Mediated communication

in bi- and multilingual health in Korea:
Perceived roles of healthcare interpreters in Korea

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Abstract

It was only in 2008 that the concept of community interpreting was introduced in Korea, and 2009 when that of healthcare interpreting was introduced (Kwak, 2010). In addition to the short history of healthcare interpreting in Korea, the fact that the majority of those who currently provide healthcare interpreting in hospitals are not professional interpreters raises questions about the quality of healthcare interpreting services in Korea. Ozolins' (2000) continuum of responsiveness to need places healthcare interpreting in Korea at the *ad hoc* stage with some instances of generic services in evidence. Due to a dearth of research, little is known about current practices. However, since Korea is witnessing a rapid increase in the number of migrants, it is essential that initiatives be taken to move closer to "comprehensiveness" in healthcare interpreting.

Based on observations undertaken during data collection at Soonchunhyang University Hospital[1] in Korea in August 2017, the role of healthcare interpreters is ill-defined and the interpreting was often undertaken by bilingual hospital staff who are playing dual roles. For example, bilingual nurses serve as interpreters when needed. The Korean healthcare system is essentially private and therefore inevitably commercialised. Hospitals prefer to hire bilingual staff rather than professional interpreters for the sake of cost-effectiveness (Kwak, 2010). This has resulted in a broadening of the role of the healthcare interpreter to encompass the role of medical coordinator or vice versa. Under the circumstances, clearly defining roles will serve as a stepping stone towards developing tailored training, an accreditation system, and comprehensiveness in the provision of healthcare interpreting in Korea.

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[1] The Administration of the hospital requested that the name of the hospital be included in the thesis

Statement of Originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

(Signed)_____   **Date:**_____09/12/17_____

Chapter 1. Introduction

In the late 1990s, despite being recognised as a pervasive practice and the focus of a relatively new discipline, the scope of community interpreting was ill-defined (Roberts, 1997). Roberts described community interpreting as a form of interpreting that takes place where communication is used as a tool to reach a common goal between speakers and listeners or to bring about outcomes which can affect an individual's welfare (ibid, 1997). Definitions evolved following this early period, to become more explicit, moving towards defining it as interpreting that occurs when interpreters are involved in mediating communication in settings such as the courtroom or hospital, that is, non-conference interpreting (Kalina, 2011). However, South Korea is at the stage where there is no consensus on the definition of community interpreting, especially healthcare interpreting, and is therefore still lagging behind in this field.

The first medical tourists started arriving in South Korea in the year 2000, but it was not until 2009, when the Korean Government launched their medical tourism program in earnest (Jeong, 2010), that the first healthcare interpreting class opened with government support. Since 2009, a total of 901,470 foreign patients have come to Korea for treatment, and the average annual rate of increase has been 34.7% over the past six years (Korea Tourism Organization, n.d.). To keep up with the development of medical tourism, the Korean government has attempted to train medical interpreters since 2009 (Kwak, 2010) as it has perceived the need to ensure adequate communication between medical personnel and medical tourists of non-Korean-speaking background. In 2016, the government ran the first healthcare interpreting accreditation test (Kwak, 2017).

These developments in Korea are of personal relevance to me and have led to my desire to examine the provision of healthcare interpreting in the Korean context following my personal experience as a healthcare interpreter at a university hospital in Seoul. Before I interned at the hospital, I took a number of interpreting and translation classes, and finally a specialised community interpreting class, which was offered in 2013 for the first time at my university. This heightened my interest in interpreting and led me to want to put theory into practice. The community interpreting class focused mostly on healthcare interpreting, and this was a new concept to me, unlike conference interpreting. I was taught that in healthcare settings interpreters should consider the power imbalance between the healthcare practitioners and non-Korean speaking patients when performing their interpreting, and due to the different status of the participants in the communication, the interpreters' expected roles are different to those of the

conference interpreter, the most prominent and highly respected field of professional practice in the Korean context. The roles that I was learning about for healthcare interpreting were in direct opposition to the role of the conference, interpreter whose main role is most commonly conceived of as the 'invisible' deliverer of meaning (Angelelli, 2004), due to the fact that the interpreting is undertaken in a booth, and therefore the interpreter has minimal physical contact with the other participants in the communication. Even though the main goal of interpreting in a community setting is also conveying the meaning of an utterance in one language into another language, the interpreter's role stretches far beyond this language transfer function. Furthermore, the issue of the visibility of interpreters has been brought into the limelight. According to Davidson (1998), the way interlocutors in community settings perceive an interpreter's role varies. For example, healthcare practitioners see the interpreter as a human instrument, while patients see the interpreter as another participant in the conversation (ibid). Davidson (2001) later found that community interpreters serve as gate keepers for the less-dominant language speakers: in other words, framing community interpreters as active participants in interpreted interactions in communication settings (Angelelli, 2003, Bolden, 2000, Davidson, 2001, Metzger, 1999, Wadensjo, 1998).

