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Zendedel, R.; van den Putte, B.; van Weert, J.; van den Muijsenbergh, M.; Schouten, B.

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Informal Interpreting in General Practice: Interpreters' Roles Related to Trust and Control

*Rena Zendedel, Bas van den Putte, Julia van Weert, Maria van den
Muijsenbergh and Barbara Schouten*

1 Introduction

Due to globalization the number of migrant patients in the health care sector is rapidly rising (Mosquera, Samuels and Flores 2016; Triemstra et al. 2016). Migrant patients often lack adequate language proficiency in the host language, which impedes the communication between the healthcare provider and the patient (Jacobs et al. 2006; Karliner et al. 2007). Using interpreters is one way to bridge this language gap. In contrast to some countries where professional interpreting services are provided for by the government (Flores 2005; Jacobs et al. 2006), in the Netherlands no funding exists for the use of professional interpreters in the primary care. The use of so-called informal interpreters, who are usually relatives of the patient, is common practice in Dutch primary care. Informal interpreters are present in around 60% of consultations with migrant patients, and especially frequent with first generation female Turkish migrant patients, who have low Dutch language proficiency (Huijnk and Dagevos 2012; Triemstra et al. 2016). As the General Practitioner (GP) has a gatekeeping function in the Netherlands, where the patients visit the GP first in order to get a referral to specialized care, adequate communication in the GP setting is of a great importance.

There is little consensus in the literature about the (dis)advantages of informal interpreting. On the one hand, the drawbacks of informal interpreting are highlighted, such as inadequate translation and omission of important information (Aranguri, Davidson and Ramirez, 2006; Flores 2005), internal role conflicts (Messias, McDowell and Estrada 2009), mistrust in informal interpreters by the GP (Gadon, Balch and Jacobs 2007; Robb and Greenhalgh 2006), and loss of control of the health care provider (Meeuwesen et al. 2010; Rosenberg, Leanza and Seller 2007). On the other hand, positive aspects are mentioned as well, such as the high trust of patients in the informal interpreters (Edwards, Temple and Alexander 2005), their emotional support for the patients (Ho 2008; Rosenberg, Seller and Leanza 2008), and empowerment of the patients (Green et al. 2005).

In order to better understand these seemingly contradictory findings, we need to take into account the different perspectives on relevant issues by the main actors, that is the GPs, the migrant patients and the informal interpreters. A recent review of the literature has highlighted three key issues for interpreting in medical settings, namely, the interpreter's role, control, and trust (Brisset, Leanza and Laforest 2013). Previous qualitative research has already provided an exploration of these issues (e.g., Edwards et al. 2005; Leanza 2005; Robb and Greenhalgh 2006). There is, however, a lack of quantitative research linking the different concepts to explain earlier, contradictory findings.

We therefore aim to compare the patients' expectations of interpreters' roles to GPs' and informal interpreters' own role expectations and link the role expectations of the patients to their perceived control of the consultation and trust in the interpreter. Both patients' control and trust have been related to positive health-related outcomes, such as better adherence to treatment and higher satisfaction of the patient (Street et al. 2009). In the next section we will discuss the theoretical concepts and present our research hypotheses.

2 Interpreters' Roles

In medical interaction interpreters perform many different roles, which have been defined as "behaviors and skills associated with being an interpreter as expected by institutions, practitioners and patients" (Brisset, Leanza and Laforest 2013, 135). Research on medical interpreting has frequently used Habermas' System versus Lifeworld metaphor to explain the different roles of medical interpreters (e.g., Robb and Greenhalgh 2006). The System in health care refers to policies and rules that provide a framework for the medical consultation, such as, for instance, the limited consultation time (ten minutes in the Dutch GP setting for a single consultation). Lifeworld is the familiar world of patients and their community, relating to patients' emotions, worries and concerns (Robb and Greenhalgh 2006).

