Communication study

Turkish migrant GP patients' expression of emotional cues and concerns in encounters with and without informal interpreters

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ABSTRACT

Objective: The aim of this study was to compare patients' expressions of emotional cues and concerns, and GPs' responses during consultations with and without informal interpreters. Furthermore, informal interpreters' expression of emotional cues and concerns and their responses were examined too.
Methods: Twenty-two audiotaped medical encounters with Turkish migrant patients, eleven with and eleven without an informal interpreter, were coded using the Verona Coding Definitions of Emotional Sequences (VR-CoDES) and the Verona Codes for Provider Responses (VR-CoDES-P).
Results: In encounters with informal interpreters, patients expressed less emotional concerns than in encounters without informal interpreters. Only half of all patients' cues is being translated by the informal interpreter to the GP. Furthermore, 20% of all cues in encounters with informal interpreters is being expressed by the interpreter, independent of patients' expression of emotions.
Conclusion: The presence of an informal interpreter decreases the amount of patients' expression of emotional concerns and cues. Furthermore, a substantial amount of cues is being expressed by the informal interpreter, corroborating the often-made observation that they are active participants in triadic medical encounters.
Practice implications: GPs should be trained in communication strategies that enable elicitation of migrant patients' emotions, in particular in encounters with informal interpreters.

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1. Introduction

A substantial amount of medical encounters takes place between healthcare providers and patients of different cultural, linguistic and ethnic background. In the Netherlands, first and second-generation migrants make up 21% of the total population (about 3.5 million citizens), over half of whom are from so-called non-Western countries [1]. As it has been estimated that around fifty percent of non-Western migrants has difficulty communicating in Dutch with their health care provider [2], the fundamental need of these migrant patients to both understand and feel understood [3] is at severe risk of not being adequately fulfilled. Previous research has indeed shown that medical consultations with migrant patients are more frequently characterized by poor communication and misunderstandings than those with patients

who share their physicians' linguistic (and cultural) background (e.g. [4–10]). As a consequence, they report lower levels of understanding and recall, adhere less to prescribed treatment regiments, and are less satisfied with received care as compared to patients belonging to the dominant culture [4,11–13].

The quality of affective communication seems to be particularly challenged in consultations with migrant patients [14]. Several studies have revealed that both physicians and migrant patients behave less affective toward each other; they conduct less social talk, show less empathy and are less emotionally engaged with each other than physicians and patients belonging to the dominant culture [5,6,15,16]. The less affective relationship between physicians and migrant patients not only hinders the establishment of rapport, but also decreases the chance of reaching a common understanding of the patient's health complaints and hence, delivering adequate treatment.

One way to tackle (affective) communication barriers between migrant patients with insufficient language proficiency and their healthcare providers is to make use of interpreters. Although professional medical interpreting and translation services have been organized by the Dutch government since 1976, due to

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budget cuts this free provision has ceased to exist from 2012. Hence, the use of informal interpreters such as family members and friends, which is already common practice in general practice [2], is likely to increase even more. Despite documented negative effects of informal interpreting on the accuracy and quality of communication (e.g. [17–19]), a few studies have pointed to several advantages of using informal interpreters. For instance, migrant patients might have increased willingness to talk about sensitive and emotional issues in the presence of an informal interpreter as compared to professional ones, because they trust them more [20,21]. Informal interpreters themselves have indeed reported to be able to adequately convey the patient's emotions to healthcare providers, because they have firsthand knowledge of their relatives' medical problems and the contexts in which they occur (e.g. [22]).

As there is at present a lack of knowledge about whether informal interpreters are indeed capable of bridging the often-observed affective communication barrier between migrant patients' and their healthcare providers, this exploratory study compared consultations between migrant patients with and without informal interpreters in primary care. As patients' and physicians' expressions of and responses to emotions are a core element of many medical encounters and have been associated with positive health outcomes [23], the main purpose of this observational study was to compare the verbal expression of patients' emotions between encounters with and without informal interpreters, as well as GPs' responses to these expressions, by making use of the Verona Coding Definitions of Emotional Sequences (VR-CoDES), a consensus based coding system to identify patients' expressions of emotional distress and healthcare providers' responses to their expressions [24,25]. It has been developed from medical consultations and successfully applied to diverse health contexts, among which hospital settings, dental settings and primary care. We also investigated informal interpreters' expressions of emotions and their responses to patients' emotional expressions. The focus in this study was on migrant patients from Turkish origin, because they are the largest ethnic minority group in the Netherlands and visit their GP significantly more often compared to the Dutch population [26].