Wadensjö (1998) also highlighted the need for community interpreters to have good social skills, reflecting Roy's (2000) argument that the community interpreter is responsible for ensuring that communication flows smoothly. These findings show community interpreters are expected to play roles which go beyond the hitherto expected role of simply conveying information.

In addition to an understanding of their role, interpreters without an understanding of the theoretical underpinning of community interpreting, especially the sociolinguistic and pragmatic aspects of healthcare interpreting, may not be able to manage potential conflicts with the minority party (normally the non-dominant-language-speaking patients). Indeed, when I interned at the hospital, I found that there were very few trained healthcare interpreters working on-site, and I occasionally witnessed poorly managed conflicts and problems due to ineffective communication, as well as a lack of skills and understanding of the characteristics of community interpreting. I realised that the absence of appropriate training may have been one of the factors contributing to the poor communication. One conflict that I remember vividly even now was when a female patient with a specific cultural background asked a staff member to change her doctor to a female doctor. The staff member tried to explain that there was no on-duty female doctor and persuaded the patient to see a male doctor. If the staff member had had an

understanding of different cultural norms, this issue could have been more effectively resolved instead of leading to distress for the patient.

My subsequent postgraduate study, both in Korea and in Australia, further developed my understanding of community interpreting and in particular healthcare interpreting. There is surprisingly little information in the Korean literature on community interpreting that focuses on building the theoretical foundations for practice. Based on my personal experience in interpreter training in Korea, there is a lack of emphasis on theory in the education of interpreters. I remember many students complaining about learning theory in their programs in Australia because they did not understand or appreciate the theoretical approaches to interpreting studies, even though the lecturers emphasised the links between theory and practice. The view that theory is not important to interpreting practice is reinforced by the two renowned graduate schools of interpretation and translation in Korea, which focus on developing practical skills for conference interpreting rather than on informing practice through the teaching of theory. And given the high status of conference interpreting as opposed to community interpreting, this was a pervasive pedagogical model not only in Korea, where most students aspire to become professional conference interpreters, but elsewhere around the world (Angelelli, 2004). Therefore, many interpreter-training organisations and interpreting courses provide conference interpreter training using this model. However, as I witnessed healthcare interpreters with and without professional training, I was interested to better understand the relationship between study that incorporated theoretical learning and the quality of performance, along with the level of satisfaction of the service users. To this end, the first step in this journey was to study the status of healthcare interpreting in Korea.

I set out to explore the occurrence of linguistic barriers, such as misinterpreting, omissions, or misunderstanding, between practitioners and their patients in face-to-face, interpreter-mediated communication that is likely to have an impact on health outcomes. Since effective communication has been demonstrated empirically to make a significant difference to health outcomes (Slade, Woodward-Kron, Stein-Parbury, Scheeres, Widin, Smith & Macqueen, 2011), it is important to clearly understand how interpreting is being organised and conducted in the Korean context, given that the majority of foreign patients coming to Korea for treatment do not speak Korean (Kwak, 2010).

This thesis reports on a case study conducted in a university hospital in Seoul, where the International Healthcare Center provides interpreting services for foreign patients. Following this introduction (Chapter 1), I review the literature relating to community interpreting and more specifically healthcare interpreting (development, role, and status in particular) (Chapter 2). In

Chapter 3, the methodological approach is outlined, and the methods, instruments and procedures described, followed by a report on the results of the study (Chapter 4). Three surveys and two interviews were conducted for the purpose of collecting data from the key participants in interpreter-mediated communication in the medical centre. In the discussion (Chapter 5) and Conclusion (Chapter 6) I summarise the findings and discuss how they address the research aims and questions, outline the limitations of the study and suggest further research avenues which can potentially be used to improve the use and training of interpreters in healthcare in South Korea.

