the use of interpreters, as well as some of the key findings from previous research on use of interpreters in Norway. Chapter three provides a theoretical framework for the "profession" of interpretation. Chapter four explains how the study is conducted, choice of methods and limitations, who participated and how data was collected and analyzed. The subsequent chapter is the presentation and interpretation of the findings from the interviews, followed by

a chapter where the findings are discussed in relation to the conceptual framework. Finally, Chapter seven offers concluding remarks on the thesis.

2 Background

The need for interpreters grows with immigration. This chapter first describes the immigration pattern. As mentioned earlier, immigrants have poorer health than the general population. The preceding section describes the relationship between immigration and health. The next section gives an outline of laws and regulations related to interpreting in healthcare, followed by policy guidelines on the need of interpreters. The chapter ends with a section on relevant previous studies.

2.1 Immigrants in Norway

The immigrant population of Norway has been rapidly increasing since the end of the 1960's. Statistics Norway (SSB 2008) defines an immigrant in several different ways. Table 1 provides a list of the different definitions. For instance, an immigrant is defined as a person born abroad with two foreign-born parents who immigrated to Norway at some point. On the other hand, a Norwegian-born to immigrant parents is a person born in Norway of two parents born abroad, and with grandparents born abroad (Previously referred to as second-generation immigrants).

At the beginning of 2014 there were 759 185 immigrants in Norway, which makes 14.9 % of the population. Of these 633 110 were born out of Norway. The immigrants come from 221 different countries and independent regions. Thus, immigrants are truly a heterogeneous group with diverse backgrounds in ethnicity, religion, education and socio-economic status (SSB 2014).

Immigrants are categorized into several groups (see table 1). Previously, Statistics Norway made a major distinction between Western and non-Western immigrants. This is now replaced by grouping immigrants into eight categories according to place of origin: EU/EEA, USA, Canada, Australia/New Zealand, Asia, Africa, Latin America, and Oceania (SSB 2012).

According to Lunde & Taxmon (2013), western immigrants are socio-economically and culturally often relatively similar to the majority population in Norway, while non-western immigrants are a very heterogeneous group. As a result there is great variation between different patient and user groups. This is important when looking at immigrants' health and healthcare needs. In comparison with the majority population, non-western immigrants have a

larger variance in health and culture. More often it is also this group that needs interpreter services, particularly people from Asia including Turkey, Africa, and South and Central America (Valio 2009).see Table 2.

As presented from SSB (2014), at present most of new immigrants are labor migrants who are usually employed as manual workers who may experience lower health status and may also present more care needs than the rest. On average these immigrants have lower educational level and poor language skills.

Table 1. SSB Immigrant categories 2008

Code	Title
A	Born in Norway to Norwegian-born parents
B	Immigrants
C	Norwegian-born to immigrant parents
E	Foreign-born with one Norwegian-born parent
F	Norwegian-born with one foreign-born parent
G	Foreign-born to Norwegian-born parents

Table 2 Immigrant categories SSB 2014

Regions	Immigrant Population
Africa	74 283
South and Central America	19 853
Asia including Turkey	179 785
Asia, Africa, Latin America Oceania(Not including Australia and New Zealand) And European countries not in the EU/EØS	325 922

2.2 Migration and Health

The topic of immigrants and health has been extensively researched internationally. There are different theories about health and immigration. One theory has it that immigrants have poorer health than the general population of the respective countries they migrate to. This can be attributed to various factors, such as disease patterns from counties of origin, reasons for immigrating, for example wars, natural famine and general poor health conditions in their country of origin. Alternatively, the higher disease incidence is assumed to procure from the slightly inferior social position and living conditions in the country they migrate to (Lunde & Taxmon 2013)

The various reasons why people migrate can be divided into *political, economic* and *social*. The majority of immigrants move in search of work, education and family reunification. There are also those who migrate to seek asylum or flee from natural disasters or wars. Moving from one social and cultural setting to another may influence an individual's health in positive and negative ways and consequently create disparities in health conditions. Health disparities for immigrants are influenced by reasons for immigrating, age, gender, ethnicity and cultural or linguistic factors. Other important factors include educational level, financial and social circumstances. There are considerable health disparities in the Norwegian population attributed to socioeconomic factors such as income and educational level. There is however varying disease patterns both individually and between ethnic groups. Most studies reveal higher health problems among immigrants compared to Norwegians and the general population (Directorate of Health 2009; Abebe 2010).

Norway has a universal health system built on the principle of equal access. Despite this, there are barriers that might affect access to healthcare. The increasing multicultural and language diversity challenges the prevailing ideals of equality and equitable services and may provide obstacles in achieving equal access. Daniels (2013) writes that the goal of universal access to healthcare is to achieve equal or equitable access to needed care. But health inequalities do not only disappear by providing universal access to healthcare, but also by addressing other barriers to access. Offering good quality interpreting services is one essential tool to attain equitable healthcare.

2.3 Laws and Regulations

Migrants who have been granted work and residence permit are entitled to equal access to healthcare just as other Norwegians. Provision of equitable health services is prescribed in Section 1 of the Municipal Health Services Act and Section 1 of the Health Authorities and Health Trusts Act. According to the Norwegian Directorate of Health (2009), the Ministry of Health calls for quality, accessibility and user participation for all patients in order to achieve equitable health care for all.

There have been several programmes in the Norwegian health sector aimed to ease migrants' interaction with the health care system. Examples include immigrant friendly Hospitals project (2002–2005). Immigrant Friendly Hospitals values diversity by accepting people of different ethnic origin as equal members of society. There is also The Individual Plan, which takes into account people who need prolonged and coordinated services. The user and provider work together to come up with a plan based on the needs of the individual.

The obligation to use of interpreters is not specifically addressed in the legislation. But the interpretation function is embedded in certain other laws. The Municipality Health Services Act (2-1) states that everyone has the right to necessary medical service in the municipality in which they reside. Information shall be given to people seeking medical aid to secure their rights and to ensure that unnecessary expenses, loss and waste of time or inconveniences do not occur. Under the Patients` Rights Act (1999 No. 63), the patient has a right to participation with regard to the individual patient's ability to give and receive information (section3-1).

The patient is also entitled to information about their health condition and the content of healthcare offered (section 3-2). The form of information should be adapted to the individual's cultural and linguistic background. Healthcare personnel have the obligation to ensure that the content and significance of the information is understood by the patient (section 3-6). The patients are also entitled to have access to their medical records (section 5-1).

The Health Personnel Act (section 2-4) has the objective to contribute to the patient's safety and improve the quality in health care service. It clearly states that the health personnel have a duty to offer responsible and diligent care in a professional manner. In response to the patients need, the health personnel should co-operate and interact with other qualified personnel (Lovdata.no).

2.4 Financing of interpretation services

Expenditure for interpretation services is part of the financial responsibility for health care. In both primary and specialist health services, interpretation and interpreting costs should cover all in need of facilitated communication using an interpreter, regardless of length of residence in the country. The municipality covers interpreting costs for municipal health care services. The framework for interpreting services is determined by the municipality's board. As such, there is considerable variation in interpreting services between municipalities (Kongshavn et al.2012)

Specialist interpreting costs are covered in the budgets of the specific Regional Health Authority (RHA). The state allocates funds partly based on the needs and partly on the activities of the specific RHA. The RHA decides how the funds are distributed internally. The fact that expenses for interpreters are part of the hospitals` budget can be a limiting factor to the use of interpreters (Valio 2009). As pointed out in report by The Norwegian Medical Association, funding of interpreted consultations should be independent of the institution's operating budget (Legeforeningen 2008).

