Author's response to reviews

Title: Boundaries and conditions of interpretation in multilingual and multicultural elderly healthcare

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Author's response to reviews: see over
At first we would like to express our sincere gratitude for the most valuable comments given on our manuscript. According to the suggestions from the editorial and reviewers changes have been made and they are marked with red text in the manuscript. We will attach a file:

1) One with changes marked with red text (main document revision 1)

**According to the suggestions from the Editorial:**

1. Concerning the Editorial major comment raised by both reviewers about the manuscript is too long:

   Please, see following explanation to the reviewer Alexander Bischoff under numbers 4 and 5).

2. Concerning the Editorial requests to copyedit the paper to improve the style of written English:

   The language has anew been reviewed by a mother tongue English speaking professional proof reader and translator, and changes are made in the text with red colour.

3. Concerning the Editorial requests concerning that title page should include email addresses of all authors:

   The email addresses of all authors are already given in the title page on page 1, line 22, page 2, lines 1 and 5.

**According to the suggestions from the reviewer Alexander Bischoff:**

4. a) Concerning the reviewer’s comment about that the findings section is too long:

   The following text has been removed from the findings section in order to shorten the text and become easier to read:

   on page 17, lines 19-24 and page 18, lines 1-2:

   Most of the informants said that using a professional interpreter improved the possibility that the interpreter would interpret literally and objectively as a mouthpiece in all healthcare situations with high-quality language skills and observing the code of confidentiality. Informants preferred professional interpreters on the spot because this made it possible to observe body language, which led to more natural and personal contact and communication. However, they could see advantages in telephone interpretation, such as improved direct communication between staff and elderly persons and easy availability for acute and unplanned healthcare requirements.
On page 18, line 20:
One problem was the type of healthcare need, frequently described as unpredictable.

On page 20, lines 21-22:
The benefit of using bilingual healthcare staff for interpreting was that no advance planning was needed because they were already in place.

On page 21, lines 2-6:
The informants could also see negative aspects when bilingual healthcare staff were used as interpreters, such as their limited medical terminology and language skills, lack of neutrality and word-for-word interpreting, confidentiality problems and staff who do not share the same origin and religion as the elderly persons in need of an interpreter.

and on page 22, lines 12-14, 17:
The positive aspects when family members acted as interpreters were the elderly people’s feelings of security and trust, easy availability, especially for unpredictable requirements at short notice, the family members’ role as an integral part of the caring relationship and their involvement in the care of elderly. In some cases, using the family members as interpreters had been associated with poorer-quality interpretation because of lack neutrality, limited knowledge of official terminology and language skills, and

5. Concerning the reviewer’s comment about that the findings section include too many descriptive sections and quotes:

First, the following descriptive sections have been removed from the findings section in order to be shortened and easier to read:

Please, see under comment 4)

Second, the following quotes have been removed from the findings section on page 16, lines 20-24 and page 17, lines 1-2 in order to be shortened and more easy to read:

You can’t force the patients to use a professional interpreter, they must be able to decide that for themselves (I:2).

I (assistant nurse) have no idea how you go about booking a (professional) interpreter. (Bilingual staff) are very good for situations that arise right now. I don’t have time to phone for an interpreter and ask them to come here. It must happen now. Because it’s now it’s needed, in five or ten minutes it might be forgotten (I:10).

on page 18, lines 3-15:
In a meeting, it’s as if you are talking to the individual person, you address them directly. The interpreter is just a mouthpiece (I:5).
It’s a question of confidentiality for one thing (I:2).
... it gives security to have an interpreter in situations where it’s needed ... that a (professional) interpreter should come to handle the matter as correctly as possible (I:15).
... a more personal conversation ... it can be more natural for many old people to talk directly to a person than to talk via a telephone (I:2).
(telephone interpreters) are ... more easily available, easier to get hold of a telephone interpreter (I:9).
... the advantage (of telephone interpreters) ... when you’re with the patient is that perhaps you can have more eye contact and focus more on the older person (I:13).