2. Method

2.1. Sample and procedure

Analyses were based on 22 transcripts of audiotapes derived from a larger database that included 120 audio recorded interactions with eleven GPs (seven men, four women) from six GP practices in three multicultural cities in the Netherlands (see [27] for a detailed description of the sample). Inclusion criteria were that patients had an appointment with the GP for themselves and were able to read in Dutch or Turkish or were accompanied by someone who could read in Dutch or Turkish. After obtaining informed consent by a research assistant in the waiting room, all patients filled out a pre-consultation questionnaire, which was available in Dutch and Turkish.

For the purpose of the present study, all available encounters from our database that involved Turkish patients accompanied by an informal interpreter (i.e. family members or acquaintances the patient took along to the consultation to help them communicating with the GP) were included ($n = 11$), allowing for a culturally homogenous group. A comparison sample ($n = 11$) of Turkish patients visiting the GP alone was established by matching the groups on age and seriousness of the health problem, because differences in the expression of emotions could be due to these factors [28]. Matching was done by securing that the two groups did not differ significantly on these variables. The Turkish

fragments in the transcripts were written in Turkish and translated into Dutch by a Turkish bilingual research assistant. The ethical committee of the Amsterdam School for Communication Research has approved the study.

2.2. Measures

2.2.1. Patients' questionnaire

Ethnic background of the patients was based on the ethnicity definition of the Dutch Central Bureau of Statistics; respondents born in Turkey and/or having at least one parent born in Turkey were categorized as Turkish. Other variables measured were gender, age, educational level (1 = elementary school, 5 = higher vocational level/university), frequency of GP visits during the last year, perceived general health and worries about the current health complaint. The two latter variables were both assessed with a single item on a 5-point Likert scale, the first ranging from 1 ('excellent perceived general health') to 5 ('bad perceived general health'), the second ranging from 1 ('not worried at all') to 5 ('extremely worried').

2.2.2. GPs post-consultation questionnaire

After each consultation the GPs filled out a short questionnaire, assessing their perception of the seriousness of the patient's health problem, the extent to which the GP knows the patient, and the extent to which psychosocial problems during the consultation were present. All variables were measured with a single item on a 5-point Likert scale, ranging from 1 ("not at all") to 5 ("very").

2.2.3. Communication behavior

2.2.3.1. Patients' communication behavior and GPs' responses. Patients' expressions of emotional distress are coded as "cues" or "concerns". Concerns are clear and unambiguous expressions of unpleasant emotions that are explicitly verbalized, while cues are verbal or nonverbal hints suggesting an underlying unpleasant emotion that lacks clarity (VR-CoDES [24]). Cues are divided in seven subcategories in the protocol: cue a refers to vague or unspecified words to describe emotions, cue b refers to verbal hints to hidden concerns, cue c refers to words or phrases which emphasize physiological or cognitive correlates of unpleasant emotional states, cue d refers to neutral expressions that mention issues of potential emotional importance which stand out from the narrative background, cue e refers to a patient elicited repetition of a previous neutral expression, cue f refers to a nonverbal expression of emotion, and cue g refers to a clear expression of an unpleasant emotion which occurred in the past. In this study, the nonverbal cue f is left out of the coding process because of the use of audiotapes. Table 1 provides examples of cues/concern from our transcripts.

Table 1
Examples of cues and concern.

Cues/concern	Examples from transcripts
Concern	*"I am really scared, if it gets worse, that is big problem for me."* (patient)
Cue a	*"But this time, she is not satisfied, the pain has not gotten less."* (interpreter)
Cue b	*".once totally floored of it [pain]. That's not normal, isn't it?"* (patient)
Cue c	*"Normally, she never cries, but this morning, she even had tears in her eyes."* (interpreter)
Cue d	*"I really have a problem with the wife; arguments, fighting."* (patient)
Cue e	*"Can she describe painkillers for my knees?"* (repeated question of patient)
Cue g	*"I have been really angry, you understand?"* (patient)