2.5 Need for Interpretation

The Norwegian Directorate of Health (2011) published guidelines on communication via interpreters for managers and health care personnel. The guidelines were developed to guide healthcare personnel and managers in the use of professional interpreters. The aim is to bridge the linguistic gap between patients and healthcare providers. The introduction to the guidelines addresses the importance of using professional interpreters towards achieving equitable services and equal access to quality healthcare services. It is stated that language barriers can lead to:

- Reduced access to health services
- Bad quality in services offered and underuse of healthcare services
- Reduced access to preventive care
- Greater risk of misdiagnosis
- Greater risk of malpractice
- Difficulties for patients to understand their illness
- Difficulty for patients to follow recommended treatment

The use of professional interpreters, however, also yields benefits and notable among these are:

- Increased access to healthcare
- Safe treatment
- Greater patient satisfaction.

The guidelines point out that it is the duty and responsibility of healthcare personnel to assess the need for and book qualified interpreters. They are also obliged to inform patients about the opportunity to use an interpreter, why it is important to use an interpreter and chances to appeal in case of unsatisfactory interpretation.

The role of the interpreter is defined in the guidelines and the need for confidentiality according to the law described. It is further well stated that healthcare personnel have a duty to make sure that children and family members are not used as interpreters. Personnel with minority background can only be used as interpreters in demanding situations where qualified interpreters cannot be obtained. This is to avoid unclear roles and to protect patient information. They also lack the necessary interpreter qualifications even if they speak the same language as the patient (Directorate of Health 2011).

2.5.1 Getting qualified Interpreters

Many studies, including Linnestad & Buzungu (2012), show that the market for qualified interpreters is not well regulated, as there is no official control of interpreters or interpreter bureaus. It is therefore difficult to control the quality of interpreter services. In an attempt to regulate the interpreter market, The National Interpreter Register (NIR) offers information on interpreters' qualifications. The register was created in 2005 and had 1 233 interpreters in 65 languages as per May 2012. However, there is need for interpreters in 109 languages, which leaves 44 more languages still in need of interpreters. Presently the use of NIR is not obligatory. Persons registered in the NIR are grouped in five categories according to their qualifications:

1. Interpreters with state authorization and interpreter education
2. Interpreters with state authorization
3. Interpreters with interpreter education
4. Translators of written material
5. Persons who have passed two languages test and introduction course in interpreting

When using the register, it is recommended to use interpreters in category 1-3, as these have higher qualifications (Health Directorate 2011).

As mentioned earlier, interpreters are accessed either directly, through public or private intermediaries. Valio (2009) describes three models used when buying or selling interpreting services in Norway. The first model involves direct orders of interpreting services between an interpreter and individuals or institutions in need of an interpreter. The second model involves public intermediaries; for example the Oslo Municipality Interpreting Service that conveys interpretation and translation services to government agencies and private individuals. The municipality has permanently employed interpreters in addition to freelance interpreters. In the third model, private agencies are used to recruit and sell interpreter services to institutions. It is up to the agencies to ensure that the interpreters they recruit are qualified. Most of interpreters are freelancers and work independently. The private agencies usually have no permanent staff of interpreters.

In addition to healthcare institutions the immigration authorities, the police and the courts are frequent users of interpretation services. The immigration authorities have their own internal system for recruiting and purchasing interpreter services. Interpreters are paid a regulated fee depending on their qualifications. These assignments usually last longer and interpreters are booked one or two weeks in advance. The conditions offered by the immigration office probably attract the best qualified interpreters. The police and law courts also follow fee regulations when paying interpreters and offer competitive conditions that attract qualified interpreters (Linnestad & Buzungu 2012).

2.5.2 Previous studies

Previous studies have documented that there is an underuse of professional interpreters in health care in Norway. For instance a questionnaire study by Kale (2006) concludes that professional language assistance remains underutilized and that healthcare workers tend to use solutions that are easily available, like friends or family members, including children, as interpreters, even though these interpreters may not be proficient in Norwegian themselves. Some of the reasons for professional interpreters not being used vary. It was viewed as unpractical, time consuming, not easily accessible, lack of good routines, and lack of professional interpreters.

An audit carried out in 2008 by Norwegian Network of Migrant Friendly Hospitals revealed that hospitals have problems getting access to interpreters. The available interpreters had inadequate medical knowledge and lacked information about hospital routines and treatment provisions. In psychiatric departments there were no special arrangements for patients who do not speak Norwegian. In addition there was inadequate coordination and communication between hospitals and municipal health services (Directorate of Health 2009).

A report from the Directorate of Integration and Diversity about general practitioners (GPs) and interpreting services (IMDi 2007) concluded that there is easy access to interpreters but their quality varies. The report based on questionnaires and interviews indicates that 74 percent of GPs preferred interpreters while 37 percent often used family members. It was easier to get access to interpreters on planned consultations but not in emergency and unplanned consultations. Access also varies depending on the language. GPs expressed that there is need for telephone interpreters in cases of unplanned and emergency consultations.

The quality of interpreting varied due to poor language and little knowledge on medical terms. In addition, confidentiality concerns were raised as a reason why some patients prefer family members to interpreters. In the study there were expressed uncertainties about who is responsible for organizing for interpreters.

A recent Internet based study on GPs use of interpreters by Kongshavn et.al (2012) shows that even though many GPs use interpreters, it is still common to use interpreters that are easily available rather than professional interpreters. Surprisingly, GPs with more non-western patients use nonprofessional interpreters including family members and children more frequently than GPs with less nonwestern patients. GP offices with three or more practitioners were more likely to use professional interpreters than those with two practitioners. In general, the use of professional interpreters is poorly facilitated.

A study by Le (2011) with perspectives from healthcare workers and patients concludes that healthcare workers overestimate patient’s language skills and lack training on use of interpreters. Procedures are also poorly defined and general practitioners and hospitals lack collaboration and communication, which leads to reduced use of interpreters. In addition, patients lack information about their rights to use interpreters.

2.5.3 The equality project

The Equality Project was a collective project between The South East Regional Health Authority, Oslo municipality and the county of Oslo, with representatives from immigrant organizations in Oslo. The project was conducted between June 2010 and June 2013 and aimed at strengthening equitable and integrative healthcare for minority populations in the metropolitan area. The basis of the project is the realization of the need for specific measures aimed at patients with immigrant background to ensure equal health services. One objective of the project was to increase patient understanding and participation in treatment. Among other things, the project was to find ways to strengthen the quality of interpreting services by mapping the quality in interpretation in healthcare within the metropolitan area. In the light of The Equality Project two reports on quality of interpretation were made.

The first report "*No longer a service of unknown quality*" is a comparative study of the interpretation services offered by the respective parties (Linnestad and Buzungu 2012). The aim of the report was to measure the quality of interpreting in health services. This was achieved by viewing different models that are currently used by the various parties in the project. Interpreters` qualifications in the year 2011 were also reviewed. In total, there were 42 000 spoken language interpreter bookings involving 84 languages. 96 % of these assignments were in 23 different languages with between 300 and 7 000 assignments in each language. Oslo University Hospital, A-hus and Sunnaas Hospital got their interpreters through a tender agreement with Noricom AS, a private interpreting agency. In these hospitals only 1 % of the assignments were done by state authorized interpreters, 8 % by interpreters with interpreter education, 3% by persons who have passed two languages test and 88 % by other persons. Interpreter services in Oslo administrative district were offered through a public intermediary. The results show that 15 % of translation services were performed by certified interpreters, 32 % by interpreters with interpreter training, 9 % by people with documented bilingual skills and basic interpreting training, while 44 % of translation's were offered by individuals with no qualification. Lovisenberg Deaconess Hospital has its own internal system for purchasing interpreting services directly from interpreters. They also provide interpreter services to Diakonhjemmet hospital and few other institutions. The results from Loviseberg were somehow better with 13 % of interpreter services offered by state authorized interpreters, 40 % by interpreters with an interpreting education, 4 % by persons with bilingual skills and 43 % by individuals with no qualification. In the report, state authorized interpreters are those that fall in category 1 and 2 in the national interpreter register. Interpreters with an interpreting education are in category 3 while persons with documented bilingual skills and introduction course in interpreting fall in category 5.

