Informal interpreting in Dutch general practice

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Informal Interpreting in Dutch General Practice

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To Ludwien Meeuwesen

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Preface

Let me start this dissertation with a riddle: “How many interpreters does it take to change a light bulb?” The answer is: “None. A good interpreter adds nothing, removes nothing, changes nothing.” If only it would be so easy to follow this rule, this dissertation would probably never have been written. Interpreting is not a clear-cut task, as languages aren’t clear-cut either. Let me illustrate this by providing an example from Italian, one of my favorite languages. “Che figata!” Literal translation: “What a fig!” Meaning: “Cool!” Quite a difference, right?

Another example comes directly from the data of this dissertation. An elderly Turkish-Dutch migrant woman visits her GP with complaints about stomach pain. Her daughter does the interpreting. The GP asks the patient whether she still uses birth control. The woman giggles and says something at first glance totally incomprehensible. “What is he saying, daughter? The sun comes up and goes under. We do not lay down and stand up together”. After discussing this phrase with several research assistants of Turkish origin, it became clear that this was an indirect way of letting the GP know that the patient did not have sexual intercourse with her husband for a long while, which makes the use of birth control unnecessary. Thus, a very implicit answer, probably because the woman is embarrassed to discuss this topic in front of her daughter, or to discuss it at all, as sexual topics are usually not openly discussed in the Turkish culture.

Both examples illustrate the potential challenges for interpreters, who are expected to transfer meaning from one language into another, and meaning, as we saw in the examples above, is not straightforwardly encoded in words. It takes an understanding of the entire context to be able to provide a good translation of what is said. Moreover, medical interpreting, which is the scope of the present dissertation, is usually done under considerable time pressure, which makes the interpreting task even more difficult. It is my passion for languages and reverence for the job of interpreters that provided the energy to continue this research project, which started with an ambition to improve the communication between health care providers and migrant patients who don’t share the same language.

This dissertation is about informal interpreting, that is, non-professional interpreting, when the interpreters are usually family members of the patients who accompany them to the medical consultation to help them to communicate with their doctors. A lot of what is written in this dissertation is about the role of informal interpreters: What are they supposed to do? What are they expected to do? And what are they actually doing? You will find out that there are no straightforward answers to these seemingly straightforward questions and that by answering these questions, more contradictions are exposed. This might be the

very core of scientific investigation: posing and answering questions only to come across new questions to be answered. I have learned a lot during the process of investigating this fascinating phenomenon and I really hope that the results of this dissertation can be used for the improvement of interpreter-mediated medical communication.

Have fun reading!

Rena Zendedel, 15 May, 2017

Chapter 1

General Introduction and Dissertation Outline

Globalization and worldwide migration have changed the health care sector into a multicultural and multilingual setting and the number of migrant patients continues to rise rapidly (Mosquera, Samuels, & Flores, 2016; Triemstra, Veenvliet, Zuizewind, Kessel, & Bos, 2016). Many migrant patients lack adequate language proficiency in the host language, which impedes the communication with their health care providers (Jacobs, Chen, Karliner, Agger-Gupta, & Mutha, 2006; Karliner, Jacobs, Chen, & Mutha, 2007). Adequate communication between the health care provider and the patient is essential for a good delivery of care (Bensing & Verhaak, 2004; Roter & Hall, 2006). Using interpreters is one way to bridge the language gap between patients and health care providers. In contrast to some countries, like the US, where professional interpreting services are provided by the government (Flores, 2005; Jacobs et al., 2006), in the Netherlands the budget for the use of professional interpreters in the health care sector has recently been cut (Triemstra et al., 2016). Therefore, the use of informal interpreters, which was already frequent in Dutch primary care before the introduced budget cuts in 2012, will also likely be prevalent in the future (Bot, 2013).

Informal interpreters in medical setting are defined as non-professional interpreters who do not get paid for their work and who are not trained as interpreters (Meeuwesen, Twilt, & Ani, 2011). They are usually family and friends of the patients who join the patient to the medical consultation to do the interpreting. In Dutch general practice (GP), informal interpreters are present in circa 60% of consultations with migrant patients who do not have sufficient Dutch language proficiency (Triemstra et al., 2016). Informal interpreters are also widely used in other countries, such as Australia, (Butow et al., 2011), Belgium (Cox, 2015), Canada (Rosenberg, Seller, & Leanza, 2008), Italy (Merlini, 2009), Germany (Meyer, Pawlack, & Kliche, 2010), New Zealand (Hilder et al., 2016), UK (Greenhalgh, Robb & Scambler, 2006), and the US (Schenker, Pérez-Stable, Nickleach, & Karliner, 2011).

Despite the worldwide use of informal interpreters, their impact on the health communication process is not clear-cut. On the one hand, it has been shown that informal interpreters often make translation mistakes, leave out important medical information (Aranguri, Davidson, & Ramirez, 2006; Flores, 2005), and may have their own agenda in the medical consultation (Leanza, Boivin, & Rosenberg, 2010). Health care providers often do not trust informal interpreters (Gadon, Balch, & Jacobs, 2007; Robb & Greenhalgh, 2006) and report a loss of control over the consultation (Meeuwesen, Twilt, ten Thije, & Harmsen, 2010; Rosenberg, Leanza, & Seller, 2007). On the other hand, positive aspects of informal interpreting are mentioned as well. For instance, informal interpreters are

perceived to act as patients' advocates and provide them with emotional support during the medical interaction (Green, Free, Bhavnani, & Newman 2005; Ho, 2008). Therefore, patients tend to trust informal interpreters, are generally satisfied with their help (Edwards, Temple, & Alexander, 2005) and often prefer informal interpreters over professional ones (Greenhalg et al., 2006).

Thus, previous research findings on informal interpreting in medical settings seem to be contradictory, which might be related to the different perspectives of the three interlocutors, that is the health care providers', the patients' and the informal interpreters'. Indeed, all three actors might have their own perspective on informal interpreting which needs to be studied together in order to explain the previous contradictory findings and to get hold of the complete picture. Besides, most previous studies lack theoretical grounding, which inhibits the integration of previous research findings. Therefore, the aim of this dissertation is to integrate the three perspectives into a theoretical framework consisting of *interpreters' roles, control* and *trust*. In a recent review article these three issues are indicated to be the key concepts for the study of interpreting in medical settings (Brisset, Leanza, & Laforest, 2013). However, until now these issues have been studied separately, which inhibits us from looking at the relationship between the different concepts and in this way to contribute to the development of a theoretical framework of interpreter-mediated communication. Therefore, in order to tackle this research gap, and to contribute to the development of the research field, the present PhD project studies the process of informal interpreter-mediated communication in Dutch general practice by integrating the perspectives of all three participants, that is, the general practitioner's (GP's), the patient's and the informal interpreter's perspective on interpreters' roles, control and trust.

The expectations of interpreters' roles will be studied as the antecedents of communication and the actual performed roles will be studied as the communication process. Control and trust will be studied as the outcomes of communication, together with satisfaction, which has shown to be an important health outcome measure (Street, Makoul, Arora, & Epstein, 2009) and of relevance for interpreter-mediated communication (e.g., Edwards et al., 2005; Garcia, Roy, Okada, Perkins, & Wiebe, 2004). Hereunder the research population will be described, followed by the explication of the main concepts, that is, interpreters' roles, control, trust and satisfaction. This chapter will be concluded with an overview of the dissertation chapters.

Research population

Turkish migrant patients form the largest minority population in the Netherlands, around 400.000 inhabitants in total (Central Bureau of Statistics, 2017a). Many Turkish men came to the Netherlands in the 1970s as guest workers. Their wives and children, who initially stayed in Turkey, followed them later in the 1980s and 1990s for the purpose of family reunification (Mügge, 2010). This delayed migration, and the fact that most Turkish women of the first generation do not work and spend most of their time inside the house, partly explain their lower command of the Dutch language compared to the Turkish first generation male migrants. As male migrants have been working in the Netherlands, their language proficiency is generally better, but still low compared to other migrant populations in the Netherland (e.g., Moroccan, Surinamese) (Huijnk & Dagevos, 2012).

Turkish migrant patients report lower perceived health and visit the general practitioner (GP) more often than native Dutch patients and other ethnic minority groups in the Netherlands (Devillé, Uiters, Westert, & Groenewegen. 2006). In order to be able to communicate with the GP, the first generation Turkish migrant patients often bring family members to the GP consultation to help them overcome the language barrier (Triemstra et al., 2016). These informal interpreters are usually adult children and spouses of the patients (Meeuwesen et al., 2011). The GP has a gatekeeping function in the Netherlands, meaning that patients have to visit the GP first in order to get a referral to specialized care (van den Brink-Muinen et al., 2000). Due to this gatekeeping function of the GP, adequate communication between GPs and patients is of a great importance. Hence, the focus of the present dissertation is on interpreter-mediated communication between Turkish migrant patients, their informal interpreters (who are most often family members), and GPs.

Interpreters' roles

Informal interpreters are considered to perform many different roles within the medical interaction. Interpreters' roles are defined as "behaviors and skills associated with being an interpreter as expected by institutions, practitioners and patients" (Brisset et al., 2013; p.135). The traditional role of interpreters has been described using the "conduit" metaphor, as a neutral, machine-like role, when interpreters literally translate a message from one language into another without taking part in the interaction (Dysart-Gale, 2005; Kaufert & Koolage, 1984). Other authors have referred to this role as *voice box* (Hatton

& Webb, 1993), *translator* (Jalbert, 1998), *language specialist* (Drennan & Swartz, 1999) and *linguistic agent* (Leanza, 2005). In this dissertation the term *conduit* will be used to refer to this role of the interpreter, which primarily entails linguistic transmission, that is converting a message from one language into another without addition or omission of information.

However, informal interpreters (and even professional ones) are shown to exceed this rigid machine-like role and perform other roles, such as acting as patients' *advocates* and *counselors*, providing *extra information* to the GP, and acting as a *cultural broker* (Brisset et al., 2013). Previous research has often described the different roles of interpreters using the *system* versus *lifeworld* dichotomy, based on Habermas' theory of communicative action (Greenhalgh et al., 2006). The system in health care refers to policies and rules that provide a framework for the medical consultation to take place, such as the limited consultation time, which is 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. Habermas further distinguishes between communicative and strategic action as two opposed forms of communication. Strategic action is oriented at pursuing goals and is linked to the system (in this case the medical system), while communicative action is oriented at achieving mutual understanding and consensus and is linked to (in this case) the patients' lifeworld. Previous research has described the system and lifeworld as opposing ends of a dichotomy with the different roles of the interpreter positioned either as a system or as a lifeworld role and representing either strategic or communicative action (Brisset et al., 2013).

For instance, when informal interpreters act as an emotional supporter to the patients, they address the patients' lifeworld and talk about the patients' worries and concerns, thus performing communicative action. Therefore, the emotional supporter role is categorized as a lifeworld role. On the contrary, when informal interpreters act as an *institutional gatekeeper*, by keeping track of the consultation time and interrupting the patients in order to not exceed the allocated consultation time, they are performing strategic action by acting on behalf of the medical system. Therefore, the role of an institutional gatekeeper is categorized as a system role. In this dissertation a dozen of different roles will be investigated and embedded in the lifeworld versus system dichotomy. Note that interpreters often switch between the different roles during the communication process. Thus, the same interpreter can perform different roles during the medical interaction varying from system to lifeworld roles.

To date, it is unclear how the different interpreters' roles are related to patients' and health care providers' trust in the interpreter, their perceived control over and satisfaction with the interaction. Answering this question will enable us to state which roles of informal interpreters are more beneficial for these communication outcomes. Thus, several studies (qualitative and quantitative) are conducted in this dissertation to explore the perspectives of the three interlocutors on the expected role of informal interpreters. Moreover, the actually performed roles during the medical interaction are assessed in an observational study. Both, the expected and the performed roles are related to patients' and GPs' perceived control, trust in the interpreter and satisfaction with the consultation (see dissertation outline for an overview of the studies).

Trust in informal interpreters

Trust is a core element in the patient-provider relationship and a prerequisite for rapport building and successful communication (Hillen, de Haes, & Smets, 2011). Trust has also been shown to be an important factor in interpreter-mediated communication, as patients and health care providers rely on interpreters to convey their voices, emotions, and medical information (Hsieh, Ju, & Kong, 2010). Thus, both the patients and the health care providers need to trust that interpreters will not distort their voices and compromise the quality of care.

Previous studies investigating patients' and health care providers' trust in informal interpreters (e.g., Edwards et al., 2005; Raval, 2003; Robb & Greenhalgh, 2006), have yielded somewhat contradictory findings. Some studies have shown that patients have more trust in informal interpreters than in professional interpreters, as informal interpreters are often patients' family members with whom they have an intimate relationship (Edwards et al., 2005; Robb & Greenhalgh, 2006). In contrast, other studies have shown that patients have more trust in professional interpreters than in informal interpreters, because the former interpret more accurately and guarantee professional confidentiality (Hadziabdic, Heikkilä, Albin, & Hjelm, 2009; MacFarlane et al., 2009). Besides these contradictions, there is a difference between the patients' and the health care providers' trust in informal interpreters: health care providers tend to trust informal interpreters less than the patients do (Edwards et al., 2005; Gadon et al., 2007; Robb & Greenhalgh, 2006).

These differences between the patients' and GPs' trust and the contradictory findings on patients' trust might possibly be explained by the different dimensions of trust. In this dissertation, trust in informal interpreters will be investigated using the five dimensions

of trust by Hall, Dugan, Zheng, and Mishra (2001) *Competence*, the first dimension, is when interpreters are trusted for their ability to provide correct translations without making mistakes. *Fidelity*, the second dimension, is when interpreters are trusted because they act in the best interests of the patient. *Honesty*, the third dimension, is when interpreters are trusted because they tell the truth and do not disguise information. *Confidentiality*, the fourth dimension, is when interpreters are trusted for their protection and proper use of sensitive information. *Global trust,* the fifth dimension, is the irreducible, holistic, component of trust, when the interpreter is 'simply' trusted, for no particular reason. Thus, the assumption in this dissertation is that patients' trust in informal interpreters might be based on different dimensions, than patients' trust in professional interpreters, which might explain the previous contradictory findings. Similarly, GPs' (mis)trust in informal interpreters might be based on different dimensions, than the patients' trust. In order to explore this idea, the different dimensions of trust are explored in the qualitative studies first. Next, a survey is constructed to measure patients' and GPs' trust in informal interpreters in order to relate it to expected and performed roles of informal interpreters (see dissertation outline for an overview of the studies).

Control in interpreted interactions

The presence of an interpreter might change the control dynamics of the medical interaction (Pope et al., 2016). Being the only one who is able to speak and understand both languages in the given interaction, the interpreter has the ability to control the course of the interaction and to shift the power balance in the patient's or in the health care provider's favor (Greenhalgh et al., 2006). Therefore, control is an important factor for the study of medical interpreting (Brisset et al., 2013). Previous research among GPs has shown that they often experience a loss of control when communicating via informal interpreters (Rosenberg et al., 2007). This happens for instance during so-called side-talk-activities, when interpreters discuss something with the patient without involving the GP into the conversation. The GP then loses control over the consultation because (s)he does not understand what is being discussed, which consequently leads to feelings of powerlessness (Meeuwesen et al., 2010).

Informal interpreters are also shown to sometimes behave like the primary interlocutor, that is speaking for the patients and leaving the health care provider in doubt about whether the interpreters express the wishes of the patients or their own wishes (Rosenberg et al., 2007). Both behaviors of the informal interpreter are shown to diminish

the control of the health care provider in the medical interaction (Meeuwesen et al., 2010). Although research investigating the patients' perceived control in interpreter-mediated interactions is lacking, it is plausible to suppose that the behavior of the interpreter, that is the interpreter's role in the interaction, also affects the patients' perceived control of the interaction. For instance, when an interpreter acts as a primary interlocutor and speaks on behalf of the patient, (s)he acts as the patient's replacer, which also might diminish the control of the patients. However, research directly relating the different roles of the informal interpreter to patients' and GPs' perceived control is lacking.

Therefore, in order to fill this research gap, a qualitative study is conducted first, aimed at exploring the patients' perspective on control dynamics in interpreted medical interactions. Subsequently, the patients' perspective is compared to the perspectives of GPs' and informal interpreters' own perspective. Based on these explorative studies, a survey is constructed to measure the patients' and GPs' perceived control in interpreted medical interactions. The patients' expectations of interpreters' roles and the actually performed roles of informal interpreters are subsequently related to patients' and GPs' perceived control of interpreter-mediated interactions (see dissertation outline for an overview of the studies).

Satisfaction with the consultation

Patients' satisfaction has been related to improved health outcomes, such as better adherence to treatment and better emotional well-being of the patient (Street et al., 2009). Previous research on patients' satisfaction with interpreted consultations has shown contradictory findings. Some studies show that patients are satisfied with informal interpreters, because they trust them and because family interpreters can provide extra information about the patients' health to the health care provider (Edwards et al., 2005). However, other studies have shown that patients are more satisfied with professional interpreters, because they provide better translations (Garcia et al., 2004). GPs are overall less satisfied with informal interpreters than patients, as they have doubts about the interpreters' competence and honesty. Besides, GPs often experience a loss of control because of the informal interpreters' dominant behaviors (e.g., answering the GPs' questions, talking instead of the patients, taking decisions for the patients) (Fatahi, Hellström, Skott, & Mattsson, 2008; Meeuwesen et al., 2011). Thus, previous qualitative studies have already proposed a relationship between the informal interpreters' behavior and patients' and GPs' satisfaction with interpreted consultations. Therefore, in the current

dissertation the relationship between the different performed roles of informal interpreters and patients' and GPs' satisfaction with the interpreted consultation will be tested (see dissertation outline for an overview of the studies).

Dissertation outline

The main research question to be answered in this dissertation is:

How can interpreter-mediated communication in general practice be characterized from the perspectives of Turkish migrant patients, GPs, and informal interpreters, taking into account the antecedents of communication (i.e., expected roles of interpreters), the communication process itself (i.e., performed roles of interpreters), and communication outcomes (i.e., patients' and GPs' perceived control of the consultation, trust in the interpreter, and satisfaction)?

The sub-questions of this dissertation will be described per chapter hereunder.

Chapter 2: To explore the perspective of Turkish-Dutch migrant patients on informal interpreting during the GP consultation, semi-structured interviews are conducted with 21 female Turkish-Dutch migrant patients focusing on interpreters' roles, their trust in the interpreter and patients' perceived control during the consultation. The main research questions are:

RQ1: How do Turkish-Dutch GP patients perceive the role of informal interpreters and which roles do they expect the informal interpreters to perform?

RQ2: How can Turkish-Dutch GP patients' trust in either professional or informal interpreters be explained by the different dimensions of trust?

RQ3: To what extent do Turkish-Dutch GP patients feel empowered or disempowered by the presence of informal interpreters?

Chapter 3: To explore differences in perspectives between Turkish-Dutch migrant patients, their informal interpreters and GPs, on interpreters' role, trust and perceived control in interpreted GP consultations, additional semi-structured interviews are conducted with 16 GPs and 17 informal interpreters.

The research questions are:

RQ1: What is the difference in perspectives between patients, GPs, and informal interpreters regarding the role of the informal interpreter?

RQ2: What is the difference in perspectives between patients, GPs, and informal interpreters regarding the different dimensions of trust?

RQ3: What is the difference in perspectives between patients, GPs, and informal interpreters on control dynamics in interpreted GP interactions?

Chapter 4: To corroborate the findings from the qualitative studies on the expected roles of informal interpreters and to relate the expectations of interpreters' roles to patients' perceived control and trust, a survey-study is conducted among Turkish-Dutch migrant patients (n = 91), their informal interpreters (n = 91) and GPs (n = 26) directly before and after their GP consultation. First, the expectations of the three parties are compared using Habermas' lifeworld versus system theory on seven roles of the family interpreter: conduit, institutional gatekeeper (system roles); and advocate, emotional supporter, information source, cultural broker and counselor (lifeworld roles). Second, patients' expectations of the informal interpreters' role are linked to their perceived control of the consultation and trust in informal interpreters. The hypotheses to test are:

H1: a) Patients and informal interpreters will have similar expectations of the informal interpreter's role and mainly expect lifeworld agent roles, that is advocate, emotional supporter, information source, cultural broker and counselor roles. b) In contrast to patients and informal interpreters, GPs will predominantly expect the system agent roles, that is the conduit and the institutional gatekeeper roles.