Previous research has described System and Lifeworld as opposing ends of a continuum with the different roles of the interpreter positioned either as a System or as a Lifeworld role (Brisset, Leanza and Laforest 2013). Informal interpreters tend to represent the patient's lifeworld and act as the patient's advocate (Green et al. 2005), counselor (Edwards et al. 2005) or provide emotional support to the patient (Ho 2008). They also often act as an extra information source by providing additional knowledge about the patient's illness and lifeworld to the doctor (Rosenberg et al. 2007; Hilder et al. 2016). A similar role is that of the cultural informant, when informal interpreters provide information

about the cultural background of patients to healthcare providers to help them better understand the patients (Leanza 2005).

Professional interpreters, on the other hand, tend to side with the doctors and to act on behalf of the system, for instance by keeping track of the consultation time (Hsieh 2006). This system agent role of institutional gatekeeper is also performed by healthcare providers who act as interpreters for migrant patients (Davidson 2000). When performing the role of a conduit, the interpreter ideally remains neutral and sides neither with the patient, nor with the doctor. However, as the voice of medicine is usually dominant during the medical consultation (Mishler 1984), when acting as a conduit the interpreter more likely transmits the dominant discourse by representing the system and is therefore classified as a system agent role (Brisset, Leanza and Laforest 2013). Thus, following Brisset, Leanza and Laforest (2013), we treat the conduit and the institutional gatekeeper as system agent roles and the advocate, emotional support, information source, cultural informant and counselor as lifeworld agent roles.

Recent qualitative research comparing the perspectives of GPs, patients and informal interpreters on the expected role of the informal interpreter has indicated that patients and informal interpreters have similar perspectives and mainly expect lifeworld agent roles from informal interpreters with advocate, information source and emotional support being the most prominent roles. GPs on the other hand, were more inclined to expect system agent roles (predominantly the conduit role) from informal interpreters (Hilder et al. 2016; Zendedel et al. 2016a). These comparative qualitative studies which have stressed the similarities of the patients' and informal interpreters' perspectives on the one hand, and GPs' divergent perspective on the other hand are in line with prior research which investigated the perspectives of the three actors separately, that is GPs' (Rosenberg et al. 2007); patients' (Edwards et al. 2005) and informal interpreters' perspectives (Green et al. 2005).

Thus, although the role of the interpreter has received ample attention in qualitative studies, to our knowledge, to date no studies have integrated the different roles in one study and compared the three perspectives (GPs', informal interpreters' and patients') on these roles in a quantitative way, which is important for consolidation of previous conclusions. Based on the System versus Lifeworld theory and on the earlier discussed empirical findings, we expect a discrepancy in role expectations between the GP on the one hand, and the patient and the informal interpreter on the other hand. Hence, we will test the following hypothesis:

H1: a) Patients and informal interpreters will have similar expectations of the informal interpreter's role and mainly expect lifeworld agent roles, that is advo-

cacy, emotional support, information source, cultural informant and counselor roles. b) In contrast to patients and informal interpreters, GPs will predominantly expect system agent roles, that is the conduit and the institutional gatekeeper roles.

3 Control in Interpreter-Mediated Interactions

The power balance in a medical consultation is generally more doctor-oriented, that is, the health care provider is usually in control and the voice of the system dominates the voice of the lifeworld (Greenhalgh, Robb and Scambler 2006; Mishler 1984). The presence of an interpreter converts the dyadic interaction into a triadic one and changes the power and control dynamics of the interactions (Brisset, Leanza and Laforest 2013). Previous qualitative studies have indicated that professional interpreters and bilingual nurses who act as interpreters side more with the health care providers and enlarge providers' control of the consultation by performing system agent roles (Davidson 2000; Hsieh 2006). Informal interpreters, on the other hand, side with the patients and enlarge patients' control, by acting as lifeworld agents, for instance, as advocate, emotional support, information source etc. (Brisset, Leanza and Laforest 2013; Greenhalgh et al. 2006). Indeed, a recent qualitative study assessing Turkish migrant patients' experiences with informal interpreters has shown that patients feel more in control when visiting the GP with an informal interpreter, as they believe that the informal interpreters will represent their interests and help them reach their health-related goals (Zendedel et al. 2016b). Especially the expectations of the advocacy role were related to higher perceived control of the patients. Thus, previous qualitative research has already suggested a connection between perceived lifeworld agent roles of the interpreter and increased patients' control of the consultation. However, to date, quantitative studies directly linking patients' expectations of informal interpreters' role to their perceived control are lacking. Hence, in this study, we link the Turkish migrant patients' expectations of the earlier mentioned roles (i.e., conduit, institutional gatekeeper, advocate, emotional support, information source, cultural informant and counselor) to their perceived control in order to test which role expectations are related to higher perceived control of the patient. Based on previous qualitative studies and on the Lifeworld versus System theory, we hypothesize the following:

H2: Patients' expectations of the lifeworld agent roles of the interpreter (i.e., advocate, counselor, emotional support, information source and cultural broker) will be positively related to patients' perceived control of the consultation.

4 Trust in Informal Interpreters

Trust is a core element of the patient-provider relationship and has been linked to positive health outcomes, such as better adherence to treatment, better access to care and eventually a better vitality of the patient (Street et al. 2009). In interpreter-mediated interactions, the interpreter becomes the link between the patient and the health care provider and therefore trust in the interpreter is crucial (Brisset, Leanza and Laforest 2013). The patients confide their health problems to the interpreters and thus they need to trust the interpreters' competence, fidelity, and honesty, which form the components of trust (Hall et al. 2001). In the present study we will use these dimensions of trust, which have also been applied in previous qualitative research on interpreter-mediated communication (Zendedel et al. 2016a).

Competence, the first dimension, refers to interpreters being trusted for their ability to provide correct translations without making mistakes. Fidelity, the second dimension, refers to interpreters being trusted because they act in the best interests of the patient. Honesty, the third dimension, refers to interpreters being trusted because they tell the truth and do not disguise information. The fourth and final dimension, global trust refers to the irreducible, holistic, component of trust, when the patient simply trusts the interpreter for no reason in particular (Hall et al. 2001). Previous qualitative research has indicated that patients' trust in informal interpreters is mainly based on the fidelity dimension, that is, they believe that the informal interpreters are acting in their best interest (Zendedel et al. 2016a). This study has also proposed a relationship between the informal interpreters' role and patients' trust by suggesting that the informal interpreter's role of the advocate is related to patients' trust in the interpreter. Based on this previous research, we hypothesize that the expectations of lifeworld agent roles, that is, advocate, emotional support, information source, cultural informant and counselor will be related to higher trust in the informal interpreter. Hence, we will test the following hypothesis:

H3: Patients' expectations of the lifeworld agent roles of the interpreter (i.e., advocate, counselor, emotional support, information source, and cultural informant), will be positively related to patients' trust in the interpreter.

The aforementioned qualitative study (Zendedel et al. 2016b) has also suggested a mediated relationship between the informal interpreters' role of the advocate, and patients' trust, through their perceived control. That is, it is assumed that patients feel more in control when informal interpreters speak on their behalf and this perceived control subsequently leads to more trust in the interpreter. In order to explore whether the patients' perceived control also

mediates the relationship between other expected roles and patients' trust in the interpreter, we will answer the following research question:

RQ: To what extent does patients' perceived control of the consultation mediate the relationship between the expected roles (i.e. lifeworld and system agent roles) of the interpreter and patients' trust in the interpreter?

5 Method

5.1 *Participants*

Of the 237 approached patient-interpreter pairs, 126 pairs agreed to participate in the study, thus a response rate of 53%, which is in line with previous findings (Ahlmarm et al. 2015; Schinkel, Schouten and van Weert 2013). Reasons for not wanting to participate were privacy issues, too little time or no interest in the study. We had to exclude 35 pairs from analysis due to different reasons, such as incomplete surveys (see Figure 4.1).

The final sample for analysis consisted of 91 interpreter-patient pairs and 26 GPs with whom they had an appointment. All patients were first generation Turkish migrant patients and the interpreters were mainly adult children and spouses of the patient (see Table 4.1 for sample characteristics).