Chapter 2. Literature Review

The nature of interpreting varies depending on the setting in which it occurs (Mikkelson, 2009). And as Interpreting Studies has evolved in tandem with the move to greater professionalism among interpreters, the attention of interpreting scholars has turned to include the examination of interpreting in different community settings and, of particular interest here, interpreting in medical domains.

In this context, unlike Australia, New Zealand, Scandinavia, the United Kingdom or the United States of America, where the practice of community interpreting in public and private institutions has a comparatively long history, South Korea has only recently acknowledged the importance of providing interpreters to assist speakers of languages other than Korean in their day to day interactions with service providers. Since the number of immigrants and foreign residents are increasing in Korea, it is vital that Korea addresses the need to provide access to essential services.

In this chapter, I will review the literature relating to interpreting practice and the research into interpreting generally and more specifically into the roles of the interpreter, especially in the healthcare context. For the purposes of a comparison between countries which have well-established interpreter services and also a body of research in community interpreting and the Korean experience, I will particularly focus on the contrast between the Australian experience and that of Korea as the two countries in which I have studied and worked. Through this literature review, I will identify where our knowledge and experience of healthcare interpreting in Korea is limited in order to demonstrate the need for research into this context of professional practice.

2.1. Overview of interpreting as a professional practice

Historically, and until fairly recently, interpreting was considered a translational activity in the spoken medium (see, for example, Holmes-Toury, 2000; Pöchhacker, 2016). Even though interpreting activities have been documented as far back as the time of Ancient Egypt (e.g. Takeda & Baiggori-Jalòn, 2016), establishing histories of interpreting as a profession and the acknowledgement of interpreting as a professional activity commenced as late as the twentieth century (Harris, 1995; Angelelli, 2004; Pöchhacker, 2016). Currently, interpreting as professional practice takes place at an international, national and interpersonal level (Crezee, 1998). At the international level, interpreters play a crucial role in the communication between government representatives when they discuss economic and

cultural exchanges in the context of world trade or tourism, for example (Clark, 2009). Interpreting at the national level is less evident, but according to Crezee (1998) it includes interpreting for different ethnic groups. On the other hand, interpreting at the interpersonal level involves communication between individuals such as a doctor and a patient, enabling people with low language proficiency access to equal opportunities (ibid, 1998).

Each level of interpreting carries differential status. At the international level, interpreting has been a higher status and more familiar form of interpreting undertaken most frequently in international scientific fora, or for the purpose of negotiation, such as the interpreting done in the aftermath of after World War I, when interpreters were recruited to enable communication between countries during the founding of the League of Nations (Pöchhacker, 2016). In this context, interpreters provided simultaneous interpreting while remaining invisible as they were located in a soundproof booth – a dominant form of interpreting in this type of international meeting. The international and high-status context in which conference interpreting took place lent status to the interpreters, and this branch of the profession continues to enjoy high status and favorable working conditions. For this reason, conference interpreting has, until recently, been the main focus of systematic interpreter training in specialist schools, as well as being the object of a large body of research into the cognitive aspects of this practice. Court interpreting, often the first domain of interpreting in the community to be established due to constitutional requirements of signatories to the International Declaration of Human Rights, emerged in the 1970s and 1980s. It was expected that the 1990s would be the time of medical interpreting and social service interpreting (Harris, 1995).

Even though the fundamental purpose of all interpreting is to enable two or more individuals to communicate effectively, as indicated above, consecutive or simultaneous interpreting performed for heads of state or high-profile international scientific and trade meetings has held the most attention from scholars. One of the reasons for this may be that dialogue interpreting, needed in everyday communication between majority language users and less dominant language users, has been regarded as less important (Angelelli, 2004) and has lower status. Consequently, there are few full-time positions offered to community interpreters in small or large institutions, such as hospitals (Roberts, 1997) and the working conditions for community interpreters have historically been less favourable than those of conference interpreters. Even in the context of New Zealand which has well established interpreter services, an interview with Kim de Jong, the manager of the Counties Manukau Health Interpreting and Translation Service in New Zealand, highlighted that there are only 21 interpreters who are permanent employees, with all others employed as casuals

despite providing high demand language services in up to 240 interpreting assignments per day being utilised on an almost full-time basis (Magill & De Jong, 2016).