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

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

Chapter 5: To observationally study the informal interpreters' roles and link them to patients' and GPs' perceived control, trust in informal interpreters and satisfaction with the consultation, the interpreters' roles are coded from transcripts of 84 audio-recorded consultations between Dutch GPs, Turkish-Dutch migrant patients and their informal interpreters. Performed interpreters' roles are subsequently related to patients' and GPs' perceived control, trust and satisfaction, which are assessed in a post consultation questionnaire. The research questions are:

RQ1: Which roles do the informal interpreters perform during the GP consultation?

RQ2: Are the performed roles of the informal interpreters related to patients' and GPs' perceived control of the consultation, trust in the informal interpreter and satisfaction with the consultation?

Chapter 2

The Patients' Perspective

An adapted version of this chapter is published as:

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Abstract

Objective: To explore the perspective of Turkish-Dutch GP patients on informal interpreting from an integrated theory base, focusing on interpreters' roles, trust and control.

Method: Semi-structured in-depth interviews were conducted with 21 first-generation Turkish-Dutch migrant patients who made use of informal interpreters to communicate with their GPs. An interview guide was designed based on the theoretical framework of interpreter's roles, trust and control, covering questions about interpreters' roles, trust in informal/professional interpreters and control dynamics in the medical consultation. The interviews were transcribed verbatim and analyzed according to the constant comparative method.

Results: Besides providing linguistic translation, informal interpreters were expected to perform the roles of advocates and caregivers of the patients. Informal interpreters were trusted more than professional interpreters, mainly for fidelity reasons, that is, because the patients assumed that informal interpreters would act in their best interests. Although informal interpreters were often perceived as the primary interlocutor, the patients did not feel dominated by them, but rather empowered by their presence.

Conclusion: Our findings indicate a connection between the role of the advocate, the fidelity dimension of trust and the perceived empowerment of the patients. By linking interpreters' roles to trust and control, this study contributes to theory building in the field of informal interpreting, which is needed to design evidence-based interventions to improve health care delivery to patients with insufficient language ability and thus to advance health care delivery to migrant patients, which is currently lagging behind.

Introduction

Migrant patients' insufficient language ability in the dominant language has been related to poor communication and misunderstanding during medical encounters (Squires & Jacobs, 2016). Inadequate medical communication might lead to adverse health outcomes, such as incorrect medication use (Divi, Koss, Schmaltz, & Loeb, 2007) and erroneous diagnoses (Quan & Lynch, 2010). Turkish migrant patients, the largest minority group in the Netherlands (around 400.000), often deal with language barriers in medical encounters and are thus at increased risk of receiving a suboptimal level of care (Suurmond, Rosenmöller, el Mesbahi, Lamkaddem, & Essink-Bot, 2016). It has been estimated that 43% of first-generation Turkish migrants experience difficulties when communicating in Dutch, with Turkish women having a lower language proficiency than men (Huijnk & Dagevos, 2012).

Using interpreters is one way of bridging the language barrier in medical encounters. Until 2012, health care providers in the Netherlands had free access to professional interpreting services, provided by the centralized, government-subsidized interpreting system. However, because of budget cuts, the government no longer provides professional interpreters in health care for free. Thus, it is likely that informal interpreters, such as family and friends of the patients, who were already widely used in Dutch general practice (Meeuwesen, Twilt, & Ani, 2011), will be relied upon even more in the future (Bot, 2013). It has been estimated that up to 60% of first-generation Turkish migrant patients in the Netherlands visit the GP with an informal interpreter. The use of informal interpreters is especially high among women, around 82% (Schaafsma, Raynor, & de Jong-van den Berg, 2003). Therefore, the focus of this study is on the perspective of female Turkish migrant patients with interpreting in GP consultations.

Most research emphasizes the negative consequences of informal interpreting (e.g., Flores, 2005). Informal interpreters often revise and omit important information and might impose their own agenda during the medical consultation (Aranguri, Davidson, & Ramirez, 2006; Rosenberg, Leanza, & Seller, 2007). Although their interference in medical interactions is often viewed as negative by scholars and health care providers (Flores, 2005; Hsieh, 2015; Rosenberg et al., 2007), little is known about the patients' perspective on the use of informal interpreters, a research gap denoted in a recent review of the literature (Brisset, Leanza, & Laforest, 2013). Besides, most studies lack a theoretical base, which hinders the consolidation of previous findings.

Therefore, we undertook this study to contribute to the existing knowledge in two ways. First, by providing the patient's perspective on informal interpreting, which

is important to consider, as patients are the ones who should benefit from triadic GP consultations. Second, by using a theory-based approach to better integrate the available findings. We will investigate the issues of trust, control and interpreters' roles, which have been identified as important themes in interpreter-mediated medical communication, but have been studied separately until now (Brisset et al., 2013). We have integrated these issues into a single study to explore the possible relations between them in order to gain a deeper understanding of informal interpreting in medical practice.

Trust in interpreter-mediated medial consultations

Trust is a crucial factor in interpreter-mediated communication and it forms the basis for rapport building and successful communication between the interlocutors (Hsieh, Ju, & Kong, 2010; Robb & Greenhalgh 2006). However, previous research focusing on patients' trust in informal and professional interpreters has shown contradictory findings. Some studies have indicated that patients trust informal interpreters (who are usually their family members) more than they trust professional interpreters, because of their lengthy and intimate interpersonal relationship (Edwards, Temple, & Alexander, 2005; Robb & Greenhalgh, 2006). In contrast, other studies have shown that patients have more trust in professional interpreters, because they interpret more accurately and guarantee professional confidentiality (Hadziabdic et al., 2009; MacFarlane et al., 2009).

Dimensions of trust proposed by Hall et al. (2001), which clearly reflect the different characteristics associated with the work of interpreters, but have so far only been applied in research on patients' trust in health care providers, might help explain these seemingly contradictory results. The first dimension, *competence*, refers to interpreters' technical competence, thus, whether the interpreter is able to interpret properly and does not make translation mistakes. The second dimension, *fidelity*, refers to the patients' belief that the interpreter acts in their best interest and avoids conflicts of interest. *Honesty*, the third dimension, refers to patients' conviction that the interpreter translates all the information and avoids intentional falsehoods, such as disguising, or purposefully altering information provided by the patient or the health care provider. The fourth dimension, *confidentiality*, entails patients' perceptions about the protection and proper use of sensitive information by interpreters. Finally, *global trust* refers to the irreducible, more holistic aspect of trust. This dimension of trust is also referred to as the 'soul of trust', when the patient simply trusts the interpreter without a particular reason.

One could assume that the earlier-mentioned differences in research results might partly be explained by these different dimensions. That is, professional interpreters

are trusted because of their professionalism, confidentiality and good interpreting skills (Hadziabdic et al. 2009; MacFarlane et al., 2009), which could be related to the dimensions of competence, honesty and confidentiality. Informal interpreters, on their turn, are trusted because they are closely related to the patients and are perceived to protect their interests (Edwards et al., 2005; Robb & Greenhalgh, 2006), which could be related to the dimensions of fidelity and global trust.

To explore whether the contradictory results of earlier research on patients' trust in either professional or informal interpreters could indeed be explained by the different dimensions of trust, the following research question is proposed:

RQ1: How can Turkish-Dutch GP patients' trust in either professional or informal interpreters be explained by the different dimensions of trust?

Control dynamics in interpreter-mediated medical consultations

The presence of an interpreter in medical encounters might change the control dynamics between the interlocutors (Pope et al., 2016). Being the only one who is able to speak and understand both languages in the given interaction, the interpreter has the ability to control the course of the interaction and shift the power balance in the patient's or in the health care provider's favor (Greenhalgh, Robb, & Scambler 2006).

Previous research among GPs has shown that they often experience a loss of control when communicating via informal interpreters (Rosenberg, Leanza, & Seller 2007). This happens for instance during so-called side-talk-activities, when interpreters discuss something with the patient without involving the GP into the conversation. The GP loses control over the consultation because (s)he does not understand what is being discussed, which consequently leads to feelings of powerlessness (Meeuwesen et al., 2010). Informal interpreters also often behave like the primary interlocutor, speaking for the patients and leaving the health care provider in doubt about whether the interpreters express the wishes of the patients or their own wishes (Rosenberg et al., 2007). Both behaviors of the informal interpreter diminish the control of the health care provider in the medical interaction (Meeuwesen et al., 2010).

Research on the perspectives of informal interpreters regarding the division of control has shown contradictory findings. Some studies show that informal interpreters aim to protect the interests of the patients (Green et al., 2005) and thus shift the power balance in the patient's favor (Greenhalgh et al., 2006). However, other studies show that informal interpreters pursue their own agenda or the agenda of the health care provider, thereby

diminishing the control of the patient (Leanza, Boivin, & Rosenberg 2010). Because the patient's perspective on the power dynamics in the interpreted GP consultation is lacking from previous research, we will address the following question in our study:

RQ2: To what extent do Turkish-Dutch GP patients feel empowered or disempowered by the presence of informal interpreters?

Interpreter's role in medical consultations

Interpreters are known to perform many and sometimes contradictory roles in the medical interaction (Angelelli, 2004; Cox, 2015; Hsieh, 2006a, 2008; McDowell, Messias, & Estrada, 2011). Roles in this context refer to the "behaviors and skills associated with being an interpreter as expected by institutions, practitioners and patients" (Brisset et al., 2013, p. 135). The main role attributed to professional interpreters is the role of conduit, which entails non-involvement and neutrality, when they literally render word-for-word translations from one language into another without siding with one of the interlocutors (Cox, 2015; Dysart-Gale, 2005). However, research has shown that professional interpreters often side with health care providers by keeping track of their time and agenda and thus performing the role of institutional gatekeeper (Greenhalgh, Robb, & Scambler, 2006; Leanza et al., 2010). Hence, professional interpreters often act as system agents during the medical encounter, thereby representing the voice of the system.

Informal interpreters, on the contrary, often report siding with the patients, protecting their interests and acting on their behalf, and thus performing the role of patients' advocates (Green et al., 2005). Also, informal interpreters bring patients' lifeworld, such as their worries and fears into the medical consultation and thus act as patients' lifeworld agents (Leanza et al., 2010). Furthermore, previous research among health care users has shown that interpreters are expected to give advice to the patients about how to act during medical consultations, thus acting as counselors (Edwards et al., 2005). Some studies have stressed the role of cultural broker, in which interpreters use their knowledge of cultural norms and values of the health care provider and the patient to help them to better understand each other. In this role the interpreter neither takes the side of the system nor of the lifeworld, but forms a bridge between the different worlds of the health care provider and the patient (Leanza, 2005). Last, informal interpreters often perform the role of caregiver, such as taking the patient to the consultation and keeping track of patients' medication (Green et al., 2005; Leanza et al., 2010). The role of the caregiver strictly falls beyond the medical interaction, but is closely related to it, as interpreters performing the

caregiver role often speak on behalf of the patients and provide extra information about patients' health, which has consequences for the medical interaction (Rosenberg et al., 2008).

The above-mentioned roles are primarily based on studies on the views of health care providers and interpreters. So far, little is known about the patients' perspective on the roles of interpreters, which might be different from health care providers' and interpreters' perspectives, possibly leading to conflicting expectations about how an interpreter is supposed to behave during the medical interaction. Therefore, our third research question is:

RQ3: How do Turkish-Dutch GP patients perceive the role of informal interpreters and which roles do they expect the informal interpreters to perform?

Method

Recruitment and sampling

Participants were included in the study if they were Turkish migrants, women, above the age of 18 and visited their GP with an informal interpreter at least once a year. Because women have lower Dutch language proficiency than men (Huijnk & Dagevos, 2012) and visit the GP more often in company of informal interpreters (Schaafsma, Raynor, & de Jong-van den Berg, 2003), we have specifically targeted female respondents.

Three female bilingual Turkish-Dutch research assistants have joined the research team to facilitate the data gathering process. We have deliberately chosen female assistants to make it easier to approach our respondents, traditionally oriented Muslim women, who would unlikely make contact with male researchers. One of the research assistants was affiliated with a Turkish Islamic Association in the Netherlands, which organizes weekly meetings for Turkish women in the local mosque. Four Turkish-Dutch women were approached during these weekly meetings by the research assistant; all of them agreed to participate. Twenty Turkish-Dutch women were recruited via personal networks of the research assistants using the snowballing method. All but three of the approached women agreed to participate. Three women refused because of a lack of time (n = 1), illness (n = 1) and mistrust in the research (n = 1).

The final sample consisted of 21 female respondents (Mage = 54 years, age range: 42–70 years), all first-generation Turkish immigrants who came to the Netherlands between 1974 and 1990 for the purpose of family reunification.

Procedure

In line with participants' preferences, most interviews (*n* = 19) took place at participants' homes, one interview took place in a public library and one in a separate room in a mosque. All interviews were conducted by the first author who has an intermediate language proficiency of Turkish. During each interview one of the Turkish-Dutch research assistants who was not acquainted with the respondent was present to translate the questions from Turkish to Dutch and vice versa to guarantee optimal understanding between the researcher and respondents. Before the start of the interview, participants were informed about the aim of the study and about their rights as participants. After obtaining their written informed consent, the interview started and was recorded on audiotape. Mean duration of the interviews was 58 minutes with a range of 35–98 minutes. The research has been approved by the Ethical Commission of the department of our University.

Materials

A topic list was designed based on the literature including the following themes: acculturation, relationship with the GP, relationship with the interpreter, interpreter's role, trust, control, and experience with professional interpreters. Table 1 shows the introductory and the main topics per study construct (i.e. trust, control, and interpreter's role).

Table 1. *Outline of the Topic List*

Introductory topics	Main topics
Acculturation level • To what extent do you feel at home in the Netherlands? • Which languages do you speak? • How important is your religion for you?	**Trust** • Are there any issues you would not discuss in the presence of the interpreter, and if so, which? • Do you think the interpreter translates everything you said? • Do you think the interpreter translates well? *(idem for other dimensions)* • How much trust do you have in the interpreter?
Relationship with the GP • For how long have you known your GP? • How is the relationship with your GP?	**Control** • Who speaks most of the time during the medical interaction? • Who usually takes the decision during the medical consultation? • How often do side-talk-activities occur? • Do you ever feel dominated by the interpreter?
Relationship with the interpreter • Which people accompany you to the GP consultation? • Do you have a preference for one of the people you just mentioned?	**Interpreter's role** • What do you expect from the interpreter during the medical consultation? • Could you describe a situation when the interpreter advocated on your behalf? • Could you describe a situation when the interpreter provided emotional support? *(idem for other roles)*

Data analysis

All interviews were transcribed verbatim. The first author transcribed the Dutch parts of the interview and the research assistants transcribed the Turkish parts and translated them into Dutch. The Dutch translations of five randomly selected transcripts were checked for accuracy performing double translations conducted by the research assistant who did not conduct the first translation. Only style differences were detected between the

two versions of double-translated transcripts (e.g. the use of synonyms and word order differences), thus translations of the Turkish text proved to be reliable.

The interview transcripts were analyzed using MAXQDA, 2007 (Kuckartz, 2007). First, each transcript was extensively read and divided into fragments, each fragment describing a single concept. For instance, a fragment describing the role of the interpreter was attributed the label 'interpreter's role'. As the coding of the transcripts proceeded, all fragments carrying the same label were constantly compared to identify specific subthemes within the theoretical constructs (Boeije, 2002). For instance, fragments describing interpreters' roles, were further grouped into subcategories, each of them describing a different role of the interpreter (e.g. conduit, advocate, caregiver etc.).

We have used the constant comparative method to code the data (Boeije, 2002). The process of coding was mostly deductive as we have used already existing labels for the main theoretical constructs, for instance by using the existing labels honesty, competence, confidentiality and fidelity to code the concept of trust. However, we have also used open coding to code the rest of the data to discover new themes. Our analyses elicited three main themes (trust, control, and interpreters' roles), which were divided into several subcategories. All (sub)themes emerging from the data corresponded with the topics covered in the interviews. We have elicited three additional subthemes from the data, which will be discussed in the results section.

Results

Sample characteristics

Most women (n = 15) attended a few years of elementary school in Turkey, none of them received higher education. Sixteen women were housewives at the time of the interviews, three of them were working as cleaners and two were working at a 'social work place', that is, an organization or environment that employs people with disabilities or long-term unemployment. Six women had previously worked as cleaners, but quit working because of health-related issues. All of the interviewees were practicing Muslims; they prayed daily, visited the mosque frequently, followed religious prescriptions and celebrated Islamic festivities.

Although most women attended Dutch language courses in the past (n = 15), they did not learn the Dutch language well. A few interviewees said to understand basic information, but to have difficulties expressing themselves in Dutch. Insufficient command of the Dutch language was the main reason why the women did not feel at home in the Netherlands,

and if they felt at home, this was usually restricted to the domestic life of participants and related to their close ties with their children and family. Despite their long stay in the Netherlands, half of the women felt that this was temporary and expressed a strong wish of returning to Turkey.

Almost all interviewees used to take along their husbands to interpret for them during GP consultations, before their children took over, usually around the age of 15. At the time of the interviews, most women took their adult children to the GP consultation to interpret for them (n = 15). Three women still visited the GP with their husbands, four of them also brought other family members (i.e. sister- and daughter-in-law). Two women used to visit the GP with their children, but switched to social workers, who were present in their GP practices to help patients with low-language proficiency to explain their health issues.

Most interviewees said to have no preference for a particular interpreter, the choice was mainly a practical one, depending on the availability of the interpreters. However, as the interviews proceeded it became clear that the women were less satisfied with their husbands as interpreters and preferred their children instead. Only a few women (n = 3) had ever used professional interpreters, but all respondents have indicated to prefer informal over professional interpreters, which was related to trust and will be discussed below.

Trust in interpreters

Fidelity. Respondents usually preferred informal instead of professional interpreters, mainly for fidelity reasons. Whereas they believed that their family members would act in their interest, they were not so sure about the fidelity of professional interpreters.

I would prefer my family members, because they know me and they know my illness and they would tell my problems like their own. He [the professional interpreter] doesn't know me, doesn't know my illness, how can I trust him? (Female, 46 years).

Competence. Overall, the women were rather uncritical about the language competence of their interpreters, assuming it to be adequate for the purpose of medical interpreting. They said to trust both the linguistic competence of informal and of professional interpreters equally. Competence was never mentioned as a trust enhancing or trust-reducing factor. A few participants mentioned the lower Dutch language proficiency of their husbands compared to their childrens' language proficiency, but they did not make a connection between the language competence and trust, not even when they were explicitly asked

whether they perhaps trusted their children more than their husbands because of their higher language competence.

Honesty. Although most women believed that informal interpreters translated all information to the GP and back, without altering or purposefully disguising it, the majority of the women explicitly stressed that this was purely a matter of trust, because they could not verify what was being said. Indeed, a few respondents have expressed doubts about whether family members, especially the children, would pass on bad news to them:

Maybe he [the son] also adds some information. I don't know. Or maybe he forgets to tell something; I could not know that, because I don't speak the language. And you don't know if they [the children] would tell you if there is something bad going on. (Female, 70 years).

There were only a few cases in which respondents openly expressed their mistrust in the honesty of informal interpreters. Notably, almost all cases were about mistrusting husbands as interpreters. The main reason for mistrusting the husbands was the belief that they did not translate all information to the doctor. In these three cases the women preferred their children above their husbands, arguing that the children translate all the information to the doctor, while the husbands do not.

Confidentiality. In a few cases respondents have indicated to trust the professional interpreters, mainly for their confidentiality. This usually referred to a hypothetical situation as the women had almost no actual experience with professional interpreters. Respondents then referred to the code of conduct of professional interpreters to explain why they would trust a professional interpreter.

If my daughter would not be there, I could go with a professional interpreter. I would trust him, because he has sworn [code of conduct]. My cousin in France is also a professional interpreter, she has sworn not to tell what is discussed during the conversation. (Female, 55 years).

Global trust. Finally, we did not find clear indications of global trust, when one trusts for no particular reason. However, some participants have indicated to trust the interpreters, because they have no other option but to trust. We will discuss this type of trust under additional themes.