The analysis in the report concludes that there is uncertainty on the quality of the interpreting services in health authorities and the formal qualifications of interpreters. The main issues related to interpretation in health care in the metropolitan area today are challenges due to lack of control over the selection of interpreters with regard to individual interpreter qualifications and expertise. Another issue is low competitive terms as well as poor coordination and organization of interpretation assignments. There are also challenges in recruitment of qualified interpreters. On the other hand, interpreters encounter challenges in communication regarding the assignments content, which affects their ability to prepare

themselves adequately. Another main challenge is the lack of training on the part of healthcare professionals on communication via interpreters.

The second report, "*Just as it is done in other specialties*" (Linnestad and Buzungu 2012) identifies two models for accelerating quality in translating, requiring structural changes. The first model is organizing interpreter services through a centralized interpreter system owned by the health institutions where interpreters are linked to the services they provide. This will ensure that the institutions have control when ordering interpreters and enable optimal organization where the work capacity of interpreters can be utilized in resource economic effective way. The second model is ordering interpreters through tenders, but this had a mixed view as it can undermine the quality of services provided and may not be cost-effective.

As a result of the equality project, Oslo University Hospital, Akershus University Hospital and Sunnaas Rehabilitation Hospital are currently underway a process to establish centralized interpreting services. The project aims is to improve the quality and expertise in interpreting services. This will be done through close consultation with and supervision of interpreters. (http://www.oslo-universitetssykehus.no/omoss_/avdelinger_/tolkesentralen

3 Theoretical framework

While some occupations are easily recognized as professional, others are not well understood. The interpreter's field in Norway can be characterized as one that is not well recognized, understood and well organized. This paper takes on a theoretical framework of professionalization in order to find out to what extend the field of medical interpreting in Norway is moving towards a professional status or not. In this chapter I will first give a brief account on how occupations become professionalized. I will then base my framework on Mikkelson`s (1996) presentation of Tseng's (1992) traits and control model on professionalization of language interpreting. Further exploration of these two theories will be discussed in the context of medical interpretation in Norway in the discussion chapter.

3.1 From Occupation to profession

Many occupations have sought to gain a professional status but few have attained the recognition of being fully professionalized such as medicine and law. There is however upcoming occupations that are being recognized as emerging professions. For most professions the process of professionalization is a naturally developing process (Wilensky 1964).

The Profession term is difficult to define and different theorists do not agree on what a profession is. Bust most do agree that professions have some things in common. Different authors of professional theory agree that a profession is an occupational group with some special skill (Abbott 1988, Freidson 1994).

According to Reynolds and O'Morrow (1985:6), a profession is born out of a societal need *"to have available certain services that require specialized knowledge and skills".* It is generally agreed that the work of professionals is acquired through formal training. It involves a complex set of skills, higher order thinking and decision-making skills, and technical knowledge. Hence, the skills and the knowledge associated with a profession are not widely held by the general public (Tseng 1992, Mikkelson 1996, Witter Merithew & Johnson 2004).

Abbott (1988:8) defines professions as "*exclusive occupational groups applying somewhat abstract knowledge to particular cases"*

For an occupation to become a profession, Wilensky (1964:142-145) suggests some steps to be followed. These include;

1. Full timework involvement in the occupation
2. Establishment of training services which should eventually involve universities
3. Establishment of professional associations
4. Establishment of codes of ethics

Abbott agrees that professionalization as a process changes with time but according to him the process does not takes one direction but rather is multidirectional. His theory first focuses on work. Structures come second to the tasks performed by members of an occupation. His presentation on the theory of professions takes a broad systemic conceptualization of the complex structures in society. He gives an extensive account of the field of professionalism taking into account tasks, jurisdiction and competition. According to him, professions constitute a system in which tasks are linked together by jurisdiction where the strengths and weakness of the ties depend on the actual professional work. As he describes;

> The central phenomenon of professional life is thus the link between a profession and its work, (…). To analyze professional development is to analyze how this link is created in work, how it is anchored by formal and informal social structure, and how the interplay of jurisdictional links between professions determines the history of the individual professions themselves (1988:20).

3.2 The Trait Theory

According to the trait theory, an occupation advances to become a profession by attaining some characteristics. These characteristics include codes of ethics, skills and knowledge, formal registration of the occupation and loyalty among colleagues. The more the characteristics are achieved the more an occupation becomes professionalized (Mikkelson 1996; Witter Merithew & Johnson 2004).

Echoing the same sentiments, Houle (1980, 1983) also states some traits that are required to enhance occupations to professions. According to him for an occupation to professionalize, the occupations defining functions need to be clarified. In addition the members have to seek self- enhancement to improve performance by incorporating theoretical knowledge, use practical knowledge and have a capacity to solve Problems. Having formal training and

attaining credentials creates a culture of collective identity. This ensures legal reinforcement where incompetence is not tolerated and ethical violations are penalized. As a result an occupation gains public acceptance and builds relations to other occupations and service users. Practitioners of an occupation should also always seek new knowledge even in areas that are not directly related to their jobs.

Winter (1988) suggests that traits are stable in established professions, that they are evidenced across professions, and that there are individual differences in the strengths and number of traits in each profession (quoted from Witter Merithew & Johnson 2004).
Witter Marithew & Johnson (2004) takes on Wilenskys` traits theory when looking at sign language interpreting. There are traits that are applicable to spoken language interpreting. For instance Code of ethics. As pointed out by Witter Merithew & Johnson (2004:14), A "*code of ethics refers to the public statement regarding the service mission of the profession"*. It relates to the protection of consumers rights, their privacy and confidentiality. Codes of ethics as applied in spoken language interpretation would uphold that the right information is translated. They also mention the trait of compensation whereby salary and benefits should reflect the knowledge and skills of an occupation.

3.3 Theory of control

The concept of control examines an occupations` relation to the labor market and other institutions in society. Subsequently, the more control members of an occupation have on their work and on the market in which they practice, the more professionalized the occupation. Hence, professions are viewed based on the power they have collectively rather than individually. This power can be used to exert control on the body of knowledge, training, and code of ethics for practitioners, working conditions and on how they relate to clients. Also, a profession gains power and controls the market by mystifying their expertise, hence blocking unqualified practitioners from practicing. This way, the profession has power to define the needs of their clients. When a profession is strong, it can establish alliance with the state by making the state recognize the importance of their services (Mikkelson 1996).

The concept of control is echoed by several other professional theorists; for instance, Larson sees *"professionalization as the process by which producers of special services sought to*

constitute and control a market for their expertise. Because marketable expertise is a crucial element in the structure of modern inequality, it appears also as a collective assertion of special social status and as a collective process of upward social mobility" (Larson, 1977: 16)

The concept is also central in Abbots work. According to him, there are various aspects that determine how much control an occupation has such as the control over tasks as defined in the profession's cultural work, in the legal discourse and in workplace negotiation. The control reflects the social structures of the profession and creates stability in the process of competition. These aspects taken together will determine how a profession acquires its jurisdictions (1988:84).

Freidson (1994) sees professions as groups aiming to dominate and control their work by using their expertise in order to avoid subordination. According to him, the control over work builds a foundation of a dominant position within occupations. This control is gained by first and foremost achieving skills and knowledge which is important to get established in the labor market. The next important step in gaining control is setting standards of the Profession and the formation of professional organization.

According to Tseng , even though the theory of control does not provide guidelines on the process to professionalization, it is more useful in understanding how an occupation becomes a profession than the trait theory

3.4 The process of professionalization based on Tseng`s model

The process of professionalization as explained by Tseng (1992) and elaborated by Mikkelson (1996) follows four phases. *Phase one* is characterized by competition among the practitioners of an occupation which brings about market disorder.