Poor job security could, therefore, be one of the reasons for many interpreter training organisations to only provide conference interpreting courses even now (Roberts, 2004), and might have contributed to the generalised use of non-professional interpreters (including family members, or bilingual staff of an organisation) providing language services outside of the conference interpreting sector. Furthermore, Antonini, Cirillo, Rossato, and Torressi (2017) note that adequate linguistic services are still not always provided to meet demand, thereby hindering visitors from abroad having access to a wide range of services. Consequently, the number of non-professional translators and interpreters has increased, and these interpreters undertake multiple roles in different settings (ibid, 2017).

The development of interpreting services for government and private sector institutions generally evolves in response to need. Based on an extensive and historical world survey, Ozolins (2000) has mapped the evolution of how different countries respond to need along a 'continuum of responsiveness' (see Figure 1 below). According to this spectrum of response to diverse linguistic needs, the first stage is a neglect to provide any resources for communication between individuals speaking a language other than the mainstream language of the country and the providers of services in those countries. Confronted by the consequent communication barriers, some institutions find *ad hoc* interpreters – family members, friends or members of the language community – to interpret until generic language services are set up. This *ad hoc* stage is the second on the spectrum. Some countries have achieved a third stage, which is the provision of generic services without the required specialisations for specific institutions, such as the courts or hospitals. The final stage of response, which is comprehensiveness of services, witnessed in Australia, for example, is attained when there are qualifications, training, professional associations and a wide range of provision across different institutions (Ozolins, 2000).

No services   Ad hoc services   Generic services   Comprehensiveness

(Ozolins, 2000)

Figure 1 The spectrum of responsiveness to Translation & Interpreting needs

The results of another study from Ozolins (1998) comparing language service provision in different countries also explains how they have addressed interpreting and translation issues. His research is a meaningful resource especially in relation to South Korea since the country is lagging behind other countries in terms of community interpreting service provision, especially in healthcare settings, and exploring other countries' pathways will give an insight into the research projects, interpreter training, and developing policies needed in the Korean context.

Back in the late 1970s and early 1980s, interpreting or translation provision in local health or education was facilitated by non-professionals or employees playing dual roles. Ozolins' findings show that 'the role of the interpreter was one of "helper" in a situation of no organised response to need' (Ozolins, 1998, p.102). The helper was inevitably a member of the language community of the service users with better English than others but without any qualifications or formally assessed ability. Government sponsored training started from the early 1980s, and since then the UK has defined the roles of interpreters and witnessed professional interpreting service provision (ibid, 1998). The USA, UK, Canada and Australia are all countries of immigration and have experienced problems in relation to the provision of interpreting. Even though the responses from each of these countries has been quite different, as Australia was showing more government-led problem solving, they all had opportunities to develop interpreter training programs, and became countries where only certified interpreters should be performing legal or medical interpreting. However, there were other countries, such as Israel, where interpreting was used for external needs, with no system of certification for interpreters for local language needs and limited interpreter training. Japan was also experiencing a growing number of immigrants into the labour force, but did not recognise their status and therefore lagged behind in providing adequate services.

Surprisingly, in the case of Hong Kong, where both English and Chinese were accepted as official languages, a decline in the need for interpreting services from the government level was witnessed in the initial stages in late 1990s. However, translation needs arose starting from the IT sector, which led to strong interpreting and translation education, including courses at Bachelor's and Master's levels, and finally trained interpreters working both in the private and public sectors (Ozolins, 1998). Even though the government chose to remain at a 'no services' level, the needs from service users inevitably brought the country to experience the first stages of response.

Therefore, countries where no provision is made for communication with multilingual populations are becoming less common (Ozolins, 2000), but the number of languages in public or

private sector institutions, for example in healthcare organisations, varies. A large number of countries, including Australia, have also evolved beyond *ad hoc* interpreting and generic services to the provision of professional community interpreting services. Those countries which fit within Ozolins' (2000) category of 'comprehensiveness' no longer accept non-professional and unqualified interpreters for communication in specific community interpreting settings such as police, court or healthcare, except in emergencies when no qualified interpreter in that language is available. The provision of language services in a broader range of languages is becoming common due to increased migration around the world. These countries usually also have one or more professional associations of translators and interpreters.