Control

Our interviewees perceived the interpreters as being in control of the medical interaction. According to the interviewed women, informal interpreters spoke most of the time, often behaving like the primary interlocutor. The interpreters were usually already informed about the complaints of the patients prior to the consultation, so they could discuss them immediately with the GP. The questions of the GP were translated to the patient and the answers back to the GP, but GPs' prescriptions and advice were usually discussed later at home. Thus, there was a delay in translation for a large part of provided information. Side-talk-activities usually occurred between the interpreter and the GP, but most respondents did not mind this and considered it a logical consequence of their low-language proficiency.

Of course she [the daughter] speaks most of the time, you don't even have to ask that. Because I don't speak the language, she speaks most of the time. I just wait, while they [daughter and GP] talk. (Female, 53 years)

This behavior of the interpreter was not perceived as disempowering. On the contrary, the patients felt more in control in the presence of interpreters because they had faith that the interpreter would help them out.

I think that the interpreter enlarges my control. He makes it possible for me to tell what I want to tell, this way I don't come into difficulties [i.e. miscommunication because of language barriers]. (Female, 52 years)

However, feelings of powerlessness were also mentioned, which were not related to the dominance of the interpreter during the medical encounter, but to the feeling of dependence on the family members. We will discuss this issue under additional themes.

Interpreters' roles

When queried about interpreters' roles, the first reaction of the respondents was to have no other expectation of the interpreter than being a translator between the GP and themselves. The respondents thus first identified the role of conduit when referring to interpreters' roles. However, during the interviews it became clear that informal interpreters are expected to and perform other roles on top of translating.

The role of caregiver was mentioned most often, which entailed making medical appointments, taking the patients to the GP, collecting and keeping track of prescribed medication and also functioning as an extra information source.

Sometimes, when I forget to tell something to the doctor, then she [the daughter] does it for me. Like for example my sweating, I forget to tell it and because I always talk about it at home, she knows it and she tells it [to the doctor]. She tells more than I do, that is really nice. (Female, 50 years).

Advocacy was another role regularly performed by and expected from informal interpreters. Although no overt conflicts with GPs were mentioned, some of the respondents have described situations in which they expected the interpreters to mediate on their behalf, for example by stressing the symptoms to get a referral to the hospital or by exaggerating the complaints to be taken seriously:

Like this time when I had bronchitis, I had a sore throat and a headache and the doctor did not take me seriously. 'I can't do anything for you', he said. And then she [the daughter] said: 'You HAVE to give her something! I have never seen my mother like this!'. (Female, 49 years)

The roles of counselor and of cultural broker were not recognized by our respondents. Overall, patients did not consider providing cultural information as the task of the informal interpreter, nor did they expect (medical) advice from the interpreter during or after the consultation.

Additional themes: taboo issues, coercive trust and helplessness

Three additional themes emerged from the data. First, when discussing the topic of confidentiality, some interviewees gave their own interpretation of confidentiality, namely as opening up to someone, or being able to comfortably discuss everything in front of the interpreter. This type of confidentiality referred to feelings of shame and embarrassment, rather than to the protection and proper use of information by interpreters.

Although most of the patients said to be able to discuss everything in front of their family members, some participants mentioned to be reluctant to discuss taboo subjects (e.g. female problems and sexual matters) in front of their children to avoid feelings of embarrassment, both for themselves and their children. Some participants also discussed

reluctance of opening up to professional interpreters of the opposite gender, also because of shame and embarrassment.

Second, when talking about trust, some of the participants came to the conclusion that they simply have to trust the interpreters, not because of their competence, fidelity or honesty, but simply because they have no other choice. Previous research has defined this phenomenon as coercive trust (Robb & Greenhalgh, 2006). This feeling of resignation to the situation was the overtone of the major part of the interviews.

Third, although the interviewees said to trust the interpreters and to be satisfied with their help, they still often felt helpless because of the dependence on their family members. Some of the respondents have also mentioned a feeling of being a burden to the family:

I feel like I am a burden to my children. They have to take off to bring me to the doctor. Wouldn't it be better if I could tell my own problems myself? Of course I feel like a burden, it is not something nice. (Female, 70 years)

Thus, although most respondents were happy with the help of informal interpreters, they still would have preferred to communicate on their own and handle their own health problems.

Discussion

The present study aimed to shed more light on patients' perspectives on informal interpreting in general practice, taking trust, control and interpreter's role as the main theoretical themes. Considering trust, our findings indicate that the female Turkish-Dutch migrant patients in our study usually prefer informal interpreters over professional interpreters, mainly for fidelity reasons, that is, because they believe that informal interpreters are acting in their best interests. Professional interpreters were considered a second best option and were trusted mainly for confidentiality reasons, that is, the patients believed that information provided to professional interpreters would be kept safe.

These findings might help explain the discrepancies in previous research regarding patients' preferences for either professional or informal interpreters. In studies that concluded that professional interpreters are preferred, the investigated population consisted of refugees and (ex) asylum seekers (Hadziabdic et al., 2009; MacFarlane et al., 2009). Because people from this research population usually have traumatic migration histories, they possibly have less trust in their own communities and therefore prefer

neutral professional interpreters who will keep the information confidential. Our research population, just as the populations of previous studies preferring informal interpreters (Edwards et al., 2005; Robb & Greenhalgh, 2006) consists of female migrants with a guest worker background who maintain close ties with their community and trust them mainly for fidelity reasons. It is thus relevant to consider the migration history of the population and the different dimensions of trust when studying trust in interpreters.

Our findings further show that the competence of interpreters, both informal and professional, is assumed to be adequate, which is in contrast with previous research showing that professional interpreters are considered to be more competent (Hadziabdic et al., 2009). One explanation for this discrepancy could be that the women from our sample had little experience with professional interpreters and thus could not compare the actual competence of both types of interpreters. Another explanation could be that the women from our sample were overall uncritical about the language competence of their family members, which could be a consequence of their dependence on them. As we have discussed under additional themes, the women from our sample have indicated to be dependent on their family members and it is possible that because of this dependence and gratitude to their family members for interpreting for them, they find it difficult to be critical about their performance. In both cases it is important to inform the patients about the importance of the (language) competence of interpreters and the possible benefits of professional over informal interpreters.

Regarding interpreters' roles, our data clearly show that informal interpreters were not perceived as neutral translating machines, but rather as caregivers and advocates of the patients, which is in line with previous findings among informal interpreters and health care providers (Green et al., 2005; Leanza et al., 2010; Rosenberg et al., 2007). The role of the cultural broker, which has been described in previous research among health care providers and interpreters (Leanza, 2005), was not recognized by our interviewees. The Turkish migrant women we interviewed expected no cultural brokering from the interpreter, whereas health care providers from previous research did (Leanza, 2005).

One possible explanation could be that the health care providers consider it as their task to understand the culture of the patient, which is in line with a patient-centered approach in medical care (Epstein et al., 2005). The Turkish migrant women, on the contrary, found it less important to share information about their cultural norms and values and consider it as irrelevant to the medical care. As our respondents were low-educated and mostly illiterate women, it is possible that they did not recognize the possible relevance of cultural brokering for their health.

Considering control, our findings indicate that patients feel empowered by the presence of informal interpreters, which is in line with previous research showing the perspective of informal interpreters on control dynamics in interpreter-mediated medical consultations (Green et al., 2005). However, these findings are in contrast with the GPs' perspective, who perceive the dominance of informal interpreters over the patients in the medical interaction (Rosenberg et al., 2007). One explanation for this discrepancy in perspectives could be the wish of the healthcare provider to communicate with the patients one on one and to hear their feelings, needs and concerns, which is inherent in patient-centered care (Epstein et al., 2005). However, the presence of the informal interpreter in the medical consultation interferes with the direct contact between patient and health care provider, especially when the interpreter behaves like the primary interlocutor speaking on patients' behalf. While patients feel empowered when informal interpreters speak for them performing the role of the advocate, the health care provider loses control and feels disempowered because of the presence of informal interpreters (Hsieh, 2015; Meeuwesen et al., 2010). Thus, our findings confirm that informal interpreters side with the patients shifting the power balance in patient's favor, which is consistent with previous findings (Brisset et al., 2013).

Our research findings have several theoretical implications. First, using the fidelity and confidentiality dimensions of trust (Hall et al., 2001), we have succeeded to provide an explanation for a part of the previous contradictory findings. Moreover, a connection can be made between the three main concepts in our study, namely, the trust dimension of fidelity, the role of the advocate and the patients' perceived feelings of empowerment. That is, the trust dimension of fidelity (i.e. the patients' belief that the interpreter acts in their best interest and avoids conflicts of interest) is closely linked to the role of the advocate, because the interpreter is seen to act in the best interest of the patients. Furthermore, the women have indicated to feel empowered by informal interpreters when they advocate for them, thus the advocacy role is also related to the control concept. The control concept could be hypothesized to be a mediator between the advocacy role and enhanced trust, which is apparent from our findings regarding the occurrence of side-talk-activities between the GPs and informal interpreters. Whereas previous research indicated that GPs are hindered by the occurrence of side-talk-activities, as it undermines their control of the medical interaction (Meeuwesen et al., 2010), the patients do not perceive a hindrance by the occurrence of such side-talk-activities, because they trust that interpreters would act in their best interests.

Thus, we could hypothesize the following relationship between the concepts: the patients have high general trust in interpreters because of their intimate family bonds. This type of trust is related to the advocacy role, that is, the patients believe that interpreters act in their interest experience more control when interpreters indeed act as such, resulting in enhanced trust in the fidelity of the family interpreter. Future research using larger samples and a combined quantitative and observational approach should verify the validity of this tentative conclusion.

There are some limitations which should be considered when interpreting the findings of our study. First, most interpreters in our study were the adult children of patients and thus very intimate relatives. This particular group of family interpreters probably differs from the broader group of informal interpreters, which also incorporates bilingual health workers, social workers and other ad hoc interpreters who are not related to the patients. It is especially important to consider this particular group of family interpreters when it comes to the interpretation of our findings regarding the issues of trust, namely, the high fidelity of patients in their children, which could be the result of their intimate bonds. It is therefore recommended to replicate the findings of this study under other groups of informal interpreters. Second, because we have studied a homogeneous sample, (i.e., female Turkish-Dutch patients), we cannot generalize the findings to a broader population. It is important to also study the male populations and other ethnic minority groups, because power differences between men and women in different cultures and gender-specific behaviors of different ethnic populations (Wood & Eagly, 2002) might lead to different findings among male respondents and respondents from populations other than Turkish.

For instance, the women from our sample who visited the GP with their husbands have indicated to be less satisfied with their interpreting than the women who visited the GP with their children. Although our data do not include enough cases of the former, these findings could be attributed to specific gender roles of and power relations between men and women in Turkish Muslim families, where the women traditionally fulfill the caretaking role inside the house and financially depend on their bread winning husbands (Phalet & Schönpflug, 2001). These traditional gender patterns are even more present in Turkish migrant families of the first generation where the women experience a language barrier, which leads to further isolation inside the house and dependence on family members in order to participate in the Dutch society (Crul & Doomernik, 2003; Idema & Phalet, 2007). As the power relations between spouses in such immigrant families differ from power relations between mothers and children, the latter being more egalitarian than the former (Idema & Phalet, 2007), we could imagine that the Turkish women from our

sample felt more dominated by their husbands than by their children and were therefore less satisfied with these consultations. As our data do not contain enough cases to fully support this argument, we suggest further research to investigate possible differences in control dynamics when different types of family interpreters (husbands, daughters, sons and brothers) are involved in the consultation.

Nevertheless, our findings clearly corroborate the often-made observation in previous research that interpreters frequently speak on patients' behalf and do not always translate information immediately, which could lead to miscommunication and consequently to adverse health outcomes (Divi et al., 2007; Meeuwesen et al., 2011; Pope et al., 2016). Our findings show that migrant patients are not aware of these possible negative consequences of informal interpreting and are also unaware of the possible benefits of professional interpreters. Thus, there is a task for policy makers and medical educators to raise awareness among migrant patients with low-language proficiency of the possible benefits of professional interpreters and the possible negative consequences of informal interpreting.

To conclude, we would like to underscore the importance of the patient's perspective in interpreter-mediated medical consultations, both for scientific research and for policy making. As it is apparent from our research, their perspective is sometimes different and even contradictory to the perspectives of health care providers or informal interpreters and should be taken into account to provide a complete picture of interpreter-mediated communication.

Chapter 3

Comparing the Perspectives of Patients, GPs and Informal Interpreters

An adapted version of this chapter is published as:

Zendedel, R., Schouten, B. C., van Weert, J. C., & van den Putte, B. (2016). Informal interpreting in general practice: Comparing the perspectives of general practitioners, migrant patients and informal interpreters. Patient Education and Counseling, 99(6), 981-987. doi:10.1016/j.pec.2015.12.021

Abstract

Objective: To explore differences in perspectives of general practitioners (GPs), Turkish–Dutch migrant patients and informal interpreters on interpreters' role, control dynamics and trust in interpreted GP consultations.

Method: 54 semi-structured in-depth interviews were conducted with the three parties focusing on interpreters' role, control and trust in interpreters.

Results: In line with informal interpreters' perspective, patients expected the interpreters to advocate on their behalf and felt empowered when they did so. GPs, on the contrary, felt annoyed and perceived a loss of control when the informal interpreters performed the advocacy role. Informal interpreters were trusted by patients for their fidelity, that is, patients assumed that informal interpreters would act in their best interest. GPs, on the contrary, mistrusted informal interpreters when they perceived dishonesty or a lack of competence.

Conclusion: Opposing views were found between GPs on the one hand and informal interpreters and patients on the other hand on interpreters' role, control dynamics and the different dimensions of trust. These opposing perspectives might lead to miscommunication and conflicts between the three interlocutors.

Practice implications: GPs should be educated to become aware of the difficulties of informal interpreting, such as conflicting role expectations, and be trained to be able to call on professional interpreters when needed.

Introduction

Due to worldwide migration the language barrier between migrant patients and healthcare providers has become a daily constraint in medical practice (Flores, 2005). Professional interpreters are provided in some countries to bridge the language gap between patients and healthcare providers (Karliner, Jacobs, Chen, & Mutha, 2007). In Dutch general practice the language barrier is often tackled with the help of informal interpreters, who are most often the family members of the patient (Meeuwesen, Twilt, & Ani, 2011). Until 2012, before the introduced cuts in the health care budget, general practitioners (GPs) could make use of professional interpreters for free, although the use of informal interpreters was also prevalent before these cuts (Meeuwesen et al., 2011). Especially Turkish–Dutch migrant patients often bring an informal interpreter to the GP practice to facilitate the communication, in up to 80% of GP consultations (Schaafsma, Raynor, & de Jong-van den Berg, 2003). Despite their wide use, informal interpreters can contribute to miscommunication by providing incorrect translations (Flores, 2005), omitting relevant information Aranguri, Davidson, & Ramirez, 2006) and following their own agenda (Leanza, Boivin, & Rosenberg, 2010; Seeleman, Suurmond, & Stronks, 2005). Therefore, communication via informal interpreters is not always optimal and might result in misunderstandings and conflicts between the three interlocutors (Meeuwesen, et al., 2011; Fatahi, Hellström, Skott, & Mattsson, 2008), which in turn could lead to adverse health outcomes (Divi, Koss, Schmaltz, & Loeb, 2007).

A recent review of the literature has identified three important issues for the study of interpreting in medical settings, that is, interpreters' role, control dynamics in the medical interaction and trust in the interpreter (Brisset, Leanza, & Laforest, 2013). Scarce previous research has shown that patients and health care providers do not always share the same perspective on these issues. For instance, patients often trust informal interpreters (Edwards, Temple, & Alexander, 2005), while GPs do not (Gadon, Balch, & Jacobs, 2007). However, we miss an overarching investigation of the perspectives of all three interlocutors (i.e., GPs, patients and informal interpreters) focusing on the exploration of all three issues. Such a study is of vital importance because different perspectives could possibly explain miscommunication and conflicts between the three interlocutors (Fatahi et al., 2008). Thus, the aim of this study is to uncover differences in perspectives of GPs, patients and informal interpreters regarding interpreters' role, control dynamics and trust in interpreted GP consultations.

First, we will explore the different perspectives regarding the role of the informal interpreter. The literature has shown that informal interpreters perform different and sometimes conflicting roles in the medical interaction. For instance, besides the basic role of the linguistic agent, when interpreters provide linguistic translations only (this role is also referred to as conduit; Dysart-Gale, 2005), they could also provide cultural information to patients and providers and thus act as cultural brokers (Leanza, 2005). When acting as caregivers, informal interpreters provide extra medical information about the patient and keep track of prescribed medication (Rosenberg, Leanza, & Seller, 2007). When performing the role of the advocate, informal interpreters advocate on behalf of the patients, for instance by exaggerating the medical symptoms to get a referral to the hospital (Green, Free, Bhavnani, & Newman, 2005; Schouten, Ross, Zendedel, & Meeuwesen, 2012). Considering the great variety of roles which informal interpreters could perform and because patients, providers and informal interpreters themselves might have different perspectives of the ideal role of the interpreter, which could result in conflicting expectations and miscommunication, it is important to unravel the perspectives of the different parties. Hence, the first research question is:

RQ1: What are the differences in perspectives of GPs, informal interpreters and patients regarding the role of the informal interpreter?

Second, the literature has investigated the influence of interpreters on control dynamics in bilingual medical consultations. Because interpreters are the only ones who speak both languages, they are able to control the course of the interaction and shift the power balance in the patient's or provider's favor (Greenhalgh, Robb, & Scambler, 2006). Previous research among GPs has shown that informal interpreters often shift the power balance in the patient's favor leaving the health providers out of control (Meeuwesen et al., 2010; Fatahi et al., 2008). However, these findings have to our knowledge not yet been verified among patients and informal interpreters, who could have a different perspective of the influence of the interpreter on control dynamics. Therefore, to fully understand the issue of control dynamics in interpreter-mediated GP consultations from all three perspectives, we propose the second research question:

RQ2: What is the difference in perspectives of the three interlocutors on control dynamics in interpreted GP interactions?

Finally, trust has shown to be an important factor in interpreter-mediated communication, being a precondition for rapport building and successful communication (Hsieh, Ju, & Kong, 2010; Robb & Greenhalgh, 2006). Previous research focusing on patients' and providers' trust in informal interpreters has shown that patients overall trust the informal interpreters, because of their lengthy intimate relationships (Edwards et al., 2005; Hsieh et al., 2010). Providers, on the contrary, have little trust in informal interpreters as they have concerns about informal interpreters' linguistic competence and neutrality (Gadon et al., 2007). We apply the four dimensions of trust proposed by Hall and colleagues (Hall, Dugan, Zheng, & Mishra, 2001) to our research, in order to gain a deeper understanding of trust in interpreter-mediated consultations. The four dimensions clearly reflect the different characteristics associated with the work of interpreters (Dysart-Gale, 2005), that is, (1) Competence, when interpreters are trusted for their ability to provide correct translations without making mistakes; (2) Honesty, when interpreters are trusted because they tell the truth and do not disguise information; (3) Confidentiality, when interpreters are trusted because they protect sensitive information provided by the patients; (4) Fidelity, when interpreters are trusted because they act in the best interests of the patient. Therefore, the third research question is:

RQ3: What are the differences in perspectives of GPs, patients and informal interpreters regarding the four dimensions of trust?

Method

Participants

To expand on an initial study on patients' perspectives about interpreter-mediated communication in general practice (see Zendedel, Schouten, van Weert, & van den Putte, 2016b), for this study informal interpreters and GPs were recruited using the snowballing method by the first author and three bilingual research assistants, who had excellent command of both the Turkish and the Dutch language. For the initial patient sample we have specifically targeted female respondents, because Turkish women have lower Dutch language proficiency than Turkish men (Huijnk & Dagevos, 2012) and consequently visit the GP more often with informal interpreters (Schaafsma et al., 2003). We used interview data of 21 Turkish–Dutch women who visited their GP with an informal interpreter at least once a year (see Zendedel et al., 2016b for a more elaborate description of the data collection of this sample). In addition, seventeen adult informal interpreters were recruited

from the personal networks of the research assistants aimed at a maximum variation in the sample (i.e., gender, age, relation to the patient). GPs were recruited from migrant dense areas in the Netherlands who regularly communicate via informal interpreters with patients of Turkish origin. Eventually, we have interviewed a heterogeneous sample of sixteen GPs (i.e., men and women, large and small practices, younger and older practitioners with different levels of experience) for maximal variation in the sample (see Table 1 for respondent characteristics).