Market disorder is characterized by practitioners not being able to keep unskilled outsiders out, as they might have entered the field without skills themselves. Also consumers may not understand what the practitioners do and hence have little confidence in their services. They think they know what interpreters do but they do not and hence end up devaluing their services and not caring about the quality.

When there is market disorder, there is also lack of quality control. Therefore, decisions are made based on the lowest fees available in the market rather than the quality of services. As a result there are minimal incentives for improving skill and knowledge and those who need quality service might not know where to get it from.

The standards of training are also varied, with some having high training while some have only basic training. However with increased competition, more may seek training to obtain a competitive edge. As the proportion of those who are highly skilled increases, they start getting organized and work towards protecting clients from bad practice and themselves from outsiders.

In *Phase two* the profession becomes consolidated and works towards developing an agreement about their ambition. A demand for quality services pushes training institutions to adapt better training goals. Professional associations emerge with the support from training institutions. *Phase three* sees professionals working together to influence job descriptions, colleague's behavior and to control admission to the occupation. Together they work towards a public recognition of the profession. The commitment of the members is strengthened by the power and achievement of the association

In *phase four,* the professional organizations work towards formulating codes of standard. This is a crucial point as it functions in gaining the public's trust and gaining internal control. At this stage they have control over who is admitted to the profession. In addition, they work towards achieving market control and to influence legislation processes. As they get stronger, the professional associations have more influence on the public and convince the public to accept their professionalism. Hence, their work and working conditions get improved. By doing so they achieve market control

Tseng warns that the transition process is not smooth; rather it involves conflicts and power struggle. One such struggle involves keeping out unqualified competitors and market invaders. The second phase is the most fragile as qualified practitioners may not hold out and instead change occupations. He proposes other obstacles to professionalization like confusion about the job title as many do not differentiate between a translator and an interpreter. He also cites "the lack of a systematic body of knowledge excusive to the profession". As a result anyone who is bilingual thinks they can interpret. On the other hand, the public has a misconception of the profession and consumers are not being aware how to find qualified

interpreters. By hiring anyone available as long as they are bilingual helps unqualified interpreters to survive in the market.

4 Method

4.1 Background of choice of method

Due to the applied nature in health services, the choice of methods is driven by a specific problem which is then turned into a research question. Hence, the research question should guide the choice of methodological technique (Brannen 1992).

Previously qualitative research methods have been criticized as being subjective, biased, non-relevant and unscientific as a research tool especially in natural sciences and did not have a place in medicine. But now qualitative research is recognized as an important research method and is increasingly used in Medicine and in Public Health (Malterud 2001a; Malterud 2001b; Ulin 2005).

Malterud (2001a) defines qualitative research method as *"systematic collection, organization and interpretation of textual material collected by talk or observation".* The main aim in qualitative research is to obtain a comprehensive understanding of the situation under study (Grbich 1999).

Qualitative methods can be used to get information that cannot be well obtained with quantitative methods, in research areas where there is not much in the literature to guide the researcher and when describing a phenomenon that is little known. In addition, Qualitative methods are useful when looking for explanations and are particularly suited when describing a social phenomenon in natural settings from an individual's perspective, with an emphasis to meanings, experiences and interactions (Pope & Mays 1995).

Qualitative studies can enrich our understanding of the complex and multifaceted nature of the use of health care services as encounters actions and perspectives are captured in a broader and more meaningful context. Qualitative methods are also useful when informing guidelines and recommendations and can be appropriate if the available evidence is limited. They can be helpful when assessing views in healthcare provision related to quality and when trying to identify barriers to practice change (Pope et al. 2002).

The objective of this study is to find out how qualified interpreter services are integrated in the health system with a focus on the organization of interpreter services with perspectives and experience of qualified interpreters on healthcare interpreting. The study aims to find out the barriers and facilitators on the use of qualified interpreters. There have been studies which have documented underuse of professional interpreters in Norwegian health care which has an effect on the quality of interpretation. As to my knowledge, there is no known research specifically targeting qualified interpreters. Consequently, the related literature is sparse. Therefore, a qualitative approach is more appropriate for this study.

4.2 Interviews

Qualitative research interviews differ from other types of interviews in a variety of ways. The first characteristic of a qualitative research interview is that it takes place as a conversation between two parties, a researcher and a respondent. The conversation arises when the researcher wants to get more detailed information on a particular theme and have chosen to speak to people who preferably have knowledge of the given topic. Those interviewed should therefore speak as freely as possible, while the researcher follows up with questions during the conversation. Qualitative research interviews allow the participants to answer questions of an explorative nature such as why, what and how (Malterud 2001a; Rubin & Rubin 2005).

There are various ways of conducting qualitative research interviews. One can have structured semi-structured or in-depth interviews. The variant that is used should be determined by the purpose of the research. Structured interviews consist of standardized questions. Semi-structured interviews are open ended questions defining the issues and a list of topics to be explored during the interview. In semi structured interviews diversions can be made to pursue an idea that come up during the interview in detail. In depth interviews goes into greater details on one or two issues where more questions are asked based on the information the interviewee offers. Most qualitative interviews have an interview schedule that guides the issues to be covered depending on the objective of the study (Britten 2006).

To get the information on my topic I conducted in-depth qualitative interviews with informants who have knowledge and experience in the topic of interpreting. These include persons working in administrative positions in interpreter services as well as qualified interpreters. In addition to the qualitative interviews, the analysis will be built on previous

studies. As expressed by Patton (1987), I had open ended questions to best capture the experience and knowledge of the interviewees. This also encouraged the interviewees to talk freely.

A qualitative interview should be structured with questions that create basis for conversation and show participants what kind of knowledge the researcher is looking for. It is also important to open up to viewpoints that are not directly asked in the interview questions. Informants can tell about something that may seem like a diversion, but often it can be a side track that leads to new knowledge (Malterud 2011). In the interviews I tried to strive for a balance between control by asking specific questions and flexibility by letting the informants speak about issues they are concerned about even though I did not directly ask about this.

4.3 Sampling

Selection of informants is a challenge in any research project. Here there are differences in quantitative methods and qualitative methods. In quantitative methods a strict selection criteria can be used while in qualitative methods, the selection criteria can be more flexible. In qualitative methods selection of informants can change as the research progresses. Normally the selection of participants can be carried out until the researcher is convinced that all aspects of the research topic are covered (Ulin et al. 2005). As Pope et al. (2002) asserts in qualitative research data collection is not aimed at statistical representativeness and the research question is not tied to hypothesis testing. The sampling strategy is based on getting participants who can shed light on the topic being investigated and are hence sampled on a predetermined criteria.

One advantage is that researcher has the flexibility to select participants who would provide the richest information for the research topic. There are several main sampling methods used in qualitative methods. In 'extreme sampling' outstanding cases will be selected as participants, in 'homogenous sampling' method a subgroup of participants who has the same type of experiences will be selected and in 'convenient sampling' the most available and easiest to reach subjects are selected to participate in a study (Ulin et al. 2005).

In this study, the main sampling methods used were purposive and snowball sampling. In purposive sampling, as the name suggests, participants are selected based on their possession of information been sought after and which the researcher deem central to the study. Through

purposive sampling, key individuals who have in-depth knowledge on particular topics though their professional roles and experience are accessed (Patton 1987; Cohen et al. 2007). Snowball sampling is used to reach subjects who are not known to the researcher by word of mouth and existing social networks (Ulin et al. 2005).

4.3.1 The informants

I conducted seven interviews with qualified interpreters from categories 1, 2 and 3 as listed in the national interpreter register. All had more than five years interpreter experience. In addition to working as interpreters, two of my informants also work in administrative positions in interpreting services. One informant no longer works as an interpreter. The informants have different language backgrounds including Spanish, Somali and Polish. The interviews took place at different places depending on what was most convenient. Three of the interviews were conducted in Norwegian and I did the translation from Norwegian to English in the transcription process. Each interview lasted for about 45 minutes.