TABLE 4.1 Sample characteristics

Sample characteristics	Patients (N=91)	Interpreters (N=91)	GPs (N=26)
Gender			
Men	19 (21%)	29 (32%)	7 (27%)
Women	72 (80%)	62 (68%)	19 (73%)
Age (SD)	59.19 (13.27)	39.47 (12.48)	47.54 (11.27)
Educational level			
No education	26 (28%)	5 (6%)	0 (0%)
Preliminary school	50 (55%)	8 (9%)	0 (0%)
High school	15 (16%)	14 (15%)	0 (0%)
Intermediate vocational education	0 (0%)	48 (53%)	0 (0%)
Higher professional education	0 (0%)	15 (16%)	0 (0%)
Academic education	0 (0%)	1 (1%)	26 (100%)

TABLE 4.1 Sample characteristics (*cont.*)

Sample characteristics	Patients (N=91)	Interpreters (N=91)	GPs (N=26)
Dutch language proficiency			
Poor	50 (54.9%)	0 (0%)	
Moderate	36 (39.6%)	9 (9.9%)	
Reasonable	3 (3.3%)	24 (26.4%)	
Good	2 (2.2%)	34 (37.4%)	
Very good	0 (0%)	24 (26.4%)	
Residence time in the Netherlands			
Born in the Netherlands	0%	32 (35.2%)	
Mean residence time in years (SD)	31.94 (11.57)	31.60 (8.55)	
Interpreter's relationship to the patient			
Daughter	34 (37%)		
Son	18 (20%)		
Spouse	25 (28%)		
Grandchild	4 (4%)		
Other family member	4 (4%)		
Friend of the patient	6 (7%)		
Perceived health status of the patient			
Not healthy at all	28 (31%)		
A little healthy	42 (46%)		
Relatively healthy	20 (22%)		
Very healthy	1 (1%)		
Time working as a GP			
Mean time in years (SD)	13.85 (10.98)		

6 Procedure

One of the authors (MM), who also works as a general practitioner, sent out 100 e-mails to her GP-colleagues and recruited six GP practices with 26 GPs in four multicultural cities in the Netherlands to participate in the study. The participating practices had a large number of Turkish migrant patients (at least 25%), which was an inclusion criterion for participation in the study. The first author (RZ) had a briefing with all practices to inform the participating GPs about the research procedure. Wall-posters in Turkish and Dutch were hung in the GP practices to inform the patients about the study. We recruited 12 Turkish-Dutch