Table 1. *Respondent Characteristics*

Characteristics	**GPs (n = 16)**	**Patients (n = 21)**	**Informal interpreters (n = 17)**
Gender	9 female; 7 male	All female	10 female; 7 male
*M*age	48 years (range 30-60)	53 years (range 42-70)	26 years (range 19-47)
Years working as GP (mean)	16 years	n.a.	n.a.
Visiting the GP with:	n.a. 67 min	Adult children: n =16 Grandchildren: n = 3 Husband: n = 3 Other kin: n = 2	Parents: n = 12 Grandparents: n = 3 Wife: n = 3 Other kin: n = 2
Duration of the interviews (mean)		56 min	51 min

Procedure

In line with participants' preferences, most interviews with patients and informal interpreters took place at participants' homes, whereas the interviews with the GPs took place at the general practice. The interviews were conducted by the first author who has an intermediate language proficiency in Turkish. During each interview with the patients one of the bilingual research assistants who was not acquainted with the respondent was present to translate the questions from Turkish to Dutch and vice versa to guarantee optimal understanding between the researcher and respondents. The interviews with GPs were conducted in Dutch by the first author.

We have used a topic list developed for the previous study that only explored the patient's perspective (Zendedel et al., 2016b) to develop similar topic-lists for the interviews with GPs and interpreters. To explore the interpreters' role, we have included the following roles: linguistic agent, advocate, cultural broker and caregiver. These roles were probed for during the interviews, after asking an open question about the expected interpreter's role. To explore trust we have used the four dimensions of trust proposed by Hall and colleagues (Hall et al., 2001): competence, honesty, confidentiality and fidelity. To explore control dynamics, we have included questions about the perceived dominance of informal interpreters and their influence on the decision-making process. In addition, we have included questions about the interpreter-mediated communication process itself (e.g., miscommunication and omission of information).

The interviews were conducted in a semi-structured way, providing space to respondents to come up with new topics and to deviate from the fixed order of the topic-list. Before the start of the interviews, participants were informed about the aim of the study and about their rights as participants. After obtaining their written informed consent, the interview started and was recorded on audiotape, each interview taking approximately an hour. The research has been approved by the Ethical Commission of the department of Communication Science of the University of Amsterdam.

Data analysis

The Dutch parts of all 54 interviews were transcribed verbatim by the first author. The research assistants have transcribed the Turkish parts of the patient interviews and translated them into Dutch. Using the double translation technique (McGorry, 2000) we have made sure that translations of the Turkish parts in the transcripts were reliable (Zendedel et al., 2016b). Consequently, each transcript was thoroughly read and divided into fragments, each of them describing a single concept, which was attributed a specific code based on the theoretical constructs outlined above. For instance, a fragment describing the role of the advocate was attributed the specific code "advocate" and was placed under the general code "interpreter's role". The coding was conducted with MAXQDA, 2007 (Kuchartz, 2007). Eventually, a coding scheme was developed consisting of general and specific codes for all three groups (i.e., GPs, patients and interpreters). We have elicited the differences between the three groups by constant comparison of the text under different codes (Gale, Heath, Cameron, Rashid, & Redwood, 2013).

Results

Communication process

We will first briefly discuss some salient aspects of the communication process followed by the description of the main theoretical themes: interpreters' role, control dynamics and trust.

Informal interpreters have indicated not to render a literal word-for-word translation during consultations, but rather to give a summary of what was discussed, especially when translating information from patients to the GP. They said to omit repetitions of the patients as well as contextual information, which they considered to be irrelevant. It was notable that especially male interpreters stated to omit contextual information. Indeed, the few patients who visited the GP with their husbands (see Table 1), have indicated to have the feeling that their husbands did not translate everything, which frustrated them. The GPs also had the idea that husbands did not translate everything and interpreted in a shortcut way (see Box 1 for quotes).

According to informal interpreters miscommunication rarely occurred, and when it occurred, they solved it during the consultation. Patients assumed that miscommunication probably happened, but as they did not speak Dutch, they could not say when, how and why. The GPs perceived miscommunication as well, but it was difficult for them to come up with specific examples. Sometimes they discovered the miscommunication during a follow-up consultation, for instance when the patients appeared to wrongly follow their treatment instructions. However, ideas about miscommunication were usually a gut feeling of the GPs that "something" was wrong, but they could not tell what exactly. Due to time pressure, GPs often left the miscommunication unsolved. Despite the fact that occurrence of miscommunication was not a prominent theme in the interviews and most of the interviewees could not come up with specific examples of miscommunication, it was clear from their accounts that miscommunication was lurking at the background of interpreted consultations (see Box 1 for quotes).

Box 1. *Quotes Illustrating the Main Results*

	GP's Perspective	Patient's Perspective	Informal Interpreter's Perspective
Communication aspects: omission of information	Sometimes, you notice, there is a long story and then he [the husband interpreter] tells it in two sentences, so I think that a lot of information is not being translated. […] I have a couple and they always come together, his first wife passed away and now he has a new wife from Turkey and they always come together and he interprets for her and I do notice quite often that she wants to say more than he says. And I think he does not find it important, he goes like: "Hush, it is fine like this, that is enough." [male, 57 years]	I don't know, sometimes I wonder if he [the husband] translates everything and I ask him like: do you translate everything? He says he does, but I don't think he translates it completely. [...] And sometimes I get really angry at him like: "Translate everything I say! Tell them exactly what I say and let them do something!" [female, 55 years]	Researcher [R]: And when you translate for your wife, do you translate literally? Interviewee [I]: No, I tell only the important things. R: So imagine, your wife would go like: "I have so much pain, the whole day long, and it is horrible" would you translate that? I: No, I would just translate: "She has pain", because the doctor does not need all that, just "pain" is enough. R: And what do you think your wife would think of this [leaving out of the information]? I: Yeah, women are like that you know (laughs), they always want to talk about their emotions and feelings, but I think the doctor just needs to know the most important part and that is what I tell. [male, 40 years, husband]

	GP's Perspective	Patient's Perspective	Informal Interpreter's Perspective
Miscommunication	GP: I think I regularly encounter miscommunication. R: And could you give an example of such miscommunication? GP: Hm, no, not concretely. Sometimes, I just wonder whether the translation is correct and whether they [patients] understand my explanation. Because then I receive an inadequate answer and then I think: "But this answer doesn't make any sense!". So I ask it again, but this sort of things, it is so complicated and it also depends on how much time you have to check it all. If you have little time, you are really not going to check it! Yes, sometimes, I think, something is really not okay (laughter). Especially with medication compliance, but then you don't know, did they [the interpreters] explain wrong, or is it just an incompliant patient? [male, 57 years]	R: And did you ever encounter miscommunication? P: I don't know, I did not encounter such a thing. R: And do you think it might have happened without you noticing it? P: I don't know, can't tell, because I don't understand everything. [female, 70 years]	Sometimes I could interpret something she [the mother] says in a wrong way and then I tell it to the doctor and when I give it [what the doctor says] back to her, she goes like: "But I didn't mean that!". And then I resolve it [the miscommunication]. [male, 33 years, son]

	GP's Perspective	Patient's Perspective	Informal Interpreter's Perspective
Interpreter's role: advocate	What I often see is that an informal interpreter, even before he has actually translated [to the patient] what I had said, that he goes like: "Yes, but we do expect that she goes to the hospital! And no, no, no, we will not let you put us off with this! I do notice this pushiness quite often. [male, 37 years]	P: Maybe she [the daughter] tells it in a more exaggerated way to fix the problem. […]. For example, before I had a special shampoo only and now the GP also gave me vitamins which I can take in with water. Maybe she [the daughter] told something to get this done. Because you know, don't look at me, I am so talkative now. When I go to the GP, I sit there silently, but my daughter, she does something, she is able to fix my problems. [female, 47 years]	I: It is important for me to find a solution for her [the mother's] problem. And I do push if that is needed to obtain a result. More than that, I go a step further: I really put some pressure on the doctor and if it is really needed, I could even pull him over his desk. [male, 30 years, son]

	GP's Perspective	Patient's Perspective	Informal Interpreter's Perspective
Control dynamics: interpreter as the primary interlocutor	Yeah, then I ask the question and the interpreter responds. [. . .] and it can really annoy me, this behavior of the interpreter, like when they just don't translate! And I notice that this happens more among husbands, that they answer instead of the patients and that makes me feel really powerless, because they expect me to treat something of which I am not sure whether it [what the interpreter says] is indeed the case. [female, 49 years]	R: And could you tell me a little bit how the interaction proceeds? Who takes the floor? Who speaks most of the time? P: We go inside and we say "hi". Then we sit down and my daughter starts to tell. She knows all my complaints in advance, so I don't have to speak. They talk [the daughter and the GP and I don't talk, because I have already told my complaints in advance. Then the doctor does the examination and tells to my daughter what he found out and then we go home . [female, 47]	I: I think that 90% of communication goes through me. Sometimes she [the mother] also shows something, like her elbow to the doctor, like: "Look! This part hurts! But she lets me do the talking. [female, 21 years, daughter]

	GP's Perspective	Patient's Perspective	Informal Interpreter's Perspective
Trust: Fidelity	GP: I have this patient and she always comes with her husband and I don't know, I don't trust it, because I have the feeling that he does not translate everything and that he has his own agenda and that is why I have offered to call a professional interpreter, but she refuses and I don't know why she doesn't want it.[..] R: So you have the feeling that the husband could have his own agenda? GP: Yes, yes, there is something going on there, but I can't find out what exactly. [female, 49 years]	I trust her because she is my daughter. She knows everything about me. But if it would be another person [not a family interpreter], I would not be sure if he tells it all correctly, I would not trust him. [female, 42 years]	R: And do you think your mother would like to participate more? I: No, I don't think so, I think she likes it this way, because she knows that her son wants the best for her and would act in her interest. [male, 33 years, son]

	GP's Perspective	Patient's Perspective	Informal Interpreter's Perspective
Trust: Honesty	GP: Well, the tricky part with informal interpreters [in contrast to professional interpreters], I don't know what they translate and if the patient receives the information. R: Do you ever have doubts about this? GP: Well, I actually know that people don't translate everything, like this case with a Turkish informal interpreter and there was a man with prostate cancer and he was going to die, but he didn't know that because the children did not tell him. And it is very tricky, because then you're totally dependent on the informal interpreters and they just refuse to tell it! [male, 46 years]	P: I had pain in my back and flanks and the results for my knees, I already received them, there was an improvement thanks to the operation, but I do still have pain in my flanks and my back and they would send those results to the GP. I guess I would have heard it if there would be something serious. But yeah, I don't know if the children would actually tell me if there would be something bad. I don't know (laughter) [female, 53 years]	I: Well sometimes, if the doctor says, you have 3 month to live, then I would change it, I then just say: it is incurable, and if we will not pay attention, it might get wrong. Because you can not tell it [the bad news] so bluntly. R: So, basically, you are not telling the truth? I: Yes, because you know that if you would tell the truth, someone will give up so fast. [female, 22 years, daughter]

Interpreters' role

The largest difference in expectations regarding the role of the interpreter considered the role of the advocate, which was a prominent one in patients' accounts. Patients expected informal interpreters to find solutions for their problems, for instance by exaggerating their symptoms in order to obtain medication or to receive a referral to the hospital. Informal interpreters were well aware of these expectations and did their best to "get things done" for the patients. Sometimes they would go as far as intimidating the GP to obtain the requested treatment. GPs reported that they perceived informal interpreters to indeed often perform the advocacy role. However, while the patients expected advocacy from interpreters and were satisfied when the interpreter performed this role, GPs were often annoyed by the imposing behavior of informal interpreters (see Box 1 for quotes).

Despite the main difference in perspectives regarding the role of the advocate, it was the role of the linguistic agent which was the first mentioned by all interlocutors during the interviews when asked about interpreters' roles. Most interviewees said that the primary role of the interpreter was translating information, or "simply interpreting". However, other roles going beyond linguistic agent were expected as well. As part of their caregiving role, informal interpreters were expected by both GPs and patients to provide disease-related information about the patient and thus function as an extra information source for the GP. In addition, GPs and patients expected the informal interpreters to keep track of the treatment process, for example by taking care of the prescribed medication and by making sure that the patients follow the treatment plan. Informal interpreters themselves have also indicated to fulfill these caregiving activities and they did so willingly in order to help their family members to get better. The role of the cultural broker, that is, providing cultural information about the patient to the GP and vice versa, was not recognized by our interviewees. Most GPs said to already possess knowledge about their patients' cultural background, and neither the patients nor the informal interpreters perceived the sharing of knowledge about one's culture as part of the interpreter's role. It was notable that despite the various expectations, GPs did not explicitly discuss the role of the informal interpreter during the consultations.

Control dynamics

Both patients and GPs perceived the interpreter as the primary interlocutor who often spoke for the patients and answered GPs' questions. However, while the patients accepted this behavior of the interpreters, GPs felt powerless because they could not control whether the information provided by the informal interpreters was the translation of the patient's

wishes or the wishes of the informal interpreters themselves. In order to regain control, GPs said to try to involve the patients into the conversation by looking at them while speaking (instead of looking at the interpreters) and by asking the interpreter to verify their answers with the patients when informal interpreters spoke instead of the patients. Informal interpreters did not consider themselves as dominant and said to let the patients speak whenever possible. However, some of them have confirmed to speak for the patient and to answer the GP's questions for them (see Box 1 for quotes).

Informal interpreters have indicated to leave the choices up to the patients when medical decisions were to be made. They said not to intervene with patients' choices unless the patients asked for their advice. This view corresponds with the perspective of the patients who have indicated to make their own medical decisions, but also sometimes to seek advice from their informal interpreters and GPs. The opinions of the GPs about the influence of the interpreter were divided: some GPs have indicated that decisions were taken in concordance with the patient and the interpreter most of the time. Other GPs have indicated that they (the GPs) were leading the decision-making process and that this was also the way the patients expected the decision-making to be. Finally, there were also some GPs who have indicated that interpreters probably had a large influence on the decision- making process. Sometimes this happened overtly, when the informal interpreters made the decisions during the consultations for the patients without asking for their opinion, that is when acting as the primary interlocutor. Some of the GPs have also indicated that they had the impression that the interpreter could ask the questions in such a way that it would lead the patients in a particular direction. Therefore, according to some GPs it is very important to persuade the interpreters when proposing taking certain medical decisions, because only when the interpreters are convinced of the effectiveness of the decision, they will take the patient in the desired direction. Thus, contrary to the perspectives of patients and most of the informal interpreters, some of the GPs perceived a large influence of the interpreter on the decision-making process.

Trust in informal interpreters

Informal interpreters were trusted more by patients than by GPs. Fidelity was the main reason why the patients trusted informal interpreters. Lack of interpreters' honesty and competence were the main reasons why GPs mistrusted informal interpreters. Confidentiality was not a prominent theme in the interviews.

Fidelity. Patients trusted the informal interpreters predominantly because of their fidelity. That is, the patients were convinced that the informal interpreters would act in their

best interests. Informal interpreters have indeed confirmed to do so. The GPs too, had the feeling that most informal interpreters were acting in the best interests of the patients. However, there were some GPs who have described situations in which they suspected the interpreters to have their own agenda in the consultation (See Box 1 for quotes).

Honesty. Honesty was a prominent theme in GPs' accounts. The majority of the GPs indicated to sometimes have doubt in the honesty of informal interpreters, referring to situations in which informal interpreters concealed medical information from patients. This happened for example during end of life situations, when informal interpreters had to tell the patients that they will die soon. Indeed, informal interpreters have confirmed that they would conceal bad news from patients, as it was according to them very important to keep up hope. The majority of the patients had trust in the honesty of informal interpreters. However, some of them also have expressed doubts about whether the informal interpreters would tell them bad news (see Box 1 for quotes).

Competence. GPs had less trust in the competence of informal interpreters than the patients, especially when interpreters were young children and husbands of the patients. Most of the patients said to trust the interpreting skills of their informal interpreters. Although some of the respondents have mentioned differences in language competence between their children and husbands, the former having better language and interpreting skills than the latter, these differences did not negatively impact on their trust in the informal interpreter. The interpreters themselves have indicated to usually manage the interpreting well, but most of them have also mentioned to experience difficulties with medical jargon and complicated words.

Confidentiality. Both the patients and the GPs trusted the confidentiality of informal interpreters. Patients believed that their informal interpreters would not disclose sensitive information to others and GPs believed that patients would not bring someone to interpret for them if they would not trust their confidentiality.

Discussion and conclusion

Discussion

The aim of this study was to identify differences in perspectives of GPs, Turkish migrant patients and informal interpreters on interpreters' role, control dynamics and trust in interpreted GP interactions, which are shown to be important issues for the study of interpreting in medical settings (Brisset et al., 2013). Our findings show clear differences in perspectives on all three concepts, with the largest differences in GPs' perspective on

the one hand, and a shared perspective of patients and informal interpreters on the other hand.

The most striking difference in perspectives regarding the role of the interpreter considers the role of the advocate. Our findings confirm previous research among interpreters who regard it as their role to push the GP to achieve certain results for the patients (Green et al., 2005; Schouten et al., 2012). To contribute to previous research our findings indicate that patients also expect and appreciate this role, whereas GP are annoyed by this imposing behavior of the interpreter. The fact that GPs do not appreciate the role of the advocate could be linked to our findings regarding the control dynamics in interpreted consultations. By advocating on patient's behalf, informal interpreters put forward the patient's agenda and shift the power balance in their favor, which also corroborates with previous research (Robb & Greenhalgh, 2006). Our findings confirm that family interpreters are more inclined to side with the patients, in contrast to findings of research among bilingual healthcare staff who are shown to side with the doctors and represent their agenda when acting as interpreters (Davidson, 2000). It is therefore very important to differentiate between family interpreters and other informal/ad hoc interpreters when drawing conclusions from research findings, which does not always happen in the literature (Hsieh, 2006b).

Considering trust, our findings indicate that GPs' and patients' trust in informal interpreters is based on different dimensions. The patients mainly trust their informal interpreters for fidelity reasons. This dimension of trust is formed a priori and based on the lengthy and intimate relationship between the patient and the family interpreter. GPs' (mis) trust on the contrary, is based on the performance of the interpreter during the medical interaction and is dependent on interpreters' competence and honesty, which they perceive as questionable. For instance, our findings show that informal interpreters do not always honestly pass on information to the patients, such as bad news. This finding is in line with previous studies, which have shown that in some cultures bad news is never delivered directly to the patient, but is discussed with the family members first (Kaufert, 1999; de Graaff, Francke, van den Muijsenberg, & van der Geest, 2012), which in our case were the informal interpreters. Sometimes it is the patients' wish not to be informed about the bad news to be able to keep up hope (Kaufert, 1999). However, it could also be the wish of informal interpreters themselves, while the patients would prefer honest disclosure of information (de Graaff et al., 2012). Hence, if it is the explicit wish of the patient to not to be informed about bad news, health care providers might solely refer to family members who act as informal interpreters to deliver bad news in a culturally appropriate way. However,

health care providers should be aware of the possible deliberate disguising of information by informal interpreters against the wishes of the patient and make use of professional interpreters when needed.

Study limitations and suggestions for further research

A limitation of this study is that we have recruited all three groups of participants (patients, GPs and informal interpreters) independently. Thus, respondents were unfamiliar to each other, meaning that we could compare only their general perspectives. Future studies can address this limitation by comparing the perspectives of patients, GPs and informal interpreters in a specific triad to achieve a clearer comparison of the different perspectives by keeping the context of the consultation the same for all three interlocutors.

Another limitation of this study is that it relies on self-reports and did neither investigate the actual communication process between patients, informal interpreters and GPs, nor its outcomes. Hence, future research should investigate how the role of the interpreter influences communicative behaviors (e.g., speaking for the patients, adding or deleting information, remaining neutral) and subsequent consultation outcomes, such as patients' understanding of information and their satisfaction with the consultation.

Conclusion

The main differences in perspectives of the three interlocutors concern the role of the advocate, which is expected by patients and performed by informal interpreters, but undesired by GPs. Moreover, reasons for (mis)trust differ for patients and GPs. Patients' trust in the informal interpreter is high and is based on the fidelity dimension. However, GPs often mistrust informal interpreters because they think they fall short in competence and honesty. Finally, GPs have indicated to feel powerless when informal interpreters speak on patients' behalf, while the patients have indicated to feel empowered instead.