4.4 Ethical issues

When doing qualitative research, there are some ethical issues that have to be addressed. These include confidentiality, anonymity and informed consent. As Goodwin et al. (2006) point out; the assurance of confidentiality safeguards the invasion of privacy in research. Confidentiality can have several meanings in different settings and is lesser clear for researchers.

At the onset of my research, I applied to the Norwegian Social Science Data Services (NSD) where I was informed that my research project did not require authorization since it does not involve sensitive information.

However, I found it necessary to protect the identity of my interviewees. In the letter of consent to participation it was clearly stated that the data collected would only be used for the purpose of the study. All the data was processed without name, Identification number or other directly recognisable type of personal information. It was further stated that participation in the study was voluntary and the participant could withdraw their consent to participate in the study at any time and without stating any particular reason.

4.5 Data analysis

The data preparation started with transcription of the recorded interviews. The transcription was done by listening to the interviews and most of what was said was written down. I had to listen to the audio recording several times to double-check the transcript against the original recording and get an accurate notion of what was said. The analytical process started when data was still being collected. This type of analysis is referred to as sequential analysis whereby the researcher interprets the data continually enabling subsequent investigation when collecting more data. This allows for emerging issues to be investigated in depth (Pope et al. 2006).

As Pope et al. (2006*)* points out, qualitative interviews are intended to identify meanings and come up with explanations. Hence, data collection continues until a point of saturation has been reached and no more information is being added by new interviews. After conducting seven interviews, I found that most of the information had been said before and no new themes were coming up.

4.5.1 Analysis approach

There are various approaches in qualitative analysis. But as pope et al. (2006) asserts, the analysis approach is influenced by theoretical perspectives and should be guided by the objective of the study. The current study was guided by a thematic content analysis approach. By reading and re-reading the data, initial sets of themes were identified. This was done by systematically searching for recurring themes in the raw data. I had a set of themes from the interview schedule and from the research questions which guided me in the searching of the themes. But I was also keen to capture themes that came up that were not predefined in the research questions and recurred in the interviews. The identified themes were coded by separation of data from their original context and labelled by different colours and later decontextualized into themes.

As explained by Anderson (2007), thematic content analysis is a descriptive presentation of qualitative data. Common themes are distilled from the text in order to give an expression of the voices of the participants. Hence, the actual words of participants are reflected in the text. In thematic analysis the researcher interpretation is kept to a minimum in the presentation.

The researcher's interpretation on the identified themes is expressed later in the research, typically in the discussion.

5 Findings and Interpretations

In this chapter I will present my findings from the interviews. It is a descriptive presentation combined with verbatim quotation reflecting the actual words of participants. The findings are systematized and presented based on themes that emerged during data processing, which I believe are relevant in answering my research questions. Even though some findings are in line with the pre-defined assumptions in the objectives of the study, the interviews also revealed a number of other themes. The following five themes emerged: Organization of interpreting services with a sub-theme in economic issues, demand vs supply, education and training, professionalism in interpreting and working conditions and rights

5.1 Organization of interpretation services

In this specific theme I focused on the general organizational issues that may hinder or encourage the uptake of qualified interpreters in medical interpreting. The key issue is to identify organizational barriers to the use of qualified interpreters in health services. Informants were asked what the major obstacles to the use of qualified interpreters in healthcare were. In the interviews there was unanimous acknowledgement that there are problems with the way interpreter services are organized.

One factor is recruitment of interpreters. Most informants indicated that the main barrier to the use of qualified interpreter's lies on the recruitment of interpreters. The main concern is the use of tenders by health institutions and the use of private interpreting agencies to recruit and supply interpreters. I got the impression that most informants opposed giving tenders to private interpreter agencies to recruit interpreters. Besides working for a profit, there is no control on qualifications of interpreters. As one informant put it:
"(…) *tenders will never work because the system makes it more financially rewarding to use unqualified interpreters who are cheap and profitable (...). In the process the person who recruits and orders the interpreter is not the healthcare personnel but a person with an economic interest*".

It was expressed that the agents want to spend as little money on interpreters as possible, which usually implies the use non-qualified interpreters.

(...) It's not that I am not interested in health interpreting or working in hospitals. They have given tenders to private interpreter bureaus companies that have a monopoly in assignments. I am not interested in working for the private agencies. I don't want to get 170kr in an hour when they take more than what I get"

It seems that how to attract and keep qualified interpreters in healthcare is a concern. All of my informants were qualified interpreters and while one no-longer work as an interpreter; all the others I interviewed work as freelancers and rarely get assignments in healthcare. As one informant expressed:

"The private companies have called me several times but I say no. When there are many of us who are qualified who says no, who do they take? Unqualified people with two languages.

Also non-qualified interpreters unlike qualified interpreters cannot get jobs on their own but through agencies. Then there are no incentives to improve their qualifications because they are on contracts and often uncertain about what will happen when their contract expires. As one informant illustrated:

***"**The private agencies have the power so it they use it. It`s up to people working for these companies to take responsibility. It is the system's responsibility to make sure there are qualified interpreters "*

Although organizational setup was a common theme which was repeated in all the interviews, there seemed to be disagreement in how the services can be best organized. As one informant put it: "*to improve the quality of interpreting, interpreters should be booked directly"*

Another respondent expressed that interpreter services should be organized regionally and incorporate the use of more technology like video and telephone interpreting. Doing this would help to fill up the working days of interpreters. Even though face-to-face interpreting was expressed to be the best, a combination of video, telephone and face-to-face would ensure better use of resources and enhance the quality. It was reported that telephone interpreting exists but it has not been well marketed. There were divided agreements about the use of video and phone interpreting. Some informants thought it was not a good alternative, others thought it is a good offer because it offers anonymity.

It is indeed important to look to the new technologies in search for solutions to ensure efficient provision of services. However, this may have some impact on both practical issues like training and cost-management, as well as ethical aspects of the interpreting

It seems like the main reason qualified interpreters are not interested in working through private agencies is because of the low pay. One informant explained: "*Most qualified interpreters do not want to work through bureaus because they keep most of the fee. A solution maybe to introduce a mediation fee while all the pay goes to the interpreter. Or to organize the bureaus like nonprofit organizations either run by the state or municipalities* "

It was however agreed by all informants that to improve the quality of interpretation in healthcare, recruitment should be based on qualifications. As one informant expressed,

"The health system should think about the quality of interpreters. It is the health authorities that should take responsibility. For example the municipality has their own system of qualifying interpreters, and they try to use qualified interpreters. But hospitals have left the responsibility to others who do not take responsibility to ensure the quality of interpreters"

Another informant expressed the need for the infrastructure to be provided by authorities' and incorporated into the health system. The idea should be to plan long term rather than short term. The informant pointed out that:

"As it is now hospitals and health facilities organize other appointments and leave the interpreters to be organized by others. If they have a complaint about the quality of an interpreter, the interpreter may not be sent there again but might be sent to another hospital".

Several informants also pointed out the logistical challenges that must be addressed in trying to arrange language services in different healthcare settings like hospitals versus physicians' offices, scheduled versus unscheduled visits. For example, one informant suggested:

"Clinics could schedule patients who speak certain languages during specific days of the week to optimize the use of interpreters"

Overall, I interpret the findings to mean that qualified interpreters are generally dissatisfied with the way the interpreting services are organized. As a result most of those who are qualified do not take assignments in hospitals because they don't want to work for the private interpreting agencies. All of the qualified interpreters I interviewed work on a freelance basis with most assignments in district court and in the immigration department. This leaves the unqualified interpreters to healthcare. Furthermore, most qualified interpreters are the ones who easily leave the profession because they have higher chances of taking other jobs.