on page 18, line 22 and on page 19, lines 1-3:  
*It gets so formal when you start calling in certified interpreters (I:11).*  
... but these everyday cases when you’re faced with the question of how they feel that day and if you have to get a doctor now or it can wait, then it’s too much trouble to get a professional every time (I:6)

on page 19, lines 19-24:  
... for if you have a third party, the interpreter there, it often gets ... he becomes a middleman and maybe you focus both on the patient and perhaps look more at the interpreter than it being a conversation between them and not between the patient and me (I:12).  
Demented patients need to have people that they recognize around them. It can be even more difficult if you bring in people they’ve never seen before (I:10).

on page 20, lines 6-7, 11-12:  
... you have to have a certain functional capacity to be able to manage a telephone interpreter (I:2).  
... a telephone interpreter ... heard badly ... Because there’s no proper equipment, there are always hassles with the telephone, poor reception (I:5).

on page 21, lines 19-20:  
*bilingual staff* ... get help quickly if something arises ... come as quick as possible to help the person and it’s very smooth and easy (I:2).

on page 22, lines 1-8, 20-24:  
... you are limited if you have staff as interpreters ... They (patients) don’t say some things that they might want to say but don’t say because a staff member is there (I:16).  
but it can be negative in that this patient can have favourites because they know the language and perhaps get a bit worried when there’s no one who knows the language and asks to see those people the whole time (I:9).  
That fear exists among bilingual staff, if I am recorded as knowing Finnish, maybe I’ll be used as an interpreter (I:15).  
If the user and the family member have a good relationship and the family member is very careful to make a direct translation and not translate according to his own needs.  
Then I think it’s good to use the family member because it makes the user feel secure (I:1).  
... using a family member as interpreter ... if someone needs help quickly (I:5)

on page 23, lines 1-2:  
*It can happen that it’s the family member’s opinions that are put forward instead of the patient’s, and that can be problematic (I:6).*

on page 24, lines 21-23:  
... surely it’s the family members’ job (to translate letters from the authority) ... or if there’s some contact person in home help who speaks the same language who can assist (I:5).
on page 25, lines 17-19:

... they don’t really have the same conditions for getting equally good care (I:2). We (bilingual staff) who go there... they (non-Swedish-speaking elderly) get better care. They get things exactly as they want them (I:1).

on page 26, lines 1-6:

... it’s very time-consuming ... where there’s a lot of body language, you use words that you expect the patient to understand. Then you don’t know how much the patient has understood or if I have understood right. You can’t just issue a pill organizer and walk away. The patient wants to put something else across and wants to talk about other things that have arisen, and that’s what takes time (I:20).

on page 27, lines 6-12:

When you use an interpreter you can never be sure of how the interpreter translates what you say (I:5).

... that we don’t get that contact with the patient when we don’t hear the nuances ... which can get lost through translation too (I:7).

... instead I observe ... if someone has, for example, a sore stomach I ask “have you got a pain in your stomach?” and then that person points to the stomach, head or legs ... communicating through body language (I:5).

on page 28, lines 5-7:

... have some document of this kind on the intranet ... be a little more clear ... to ensure how to do things in practical terms ... a contact person, someone who’s a bit better informed ... and spreads information (I:11).

on page 29, lines 3-4, 11-12, 19-20:

it (the procedure for using interpreters) could be simpler somehow and not feel ... long-winded (I:7).

... to employ a person of foreign origin so that, if you’re lucky, that person is at the unit and can interpret (I:2)

... if there was some department with their language, with the culture and people and the food, and staff who speak their language (I:10)

on page 30, lines 12-17:

... should think about how long sentences you should say when using an interpreter. How much can you expect of an interpreter and then, should you break up sentences, should you say the whole sentence, ... that you have a patient with a different culture, a different religion, perhaps they don’t want a man coming to them, and there are also aspects like that you have to take into consideration (when booking interpreters) (I:13).

and on page 31, lines 1-2, 5-8:

... that the interpreter who comes behaves professionally ..., that they manage to be professional (I:21).

... high knowledge requirements for interpreter training that they can’t manage ... that being an interpreter is not a full-time job ... then it’s not something you want to go in for and instead you take an education that generates a steady job (I:15: Coordinator).
b) Concerning the reviewer’s comments that categories and their subcategories need to be explained how they emerged:

The following information is already given in method on page 12, lines 21-24, and on page 13, lines 1-18 concerning data analysis step to build the categories and their subcategories.

Data analyses
In order to identify patterns in the data and to discover relationships between experiences, inductive qualitative content analysis was used to analyse individual and focus group interviews [37].