Practice implications

It is important to raise awareness among health care providers about the possible differences in role expectations between patients, informal interpreters and themselves, because these differences could lead to miscommunication and frustrations during the medical consultation. Health care providers should be educated to acknowledge the daunting task of informal interpreters performing multiple and sometimes contradicting roles at the same time (Seeleman et al., 2005; Brisset et al., 2013) and be trained to be able to decide when a professional interpreter is needed. The fact that most GPs did not

make use of professional interpreters, while they frequently mentioned miscommunication with and mistrust in informal interpreters, indicates that there is a lack of awareness of the possible negative consequences of informal interpreting and a lack of skills to work with professional interpreters. Training GPs to make use of the Dutch field norms for the use of interpreters in health care, which describe under which circumstances it may be sufficient to use informal interpreters and when to use professional interpreters (KNMG, 2014), could help them in this decision-making process. Such a training for GPs can be a first step in improving the communication process with low language proficient migrant patients.

Chapter 4

Expected Interpreters' Roles Related to Patients' Control and Trust

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Abstract

In order to complement previous qualitative research and to provide explanations for previous contradictory findings, we have conducted a survey-study among Turkish-Dutch migrant patients (*n* = 91), informal interpreters (*n* = 91) and GPs (*n* = 26) directly before and after their GP consultation. First, we compared the expectations of the three parties on seven roles of the informal interpreter using Habermas' Lifeworld versus System theory: conduit, institutional gatekeeper (system roles); and advocate, emotional supporter, information source, cultural broker and counselor (lifeworld roles). Second, patients' expectations of the informal interpreters' role were linked to their perceived control of the consultation and trust in informal interpreters.

Results show a discrepancy between the expected roles by GPs on the one hand, who mainly expected the system role of conduit, and informal interpreters and patients on the other hand, who mainly expected lifeworld agent roles from informal interpreters. Moreover, patients' expectations of the lifeworld agent roles (especially emotional supporter role) were positively related to patients' increased perceived control and trust in informal interpreters. Thus, our study indicates that patients do not expect a neutral conduit role from informal interpreters, but rather benefit from interpreters who are expected to provide emotional support, extra information to the GP, cultural brokering and advocacy.

Introduction

Due to globalization the number of migrant patients in the health care sector is rapidly rising (Mosquera, Samuels, & Flores, 2016; Triemstra, Veenvliet, Zuizewind, Kessel, & Bos, 2016). Migrant patients often lack adequate language proficiency in the host language, which impedes the communication between the healthcare provider and the patient (Jacobs, Chen, Karliner, Agger-Gupta, & Mutha, 2006; Karliner, Jacobs, Chen, & Mutha, 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 primary care. The use of so-called informal interpreters, who are usually the family members of the patient, is common practice in Dutch primary care. Informal interpreters are present in around 60% of consultations with migrant patients, and especially frequently with first generation female Turkish migrant patients, who have low Dutch language proficiency (Huijnk & 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, & Ramirez, 2006; Flores, 2005), internal role conflicts (Messias, McDowell, & Estrada, 2009), mistrust in informal interpreters by the GP (Gadon, Balch, & Jacobs, 2007; Robb & Greenhalgh, 2006), and loss of control of the health care provider (Meeuwesen, Twilt, ten Thije, & Harmsen, 2010; Rosenberg, Leanza & 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, & Alexander, 2005), their emotional support for the patients (Ho, 2008; Rosenberg, Seller, & Leanza, 2008), and empowerment of the patients (Green, Free, Bhavnani, & Newman, 2005).

In order to better understand these seemingly contradictory findings, we need to take into account the different perspectives of the actors, that is the GPs', the migrant patients' and the informal interpreters' on the relevant issues. A recent review of the literature has highlighted three key issues for the study of interpreting in medical settings, that is, interpreters' role, control and trust (Brisset, Leanza, & Laforest, 2013). Previous qualitative research has already provided an exploration of these issues (e.g., Edwards et al., 2005;

Leanza, 2005; Robb & Greenhalgh, 2006). However, there is a lack of quantitative research linking the different concepts to each other, which is needed to provide explanations for previously found contradictory findings.

Hence, we 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 with the consultation (Street, Makoul, Arora, & Epstein, 2009). In the next section we will discuss the theoretical concepts and present our research hypotheses.

Interpreters' roles

Interpreters perform many different roles within the medical interaction, which have been defined as "behaviors and skills associated with being an interpreter as expected by institutions, practitioners and patients" (Brisset et al., 2013; p.135). Research on medical interpreting has frequently used Habermas' System versus Lifeworld metaphor to explain the different roles of medical interpreters (e.g., Robb & 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 & Greenhalgh, 2006).

Previous research has described the 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 et al., 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 broker, when the informal interpreters provide information about the cultural background of the patients to the healthcare providers to help them better understand the patients (Leanza, 2005).

Professional interpreters on the other hand, tend to side more with the doctors and to act on behalf of the system, for instance by keeping track of the consultation time (Hsieh, 2006a). 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 the 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 et al., 2013). Thus, following Brisset et al. (2013), we treat the conduit and the institutional gatekeeper as system agent roles and the advocate, emotional support, information source, cultural broker and counselor as lifeworld agent roles.

Recent qualitative research comparing the perspectives of GPs, patients and informal interpreters on the expected roles of the informal interpreter has indicated that patients and informal interpreters have similar perspectives and mainly expected 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, Schouten, van Weert, & van den Putte, 2016a). These comparative qualitative research 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 has 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 interpreters' role and mainly expect lifeworld agent roles, that is advocacy, emotional support, information source, cultural broker and counselor roles. b) In contrast to patients and informal interpreters, GPs will predominantly expect the system agent roles, that is the conduit and the institutional gatekeeper roles.

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, & 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 interaction (Brisset et al., 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, 2006a). Informal interpreters on the other hand, side with the patients and enlarge patients' control, by acting as lifeworld agents, for instance, as advocate, emotional supporter, information source etc. (Brisset et al., 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 to reach their health-related goals (Zendedel, Schouten, van Weert, & van den Putte, 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 supporter, information source, cultural broker 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' higher expectations of the lifeworld agent roles of the interpreter (i.e., advocate, counselor, emotional supporter, information source and cultural broker), will be related to patients' higher perceived control of the consultation.

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 et al., 2013). The patients confide their health problems to the interpreters and thus they need to trust the interpreters' honesty, fidelity and competence, which form the components of trust (Hall, Dugan, Zheng, & Mishra, 2001). We will use these dimensions of trust in the present study, which have also been applied in previous qualitative research on interpreter-mediated communication (Zendedel et al., 2016a).

Competence, the first dimension, is when interpreters are trusted for their ability to provide correct translations without making mistakes. Fidelity, the second dimension, is when interpreters are trusted because they act in the best interests of the patient. Honesty, the third dimension, is when interpreters are trusted because they tell the truth and do not disguise information. Finally, the fourth dimension, global trust is 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, because they believe that the informal interpreters are acting in their best interests (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' fidelity in the interpreter. Based on this previous research, we hypothesize that the expectations of lifeworld-agent roles, that is, advocate, emotional supporter, information source, cultural broker and counselor will be related to higher trust in the informal interpreter. Hence, we will test the following hypothesis:

H3: Patients' higher expectations of the lifeworld agent roles of the interpreter (i.e., advocate, counselor, emotional supporter, information source, and cultural broker), will be related to patients' higher 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 advocate on their behalf and this perceived control 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 mediates the relationship between the expected roles (i.e., lifeworld and system agent roles) of the interpreter and patients' trust in the interpreter?

Method

Procedure

One of the authors (MM), who also works as a general practitioner, has 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 to participate 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 have recruited 12 Turkish-Dutch 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.

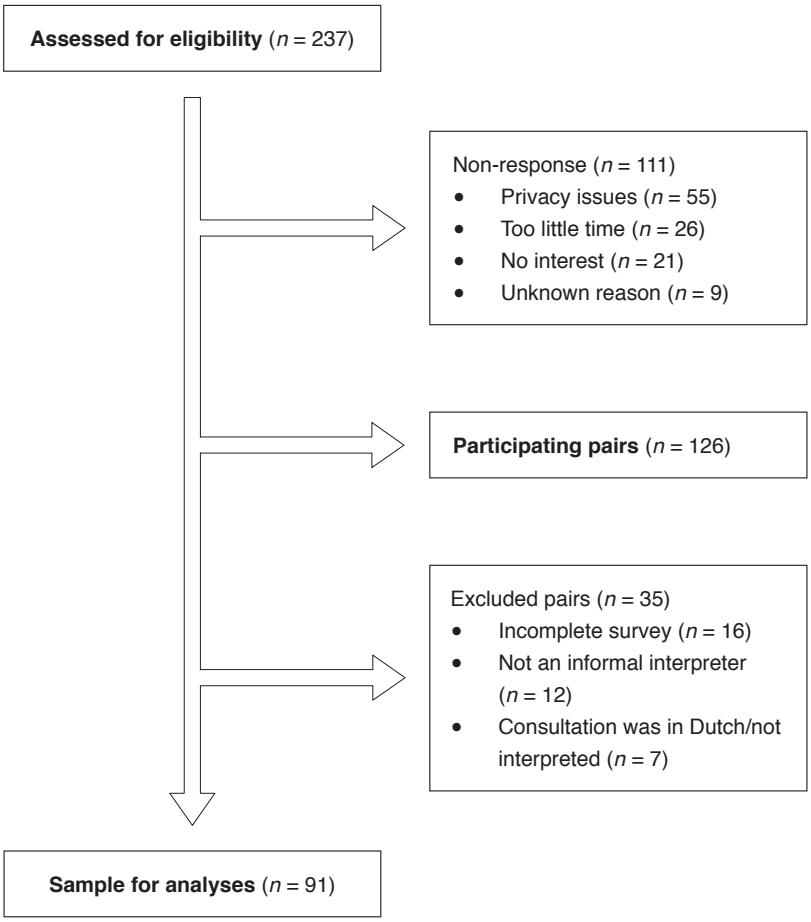
The study ran from November 2015 to May 2016 in all six practices. At least two different assistants were collecting data in each practice at the same time. Each practice was visited on different days of the week during the research period to make sure every GP of each practice had an equal chance to 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 visited the GP accompanied by an informal interpreter and that both the patient and the interpreter were above 18 years. After explaining the study purpose, patients and informal interpreters were asked for their consent to participate. All participants (patients, informal interpreters and GPs) have given their written informed consent to the study. The study has been approved by the Ethical Commission of our University (number 2015-CW-71).

The GPs and informal interpreters answered the paper-and-pencil 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 noted down their answers. All patients' surveys were collected in this oral way and were completely in Turkish.

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 (Ahlmark et al., 2015; Schinkel, Schouten, & 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 1).

Figure 1. *Flow Chart of the Sampling Procedure*



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 1 for sample characteristics).

Measures

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 have been 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 have 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.

Pre-consultation questionnaire. The pre-consultation questionnaire consisted of demographic questions and questions regarding the expectations of the interpreter's role. We asked about the following roles of the interpreter: conduit, institutional gatekeeper, advocate, information source, emotional supporter, cultural broker and counselor in de following way (patients' version of the questionnaire): "What do you expect from the person who came with you today to interpret?". We have 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 supporter*: to emotionally support you; *Cultural broker*: to give the doctor information about the Turkish culture in order to better understand you; *Counselor*: to give you advice during decision making. We have 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*.

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; α = .76). Thus we have 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 another dimension, that is, competence, fidelity, honesty and global trust (based on Hall et al., 2001; see theoretical framework for explanation of the items). We have 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; α = .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).

Table 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%)
Primary 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%)
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 relation 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)

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.

Results

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', as well as from informal interpreters' expectations, except for the role of the conduit, the expectations of which did not differ between the three groups (see Table 2).

Both the patients and informal interpreters mainly expected lifeworld agent roles, that is, advocate, information source, emotional supporter 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 expected the conduit role from informal interpreters (see Table 2).

Table 2. *Differences in Expectations of Interpreters' Roles between the Patients, Interpreters and GPs*

	Patients (N = 91) **Mean *(SD)***	**Interpreters (N = 91)** **Mean *(SD)***	**GPs (N = 26)** **Mean *(SD)***
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 supporter	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 broker	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*

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).

Patient's control and trust: Which role expectations are the best predictor?

Direct effects on patients' perceived control. In line with H2, patients' expectations of emotional supporter, information source and cultural broker roles were positively related to patients' perceived control of the consultation (see Table 3).

Table 3. *Mediation analyses: Direct Effects (DE) and Indirect Effects (IE) of Role Expectations on Perceived Control and Cognitive and Affective Trust*

	Perceived Control *DE* Effect *(SE)* [95%BCBCI]	**Cognitive trust *DE***	**Affective trust *DE***	**Cognitive trust *IE* via control**	**Affective trust *IE* via control**
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 Broker	.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 interpreters' gender and patients' language proficiency.

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' higher expectations of the lifeworld agent roles are related to increased perceived control of the patient; H2 holds true for all lifeworld agent roles, except for the role of the counselor.

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 supporter, advocate, information source, and cultural broker) and patients' trust in the informal interpreter. The expectations of the information source role and of the cultural broker role were only related to patients' affective trust and the expectations of the emotional supporter role were only related to patients' cognitive trust. The expectation of the advocate role was related to both cognitive and affective trust of the patients. Furthermore, contrary to our expectations, we also found a positive relation between the expected role of institutional gatekeeper and patients' cognitive trust. Thus, the results largely confirm the hypothesis that patients' higher expectations of the lifeworld agent roles are related to patients' increased 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.

Mediated effects on patients' trust in the interpreter. In order 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 information source and the role of cultural broker. These roles were only related to patients' increased cognitive trust. We did not find any mediated relations between patients' role expectations and patients' affective trust.

Discussion

The present study has compared the expectations of GPs, patients and informal interpreters on 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 the expectation of 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 obviously define their role in contrast to 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 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 supporter) 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 supporter, 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 earlier discussed advantages of lifeworld-agent roles for perceived control of the patients (Brisset et al., 2013; Greenhalgh et al., 2006).

Regarding patients' trust in the interpreter, the present study shows that the role of the advocate and the role of emotional supporter, 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 migrant patients, as the cognitive trust dimension was based on patients' trust in informal interpreters' competence. It seems that interpreters' competence is defined differently by patients compared to 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 has been understudied due to the difficult access to the research population (Brisset et al., 2013).

Despite the merits of our study, there are also some limitations. First, we have studied a particular population, namely 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 explore 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' roles 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 patients' control and trust.

Apart from these study limitations, 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' perspective 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 the patients' perspective is often lacking from medical-interpreting research. It is crucial to investigate the patients' perspective in order to align the 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-mediated interactions.

Chapter 5

Performed Interpreters' Roles Related to Patients' and GPs' Control, Trust and Satisfaction

This Chapter is submitted for publication as:

Zendedel, R., Schouten, B. C. , van Weert, J. C., & van den Putte, B., (submitted). Informal Interpreting in General Practice: Are Interpreters' Roles Related to Perceived Control, Trust, and Satisfaction?

Abstract

Objective: The aim of this observational study was twofold. First, we examined how often and which roles informal interpreters performed during consultations between Turkish-Dutch migrant patients and general practitioners (GPs). Second, relations between these roles and patients' and GPs' perceived control, trust in informal interpreters and satisfaction with the consultation were assessed.

Methods: A coding instrument was developed to quantitatively code informal interpreters' roles from transcripts of 84 audio-recorded interpreter-mediated consultations in general practice. Patients' and GPs' perceived control, trust and satisfaction were assessed in a post consultation questionnaire.

Results: Informal interpreters most often performed the conduit role (almost 25% of all coded utterances), and also frequently acted as replacers and excluders of patients and GPs by asking and answering questions on their own behalf, and by ignoring and omitting patients' and GPs' utterances. The role of information source was negatively related to patients' trust and the role of GP excluder was negatively related to patients' perceived control.

Conclusion: Patients and GPs are possibly insufficiently aware of the performed roles of informal interpreters, as these were barely related to patients' and GPs' perceived trust, control and satisfaction.

Practice Implications: Patients and GPs should be educated about the possible negative consequences of informal interpreting.

Introduction

Informal interpreters are frequently used in medical settings all over the world in order to bridge the language gap between health care providers and migrant patients (Karliner, Jacobs, Chen, & Mutha, 2007). In Dutch general practice (GP), informal interpreters, who are usually family and friends of the patients, are present in circa 60% of GP consultations with first generation migrant patients (Triemstra, Veenvliet, Zuizewind, Kessel, & Bos, 2016). In contrast to their professional counterparts, who are mainly expected to perform the role of a conduit, that is, literally translate information from one language into another (Dysart-Gale, 2005), informal interpreters also perform other roles within the medical interaction.

Previous qualitative studies have shown that informal interpreters often are reported to act as patients' advocates (Green, Free, Bhavnani, & Newman, 2005), counselors (Edwards, Temple, & Alexander, 2005) and cultural brokers (Leanza, 2005) (see Table 1 for definitions of the roles). They also provide emotional support to the patients (Ho, 2008), and act as an extra information source for health care providers (Rosenberg, Leanza, & Seller, 2007). In contrast to these facilitating roles, informal interpreters are also shown to act as replacers and excluders of both the patients (Hasselkus, 1992; Meyer, Pawlack, & Kliche, 2010) and health care providers (Hatton & Webb, 1993). The mentioned roles are usually investigated via qualitative interviews with the three interlocutors (i.e., the health care provider, the patient and the informal interpreter), discussing expected and perceived roles of the informal interpreters (e.g., Hadziabdic, Heikkilä, Albin, & Hjelm, 2009; Hilder et al., 2016; Rosenberg, Seller, & Leanza, 2008; Zendedel, Schouten, van Weert, & van den Putte, 2016a).

Previous observational studies have also investigated the communicative behavior of informal interpreters, for instance by coding omissions, additions and ignoring of the patients' and health care providers' utterances (Aranguri, Davidson, & Ramirez, 2006; Leanza, Boivin, & Rosenberg, 2010). However, to our knowledge, to date there are no studies which have observationally investigated the specific roles previously mentioned in self-report literature, that is, advocate, information source, counselor, emotional supporter, cultural broker, conduit, system agent and patients' and GPs' excluder and replacer. To enlarge our understanding about whether and to what extent informal interpreters actually perform the roles which are expected from them by patients and health care providers (Hilder et al., 2016; Zendedel et al., 2016a), we conducted an observational study to measure performed roles of informal interpreters.

Moreover, as previous research describing the different roles of interpreters is mainly qualitative (Brisset, Leanza, & Laforest, 2013), there are no studies which have related the different performed interpreters' roles to three potential communication outcomes, that is, perceived control of the consultation, trust in the interpreter and satisfaction of patients and GPs with the consultation. These outcome measures are shown to be important factors for interpreted medical communication (Brisset et al., 2013) and are related to patients' improved health outcomes (Street, Makoul, Arora, & Epstein, 2009). Linking the different roles to these communication outcomes will provide us with valuable insights about the possible positive and negative effects of the different roles of informal interpreters on communication outcomes and could be used in designing evidence-based interventions to improve interpreter-mediated interactions.

Therefore, we have conducted a mixed-methods study in which we have coded for different interpreters' roles based on audio-recordings of GP consultations with Turkish migrant patients and their informal interpreters. The coded roles were subsequently related to GPs' and patients' perceived control of the consultation, trust in the interpreter and satisfaction with the consultation, which were assessed in a post-consultation survey. Hence, the following RQs will be answered in this paper.

RQ1: Which roles do informal interpreters perform during the GP consultation?

RQ2: Are the performed roles of the informal interpreters related to patients' and GPs' perceived control of the consultation, trust in the informal interpreter and satisfaction with the consultation?

Method

Participants and procedure

This study is part of a larger research project on informal interpreting in general practice. Results of previous studies have been reported elsewhere (Zendedel et al., 2016a, 2016b; Zendedel et al., submitted). In the present study we describe the observational findings and their relation with the outcome measures.