5.1.2 Economic issues

Language access competes with other program areas in healthcare and is not viewed as a priority by healthcare service providers. Participants expressed a need to make language services just as important as other priorities. Most informants pointed out that organizational problems and economic issues go hand in hand. These, according to most of them, were reasons behind the under-use of qualified interpreters in health services. They expressed the main problem behind this to be cost saving. But as one of my informant echoed,

"*This might be a short term solution as the costs eventually rise when patients don't get care they need which may lead to readmissions*"

Another informant expressed it this way: *"Users have a strong belief that somehow it can be managed without using qualified interpreters and not affect outcome, but in reality the overall costs of treating patients may go up"*

On the issue, most of the respondents agreed that this is a result of using private agencies where users are obligated to choose agencies that offer the lowest prices. As another informant expressed:

" *when you choose the lowest prices you cannot expect the quality of interpretation to be good*".

While private companies work towards getting a profit, they cannot have very high prices because of competition in the market. My informant further comments that:

"*To have a competitive price they have to take interpreters without qualification. The biggest organization problem is here and it is pushing qualified interpreters from the profession"*

Most of my interviewees agreed that there is a lot of money used today in interpreting services. But they expressed the need for better organization to ensure cost-effectiveness of the services. Reorganizing the interpreter service would cost in the short term but will have long-term benefits.

5.2 Demand vs supply

The demand for interpreters is growing due to the changing patterns of immigration. Keeping up with the demand is challenging as the demand for interpreters far exceeds the supply (Directorate of Health 2011) Issues related to the supply of interpreters are twofold and incorporate not just the number of interpreters but also the quality of the interpreters. Equally of importance to note is that the needs for interpreters regarding various languages change over time.

For instances, as one of my informant explained, the polish language had a big demand for interpreters in the 80's. In the 90's the demand disappeared and interpreters had to find something else to do. But then there has been an exploding demand for Polish interpreters for a couple of years back and it is one of the biggest languages in need of interpreters in addition to Somali and Arabic. It is clear that there is need for more interpreters with interpreter education especially in languages with majority asylum seekers as most of the already qualified ones have moved to the immigration department. As the informant pointed out:

"In Tigrinya it has been hard to get qualified interpreters yet most of the asylum seekers are now coming from Ethiopia and Eretria"

Another issue is the distribution of immigrants in need of interpreters. The non-Norwegian speaking population is highly diverse in terms of their countries of origin and languages spoken. Even though Oslo has the biggest concentration of immigrants, the newly immigrated asylum seekers are widely spread over the country. Interpreter services operate within a context that is defined by the broader political and social context. Thus immigration issues influence interpreting service provision. As one informant stated:

"The government does not think about interpreters when settling immigrants in different areas. 10 years ago the government took 10,000 immigrants from Burma and settled them in different places and it's was a big problem to get interpreters"

It was also noted that the there is a changing demographic profile of service users and there are languages where qualified interpreters are not available

It also seems like there is a problem to categorize who is a qualified interpreter. One informant explained that there are about 500-600 qualified interpreters (i.e. certified public interpreters) in the country. Of these there are fewer than 200 with state authorization. Most of those with state authorization do not work as interpreters on a daily basis. There are also many who are registered as interpreters in the interpreters' registry (NIR) but do not work as interpreters.

This gives the appearance that the pool of interpreters is large when in reality there are few qualified interpreters. Considering that the majority of qualified interpreters prefer to work in courts and the immigration department, very few qualified interpreters are available for medical interpreting.

5.3 Education and training

One of the major approaches to provide access to services and ensuring implementation of qualified interpreter services is education and training. An effective interpreter service relies on the availability of well-trained, competent, professional health care interpreters in the languages needed. In Norway, interpreter training programs are striving to fill this need.
Training and accreditation are among many other factors that interactively determine interpreter service delivery. Most of my informants identified a number of issues regarding the accreditation process. It was mentioned that there are declining levels of accreditation due to limited incentives to upgrade qualifications. Another issue mentioned was the high failure rates for accreditation

As one informant noted:
"*There is no incentive for interpreters to upgrade their qualifications as the market makes it lucrative to work without qualifications"*

Another issue mentioned was that the accreditation exam has a high failure rate. It is hence counterproductive to recruit more individuals without addressing some of the reasons behind

the large failure rate as it discourages new candidates to register for exams and enter the profession. It also encourages interpreters to work without accreditation.

There have been offers for interpreter training and education for many years. At Oslo University College there has been a permanent offer since 2007. The course is offered as a 30 European Credit Transfer system (ECTs) with chances of taking up extra credits. The goal is to have a bachelor's degree by 2015.

One informant explains how she took up her interpreter education;

"It was difficult to start with because I had an education in nursing and not in interpreting. So I decided to start building my education in interpreting by first taking interpreter courses. The first one was 30 ECTS in public interpreting in Oslo University College. As time went by I took more supplementary courses"

In addition there are independent State authorized exams. But there is high failure rate in this exam, which means that there are very few state authorized interpreters in the country. As pointed out by one informant:

"Of those who register for the exam almost 90 % fail. Only 200 have passed the exam since 1997."

Even though there are many who have taken interpreter education, the framework to work as an interpreter in health services is poor. As a result, most qualified interpreters take assignments in immigration departments or the courts where they get more working hours and better pay.

These sentiments were echoed by one of my informants:

"The investment in taking interpreter education might be justified if there were assurances of gainful employment. However, most interpreters have no guarantee of steady work. Even where certification of interpreters is required, there are loopholes that allow the use of non-certified interpreters. As a result, interpreters have little incentive to participate in certification programs"

Another concern was that as it is now, it is not clear who should control the interpreters' formal qualifications. As one interviewee put it:

"The interpreter registry does not reflect the real qualifications"

5.4 Professionalism in interpreting

The qualified interpreters also shared some concerns about professionalism. They stressed the importance of making clear distinctions between qualified interpreters and bilingual speakers. While bilingual speakers may communicate in two languages, they do not have sufficient qualifications to operate in a fully professional manner. Another issue mentioned is the upholding of codes of conduct. Concerns about relying on unqualified interpreters, range from issues that compromise the efficiency of a consultation to very serious ethical issues regarding confidentiality.

Most of the qualified interpreters were concerned about the de-professionalization of the industry because non-qualified individuals are used to interpret. Those purchasing interpreting services are often not enough concerned about the quality of the service. The consequences are generally a lack of public trust in the profession and a market disorder. One of my informants had this to say:

"There should be rules and guidelines on who should be an interpreter agent. As per today it doesn't exist. Whoever can open an interpreting agency company and whoever can refer to themselves as interpreters because an interpreter is not a protected title. The only protected title is state authorized interpreters"

I wanted to find out about the qualified interpreters view on the users of the interpreter services in regard to qualifications. This is important because users should know what to look for when ordering qualified interpreters and the fact that professionalization of interpreters goes hand in hand with awareness of users. It seems like even though users are getting more conscious about qualifications; there is an expressed need for them to take courses on how to work with interpreters. The main challenge here as explained by one informant is that;

"It is not easy to control the quality of an interpreted conversation because the user does not understand the other language. A person may be good in one language, but it is not always easy to know how it is going on the other side of the language. So it is important for users to take courses on how to use an interpreter"

Sharing best practices among service providers many also enhance commitment to improve quality in language access. Collaboration among them can help utilize efficient and cost-effective means to offering language access via qualified interpreters. One informant pointed out that, because interpreted consultations are complex, training other key professionals on the use of interpreters is critical with respect to conducting an interpreted consultation. Another issue is creating trust, openness and confidence of the parties involved in an interpreted consultation. Another interviewee expressed the importance of good communication between user and interpreters:

"It is important to give feedback when things do no work as they should. It can be simple things that the interpreter can rectify the next time or bigger things that cannot be rectified"

I was interested in finding the qualified interpreters opinion about their work. Even though most of my informants were qualified in other occupations, they choose to interpret. As one informant expressed:

"I am interested in interpreting because it is important for me to contribute to people understanding each other. As an interpreter I do what I like. I am interested in the work and it is my duty to build up my competence, it's just to take responsibility"

The qualified interpreters described how important it is to be clear about their role when interacting with clients:
"When I go to interpret, I have to explain my role as an interpreter and say that I have confidentiality and that whatever is said remains there. I also explain that if I misuse my position I can be punished. By doing so I give the power to the person I am interpreting for and when they know they have the power to hurt me if I do something wrong then they can talk freely. You have to have a technique as a professional"

It was also expressed that the qualified interpreters who have remained in the profession are concerned about improving their skills:

"What I think about is developing my skills to be better and be more competitive in the market. It's all about organizing myself".

