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Informal interpreting in Dutch general practice

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Chapter 2

The Patients' Perspective

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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 medical 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 ($M_{age} = 54$ 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
<p>Acculturation level</p> <ul style="list-style-type: none"> • To what extent do you feel at home in the Netherlands? • Which languages do you speak? • How important is your religion for you? 	<p>Trust</p> <ul style="list-style-type: none"> • 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? <p><i>(idem for other dimensions)</i></p> <ul style="list-style-type: none"> • How much trust do you have in the interpreter?
<p>Relationship with the GP</p> <ul style="list-style-type: none"> • For how long have you known your GP? • How is the relationship with your GP? 	<p>Control</p> <ul style="list-style-type: none"> • 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?
<p>Relationship with the interpreter</p> <ul style="list-style-type: none"> • Which people accompany you to the GP consultation? • Do you have a preference for one of the people you just mentioned? 	<p>Interpreter's role</p> <ul style="list-style-type: none"> • 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? <p><i>(idem for other roles)</i></p>

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 & Schönplflug, 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 & Doornik, 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.