Twelve Turkish-Dutch research assistants have collected the data in six GP practices from November 2015 to May 2016. The research assistants have been approaching all patients of Turkish origin who visited the GP in the company of another person in the waiting room of the GP practice. Inclusion criteria were that the patients should be of

Turkish origin, above 18 years and visit the GP with an informal interpreter who is a family member or an acquaintance of the patient. Of the 237 approached patient-interpreter pairs, 126 pairs agreed to participate in the study, thus a response rate of 53% was obtained, which is in line with previous findings (Ahlmark et al., 2015; Schinkel, Schouten, & van Weert, 2013). Reasons for not wanting to participate were privacy issues (n = 55), too little time (n = 26), no interest in the study (n = 21) or unknown reason (n = 9). We had to exclude 42 pairs from analysis due to different reasons, such as failed audio recordings or incomplete surveys (see Figure 1 for the flow chart of the sampling procedure). The final sample consisted of 84 patient-informal interpreter pairs who visited 26 different GPs (see Table 2 for description of the sample characteristics). All participants (patients, informal interpreters, and GPs) have given their written informed consent to the study. The study has been approved by the Ethical Commission of our University (number 2015-CW-71).

Figure 1. *Flow Chart of the Sampling Procedure*

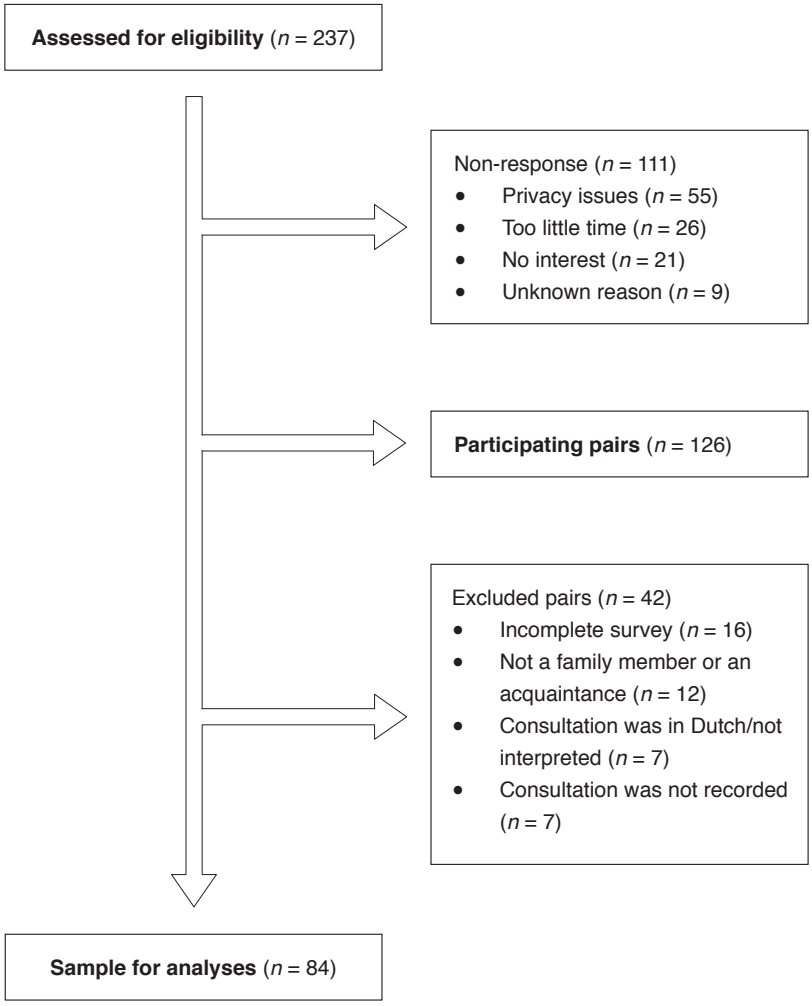


Table 1. *Sample Characteristics*

Sample Characteristics	Patients (N = 84)	Interpreters (N = 84)	GPs (N = 26)
Gender			
Men	19 (21%)	37 (44%)	7 (27%)
Women	65 (79%)	47 (56%)	19 (73%)
Age (SD)	59.53 (13.49)	39.57 (12.53)	47.54 (11.27)
Educational level	25 (30%)	0 (0%)	0 (0%)
No education	46 (55%)	13 (16%)	0 (0%)
Primary school	12 (14%)	12 (14%)	0 (0%)
High school	1 (1%)	44 (52%)	0 (0%)
Intermediate vocational education			
Higher professional education	0 (0%)	14 (17%)	0 (0%)
Academic education	0 (0%)	1 (1%)	26 (100%)
Dutch language proficiency	48 (57%)	0 (0%)	
Poor	31 (37%)	9 (11%)	
Moderate	3 (4%)	23 (27%)	
Reasonable	2 (2%)	32 (38%)	
Good	0 (0%)	20 (24%)	
Very good			
Residence time in the Netherlands			
Born in the Netherlands	0%	29 (35%)	
Mean residence time in years *(SD)*	31.96 (11.67)	31.65 (8.55)	
Interpreter's relation to the patient			
Daughter	32 (38%)		
Son	15 (18%)		
Spouse	24 (29%)		
Grandchild	4 (5%)		
Other family member	4 (5%)		
Friend of the patient	5 (6%)		

Demographic characteristics of all participants (i.e., patients, GPs and informal interpreters) were assessed before the start of the consultation. The consultation itself was recorded on audio. The research assistants handed over the recorder to the GP just before the start of the consultation and were not present in the consultation room. The GPs answered the post-consultation survey in their office after the patient left. The patients and informal interpreters answered the post-consultation survey in the waiting room of the GP practice. The informal interpreters filled in the paper and pencil questionnaires themselves in either Turkish or Dutch, while the patients' questionnaire was delivered orally in Turkish by the research assistants, as most of the patients were illiterate.

Survey measurements

Separate post-consultation surveys were constructed for patients and GPs to measure their perceived control of the consultation, trust in the informal interpreter and satisfaction with the consultation. The patient survey was translated into Turkish by a professional translation service and double-checked by two Turkish-Dutch research assistants. All questionnaires have been pilot tested among patients and GPs during a pilot-testing week in a GP practice to ensure that all items were understood by the respondents. Based on this pilot test, we have reformulated a few questions of the patients' questionnaire to make them easier to understand. The pretest data were not included in the final dataset.

Patients' and GPs' perceived 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? (the patients' version of the questionnaire). 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 for both patients' perceived control (EV = 2.02; R^2 = .67; α = .75) and GPs' perceived control (EV = 1.99; R^2 = .66; α = .73). Thus, we have created scales of patients' (M = 4.53, SD = .75) and GPs' perceived control (M = 3.89, SD = .63) by calculating the mean scores.

Patients' and GPs' 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 another dimension of trust, that is, competence, fidelity, honesty and global trust (based on Hall et al., 2001). Competence was assessed with the following statement: "I trust that the interpreter has provided a correct translation and did not make translation mistakes". Fidelity was assessed with: "I trust that the interpreter acted in my best interests". Honesty with: "I trust that the interpreter was honest and did not disguise information"

and global trust with: "I completely trust the interpreter". Based on factor analysis, the four dimensions were split into an affective and cognitive component. Fidelity, honesty and global trust all loaded on one factor and proved to be reliable for both patients' trust (*EV* = 1.93; R^2 = .64; α = .64; *M* = 3.92, *SD* = .22) and GPs' trust (*EV* = 2.14; R^2 = .71; α = .75; *M* = 3.08, *SD* = .78), forming the affective component of trust. The competence dimension did not form a scale with the items of the affective dimension and was analyzed as a separate item, forming the cognitive component of patients' (*M* = 3.60, *SD* = .81) and GPs' trust (*M* = 3.02, *SD* = .98).

Patients' (*M* = 3.57, *SD* = .62) and GPs' satisfaction (*M* = 3.09, *SD* = .74) was measured with a single item on a four point scale (1) *totally not satisfied* to (4) *totally satisfied*, in the following way: "To what extent are you satisfied with the consultation?".

Coding procedure of observational data

All audio-taped consultations were transcribed verbatim by the first author. Turkish-Dutch research assistants have translated the Turkish parts of the consultations in Dutch; translations were double-checked by other Turkish-Dutch research assistants and a few different visions on the translation were solved by discussion. A first version of the coding-manual was developed based on the previous literature (Brisset et al., 2013; Schouten & Schinkel, 2014). In order to probe the coding manual, the first author (RZ) and the second author (BS) have individually coded several randomly selected consultations and discussed and adapted the manual until the final version. All interpreters' utterances were coded, which fitted in one of the following roles: conduit, advocate, information source, emotional supporter, cultural broker, counselor, system agent, patient replacer, GP replacer, patient excluder, GP excluder (see Table 1 for operationalizations of the roles).

We define an utterance as the smallest discernable segment of speech that conveys only one thought or relates to one item of interest (e.g., a question, an answer, a request). An utterance may vary in length from a single word (e.g., yes or no) to a complete sentence (Roter, 1991). As we were interested in triadic communication, we excluded the so-called side-talk from coding, that is, when the interpreter exchanged more than two turns with either the patient or the provider and thus turned the triadic communication into a dyadic one (Meeuwesen, Twilt, ten Thije, & Harmsen, 2010). We report the frequencies and duration of the side-talk in the results section.

Table 2. *Definitions and Operationalizations of Informal Interpreters' Roles*

Role	Definition	Operationalization (*n*) = total number of utterances per operationalization
1. Conduit	Interpreter translates without adding or omitting information	a. Literally translates what is being said, does not add or omit anything (*n* = 45) b. Provides a paraphrasing of what is being said, without adding or omitting information (*n* = 786) c. Provides an incorrect translation of what is being said (*n* = 108)
2. Advocate	Interpreter does whatever is needed to reach the patient's goal	a. Exaggerates the patients' complaints (*n* = 102) b. Disagrees with the GP (*n* = 30) c. Requests the GP to do certain things (e.g., write a prescription, examine the patient) (*n* = 22) d. Adds affective information to the patient's utterance (*n* = 20)
3. Information Source	Interpreter provides additional information about the patient's health to the doctor	a. Within translating the patient's utterance to the GP (*n* = 102) b. Within a reaction to the GP (*n* = 85) c. Incorporated in the answer to the GP's question (*n* = 81) d. Within an initiation to the GP (*n* = 39)
4. Emotional Supporter	Interpreter provides emotional support to the patient	a. By reacting to the patient with reassuring words (*n* = 18) b. By initiating a turn to the patient with reassuring words (*n* = 7) c. By adding reassuring words to the GP's utterance within a translation to the patient (*n* = 5)
5. Cultural Broker	Interpreters acts like a bridge between the patient's and the GP's world	a. Provides information to the GP about the Turkish culture within an initiation or reaction (*n* = 0) b. Provides information to the patient about the medical system within an initiation or reaction (*n* = 9) c. Adapts GP's utterance to make it understandable for the patient within a translation (*n* = 139) d. Adapts patient's utterance to make it understandable for the GP within a translation (*n* = 180)

Role	Definition	Operationalization (*n*) = total number of utterances per operationalization
6. Counselor	Interpreter provides medical advice to the patient	a. Within a reaction to the patient (*n* = 20) b. Within an initiation to the patient (*n* = 14)
7. System Agent	Interpreter acts on behalf of the system by aligning with the GP and excluding the patient's lifeworld from the interaction	a. Rushing the patient within an initiation (*n* = 5) b. Downplaying the patients' complaints within a translation of a patient's utterance (*n* = 38) c. Omitting affective cues of the patient within a translation of a patient's utterance (*n* = 11) d. Agreeing with the GP within a reaction (*n* = 12) e. Disagreeing with the patient within a reaction (*n* = 30)
8. Patient Replacer	Interpreter acts like the main interlocutor by replacing the patient	a. Answers the GP's questions within a reaction towards the GP (*n* = 435) b. Asks questions to the GP within initiations and reactions (*n* = 197)
9. GP Replacer	Interpreter takes the place of the GP	a. Requests the patients to do certain (medical) things within initiations and reactions (*n* = 24) b. Asks the patient (medical) questions within initiations and reactions (*n* = 210) c. Answers the patients' (medical) questions within reactions (*n* = 113) d. Provides advice to the GP within initiations and reactions (*n* = 8) e. Provides the patient with extra (medical) information within reactions and translations (*n* = 120)
10. Patient Excluder	Interpreter excludes the patient from the consultation	a. Shutting up the patient: within initiations and reactions (*n* = 17) b. Omitting a patient's utterance within translations (*n* = 119) c. Ignoring a patient's entire speech turn (*n* = 315)
11. GP Excluder	Interpreter excludes the GP from the consultation	a. Shutting up the GP within initiations and reactions (*n* = 0) b. Omitting GP's utterances within translations (*n* = 235) c. Ignoring GP's entire speech turn (*n* = 191)

The operationalization of interpreters' roles was based on four mutually exclusive main categories, that is: translations, reactions, ignoring and initiations. Translations referred to all GPs' and patients' utterances, which were translated by informal interpreters, either literally, paraphrased or incorrect. Reactions were coded when the interpreters' utterance was a reaction towards the patient or the GP. Ignoring was coded when the patient's or GP's entire speech-turn was ignored. Initiations were coded in utterances where interpreters initiated a new topic towards the GP or the patient. We did not code an initiation if it was immediately preceded by ignoring of the patient's or the GP's speech-turn.

Each coded role consisted of utterances based on a main code (e.g., initiations) and a subcode (e.g., omitting, adding, exaggerating; see Table 1 for exact operationalizations of each role). For instance, the role of conduit was based on the main code 'translations' and contained utterances of the GP and the patient which were literally translated (subcode 'literal'), paraphrased without adding or omitting any information (subcode 'paraphrasing') or incorrectly translated (subcode 'incorrect') by the informal interpreter. The role of patient replacer was based on the main codes 'initiations' and 'reactions' and contained 1) questions of informal interpreters to the GP (subcode 'asking questions GP') that were either a reaction to the GP (i.e., main code 'reactions') or an initiation of a new topic (i.e., main code 'initiations'), 2) or answers to the GPs' question (subcode 'answer questions GP'; main code 'reactions'). Thus, the coded roles were based on a unique combination of a main code, (i.e., translation, initiation, reaction, or ignoring) and a subcode (e.g., literal, paraphrasing, omission, addition, request, or answer to the question) (see Table 1 for all subcodes).

RZ coded all 84 consultations based on the finalized manual. BS coded ten randomly selected consultations and inter-coder reliability was assessed for all categories > 2% (Deveugele, Derese, & de Maeseneer, 2002). Intercoder-reliability was good (M_{ICC} =.89; SD = .10; range .61-.97)

Analyses

In order to answer RQ1, interpreters' roles were calculated based on the sum of the frequencies of the coded utterances per role (see Table 3). In order to answer RQ2, we have conducted regression analyses with interpreters' performed roles (i.e., frequency utterances per role) as predictors of patients' and GPs' perceived control, trust and satisfaction. In order to reduce the number of predictors for regression analyses, we selected the roles that at least marginally correlated with the outcome measures ($p < 0.10$).

We have controlled the models for all demographic variables that at least marginally correlated with the outcome measures, ($p < 0.10$) (see Table 4a and 4b for all regression models).

Results

Sample and consultation characteristics

Interpreters were most often the adult children (56%) or spouse (29%) of the patients. The majority of the interpreters (62%) indicated to have a (very) good Dutch language proficiency. The patients were all first generation Turkish-Dutch female patients, with a mean age of 60 years ($SD = 13.49$) The majority of the patients (57%) indicated to have a poor language proficiency in Dutch (see Table 2 for all sample characteristics).

Mean duration of all consultations was 14 min. and 08 sec. ($SD = 5.53$, range 3.2-31.75 min.). We coded a total of 3892 utterances, excluding the side-talk between the interpreters with either the GP or the patient. The informal interpreters translated 48% of patients' and GPs' utterances. 28% Of the utterances was a direct reaction of the informal interpreter towards the GP or the patient. 13% Of the utterances of the GPs and patients was ignored by the informal interpreter and 11% of the utterances was an initiation by the informal interpreter. Side-talk occurred on average four times per consultation ($M = 3.9$; $SD = 2.66$) and lasted on average 3 minutes ($M = 3.28$; $SD = 3.16$).

Which roles do the informal interpreters perform?

The conduit role was the most frequently performed role by the informal interpreters and covered 24% of all coded utterances. The role of patient replacer covered 16% of all coded utterances, followed by the role of GP replacer (12%), patient excluder (also 12%) and GP excluder (11%). The roles of the emotional supporter and of counselor were the least frequently performed roles and covered less than 1% of all coded utterances (see Table 3 for all frequencies).

Relation between performed roles and patients' and GPs' control, trust, and satisfaction

We found a few significant relationships between the interpreters' performed roles and patients' perceived control, trust and satisfaction. First, patients' perceived control was significantly predicted by the role of the GP excluder ($F(2,81) = 6.26$, $p = .003$, $R^2 = .13$, $b^* = -.28$, $p = .008$).

Thus, the more often the informal interpreters performed the role of the GP excluder, the less control the patients perceived. Overall, the patients perceived more control with female interpreters (b^*= .27, p = .013). Second, the role of information source was a significant negative predictor of patients' cognitive (F (2,81) = 3.85, R^2 = .09, p = .025, b^*= -.24, p = .031) and of patients' affective trust (F (3,80) = 4.11, R^2 = .13, p = .009; b^* = -.22, p = .036). Thus, the more the informal interpreters performed the information source role, the less trust in the interpreter the patients had. Patients were more satisfied with female interpreters (b^* = -.22, p = .037). Overall, higher educated patients were more satisfied with the consultation (b^* = .22, p = .043) (see Table 4a for all results).

Table 3. *Frequencies and Proportions of Utterances per Role*

	Frequency utterances per role	**Proportion utterances per role**	**Frequency utterances per consultation M *(SD)***
Conduit	939	24.13	11.18 (9.31)
Patient Replacer	632	16.24	7.52 (4.72)
GP Replacer	475	12.20	5.72 (4.58)
Patient Excluder	451	11.59	5.37 (5.23)
GP Excluder	426	10.95	5.07 (5.42)
Cultural Broker	328	8.43	3.90 (4.38)
Information Source	307	7.89	3.65 (3.10)
Advocate	174	4.47	2.09 (1.96)
System Agent	96	2.47	1.14 (1.62)
Counselor	34	.87	.40 (.75)
Emotional Supporter	30	.77	.36 (.71)
Total	3892	100%	

Table 4a: *Regression Models with Interpreters' Roles and Background Characteristics as Predictors of Patients' Perceived Control, Trust, and Satisfaction*

	Control Patient	**Trust Patient Cognitive**	**Trust Patient Affective**	**Satisfaction Patient**
	*b**	*b**	*b**	*b**
Interpreters' roles				
Advocate				-.17
Information Source		-.24 *	-.22 *	
System agent				.02
Patient Excluder				-.08
GP Excluder	-.28*			-.14
Background characteristics				
Interpreter's Gender	27 *	.21†		.22 *
Patients' Gender				-.13
Education Patient				.22*
Education Interpreter			-.20 †	
Language proficiency patient			-.20 †	-.16
R^2	.13**	.09*	.13**	.15**

Note. Variables corresponding with empty cells have not been included in the regression model. Interpreters gender: 0 = male; 1 = female. † $p < 0.10$ *$p < 0.05$; ** $p < 0.01$.

We did not find any relationships between the performed roles of informal interpreters and GPs' perceived control, trust and satisfaction. Only marginally significant positive correlations were found between the emotional supporter role and GPs' cognitive trust (b^* = .26, p = .059) and between the cultural broker role and GPs' control (b^* = .22, p = .061).

Overall, female GPs had more affective trust in the interpreter (b^* = .29, p = .008). Also, GPs had more cognitive trust in female interpreters, that is, they trusted the competence of female interpreters more (b^* = .25, p = .025) (see Table 4b for all results).

Table 4b. *Regression Models with Interpreters' Roles and Background Characteristics as Predictors of GPs' Perceived Control, Trust, and Satisfaction*

	Control GP	**Trust GP Cognitive**	**Trust GP Affective**	**Satisfaction GP**
	*b**	*b**	*b**	*b**
Interpreters roles				
Emotional Supporter		.26 †		
Information Source	.18		-.22 *	
Cultural Broker	.22 †	.03		.10
Patient Replacer	.06			
GP Replacer	-.02	-.027		
Background characteristics				
Interpreter's Gender	.19 †	.25 *		
GP's Gender			.29**	
Education Interpreter		.14	.20 †	
Language proficiency patient		-.17		
Age patient	.07	-.20		
Years living in the Netherlands patient	.10	.18		.05
R^2	.20*	.28**	.11**	.01

Note. Variables corresponding with empty cells have not been included in the regression model. Interpreters' gender: 0 = male; 1 = female. † $p < 0.10$ *$p < 0.05$** $p < 0.01$.

