Informal interpreting in Dutch general practice

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Chapter 3

Comparing the Perspectives of Patients, GPs and Informal Interpreters

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Abstract

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

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

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

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

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

Introduction

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

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

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

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

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

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

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

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

Method

Participants

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

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

Table 1. *Respondent Characteristics*

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

Procedure

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

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

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

Data analysis

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

Results

Communication process

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

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

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

Box 1. *Quotes Illustrating the Main Results*

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

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

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

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

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

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

Interpreters' role

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

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

Control dynamics

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

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

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

Trust in informal interpreters

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

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

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

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

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

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

Discussion and conclusion

Discussion

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

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

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

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

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

Study limitations and suggestions for further research

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

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

Conclusion

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

Practice implications

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

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