Directly after the focus group interviews, the interviewers noted the content of what participants had discussed and the interaction in the group [30]. Then, all individual and focus group data were read thoroughly several times to achieve a sense of the whole. The texts were then broken into smaller textual units. The next step was to search for similarities and patterns to develop sub-categories and categories from the context of the textual units. During the whole analysis process, authors searched for regularities, contradictions, similarities and patterns, returning to the data analysis and rereading all the transcripts until no new information was found. Categories were developed, modified and refined until an acceptable system was recognized. In naming categories, concepts as close as possible to the text were used. Analysis of data proceeded until no new information was obtained [37].

To enhance the trustworthiness of this study, the following steps described by Patton (28) were taken. Credibility was confirmed by the first and second author conducting and analysing the data. Furthermore, the codes and categories were also reviewed and assessed for relevance by the co-authors having research and practical experience in healthcare. Confirmability was ensured by having categories accompanied by literal quotations and by naming categories as closely as possible to the text. Dependability was confirmed by describing the investigation process as clearly as possible [28].

c) Concerning the reviewer’s comments that the category; “Organization of interpreter practice in daily work requires short planning in unpredictable situations” described a content that is obvious:

The following information has been removed from the category on page 17, lines 6-7 and in the Table 2 on page 44:

requires short planning in unpredictable situations

6. Concerning the reviewer’s suggestion to refer to the main topic which is multilingual elderly healthcare and focus on that:

The word “multilingual” has been added in the abstract on page 3 lines 6, 10, 16 and on page 4 lines 1, 4, in the manuscript text on page 5 line 15, on page 6 line 19, on page 8 line 20, on page 14 line 19, on page 22 line 11, on page 25 lines 3, 8, on page 26 line 16, on page 28 line 10, on page lines 14, 24, on page 32 lines 1, 13, on page 33 lines 14, 17, 23, on page 34, lines 6,11, 24, on page 35, line 16 and on page 36, line 21, in the
categories on page 14, line 14, on page 23 line 10 and on page 27, line 15, in the
subcategories on page 15, line 18, on page 20, line 15 and on page 30 line 19 and in the
Table 2 on page 44.

7. Concerning the reviewer’s comment about given information that “this is the first study” is repeated many times and to highlight what is new in the findings:

The following information has been removed from the discussion on page 31, lines 12-13:

To our knowledge, this is the first study focusing on interpretation practices in elderly healthcare.

Thus, the following word has been added in the discussion on page 37, lines 3-7 to clarify the new findings in elderly healthcare:

The main new result showed that, although there was an established law in multilingual elderly healthcare concerning the availability of an interpreter agency with which the municipalities have an agreement according to the Swedish Management Act [31] and the Public Procurement Act [33].

Further, the following information is already given in discussion on page 32, lines 9-11 concerning what is new in the findings:

The first new finding, not previously described, was that the municipalities followed the existing law that included the contract about access to a certain interpreter agency but that there was a lack of guidelines concerning the procedure for using an interpreter.

on page 32, lines 17-22:
The healthcare staff mostly relied on and preferred bilingual colleagues and family members as interpreters to fill the communication gaps between them, because they fitted better with existing routines and ways of working in the institution. This result was contrast to previous findings from different healthcare staff [16] and migrants with different cultural and language background [31, 35, 36] stating that they preferred using professional interpreters in healthcare encounters.

on page 33, lines 16-16:
The second new finding, not previously described, was that elderly person’s expectations, behaviour and illness, according to the healthcare staff interviewed, affected the use and role of the interpreter.

and on page 34, lines 15-16:
The third new finding of this study was the several challenges in healthcare and communication when healthcare staff used interpreters.
8. Concerning the reviewer’s suggestion about to discuss the findings in view of improvements to be made in elderly healthcare:

   The following information is already given in discussion on page 33, lines 13-16 concerning significance of findings and recommendations to clinicians regarding interpretation practice in elderly healthcare:

   Thus, our findings indicate the need for development at the organizational levels of elderly healthcare in order to provide interpreting, to give access a professional interpreter service and not only rely on bilingual healthcare staff and family members as interpreters.

   on page 34, lines 5-19:
   This study confirms that the interpretation situation in the field of elderly healthcare is a social and structural act, and as such is multifaceted and dependent [3] on social context, power relations, cultural beliefs, religious and traditional values, the physiology of illness and treatment, through the interpersonal dynamics of the healthcare encounter, to the social, institutional and governmental policies and practices [3, 19]. This highlights the need to improve the interpreter situation in healthcare, considering not only the individual’s language skills, cultural beliefs, and socio-economics factors but also organizational cultural competence [3].