Discussion

From the eleven investigated roles (i.e., conduit, system agent, advocate, cultural broker, information source, emotional supporter, counselor, patient excluder, GP excluder, patient replacer, and GP replacer), informal interpreters most often performed the role of the conduit, which is not surprising, as conduit is defined to be the primary role of interpreters (Cox, 2015; Dysart-Gale, 2005). However, our findings indicate that apart from the conduit role, which covered around a quarter of all coded utterances, informal interpreters twice as often, that is in 50% of all coded utterances, acted as replacers and excluders of both patients and GPs. The performance of these dominant and excluding roles could explain

previous qualitative findings in which the GPs reported a loss of control because of the dominant behavior of informal interpreters (Fatahi et al., 2008; Rosenberg et al., 2007). In the present study, the role of GP excluder was negatively related to patients' perceived control, indicating that the patients perceive a loss of control too when the GP is excluded from the conversation. Thus, our study corroborates previous findings by showing that informal interpreters indeed perform dominant and excluding roles (Leanza et al., 2010).

In contrast to previous literature, where informal interpreters were often perceived as advocates of the patients (Green et al., 2005; Zendedel et al., 2016a), counselors (Edwards et al., 2005), cultural brokers (Leanza, 2005), extra information source (Rosenberg et al., 2007) and emotional supporter (Ho, 2008), these roles were not at all prevalent in the present study. One explanation for this discrepancy between the perceived and performed roles of informal interpreters could be the language barrier between patients and health care providers, which inhibits them from understanding the actually performed roles of informal interpreters. For instance, when informal interpreters act as patients' replacers, they answer the GP's questions and ask questions on patients' behalf. When acting as patients' advocates, the informal interpreters exaggerate the patients' complains and add affective information to what the patient is saying. It could be that the patients do not perceive the difference between these roles, because they do not understand what the interpreter is saying and thus they perceive their family interpreters, with whom they have a close relationship, as advocates, even when they are actually performing the role of the patients' replacer.

Our explanation for the absence of relationships between interpreters' performed roles and patients' and GPs' perceived control, trust and satisfaction follows the same line of reasoning. As patients and GPs might not have sufficient insight in the actually performed roles of the informal interpreters, these outcomes are probably rather based on their perceived roles of the interpreter, than on interpreters' performed roles. The findings of a previous study in which we have found significant relationships between the expected roles of informal interpreters and patients' perceived control and trust (Zendedel et al., submitted) support this idea. The findings of our present study in which the role of information source was related to patients' lower trust in the interpreter support this assumption. Namely, because the patients do not understand what the informal interpreters are saying, their trust is declining. However, informal interpreters are actually acting in patients' best interests by providing extra information to the GP. If the patients would be aware of this role of the informal interpreters their trust would probably not decline.

Apart from acting as replacers and excluders, our findings indicate that less than half of all utterances is being translated by informal interpreters, which might lead to negative clinical consequences. Although a recent study has shown that professional interpreters also often omit information (Sleptsova et al., in press), a previous study comparing professional and informal interpreters has shown that omissions by informal interpreters more often led to negative clinical consequences (Flores, Abreu, Barone, Bachur, & Lin, 2012). Therefore, patients and health care providers should be educated about possible detrimental consequences of informal interpreting, such as omission of information and dominant and excluding behavior of informal interpreters. Health care providers should be trained in how to prevent these behaviors when working with informal interpreters.

Study limitations and suggestions for further research

Our study has some limitations. First, we coded only the interpreter's utterances; thus we lack insight into which behaviors of the patients and the GPs provoke certain roles of the informal interpreter. Future research should study the interaction process of the three parties together in order to arrive at a more complete picture. Second, the codebook is developed in the Dutch context with Turkish migrant patients only and is not validated under different populations. Thus, our conclusions should be interpreted cautiously and replicated in future studies. Third, we coded only verbal communication and thus have possibly missed important non-verbal communication factors in our scheme. Thus, our codebook should be further developed based on video-recordings of real-life interpreted consultations.

Overall, it is necessary to continue investigating the relationships between the communicative behavior of different types of interpreters and outcome measures, such as understanding, recall, satisfaction, perceived control and trust in order to uncover the possible positive and negative effects of the communicative behavior of interpreters. Also, interpreters' personal characteristics, such as age, gender and relationship to the patients should be taken into account. For instance, the present study has shown that patients perceive more control and are more satisfied with female interpreters than with male interpreters and that female interpreters are also trusted more by GPs compared to male interpreters. Thus, future studies should continue to investigate the relationships between the different factors in order to move towards an explanatory model of informal interpreting and to be able to design evidence-based interventions for the improvement of the interpreter-medicated communication.

Conclusion

Besides the role of conduit, which occurred in a quarter of all coded utterances, informal interpreters often performed the roles of patients' and GPs' replacers and excluders. However, interpreters' roles were barely related to patients' and GPs' perceived control, satisfaction and trust in the interpreter, which might indicate that patients and GPs are not aware of the actually performed roles of informal interpreters. Informal interpreters translated less than half of all utterances, which might lead to the loss of important medical information and have negative clinical consequences.

Practice implications

The findings of this study could be used for education and training purposes. For instance, GPs and patients should be informed about the excluding roles of informal interpreters, which might lead to loss of information and adverse health outcomes. GPs should be trained in how to prevent the excluding behavior of informal interpreters and how to facilitate appropriate interpreting, a training example provided in a previous project (Meeuwesen et al., 2011). Informal interpreters could be educated in how to interpret in an adequate way without omission of relevant information.

Chapter 6

Summary of the Results and General Discussion

Summary of the results

The aim of this dissertation was to study informal interpreter-mediated communication in general practice by taking an integrative approach which combines the perspectives of all three interlocutors, that is the patients', the GPs' and the informal interpreters' on interpreters' roles, trust in the interpreter, perceived control and satisfaction with the consultation. The main research question was:

How can interpreter-mediated communication in general practice be characterized from the perspectives of Turkish migrant patients, GPs, and informal interpreters, taking into account the antecedents of communication (i.e., expected roles of interpreters), the communication process itself (i.e., performed roles of interpreters), and communication outcomes (i.e., patients' and GPs' perceived control of the consultation, trust in the interpreter, and satisfaction)?

As the patients are the ones who should benefit from care, the investigation started by focusing on the patients' perspective. In Chapter 2 semi-structured interviews were conducted with 21 Turkish-Dutch female migrant patients in order to explore their perspective on informal interpreting during the GP consultation focusing on interpreters' roles, trust in the interpreter and patients' perceived control during the consultation. The main RQs were:

RQ1: How do Turkish-Dutch GP patients perceive the role of informal interpreters and which roles do they expect the informal interpreters to perform?

RQ2: How can Turkish-Dutch GP patients' trust in either professional or informal interpreters be explained by the different dimensions of trust?

RQ3: To what extent do Turkish-Dutch GP patients feel empowered or disempowered by the presence of informal interpreters?

The findings indicated that besides providing linguistic translation, that is, performing the conduit role, informal interpreters were expected to perform the roles of advocates and caregivers of the patients. That is, informal interpreters were expected to provide extra information to the GP about the patients' health, to keep track of the medication for

the patient at home (i.e., the caregiver role) and to accomplish the patients' goals during the consultation (i.e., the role of the advocate). Informal interpreters were trusted more than professional interpreters, mainly for fidelity reasons, because the patients assumed that informal interpreters would act in their best interests. Although informal interpreters were often perceived as the primary interlocutor, (i.e., as the ones who answered the GPs' questions and spoke on behalf of the patients), the patients did not feel dominated by them, but rather experienced more control during the consultation.

In order to compare the patients' perspective to the perspectives of informal interpreters and GPs and to uncover possible differences in perspectives, in **Chapter 3**, additional interviews were conducted with 16 GPs and 17 informal interpreters focusing on interpreters' role, control dynamics in interpreted interactions and trust in the informal interpreter. The main RQs were:

RQ1: What is the difference in perspectives between patients, GPs, and informal interpreters regarding the role of the informal interpreter?

RQ2: What is the difference in perspectives between patients, GPs, and informal interpreters regarding the different dimensions of trust?

RQ3: What is the difference in perspectives between patients, GPs, and informal interpreters on control dynamics in interpreted GP interactions?

The results showed that informal interpreters overall aligned with the patients on all three issues, sharing the same perspective on the expected interpreters' roles, trust and control. The role of the advocate was expected by patients and reported to be willingly performed by informal interpreters. However, the GPs were often annoyed when informal interpreters advocated on patients' behalf. Also, in contrast to patients, who had much trust in their informal interpreters, mainly for fidelity reasons, GPs mistrusted informal interpreters, mainly their competence and honesty. Thus, patients and GPs (mis)trusted the informal interpreters for different reasons. Regarding control, all three interlocutors indicated that informal interpreters often answered GPs' questions for the patients and spoke on their behalf. However, while the patients did not experience a loss of control, the GPs did, because they did not know whether the informal interpreters convey the patients' wishes or have their own agenda in the medical interaction.

In **Chapter 4** a survey was conducted to corroborate the findings from the two previous studies (i.e., chapter 2 and chapter 3). The expectations of different informal interpreters roles were compared between 91 Turkish-Dutch migrant patients, their GPs and informal interpreters. The hypotheses to test were:

H1: a) Patients and informal interpreters will have similar expectations of the informal interpreter's role and mainly expect lifeworld agent roles, that is advocate, emotional supporter, information source, cultural broker and counselor roles. b) In contrast to patients and informal interpreters, GPs will predominantly expect the system agent roles, that is the conduit and the institutional gatekeeper roles.

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

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

In line with the qualitative study in Chapter 3, differences were found between the GPs' expectations on the one hand, and the expectations of patients and informal interpreters on the other hand. GPs mainly expected the system role of conduit from informal interpreters and patients and informal interpreters mainly expected lifeworld agent roles, that is, advocate, information source, emotional supporter and counselor. Moreover, patients' expectations of the lifeworld agent roles (especially the emotional supporter role) were positively related to patients' perceived control and trust in informal interpreters. Thus, the findings indicate that patients do not expect a neutral conduit role from family interpreters, but rather benefit from interpreters who are expected to provide emotional support, extra information to the GP, cultural brokering and advocacy.

In **Chapter 5** the actually performed roles of informal interpreters were investigated by coding interpreters' roles from audio-recordings of 84 real-life interpreted GP consultations. The different roles were subsequently related to patients' and GPs' control of the consultation, trust in informal interpreters and satisfaction with the consultation. The main questions were:

RQ1: Which roles do the informal interpreters perform during the GP consultation?

RQ2: Are the performed roles of the informal interpreters related to patients' and GPs' perceived control of the consultation, trust in the informal interpreter and satisfaction with the consultation?

From the eleven investigated roles (i.e., conduit, system agent, advocate, cultural broker, information source, emotional supporter, counselor, patient excluder, GP excluder, patient replacer, GP replacer), informal interpreters most often performed the role of the conduit, in around a quarter of all coded utterances (24%). However, informal interpreters also frequently acted as patient replacers (16%), GP replacers (12%), patient excluders (11%) and GP excluders (11%), by asking and answering questions on their own behalf and by ignoring and omitting the patients' and the GPs' utterances. Only a few relationships were found between the performed roles of informal interpreters and patients' perceived control, trust in the interpreter and satisfaction with the consultation. The role of information source was negatively related to patients' trust and the role of GP excluder was negatively related to patients' control of the consultation. No significant relations were found between the performed roles of informal interpreters and GPs' perceived control, trust and satisfaction. Overall, both the patients and GPs trusted female interpreters more and patients experienced more control and satisfaction with female interpreters.

General discussion

The comparison of the perspectives of the three actors on interpreters' role, trust and control shows that patients and informal interpreters align in their perspectives and that the perspective of GPs is overall different. This finding, which showed to be consistent throughout the different chapters fits in the system versus lifeworld dichotomy of Habermas (Brisset, Leanza, & Laforest, 2013; Greenhalgh, Robb, & Scambler, 2006). Informal interpreters, who in this case were mainly family members of the patients, perceived themselves as advocates of the patients, who do whatever is needed to reach the patients' goal, for instance by exaggerating the patients' complaints to get a referral to specialized care. Thus, informal interpreters claim to represent the patients' lifeworld by acting as patients' advocates and the patients align with this perspective, as well expecting the informal interpreters to act as such. GPs on the other hand, have indicated to be annoyed by the demanding behavior of the informal interpreters when they acted as the patients'

advocates and have indicated to rather expect the conduit role form informal interpreters, thus expecting a system role. The discovery of this difference in perspectives is a valuable insight, which might explain the large occurrence of miscommunication and perceived difficulties in informal interpreter-medicated medical encounters (Meeuwesen, Twilt, & Ani, 2011; Seeleman, Suurmond, & Stronks, 2005). The fact that patients and GPs appear not to share the same perspective on the role of informal interpreters might contribute to miscommunication during the medical encounter.

However, it was notable that the role of the advocate was not so often performed, as shown in our observational study of informal interpreters' roles (i.e., chapter 5). Thus, there seems to be a discrepancy between the role which is expected by patients and claimed to be performed by informal interpreters (and which annoys the GPs), and the role which the informal interpreters actually perform. One explanation for this notable result is that in the observational study only verbal communication was coded to define the interpreters' performed roles. The role of the advocate was coded when informal interpreters requested certain things from the GP (e.g., to write a prescription, to give a referral to specialized care, to alter the medication), exaggerated the patients' complaints (e.g., "She is so very tired!" instead of "I am tired") and added affective information to the patients' comments (e.g. "The pain is killing her" instead of "It hurts a lot"). It is possible that the role of the advocate was not so much reflected in the verbal communication of informal interpreters, but rather in their non-verbal communication, for instance by certain facial expressions indicating concern and frustration or certain (harsher) intonation of voice. It might be exactly these non-verbal and paralinguistic aspects that annoyed the GPs, and not so much the content of informal interpreters' messages which was coded in the observational study.

Another explanation for this discrepancy between the perceived and performed role of the advocate could be our operationalization of this role. It is possible that the patients perceive advocacy when informal interpreters are able to reach their goals, as was indicated in the qualitative study in chapter 2. Thus, the operationalization of the role of the advocate in the observational study, which merely entailed the coding of verbal communicative behavior of informal interpreters is possibly deviant from the patients' own understanding of this role. Therefore, the mere analysis of verbal communication was possibly insufficient in grasping the entire role of the advocate.

There was another notable finding regarding the expected versus performed roles, that is the frequent occurrence of patients' and GPs' replacers and excluders roles, as indicated in chapter 5. The roles of patients' and GPs' replacer and excluders were mentioned in previous literature (Fatahi, Hellström, Skott, & Mattsson, 2008; Hatton &

Webb, 1993; Meeuwesen et al., 2011) and also in the interview-study with GPs described in chapter 3, in which the GPs have expressed concerns about these dominant roles of informal interpreters. However, the patients seem not to be bothered by the fact that informal interpreters speak on their behalf and answer the GP's questions, as is shown in chapter 2. The patients willingly accept the dominant behavior of their family interpreters, because they trust that their family interpreters will defend their interests. Although trust in interpreters might facilitate the communication process during the medical interaction, the uncritical stance of patients towards the role of their family interpreters might have negative consequences as well. For instance, when informal interpreters do not translate all information and answer the questions of the GP instead of the patients, a part of possibly valuable information gets lost, which consequently might negatively affect the quality of health care provision (Divi, Koss, Schmaltz, & Loeb, 2007; Flores, Abreu, Barone, Bachur, & Lin, 2012). Thus, patients need to become aware of the possible negative consequences of informal interpreting and the advantages of professional interpreters regarding the adequate translation of information.

Practice implications

One recommendation for practice following from the present dissertation is to use informal interpreters mainly as caregivers of the patients, who may act as an extra information source for the health care providers and as emotional supporters for the patients. The findings of the survey study (chapter 4) show that the emotional supporter role is positively related to patients' trust and control and the findings from the qualitative studies (chapter 2 and 3) indicate that both the patients and the GPs appreciate the role of the extra information source.

However, the observational study (chapter 5) shows that less than half of all utterances are actually being translated by informal interpreters, which might lead to loss of important medical information. Thus, on the one hand, the findings of the present dissertation indicate that certain lifeworld roles of informal interpreters (e.g., emotional supporter role) lead to patients' increased control of the consultation and trust in the interpreters. On the other hand, informal interpreters do not translate all information and often exclude the patients and providers from the interaction, which might lead to detrimental health outcomes. Therefore, to bridge the language gap effectively, health care providers should rather rely on other sources, such as professional interpreters and/or digital health communication tools. A digital medical tool "Universal Doctor" has already shown to successfully bridge the barrier between health care providers and migrant patients who do not share the same

language (Cox, 2017).

In situations where digital tools are not sufficient (e.g., complicated diagnoses, difficult subjects, tool not available in certain languages), professional interpreters can be best used to bridge the language gap between migrant patients and health care providers. In this way, by separating the roles of translators and caregivers, the detrimental effects of informal interpreters (e.g., erroneous translations, omission of information, exclusion of patients and providers) will be circumvented, while the positive effects (e.g., provision of extra information, patients' increased trust and control) will remain.

As budget cuts make it impossible to use paid professional interpreters at all times, another possibility for improving the interpreter-mediated medical communication is to train informal interpreters in becoming more proficient in their task. For instance, informal interpreters can be trained to translate all information and not to speak for the patients. Most informal interpreters acts as interpreters on a frequent basis (see chapter 3; Meeuwesen et al., 2011). Thus a local training in the GP practice can be organized to train the informal interpreters who often accompany their family members to the GP practice. In this way GPs can benefit from the extra knowledge of informal interpreters about the patients' health and at the same time trained informal interpreters will be better able to perform their task without jeopardizing the communication process. Besides, in this way informal interpreters will be empowered to use their bilingual skills for a useful purpose (Angelelli, 2010; Schouten, Ross, Zendedel, & Meeuwesen, 2012).

Strengths, limitations and future recommendations

The present dissertation is the first to combine the different interpreters' roles mentioned in previous literature and to quantitatively compare the GPs', migrant patients' and informal interpreters' perspective on these roles. This integrative approach enabled us to find differences in perspectives, which might cause miscommunication and frustrations during the medical encounter. Besides, this dissertation is 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 dissertation, as the patients' perspective is often lacking from medical-interpreting research due to the difficult access to the population. Therefore, it is crucial to investigate the patients' perspective in order to align the health care provision with patients' wishes and needs.

Despite the merits, there are also some limitations to this dissertation. First, a particular population was studied, that is, Turkish migrant GP patients in the Netherlands,

which means that the results of the studies might not be generalizable to other populations and settings. It is therefore important to replicate the studies among different migrant groups and in different medical settings to enlarge the generalizability of the findings. A recent study from New-Zealand (Hilder et al., 2016) investigating a different population (Assyrian, Gujarati, and Samoan patients and their family interpreters and GPs) has already corroborated some of the findings. Hilder et al. (2016) also confirmed that the patients and family interpreters often align in their perspectives on informal interpreting and that the GPs perspective is different. Besides, it was shown that patients trusted their family interpreters for fidelity reasons (however, not defined with this term in their study), but that the GPs had less trust in family interpreters and mentioned more negative aspects of informal interpreting. However, more studies in different medical and regional contexts are needed to corroborate the findings of this study and the present dissertation.

Second, interpreters in this dissertation were predominantly family members of the patients, which has specific consequences for the concepts studied. For instance, the findings regarding the patients' trust in informal interpreters, which was mainly based on the fidelity dimension, could be different with other types of interpreters. Also regarding control, different relationships could have been found if interpreters would not have been the family members of the patients. Therefore, it is important to replicate the findings of this dissertation among other types of informal interpreters (i.e., ad hoc interpreters, bilingual health care providers) in order to generalize the findings of the present dissertation to other types of informal interpreters.

Third, in the observational study we have coded only verbal communication, which means that we might have underestimated the occurrence of certain roles which are mainly manifest in non-verbal communication. For instance, the role of emotional supporter, which occurred in less than 1% of all coded utterances according to our coding scheme would possibly be much more prevalent if non-verbal communication would have been taken into account. Therefore our coding scheme should be extended with non-verbal communication aspects and used to code video-recorded interpreted consultations.

Finally, in the present dissertation only affective communication outcome measures have been investigated, that is, control, trust and satisfaction. In order to find out more about the effects of interpreters' roles on communication outcomes, cognitive outcome measures, such as understanding should be taken into account as well. Thus, future research should investigate the effects of the different roles of interpreters on mutual understanding between patients and GPs (Harmsen, Bernsen, Meeuwesen, Pinto, & Bruijnzeels., 2005).