The practice of relying on unqualified interpreters is without doubt a key factor in the low uptake of qualified interpreters in medical interpreting services. Compounding the problem is

the fact that even when certification is required, enforcement may be lacking and buyers of the services opt for the lowest bidder in the market, regardless of qualifications.

Clearly, qualified interpreters perceive their part as important in the role of communication. They understand and describe their own role with respect to codes of ethics in the interpreting profession. The clarity about the formal and informal rules of interpreting is crucial to effective communication

5.5 Working conditions and rights

From the individual interpreter's perspective, a more practical problem arises with respect to working conditions and rights of interpreters. Interpreters are reportedly leaving the profession at higher rates. The suggested reasons why interpreters are leaving the profession include poor payment and little opportunities in enhancing a career in interpreting. Income insecurity and job insecurity were issues of significant concern for qualified interpreters. These are sentiments that were expressed by all my interviewees. One of them summarized this as follows:

"*About rights like pension then I don`t have any. When we look at the commission and the hourly income as long as we are healthy we are winners, but the day you get sick you lose because you are your own employer. It doesn't matter how much you earn, if you have not paid your own insurance to social insurance to NAV, then you have no right to pension or you get very low pension."(...). We don't have many rights but it's something we have chosen* "

It was expressed throughout the interviews that when recruiting interpreters, priority should be given to qualified interpreters and they should be offered conditions that make it desirable for them to take assignments. It was expressed that qualified interpreters are the ones who leave the profession because they are highly educated and can take other jobs because of the uncertainty in the interpreting profession. This has led to reduced access to competent interpreters.

One informant who has since left the profession had this to say:

"In practice, working as an interpreter meant that I would get a salary below 70 kroners in an hour plus travel allowance. I no longer work as an interpreter because I got a better paid

job. But many don`t have the same opportunities and because interpreters are rarely organized, some of the companies misuse this"

He estimates an interpreter who works two to three hours a day:

"This does not provide a minimum wage to live on. (...) This is social dumping and the result is that good interpreters disappear. It affects the quality of the profession"

He points out the tendering system to be the main problem. Another interviewee expressed the same sentiments:

"It is also the hours I get that determine where I work. I'm interested in working for hospitals but I have to think of my economic situation. Even as a freelancer my salary varies. Usually I don't think about the monthly salary but the yearly income. Some months I work more than other months but in the end of the year it's even. So it's my responsibility to organize my economy in that I balance the months with low income"

The same interpreter used to work for a hospital but had to quit due to the few working hours. As she explains:

"*I have worked in a hospital which has their own system for recruiting interpreters and it is good. But I did not work there for a long time. I liked working in the hospital but the problem is that I got only few hours and it was not easy to organize my days. I can count the number of assignments that I got. After some time I just called and told them to remove me from their system"*

It is clear that many qualified interpreters move on to other jobs because of the working conditions. The main concern is that the private agencies are not in a position to give the working conditions that qualified interpreters would require.

6 Discussion

The chapter part is divided into two parts. In the first part I will discuss the methods and the limitations of the study. In the second part I will discuss the findings in light of the research questions, objective of the study and the theoretical framework.

6.1 Discussion of methods

The main purpose of this study was to investigate how qualified interpreter services are organized and integrated in the health system. The research was guided by three research questions which aimed at finding out; why qualified interpreters are underused in Norwegian health sector, to identify barriers and facilitators to use of qualified professional interpreters and to identify measures to improve the quality of interpretation

The field of interpreting has various players. Previous studies have taken the perspectives of health personnel and patients. To understand why qualified interpreters are underused, it is essential to get the perspectives of qualified interpreters. The choice of informants was therefore guided by this and seven qualified interpreters were interviewed.

6.1.1 Interview situation

The recruiting process for the interviews was time consuming due to the varied work schedules of my informants. It was however my impression that the interviewees were engaged and very interested in the topic. During the interviews, some informants expressed frustration and were emotionally engaged. This is partly an advantage of qualitative methods in the form of interviews in that the researcher, in addition to getting answers to questions and opinions from the informant, any emotional reactions associated with the topic is also captured.

All informants had several years of experience in the interpreting field. I perceived most informants as having a good knowledge of the subject .I experienced the interview situation as open and it was easy to get informants to express their knowledge on the subject and to talk about their experiences. Most interviewees needed no further explanation of concepts or questions and the interviews evolved gradually into ease conversation. Several said they hoped that the information would contribute to changes in how the interpretation services are

organized. Most of my respondents are members of the Norwegian Interpreter Association (http://www.tolkeforeningen.no/) that aims to bring together professional interpreters to promote joint academic, social and economic interests. In addition the association works towards promoting professional and ethical standards among its members, and to work for the members' interests in wages and working conditions.

6.1.2 Limitations

This is a qualitative study and in-depth interviews were chosen as a method of data collection. By using this method, the informants have the freedom to raise issues of concern to them; hence, potential researcher bias is reduced. It is however important to mention that even though all my informants have worked as interpreters for over five years, they have varied levels of knowledge and experience with interpreting. Given the small number of interviewees, the researcher could not be confident of collecting comprehensive information, but most of the findings are so unanimous that there is reason to believe in that they to a large extent are generalizable.

It would have been interesting to compare the situation on the use of qualified medical interpreters with other countries. But due to the time frame and scope of the study I was not able to do so. In addition, even though there numerous studies in the field of interpretation, I did not come across studies in the specific topic of quality with views of qualified interpreters.

6.2 Discussion of findings

As a point of departure from the findings of the preceding chapter, this section discusses the pertinent issues that were raised. The discussion is guided by the research questions:

1. Why is there an underuse of qualified interpreters in Norwegian health care?
2. What are the barriers and facilitators to the use of qualified professional interpreters?
3. How can the quality of interpreting services be improved?

The collected data present a good basis for answers to these questions.

6.2.1 Underuse of qualified interpreters in Norwegian health care system

The data point to the presence of a dysfunctional organizational setup as one of the prominent reasons for underuse. In the theoretical framework, three main building blocks are identified as the basis for discussing the underuse. These include the lack of control in the market of interpreters, the lack of collective power, and inadequate and un-systematized education and training programs.

As shown in the findings, the biggest challenge in the professionalization of interpreting in Norway is the inability to control who works as an interpreter. This is clearly what Tseng (1992) calls a market disorder. In Norway, language interpreter is not a protected title and hence not considered a profession. According to Schmitz (1988), the root cause lies in the lack of knowledge as to what interpreters do. The consequence of this ignorance is the openness of the profession to anyone, qualified or not. Schmitz (1988) displays his displeasure over this by stating that *"anyone can decide to use the title [translator/ interpreter], however dim their consciousness may be of the intellectual equipment required for the jobs"* (Schmitz 1988: 273).
The market disorder is further maintained by the use of private agencies in recruiting interpreters. As mentioned earlier, the Norwegian system of recruiting interpreters in health institutions involves the use of third parties; mainly private interpreting services agencies. Clearly these interpreting service agencies are profit-driven and more concerned with quantity than quality. Since the tenders are offered are price-based only, it makes sense for these agencies to employ unqualified interpreters who are less expensive and demand less pay. The result is an interpreter market dominated by unqualified interpreters, with poor working conditions and low professional standards. This situation represents a high barrier to attracting qualified interpreters. As long as these conditions persist, recruiting and sustaining qualified interpreters will remain one of the main challenges to improving the current state of market disorder in medical interpreting.

