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Informal interpreting in Dutch general practice

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Publication date

2017

Document Version

Other version

License

Other

[Link to publication](#)

Citation for published version (APA):

Zendedel, R. (2017). *Informal interpreting in Dutch general practice*.

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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 from 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-mediated 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.