   And on page 35, lines 3-6:
   The results emphasize the need for better organization, making interpreter routines simpler, easily available and understandable, and for the development of specific training for healthcare professionals and professional interpreters working in the field of elderly healthcare.

   Thus, the following information has been added in the abstract on page 4, line 5 to clarify the significance of findings and recommendations of improvements in elderly healthcare to clinicians:
   In order to formulate interpreter practice in the context of multilingual elderly healthcare it is important to consider organizational framework and cultural competence and cultural health knowledge, beliefs and customs.

   and in the conclusion on page 37, lines 4-6
   This study highlights the importance of improvements in the multilingual elderly healthcare considering the dynamics of organizational routines, organizational cultural awareness and individual cultural health knowledge, beliefs and customs when formulating interpretation practice to improve individual-centred healthcare for elderly migrants.

9. Concerning the reviewer’s minor essential revisions:
   “Ad p 3, abstract, ‘The main results showed that interpreting practice in elderly healthcare was linked to institutional, interpersonal and individual levels’ – rather evident, sounds a bit trivial”

   The following word has been added in the abstract on page 3, line 17:
   The main results showed that interpreting practice in elderly healthcare was closely linked to institutional, interpersonal and individual levels’.
10. Concerning the reviewer’s minor essential revisions that it would be interesting to add percent increase of the elderly migrant population in the manuscript:

The following information has been added in the introduction on page 5, lines 5-7:
Data on the number of elderly immigrants in Europe are limited and unsatisfactory, but the number of elderly migrants in Europe is estimated to increase [3].

And on the reference list on page 38, lines 11-17 we have added the following source:
http://cermes.info/upload/docs/Elderly_migrants_in_Europe_paolo_ruspini_14_07_10.pdf: This article draws from a preliminary report prepared in 2009 for the European Committee on Migration of the Council of Europe (CDMG) . The opinions expressed in this work are the responsibility of the author and do not necessarily reflect the official policy of the Council of Europe.; 2009.

11. Concerning the reviewer’s minor essential revisions that data of complexity were missing:

In order to more deeply explain the data, we have removed complexity from page 9, line 7 and we have added the following information:

on page 9, line3:
descriptive

and on page 9, lines 7-8:
And by the interaction in the group to reach a person’s more or less unconscious perceptions (29, 30)

12. Concerning the reviewer’s minor comment that “Patton 2002” references should be referenced in the reference section:

The reference has been added on page 13, line12:
(28)

13. Concerning the reviewer’s comments concerning to put the theoretical framework in the methods section, and be used to run the analysis:

According to the method used for analyzing inductive qualitative content analysis (Krippendorff, 2004) the data analysis is made as described on page 12, lines 21-24 and on page 13, lines 1-18 under Data analysis. The qualitative analysis is an iterative process that means to identify certain patterns in the text and then develop codes, subcategories and categories based of the text without presupposing in advance what the categories will be, then the theoretical framework is used for discussing findings when categories have been developed (Patton 2002). However, in order to more explain the process of the content in the analysis, we have added inductive the on page 12, line 23.
According to the suggestions from the reviewer Ludwien Meeuwesen:

14. Concerning the reviewer’s comment about that authors have included too many citations:

    Please, see explanation above to the reviewer Alexander Bischoff under numbers 4) and 5).

15. Concerning the reviewer’s comment concerning that interpreting processes are much more than translating word-by-word and to be more critical about this issue, not just in the discussion:

    The following information has been added in the background on page 6, lines 11-16:
    According to recommendations in guidelines for interpreters in Sweden (19) the interpreter’s role is to do word-by-word interpretation. Further, satisfactory interpretation is achieved when the message and all its nuances are reproduced as correctly as possible. However, word-by-word interpretation has also been questioned previously [20, 21] as the interpreter affects communication by being present [22].

16. Concerning the reviewer’s statement about that some comments on practice implications are missing.

    Please, see explanation above to the reviewer Alexander Bischoff under number 8).