As it came out strongly in the findings, a market that values the work of qualified interpreters with accepted compensation and benefits is one way to combat this challenge and an important factor that will contribute to professionalization efforts. Another important issue is how the general public relates to the interpreting field. As mentioned by Houle (1983), for an

occupation to professionalize it requires the acceptance of the general society. Subsequently acceptance will enforces the exclusion of unqualified interpreters only when the minimum standards of competence set by the profession are met. For this to happen, an ability to assess the quality and effectiveness of the work of interpreters is required.

As of today, there have been no measures to control who the private agencies recruit, and their competencies. The main challenge here is that the market does not value the certification standards set by the profession. This is a major challenge to improving the quality of interpreting in Norway. It is unrealistic to expect that the market will provide cost-effective interpreting services when the quality of the work of the interpreters in the market is not assessed. The result is that consumers, users and providers of the services will continue to suffer the consequences and market disorder will continue. This is one factor mentioned by Tseng (1992) when he points out that quality control cannot exist where there is market disorder.

6.2.2 Barriers and facilitators to use of qualified interpreters

I consider the study to be helpful in identifying these barriers and facilitators that can be important in improving the quality of medical interpreting and for future policy development. Undoubtedly, the success of language services is depended on how it is organized, but its response to challenges and opportunities for growth also play a vital role.

A number of barriers to the use of qualified interpreters were identified and most of these are intertwined and can therefore be discussed under one theme. The top of the list of barriers was the rate at which qualified interpreters are leaving the occupation, especially the medical interpreters. There are many reasons for this development. Of note however are the bad working conditions and minimal rights, the inability to enhance a career in interpreting, lack of incentives to keep interpreters and to encourage those willing to join the occupation to improve their skills and knowledge. This is a challenge mentioned in Tsengs (1992) model in phase two in the professionalization of interpreting. Opportunities also exist that can facilitate the use of qualified interpreters. One such facility is the establishment of the Norwegian Medical Interpreter Association. Even though there is a Norwegian Interpreter Association, medical interpreters in Norway lack a professional association that work towards enhancing

medical interpreters' academic, social and economic interests. As mentioned by Tseng (1992) associations are important in developing an agreement about members' ambitions and standards of training. They also work towards enhancing the pay and working conditions of their members. The fact that most of the interpreters working in healthcare have limited authority or power over their working conditions and working standards severely limits their collective power in the work they do and in improving their skills.

Another important contributing factor that leads to the lack of collective power in medical interpreting is the number of individuals working with insufficient qualifications. As Witter-Merithew, & Johnson (2004) comments, this results in the profession having minimal control over their own market.

Primarily, as identified in the findings, private interpreting agencies have much authority regarding who is hired or take assignments in medical interpreting. And even though there are agreed standards regarding minimal competency, the agencies do not control the qualifications. This is well documented in a previous study by Linnestad and Buzungu (2012), where 88 % of hospitals' interpreting assignments were done by people without qualification. This problem is compounded by the fact that even when certification is required, there is lack of enforcement since the users of interpreter services opt for the lowest tender bidder. Hence quality comes second to price.

Additionally, when a high percentage of medical interpreters are unqualified and lack a standard certification, they cannot be able to exercise effective control over their working conditions and employment standards. Neither can they have an influence on policy-making that has an impact on their work. As Witter-Merithew (2004) writes, this creates a cycle that hinders the field of interpreting to gain collective power.

The field of interpreting is complex in that it involves different stakeholders. To improve collective power and quality of medical interpreting, collective efforts between healthcare institutions, interpreters, users, consumers and providers of interpreting services are needed. As mentioned earlier, in Norway the field of interpreting is fragmented. The various stakeholders often work independently of each other. This creates a challenge in assessing the quality of medical interpretation

Another area of concern when it comes to barriers and facilitators is education and training. As noted in the findings, due to increased migration, there is a growing need for interpreters in various languages. This poses a great challenge to the health sector, as it is impossible to qualify interpreters in all languages. The need for interpreting in different languages also changes over time as there is always changing patterns of immigration. In addition, the different migrant groups have different cultural backgrounds with different expectations. Not only is it difficult to set quality standards for such a vast array of languages, it is also extremely challenging and expensive to develop language-specific certification.

6.2.3 Improving quality of interpretation

The need for improved quality of interpreting services in Norway is higher than ever before, and the benefits are numerous. Improved quality of care reduces medical errors, increases access to services and reduces unnecessary health expenditure. Using qualified professional interpreters is essential in improving the quality of interpreting in healthcare.

The Norwegian healthcare is built on the principle of equal access to healthcare services. Language is one of the neglected barriers to equal access. Accessibility of services refers to the ease with which people can make use of services. Whitehead (1990) writes that inadequate or unjust access to essential health services is one determinant of health differences that is avoidable. Therefore, equity in healthcare is about equal access and utilization of available resources for equal need and equal quality for all. Equal access is then about equal entitlement and a fair distribution of available services based on healthcare needs. It also implies geographical access and removal of other barriers to access such as language problems.

One of the principles for action that Whitehead (1990) mentions is the principle of making high quality healthcare to be accessible to all by checking the experience of different social groups' attempts to gain access to health facilities. To achieve equal access implies that every person should have equal opportunity through a fair procedure based on need and a commitment to deliver services to all social groups to achieve same standard of professional care (Whitehead 1990).

Norwegian government policy states that those in need of language services should have access to professional interpreters. This is stated in the guidelines on the use of interpreters where the importance of using professional interpreters in achieving equitable services and equal access to quality healthcare services is stressed. The right to receive the right information and quality health care services is also embedded in several laws and regulations.

It is however admitted that it is difficult to control the quality of interpreting and interpreting services since the market for qualified interpreters is not well regulated The most recent efforts to map the use of interpreters through the equality project further confirms that there still are serious quality issues in the field of interpreting where the majority of medical interpreters are unqualified.

To improve the quality of interpreting in the health sector therefore will require a better control of the market of interpreters and interpreting service agencies. There should be measures to control the competencies of the interpreters and the quality of their work. There is also a need for incentives that makes it attractive for qualified interpreters to take medical interpreting assignments and for those who are unqualified to improve their qualifications.

7 Concluding remarks

The current standards and quality of medical interpreting in Norway is questionable. Interpreter in Norway is not a protected title. Going by Tseng`s model, we see some characteristics in all phases of professionalization in the field of medical interpreting in Norway although most are seen in phase one. The field is experiencing a market disorder whereby the market is invaded by unskilled practitioners. There is also lack of quality control in interpreting service providers making it difficult to control who takes the interpreting assignments. We also see from the findings that decisions are made based on the lowest fees available in the market rather than the quality of services.

Another characteristic is the varied of training and qualifications with some interpreters having high education while some have only basic training. But we also see an increased demand for quality medical interpreting services a characteristic in phase two. In addition, the training institutions are working towards achieving an improved educational program. There are also developed codes of conducts even though these are not well regulated and followed

Are we then experiencing any professionalization in medical interpreting? As we saw earlier it is difficult to define what a profession is and according to Abbott (1988) professionalization does not follow one direction but is multidirectional. But it is agreed that a profession is associated with some special skills and knowledge. Based on my findings, the field of medical interpreting is yet to professionalize. My findings suggest that the interpreter market is highly fragmented and unregulated. Medical interpreting is mostly done by individuals with no education or training and a limited knowledge on skills and competencies needed to interpret. The core of the problem lies in the way recruitment of interpreters is organized, working conditions, payment and salaries which are insufficient to attract qualified interpreters in healthcare. To increase the number of qualified interpreters, there should be incentives that make it attractive for unqualified interpreters to attain qualifications.

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