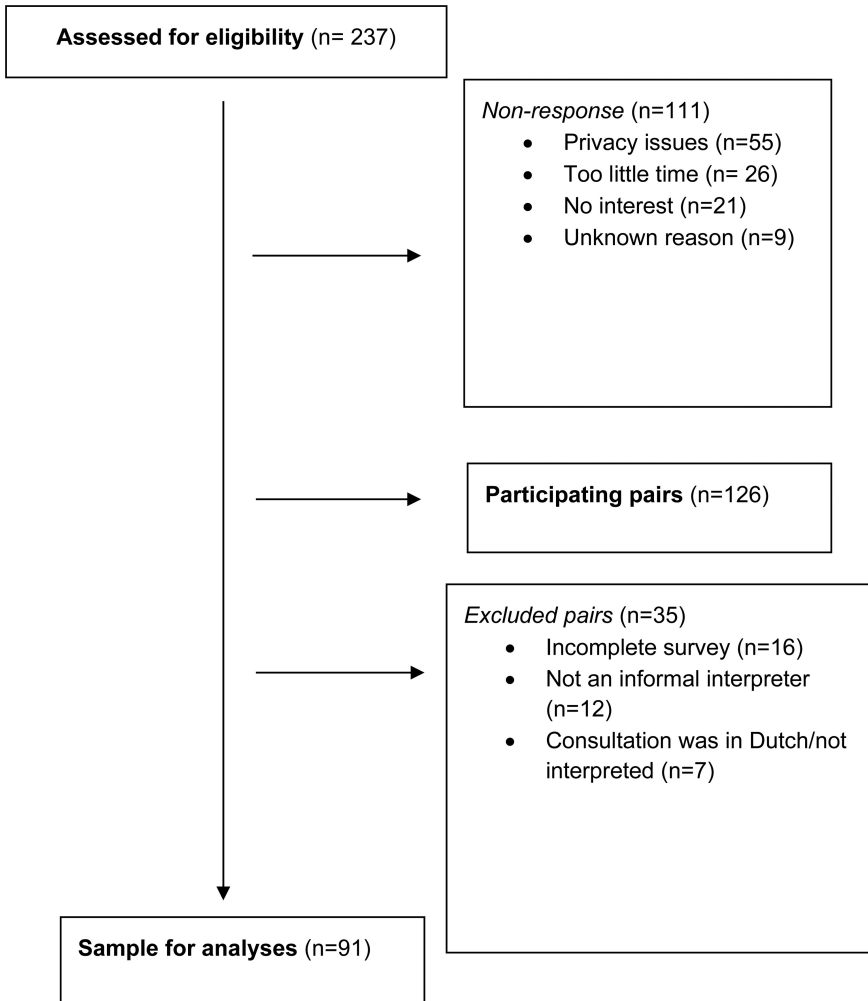


FIGURE 4.1 Flowchart of the sampling

research assistants with a sound knowledge of Turkish and Dutch to approach the patients in the GP practices. All research assistants received training about the research procedure.

The study ran from November 2015 to May 2016 in all six practices. At least two different assistants collected data in each practice at the same time. Each practice was visited on different days of the week during the research period to make sure every GP of each practice had an equal chance to participate in the study. All patients in the waiting room who according to the research assistants could be of Turkish origin and who were in the company of another

person were invited to participate in the study. Inclusion criteria were that the patients who visited the GP were accompanied by an informal interpreter and that both the patient and the interpreter were at least 18 years old. After explaining the study purpose, patients and informal interpreters were asked for their consent to participate. All participants (patients, informal interpreters and GPs) gave their written informed consent to the study. The study has been approved by the University of Amsterdam Ethical Commission (number 2015-CW-71).

The GPs and informal interpreters completed the paper surveys themselves; for informal interpreters, there was a Dutch and Turkish version of the surveys available. As most patients were illiterate, the research assistants read the questions of the survey to the patients and wrote down their answers. All patient surveys were collected in this oral way and were completely in Turkish.

6.1 *Materials*

Separate pre-consultation and post-consultation questionnaires were constructed for each of the three groups of participants (patients, GPs and informal interpreters). The patient questionnaire was translated into Turkish by a professional translation service and double-checked by two Turkish-Dutch research assistants. All questionnaires were pilot tested among patients, informal interpreters and GPs during a pilot-testing week in a GP practice to ensure that all items were understood by the respondents. We then reformulated some of the questions of the patients' questionnaire to make them easier to understand. The pretest data were not included in the final dataset.

6.2 *Pre-consultation Questionnaire*

The pre-consultation questionnaire consisted of demographic questions and questions regarding the expectations of the interpreter's role. We asked participants to comment on the following roles of the interpreter: conduit, institutional gatekeeper, advocate, information source, emotional support, cultural informant and counselor in the following way (patients' version of the questionnaire): "What do you expect from the person who came with you today to interpret?" We described the roles in the following manner: 'Conduit': to provide a literal translation of what is communicated; 'Institutional gatekeeper': to make sure the consultation does not exceed the allocated time; 'Information source': to provide additional information about your health to the doctor; 'Advocate': to do whatever is needed to reach your goals; 'Emotional support': to emotionally support you; 'Cultural informant': to give the doctor information about the Turkish culture in order to better understand you; 'Counselor': to give you advice during decision making. We asked the patients, the informal

interpreters and the GPs to what extent they think these roles should be performed by the informal interpreter on a four-point scale ranging from (1) totally disagree to (4) totally agree.

6.3 *Post-consultation Questionnaire*

The post consultation questionnaires consisted of questions measuring the patients' control and trust. Control was measured with three items on a five-point scale, that is: "To what extent did the person who came with you to interpret, facilitate or hinder 1) the communication 2) reaching your goal 3) relationship building with your doctor?" Answers had to be given on a scale ranging from (1) totally hindered to (5) totally facilitated, which all loaded on one factor that proved to be reliable ($EV = 2.03$; $R^2 = .68$; $\alpha = .76$). We thus created a scale for control by calculating the mean scores ($M = 4.56$, $SD = .72$).