Conclusion

This dissertation shows that patients and informal interpreters often align in their perspectives on interpreting in medical setting and that the perspective of GPs is different. Patients mainly expected lifeworld roles from informal interpreters, that is advocate, information source, emotional supporter and counselor. GPs on the other hand mainly expected the conduit role, which is defined as a system role. These differences in expectations of interpreters' roles might lead to miscommunications and frustration during the medical interaction. The patients' expectations of the lifeworld agent roles, that is the emotional supporter, information source, cultural broker and advocate roles were related to patients' higher perceived control and trust in informal interpreters, which indicates that patients seem to benefit from a broader role of the informal interpreter than just the translation of information. However, our observational study has shown that informal interpreters more often performed the roles of conduit and of patients' and GPs' excluder and replacer, which indicates a discrepancy between expected and performed roles of informal interpreters. Performed roles were barely related to patients' and GPs' trust, control and satisfaction with the consultation, which indicates that patients (and GPs) rather base their trust and control on their perceptions. GPs and patients should be educated about the possible detrimental effects of informal interpreters and the benefits of professional interpreters when it comes to adequate translation of medical information.

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Dutch summary

Nederlandse samenvatting

Informele tolken worden dagelijks ingezet in de medische praktijk wanneer arts en patiënt niet dezelfde taal spreken. Informele tolken zijn dikwijls familieleden van de patiënt die meegaan naar het consult om de taalbarrière tussen arts en patiënt te slechten. Uit eerder onderzoek is gebleken dat de communicatie tussen huisartsen en migrant patiënten die via een informele tolk communiceren niet altijd vlekkeloos verloopt. Een van de redenen hiervoor is dat enerzijds de huisarts en anderzijds de patiënt van de informele tolk verschillende en soms tegenstrijdige rollen verwachten. Daarnaast speelt het vertrouwen in de informele tolk een grote rol voor het slagen van het communicatieproces. De tussenkomst van de tolk kan ook resulteren in verlies van controle van de artsen en/of de patiënten en hun tevredenheid met het consult.

De rol van de tolk, controle en vertrouwen zijn dus belangrijke concepten voor onderzoek naar tolk-gemedieerde communicatie in de medische setting. Het was tot nu toe echter niet duidelijk hoe deze verschillende concepten met elkaar samenhangen en wat het precieze verschil is in het perspectief op informeel tolken van de drie actoren (de arts, de patiënt en de informele tolk). Om meer duidelijkheid te krijgen over de verschillende perspectieven van de betrokken partijen op de rol van de informele tolk, het vertrouwen in de tolk, ervaren controle en tevredenheid van de arts en de patiënt, richt de huidige dissertatie zich op alle drie de participanten. Omdat in de Nederlandse gezondheidszorg de huisarts een poortwachtersfunctie vervult, richt het onderzoek zich specifiek op de huisartsenpraktijk. Daarnaast richt dit proefschrift zich specifiek op de Turkse migrant patiënten, omdat dit de grootste migrantengroep is in Nederland. Onderstaande hoofdvraag zal in dit proefschrift worden beantwoord.

Hoe kan tolk-gemedieerde communicatie in de huisartsenpraktijk worden gekarakteriseerd vanuit het perspectief van huisartsen, Turkse migrant patiënten en informele tolken, zich richtend op de antecedenten van communicatie (verwachte rol van de informele tolk), het communicatie proces (uitgevoerde rol van de tolk), en de communicatie uitkomsten (ervaren controle van de huisarts en patiënt, vertrouwen in de informele tolk en tevredenheid)?

Hieronder zullen per hoofdstuk de bevindingen van de studies in dit proefschrift worden besproken.

Hoofdstuk 2: Perspectief van de patiënten

In dit hoofdstuk staat het perspectief van de patiënten centraal. Door middel van semigestructureerde interviews zijn 21 Turks-Nederlandse eerste generatie migrant patiënten bevraagd naar hun perspectief op de rol van de informele tolk, hun vertrouwen in informele tolken en hun ervaren gevoel van controle tijdens tolk-gemedieerde gesprekken. De volgende vragen werden in dit hoofdstuk beantwoord:

1. Hoe ervaren de Turkse migrant patiënten de rol van de informele tolk en welke rollen verwachten ze van de informele tolk?

2. Hoe kan het vertrouwen van de Turkse migrant patiënten in informele versus professionele tolken worden verklaard vanuit de verschillende dimensies van vertrouwen, te weten: loyaliteit, competentie, eerlijkheid, vertrouwelijkheid en globaal vertrouwen?

3. In hoeverre voelen de Turkse migrant patiënten zich gesterkt of juist machteloos door de aanwezigheid van informele tolken?

De bevindingen van deze studie lieten zien dat behalve de rol van de spreekbuis (simpelweg vertalen wat er wordt gezegd), er ook de rol van belangenbehartiger en van zorgdrager werd verwacht van informele tolken. De informele tolken werden geacht om in het belang van de patiënten te handelen en hun doelen te bereiken (de rol van de belangenbehartiger), maar ook om extra informatie te geven aan de huisarts over de gezondheid van de patiënten en de voorgeschreven behandeling in de gaten te houden (rol van de zorgdrager). De informele tolken werden vaak beschouwd als woordvoerders van de patiënten. Zo gaven de ondervraagde patiënten aan dat de informele tolken meer spraken tijdens het consult dan zij zelf. Echter, deze prominente rol van de informele tolk gaf de patiënten geen gevoel van machteloosheid. Integendeel, de ondervraagde patiënten voelden zich gesterkt door de aanwezigheid van informele tolken en gaven aan door hun aanwezigheid meer controle te ervaren over het consult. Daarnaast zeiden de patiënten meer vertrouwen te hebben in informele tolken, dan in professionele tolken, gebaseerd op de loyaliteit dimensie van vertrouwen.

Hoofdstuk 3: Vergelijking van het perspectief van de patiënten, huisartsen en informele tolken

Om mogelijke verschillen en overeenkomsten aan het licht te brengen tussen het perspectief van de patiënten en dat van de huisartsen en informele tolken zelf, zijn aanvullende interviews gehouden met 16 huisartsen en 17 informele tolken. De volgende vragen stonden in dit hoofdstuk centraal:

1. Wat is het verschil in perspectieven van patiënten, huisartsen en informele tolken betreffende de rol van de informele tolk?

2. Wat is het verschil in perspectieven van de patiënten, huisartsen en informele tolken betreffende de verschillende dimensies van vertrouwen (loyaliteit, competentie, eerlijkheid, vertrouwelijkheid en globaal vertrouwen)?

3. Wat is het verschil in perspectieven van de patiënten, huisartsen en informele tolken betreffende de controle dynamieken in getolkte huisartsconsulten?

De bevindingen lieten zien dat patiënten en informele tolken een vergelijkbaar perspectief op de rollen, controle en vertrouwen hadden, terwijl huisartsen hier anders over dachten. Zo zagen de informele tolken zich in de eerste plaats als belangenbehartigers van de patiënt, terwijl de huisartsen het juist vervelend vonden wanneer de informele tolken deze rol op zich namen. Daarnaast hadden de huisartsen ook minder vertrouwen in de informele tolken dan de patiënten (gebaseerd op de competentie dimensie en de eerlijkheid dimensie van vertrouwen). Patiënten hadden juist veel vertrouwen in informele tolken (gebaseerd op de loyaliteit dimensie van vertrouwen). Ook ervoeren de huisartsen minder controle over het gesprek door de tussenkomst van de informele tolk, terwijl de patiënten er juist meer controle door ervoeren. Kortom, dit hoofdstuk laat de verschillende perspectieven zien met aan de ene kant de huisartsen en aan de andere kant de alliantie van de patiënt en de informele tolk samen.

Hoofdstuk 4: Verwachte rol van de tolk gerelateerd aan het vertrouwen en ervaren controle van de patiënt

Dit hoofdstuk beschrijft de resultaten van een vragenlijstonderzoek om enerzijds de bevindingen van de bovenbeschreven kwalitatieve studies te bestendigen en anderzijds om een verband te kunnen leggen tussen de verschillende concepten (de rol van de tolk, ervaren controle en vertrouwen). Dit onderzoek is uitgevoerd in de wachtkamer van zes huisartspraktijken onder Turkse migrant patiënten (n = 91), de informele tolken die meekwamen (n = 91) en de behandelende huisartsen (n = 26). Allereerst is gevraagd welke rol de patiënten, de informele tolken en de huisartsen verwachtten van de informele tolk. De rollen van de tolk zijn daarbij verdeeld in de zogenaamde systeem rollen en leefwereld rollen die volgens de theorie van Habermas tegenstrijdig zijn. Voorafgaand aan het consult met de huisarts is aan de patiënten, de informele tolken en de huisartsen gevraagd naar hun verwachtingen over de volgende zeven rollen: spreekbuis en poortwachter (systeem rollen) en belangenbehartiger, emotionele steun, informatiebron, cultureel bemiddelaar en raadgever (leefwereld rollen). Onmiddellijk na het consult hebben de patiënten een tweede vragenlijst ingevuld waarin ze hebben aangegeven in hoeverre ze vertrouwen hadden in de informele tolk en in welke mate ze controle over het gesprek ervaren hadden.

De volgende hypothesen zijn getoetst:

H1: a) Patiënten en informele tolken hebben dezelfde verwachtingen ten aanzien van de rol van de informele tolk en verwachten met name de leefwereld rollen, te weten: belangenbehartiger, emotionele steun, informatiebron, cultureel bemiddelaar en raadgever. b) Huisartsen verwachten met name de systeem rollen van informele tolken, te weten: spreekbuis en poortwachter.

H2: De hogere verwachtingen van de patiënten van de leefwereld rollen van de tolk (belangenbehartiger, emotionele steun, informatiebron, cultureel bemiddelaar en raadgever) zijn positief gerelateerd aan het ervaren gevoel van controle over het gesprek van de patiënten.

H3: De hogere verwachtingen van de patiënten van de leefwereld rollen van de tolk (belangenbehartiger, emotionele steun, informatiebron, cultureel bemiddelaar en raadgever) zijn positief gerelateerd aan hun vertrouwen in de informele tolken.

De bevindingen over de verwachte rol van de tolk lieten een verschil zien in de verwachtingen van de patiënt en de informele tolk enerzijds, en de verwachtingen van de huisarts anderzijds. Daarbij verwachtten de informele tolk en de patiënt vooral leefwereld rollen en de huisarts voornamelijk systeem rollen. Hypothese 1 werd daarmee grotendeels bevestigd. Daarnaast werd er een positief verband gevonden tussen de verwachte leefwereld rollen door de patiënten en hun vertrouwen in de informele tolk en het gevoel van ervaren controle over het getolkte consult. Vooral de verwachting van de rol van de emotionele steun was in sterke mate positief gerelateerd aan het vertrouwen en de ervaren controle van de patiënten. Hoe meer de patiënten de leefwereld rol van de informele tolk verwachtten, hoe groter hun vertrouwen in de tolk en de ervaren controle over het gesprek was. Daarmee zijn zowel hypothese 2 als 3 in deze studie bevestigd.

Hoofstuk 5: Uitgevoerde rol van de tolk gerelateerd aan het vertrouwen, ervaren controle en tevredenheid van de huisarts en de patiënt

In de laatste studie is de uitgevoerde rol van de informele tolk bestudeerd door 84 audio-opnamen van tolk-gemedieerde huisartsconsulten te analyseren door middel van coderingen van alle uitingen van de tolk. Er zijn in totaal 11 rollen van de informele tolk gecodeerd, te weten: spreekbuis, systeem vertegenwoordiger, belangenbehartiger, cultureel bemiddelaar, informatiebron, emotionele steun, raadgever, uitsluiter van de patiënt, uitsluiter van de huisarts, vervanger van de patiënt, vervanger van de huisarts. De volgende vragen zijn in dit hoofdstuk beantwoord:

1. Welke rollen voeren de informele tolken uit tijdens huisartsconsulten?

2. In hoeverre zijn de uitgevoerde rollen gerelateerd aan het vertrouwen van huisartsen en patiënten in informele tolken, aan hun ervaren gevoel van controle over het gesprek en hun tevredenheid met het consult?

De bevindingen van deze studie lieten zien dat dat de informele tolken voornamelijk de rol van de spreekbuis vervulden (in 25% van alle gecodeerde uitingen van de informele tolk). Naast deze rol traden de informele tolken ook vaak op als vervangers van de patiënt (in 16% van gecodeerde uitingen), als vervangers van de huisarts (in 12% van de gecodeerde uitingen), als uitsluiters van de patiënt (in 11% van de gecodeerde uitingen) en tevens ook als uitsluiters van de huisarts (in 11% van de gecodeerde uitingen). De

gecodeerde rollen zijn vervolgens gerelateerd aan het ervaren gevoel van controle over het gesprek van de patiënten, hun vertrouwen in de informele tolk en hun tevredenheid met het getolkte gesprek. Er zijn slechts enkele significante relaties gevonden. Zo was de rol van informatiebron (waarin de tolk extra informatie toevoegt aan wat de patiënt heeft gezegd) negatief gecorreleerd met het vertrouwen van de patiënt in de informele tolk en was de rol van de uitsluiter van de huisarts negatief gecorreleerd met het ervaren gevoel van controle van de patiënt. Er zijn geen verbanden gevonden tussen de verschillende rollen van de tolk en de ervaren controle over het gesprek, vertrouwen in informele tolken en tevredenheid van de huisarts.

Conclusie

Dit proefschrift laat zien dat het perspectief van de huisartsen op informeel tolken verschilt van het perspectief van de patiënten en van de informele tolken zelf. Patiënten en informele tolken verwachten voornamelijk leefwereld rollen van de informele tolk, te weten, belangenbehartiger, informatiebron, emotionele steun en raadgever. De huisartsen verwachten voornamelijk de spreekbuisrol, die in dit proefschrift is gedefinieerd als een systeem rol. Dit verschil in verwachtingen kan leiden tot misscommunicatie en fricties in het gesprek. De verwachting van de leefwereld rollen van de informele tolk (emotionele steun, informatiebron, cultureel bemiddelaar en belangenbehartiger) zijn positief gerelateerd aan het vertrouwen van de patiënt in de informele tolk en aan een hogere mate van ervaren controle over het gesprek. Echter, de bevindingen van de observationele studie laten zien dat informele tolken veel vaker de rollen van spreekbuis, vervanger en uitsluiter op zich nemen. Er lijkt dus een discrepantie te zijn tussen de rollen die worden verwacht van informele tolken door de patiënten en de rollen die ze daadwerkelijk uitvoeren. Hoewel er nauwelijks verband is gevonden tussen de uitgevoerde rollen van de tolk en het vertrouwen in de informele tolk, de controle over het gesprek en de tevredenheid van patiënten en huisartsen, wijst de negatieve correlatie tussen de rol van de uitsluiter en ervaren controle van de patiënten er op dat deze veelvuldig vervulde rol van de tolk negatief uitpakt voor de patiënten. Aanbevolen wordt om zorgverleners en patiënten te informeren over de mogelijk nadelige gevolgen van tolken door informele tolken (uitsluiten van artsen en patiënten) en waar mogelijk een beroep te doen op de professionele tolken.

Author Contributions

Chapter 2

Title: Informal interpreting in general practice: The migrant patient's voice.

Researchers involved: Rena Zendedel (RZ), Barbara Schouten (BS), Julia van Weert (JW), Bas van den Putte (BP)

	Limited Contribution	**Substantial Contribution**
Conceptualization (main idea, theory)	JW, BP	RZ,BS
Methodology (design, operationalization)	JW	RZ, BS, BP
Data collection		RZ
(Statistical) Analysis	BS	RZ
Writing (original draft preparation)	BS, JW, BP	RZ
Writing (review and editing)		RZ, BS, JW, BP
Visualization		RZ
Funding acquisition	JW, BP	RZ, BS

Chapter 3

Title: Informal interpreting in general practice: Comparing the perspectives of general practitioners, migrant patients and informal interpreters.

Researchers involved: Rena Zendedel (RZ), Barbara Schouten (BS), Julia van Weert (JW), Bas van den Putte (BP)

	Limited Contribution	**Substantial Contribution**
Conceptualization (main idea, theory)	JW, BP	RZ,BS
Methodology (design, operationalization)	JW	RZ, BS, BP
Data collection		RZ
(Statistical) Analysis	BS	RZ
Writing (original draft preparation)	BS, JW, BP	RZ
Writing (review and editing)		RZ, BS, JW, BP
Visualization		RZ
Funding acquisition	JW, BP	RZ, BS

Chapter 4

Title: Informal interpreting in general practice: Expectations of interpreters' roles in relation to patients' perceived control and trust.

Researchers involved: Rena Zendedel (RZ), Bas van den Putte (BP), Julia van Weert (JW), Barbara Schouten (BS), Maria van den Muijsenbergh (MM)

	Limited Contribution	**Substantial Contribution**
Conceptualization (main idea, theory)		RZ, BS, JW, BP
Methodology (design, operationalization)		RZ, BS, JW, BP
Data collection		RZ, MM
(Statistical) Analysis		RZ, BS, BP, JW
Writing (original draft preparation)	BS, JW, BP	RZ
Writing (review and editing)	MM	RZ, BS, JW, BP
Visualization		RZ
Funding acquisition	JW, BP	RZ, BS

Chapter 5

Title: Informal interpreting in general practice: Are interpreters' roles related to perceived control, trust and satisfaction?

Researchers involved: Rena Zendedel (RZ), Barbara Schouten (BS), Julia van Weert (JW), Bas van den Putte (BP)

	Limited Contribution	**Substantial Contribution**
Conceptualization (main idea, theory)		RZ, BS, JW, BP
Methodology (design, operationalization)	JW, BP	RZ, BS
Data collection		RZ
(Statistical) Analysis		RZ, BS, BP, JW
Writing (original draft preparation)	BS, JW, BP	RZ
Writing (review and editing)		RZ, BS, JW, BP
Visualization		RZ
Funding acquisition	JW, BP	RZ, BS

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Rena Zendedel, juni 2017

Curriculum Vitae

Rena Zendedel was born on the 30th of June 1986 in Baku, Azerbaijan. After migration to the Netherlands in 1997, Rena completed her secondary education in IJsselstein/ Nieuwegein and received a bachelor degree in Language and Culture Studies at the Utrecht University.

After graduating cum laude in Communication Studies at the Utrecht University in 2010, Rena worked at the VU University Medical Centre, Utrecht University and the Van der Hoeven Forensic Psychiatric Clinic on different projects, all about intercultural communication, multiculturalism and diversity research. Following her research interests, she wrote a PhD project proposal for the NWO Graduate Program competition of the Amsterdam School of Communication Research (ASCoR). Her PhD proposal about interpreter-mediated communication in general practice was selected for funding in 2013. She started conducting her PhD research in the same year. After completing her dissertation, Rena returned to Utrecht University, now as a lecturer in intercultural communication. She teaches different courses in the bachelor of Communication and Information Sciences and the master in Intercultural Communication. Rena is eager to continue working in the research area of health communication, intercultural communication, and migration studies.

Publications

Zendedel, R., Schouten, B. C., van Weert, J. C. M., & van den Putte, S. J. H. M. (2016). Informal interpreting in general practice: Comparing the perspectives of general practitioners, migrant patients and family interpreters. *Patient Education and Counseling*, *99*(6), 981-987.

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Wolffers, I. N., Zendedel, R., Jaspers, D., & Ham, L. T. (2012). Dadels en McDonalds: moeders op islamitische basisscholen over (on)gezond eten en bewegen.

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When health care providers and migrant patients do not share a common language, informal interpreters - usually family members of the patients - come along to bridge the language gap. While patients usually feel comfortable with having an informal interpreter, this type of interpreter-mediated communication is shown to be problematic for several reasons. First, the different and sometimes incompatible roles of informal interpreters lead to frictions between the patient, the provider and the interpreter. Also, trust and control issues are at stake. This dissertation takes an integrative approach to studying informal interpreter-mediated communication in general practice (GP), ultimately aiming at improving this type of medical interaction. Using mixed research methods, this dissertation provides a better understanding of the patients', GPs' and informal interpreters' perspectives on interpreters' roles, trust in the interpreter, perceived control, and satisfaction with the consultation.