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

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ABSTRACT

Objective: To explore differences in perspectives of general practitioners, Turkish–Dutch migrant patients and family interpreters on interpreters' role, power dynamics and trust in interpreted GP consultations.
Methods: 54 semi-structured in-depth interviews were conducted with the three parties focusing on interpreter's role, power and trust in interpreters.
Results: In line with family 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 disempowered when the family interpreters performed the advocacy role. Family interpreters were trusted by patients for their fidelity, that is, patients assumed that family interpreters would act in their best interest. GPs, on the contrary, mistrusted family interpreters when they perceived dishonesty or a lack of competence.
Conclusion: Opposing views were found between GPs on the one hand and family interpreters and patients on the other hand on interpreter's role, power 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 family interpreting, such as conflicting role expectations, and be trained to be able to call on professional interpreters when needed.

1. Introduction

Due to worldwide migration the language barrier between migrant patients and healthcare providers has become a daily constraint in medical practice [1]. Professional interpreters are provided in some countries to bridge the language gap between patients and healthcare providers [2]. In Dutch general practice the language barrier is often tackled with the help of family interpreters [3]. 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 family interpreters was also prevalent before these cuts [3]. Especially Turkish–Dutch migrant patients often bring a family member to the general practitioner (GP) to facilitate the communication, in up to 80% of GP consultations [4]. Despite their wide use, family interpreters can contribute to miscommunication by providing incorrect translations [1], omitting relevant information [5] and following their own agenda [6,7]. Therefore, communication via family interpreters is not always optimal and might result in misunderstandings and conflicts between the three interlocutors [8,9], which in turn could lead to adverse health outcomes [10].

A recent review of the literature has identified three important issues for the study of interpreting in medical settings, that is, interpreter's role, power dynamics in the medical interaction and trust in the interpreter [11]. 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 family interpreters [12], while GPs do not [13]. However, we miss an overarching investigation of the perspectives of all three interlocutors (i.e. GPs, patients and family interpreters) focussing 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 [9]. Thus, the aim of this study is to uncover differences in perspectives of GPs, patients and family interpreters regarding interpreter's role, power dynamics and trust in interpreted GP consultations.

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First we will explore the different perspectives regarding the role of the family interpreter. The literature has shown that family 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, they could also provide cultural information to patients and providers and thus act as *cultural brokers* [14]. When acting as *caregivers*, family interpreters provide extra medical information about the patient and keep track of prescribed medication [15]. When performing the role of the *advocate*, family interpreters advocate on behalf of the patients, for instance by exaggerating the medical symptoms to get a referral to the hospital [16,17]. Considering the great variety of roles the family interpreter could perform and because patients, providers and family 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: what are the differences in perspectives of GPs, family interpreters and patients regarding the role of the family interpreter?

Second, the literature has investigated the influence of interpreters on power 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 [18]. Previous research among GPs has shown that family interpreters often shift the power balance in the patient's favor leaving the providers feeling out of control [8,9]. However, these findings have to our knowledge not yet been verified among patients and family interpreters, who could have a different perspective of the influence of the interpreter on power dynamics. Therefore, to fully understand the issue of power dynamics in interpreter-mediated GP consultations from all three perspectives, we propose the second research question: what is the difference in perspectives of the three interlocutors on power 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 [19,20]. Previous research focussing on patients' and providers' trust in family interpreters has shown that patients overall trust the family interpreters, because of their lengthy intimate relationships [12,19]. Providers, on the contrary, have little trust in family interpreters as they have concerns about family interpreter's linguistic competence and neutrality [13]. We apply the four dimensions of trust proposed by Hall and colleagues [21] 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 [22], 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 final research question is: what are the differences in perspectives of GPs, patients and family interpreters regarding the four dimensions of trust?

2. Method

2.1. Participants

To expand on an initial study on patients' perspectives about interpreter-mediated communication in general practice (see [23]), for this study family 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 [24] and consequently visit the GP more often with family interpreters [4]. We used interview data of 21 Turkish–Dutch women who visited their GP with a family interpreter at least once a year (see [23] for a more elaborate description of the data collection of this sample). In addition, seventeen adult family 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 family interpreters with patients of Turkish origin. Eventually, we have interviewed a heterogeneous sample of sixteen GPs (i.e. males and females, 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).

2.2. Procedure

In line with participants' preferences, most interviews with patients and family 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 [23] to develop similar topic-lists for the interviews with GPs and interpreters. To explore

Table 1
Respondent characteristics.

	GPs ($n = 16$)	Patients (n = 21)	Family interpreters (n = 17)
Gender	9 female 7 male	All female	10 female 7 male
Mean age	48 years (range 30–64)	53 years (range 42–70)	26 years (range 19–47)
Mean years working as GP	16 years (range 2-36)	n.a.	n.a.
Visiting the GP with:	n.a.	Adult children: $n = 16$ Husband: $n = 3$ Other kin: $n = 2$	Parents: $n = 12$ Grandparents: $n = 3$ Wife: $n = 2$ Other kin: $n = 3$
Mean duration of the interviews	67 min	56 min	51 min

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