Trust in the interpreter was assessed with four items on a four-point scale, ranging from (1) totally disagree to (4) totally agree, each measuring one of the four dimensions, namely competence, fidelity, honesty and global trust (based on Hall et al. 2001; see theoretical framework for explanation of the items). We split the trust dimensions into cognitive and affective components. Fidelity, honesty and global trust all loaded on one factor and proved to be reliable ($EV = 1.93$; $R^2 = .64$; $\alpha = .64$; $M = 3.93$, $SD = .21$) forming the affective component of trust. The competence dimension did not form a scale with the items of the affective dimension and was treated as a separate item, forming the cognitive component of trust ($M = 3.60$, $SD = .79$).

7 Analyses

ANOVAS with Bonferroni post-hoc tests were conducted to compare the three groups regarding the expected role of the interpreter (H1). Regression analysis was used to assess the relationship between the different role expectations as predictors of patient's perceived control of the consultation (H2). Model 4 of Process (Hayes 2012), was used to test the mediation models, that is assessing the direct relationships between the different role expectations as predictors of patients cognitive and affective trust (H3) and mediated relationships via control (RQ1). All models were controlled for background variables that were correlated with the outcome measures, that is, interpreters' gender with patients' perceived control and patients' language proficiency with patients' affective trust.

8 Results

8.1 *Interpreters' Roles: Comparison of Patients', Interpreters' and GPs' Expectations*

In line with H₁, there were no significant differences between the role expectations of interpreters and patients. GPs' expectations of informal interpreters' roles significantly differed from both the patients' and informal interpreters' expectations, except for the role of the conduit (see Table 4.2).

TABLE 4.2 Expectations of interpreters' roles between the patients, interpreters and GPs

	Patients (N=91)	Interpreters (N=91)	GPs (N=26)
Lifeworld agent roles			
Advocate	3.70 (0.71) ^{a***}	3.54 (0.74) ^{a***}	1.54 (0.76)
Information source	3.65 (0.74) ^{a***}	3.53 (0.77) ^{a***}	2.73 (0.83)
Emotional support	3.57 (0.70) ^{a***}	3.45 (0.77) ^{a***}	2.73 (0.87)
Counselor	3.49 (0.87) ^{a***}	3.33 (0.92) ^{a***}	2.00 (0.80)
Cultural informant	3.23 (1.02) ^{a**}	2.97 (1.06) ^{a*}	2.38 (0.98)
System agent roles			
Conduit	3.37 (0.91)	3.32 (0.96)	3.15 (0.88)
Institutional gatekeeper	2.68 (1.08) ^{a**}	2.44 (1.07) ^{a*}	1.85 (0.92)

^a score differs significantly from the GPs' mean score

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Both the patients and informal interpreters mainly expected lifeworld agent roles, that is, advocate, information source, emotional support and counselor. The role of the institutional gatekeeper was the least expected role. In contrast to informal interpreters and patients, the GPs least expected the advocacy role. GPs did not expect the institutional gatekeeper role either, but mainly the conduit role (see Table 4.2).

Thus, except for the conduit role, we accept H₁, by concluding that patients and informal interpreters indeed have similar expectations of the informal interpreter's role (mainly expecting the lifeworld agent roles), but that the expectations of the GPs are different from both the patients and the informal interpreters (mainly expecting the system agent roles).

TABLE 4.3 Mediation analyses: Direct Effects (DE) and Indirect Effects (IE) of role expectations on perceived control and cognitive and affective trust

