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Informal interpreting in Dutch general practice

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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 (Deville, 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?