	<i>Perceived Control</i> <i>DE Effect (SE)</i> [95%BCBCI]	<i>Cognitive</i> <i>trust DE</i>	<i>Affective</i> <i>trust DE</i>	<i>Cognitive</i> <i>trust IE</i> <i>via control</i>	<i>Affective</i> <i>trust IE</i> <i>via control</i>
Lifeworld agent roles					
Emotional support	.45 (.10) [.25,.65]***	.25 (.12) [.01,.49]*	.06 (.03) [-.01,.12]	.13 (.08) [.02,.32]	.03 (.03) [-.00,.12]
Advocate	.20 (.11) [-.01,.42] †	.22 (.11) [.00,.44]*	.07 (.03) [.02,.13]*	.07 (.06) [-.01,.23]	.02 (.02) [-.00,.07]
Information source	.27 (.10) [.07,.47]**	.13 (.11) [-.08,.35]	.06 (.03) [.00,.10]*	.10 (.07) [.00,.28]	.02 (.02) [-.00,.10]
Cultural Informant	.19 (.07) [.04,.33]**	-.02 (.08) [-.18,.14]	.05 (.02) [.01,.09]*	.08 (.05) [.00,.21]	.02 (.02) [-.00,.06]
Counselor	.02 (.09) [-.14,.21]	.14 (.09) [-.04,.31]	.03 (.02) [-.02,.08]	.01 (.03) [-.06,.09]	.00 (.01) [-.01,.02]
System agent roles					
Conduit	.09 (.08) [-.08,.26]	.15 (.08) [-.01,.32]	-.01 (.02) [-.05,.04]	.03 (.03) [-.01,.13]	.01 (.01) [-.00,.04]
Institutional gatekeeper	.05 (.07) [-.09,.19]	.18 (.07) [.04,.32]*	.03 (.02) [-.01,.06]	.02 (.02) [-.02,.09]	.00 (.01) [-.00,.03]

† $p < 0.07$ * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Note. Model controlled for interpreter's gender and patients' language proficiency.

8.2 Patient's Control and Trust: Which Role Expectations Are the Best Predictor?

8.2.1 Direct Effects on Patients' Perceived Control

In line with H2, patients' expectations of emotional support, information source and cultural informant roles were positively related to patients' perceived control of the consultation (see Table 4.3). We also found a marginally significant relation between the expected role of the advocate and increased patients' perceived control. Contrary to our expectations, the expected role of the counselor was not related to an increase in patients' perceived control. Thus, the results largely confirm the hypothesis that the patients' expectations of the lifeworld agent roles are positively related to perceived control of the patient; H2 holds true for all lifeworld agent roles, except for the role of the counselor.

8.2.2 Direct Effects on Patients' Trust in the Interpreter

In line with H₃, we found a positive relation between most lifeworld agent roles (i.e., emotional support, advocate, information source, and cultural informant) and patient trust in the informal interpreter. The expectations of the information source role and of the cultural informant role were only related to patients' affective trust and the expectations of the emotional support role were only related to patients' cognitive trust. The expectation of the advocate role was related to both the cognitive and also to affective trust of the patients. Furthermore, contrary to our expectations, we also found a positive relation between the expected role of an institutional gatekeeper and patients' cognitive trust. Thus, the results largely confirm the hypothesis that patients' expectations of the lifeworld agent roles are positively related to patients' trust in the interpreter; H₃ holds true for all lifeworld agent roles, except for the role of the counselor and also applies to the system agent role of institutional gatekeeper.

8.2.3 Mediated Effects on Patients' Trust in the Interpreter

To answer RQ₁, we found a mediated relationship between the expected interpreters' role and patients' increased trust via control as a mediator for the expected role of the emotional support, the role of advocate and the role of cultural informant. Thus, the patients' role expectations regarding emotional support, advocate and cultural informant were indirectly related to cognitive trust in the interpreter through enhanced control of the patient. We did not find any mediated relations between the patients' role expectations and patients' affective trust.

9 Discussion

The present study has compared the expectations of GPs, patients and informal interpreters regarding the role of the interpreter and has linked patients' expectations of the role of the informal interpreter to their perceived control and trust in order to corroborate previous qualitative findings and to integrate the different key concepts (i.e., interpreters' role, control and trust) in one study.

The comparison of the three perspectives on expectations regarding the interpreter's role has confirmed previous findings from qualitative studies that informal interpreters tend to align with the patients in their expectations of the interpreter's role (Green et al. 2005; Ho 2008; Zendedel et al. 2016a). Also, in line with previous research, the role of the advocate was the most expected role of the informal interpreter by patients and informal interpreters (Zendedel et al. 2016a), and the role of the institutional gatekeeper their least expected

one, which fits with the system versus lifeworld theory (Greenhalgh et al. 2006). The GPs' expectations differed significantly from patients' and informal interpreters' expectations on all roles except for the conduit role, which indicates that there is a clash of expectations between the GP on the one hand, and informal interpreters and patients on the other hand. This finding might explain the loss of control of the GPs described in previous studies (Meeuwesen et al. 2010; Rosenberg et al. 2007) and their mistrust in the informal interpreter (Gadon et al. 2007), as the informal interpreters' view of their own role obviously contrasts with GPs' expectations. Furthermore, we are now better able to understand the positive experiences of patients with informal interpreters (Hilder et al. 2016; Zendedel et al. 2016b), as informal interpreters have shown to align with patients' expectations of their role. Hence, after comparing the expectations of the three interlocutors, we are better able to explain the contradictory findings in previous studies (Araguri et al. 2005; Edwards et al. 2005; Flores 2005; Ho et al. 2008) about the practice of informal interpreting.

Moreover, our findings have shown that predominantly the expectations of the lifeworld agent roles (especially that of the emotional support) lead to increased patients' perceived control, which might explain why migrant patients often prefer informal interpreters over professional ones and are satisfied with their help (Edwards et al. 2005; Hilder et al. 2016). The results of our study indicate that the ideal role of the interpreter as expected by patients is not the conduit, who simply converts the information from one language into another, which is traditionally seen as the ideal role of the professional interpreter (Dysart-Gale 2005). Conversely, the expectations of the lifeworld agent roles (i.e., emotional support, advocate, information source and cultural broker), which require an active and partial stance of the informal interpreter are shown to increase patients' perceived control. Thus, our study provides statistical support for the advantageous effect of lifeworld agent roles on the perceived control of patients as noted in earlier research (Brisset, Leanza and Laforest 2013; Greenhalgh et al. 2006).

Regarding the patients' trust in the interpreter, the present study shows that the role of the advocate and the role of emotional support, which are widely expected by patients from informal interpreters, significantly increase patients' cognitive trust. This finding indicates that these lifeworld agent roles are the ones which are expected from a competent interpreter according to Turkish migrant patients, as the cognitive trust dimension was based on patients' trust in informal interpreters' competence. It seems that patients' definition of interpreters' competence differs from the definition used by health care providers and scholars, who attach much more importance to the neutral role of the interpreter (e.g., Cox 2015). Thus, the present study has added the patients'

perspective to previous research findings, which perspective has been understudied due to the difficult access to the research population (Brisset, Leanza and Laforest 2013).

Despite the merits of our study, there are also some limitations. First, we have studied a particular population, namely illiterate Turkish migrant GP patients in the Netherlands, which means that the results of our study might not be generalizable to other populations and settings. It is therefore important to replicate this study among different migrant groups and in different medical settings to enlarge the generalizability of the findings. Second, we have studied correlational data, which prevents us from drawing causal conclusions. However, correlational research is the first step to exploring the relationship between the different factors, which should be verified in future experimental studies. Third, in this study we have related patients' expectations of interpreters' role to patients' perceived control and trust. Future observational studies should investigate whether the informal interpreters actually perform the roles which are expected from them by patients and whether these performed roles are also related to higher patient control and trust.

The present study is one of the first to combine the different interpreter roles mentioned in previous literature and to quantitatively compare the GPs', migrant patients' and informal interpreters' perspectives on these roles. Our study largely confirms the findings from qualitative studies, which contributes to the consolidation of previous research. Besides, this study was the first to statistically relate the different issues (i.e., interpreter's role, control, and trust) to each other, which moves us closer to an explanatory framework of informal interpreting in medical settings. The emphasis on the patients' perspective is one of the greater merits of the present study, as patients' perspective is often lacking from medical-interpreting research. It is crucial to investigate the patients' perspective in order to align health care provision with patients' wishes and needs. The findings of our study could also be used to design a training for GPs and informal interpreters in order to improve the communication process in interpreter-medical interactions.

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