Professional associations of interpreters have existed since the 1950s when (conference) interpreting started to gain professional status, beginning with the Association Internationale des Interprètes de Conférence (AIIC) in France and followed by The American Association of Language Specialists (TAALS) in 1957 in America. After the National Association of Judicial Interpreters (NAJIT) was established in the USA in 1978, many state and national level court and medical associations of interpreters, such as the International Medical Interpreters Association (IMIA) established in 1986, emerged. This association now has chapters in a range of countries including Japan (Angelelli, 2004). However, it should be noted that associations specifically for professional community interpreters are rare with a notable exception being The Critical Link, launched in 1992 which unites research and practice in community interpreting in an international association (ibid, 2004, p.12).

The advantages of a professional association are the sense of community and the setting of standards, usually based on a code of practice or code of ethics. The codes of ethics and codes of practice in many professional associations consider neutrality, invisibility and accuracy to be key features of interpreting (Hale, 2007; Slatyer, 1998). According to the AUSIT Code of Ethics and Code of Conduct, which regulate the professional conduct of members of the Australian Institute of Interpreters and Translators (AUSIT), professional conduct of interpreting, confidentiality, competence, impartiality, accuracy, clarity of role boundaries, and professional development are introduced as mandatory principles for interpreters to adhere to. It especially emphasises relations with other parties and the interpreting role in dialogue situations. Bell (1997) also stressed that an appropriate level of bilingual proficiency is a prerequisite for developing interpreting skills, followed by good background and cultural knowledge in both languages. Once these prerequisite skills have been acquired, specialised healthcare interpreting qualifications and training must

follow. In other words, to meet comprehensiveness of interpreting services as defined by Ozolins, interpreters should be trained to obtain the necessary skills.

However, before training can be developed, a clear definition or construct of interpreting is required in order to adapt and perform the skills correctly. There are many ways of classifying and defining interpreting in the literature. So far, we have been referring mainly to community interpreting and conference interpreting as two contrasting types and contexts of interpreting. Smirnov (1997), in fact, classified interpreting into two types:

- conference interpreting where an interpreter shows no physical presence and performs simultaneous interpreting in one language direction, and
- liaison interpreting where an interpreter shows physical presence and performs consecutive interpreting in two language directions.

Others (e.g. Gentile, Ozolins and Vasilakakos, 1996; Kalina, 2002; Mikkelson, 2009; Roberts, 1997) have identified parameters that can be used to describe interpreting, including: setting, mode, language direction and the interpersonal features of the interaction.

Gentile (1997) noted that clarifying the features of one type of interpreting which distinguish it from other forms of interpreting must come before defining it. He classified the different types of interpreting by the setting or environment where the interpreting takes place, such as health, law, social services, etc. Mikkelson (2009) has provided the most detailed categorisation of interpreting. In her definition, interpreting is classified according to mode. She identifies 14 different types of interpreting including simultaneous, consecutive, whispered (*chuchotage*), conference, seminar, escort, media, court, legal, business, medical (also called healthcare interpreting), educational, over-the-phone, and community interpreting. Though this classification confuses mode, setting and modality, notable here is that medical interpreting and community interpreting were considered as different types of interpreting. Some other authors include healthcare and court interpreting in community interpreting, demonstrating the different approaches to categorising the types of interpreting.

In this thesis, we are particularly interested in the medical context, and whether healthcare interpreting falls into community interpreting or not will not be discussed in detail as the aim of the research is to first define what healthcare interpreting is, and then to discuss the roles of healthcare interpreters in the Korean context. In the next section, we provide a review of interpreting in the medical domain as one of the 'types' of interpreting.

2.2. Interpreting in the medical context

Access to healthcare services is fundamental to an individual's welfare. Therefore, when quality communication cannot take place between healthcare practitioners and patients due to a language barrier, healthcare interpreters are required to mediate the conversation to bridge the communication barrier (Perez, 2012). Tackling any language barrier is directly linked to quality communication, which is crucial in healthcare settings, especially in the medical context, as there is strong evidence that the whole healthcare process is at risk when language barriers are not overcome (Leanza, 2005, Pöchhacker & Shlesinger, 2007), and many researchers, including Slade and her colleagues, have found that the quality of communication between practitioners and patients in a healthcare setting defines health outcomes (Slade et al., 2011). To be more specific, without the presence of interpreters or quality communication between patients, inappropriate diagnostic investigations (Angelelli, 2004), incomplete investigations (Hampers & McNulty, 2002), and lower rates of preventative interventions by physicians (Sarver & Baker, 2000) have been found to occur.

Healthcare interpreting is a tool 'to facilitate understanding and communication between people in the healthcare setting who speak different languages' (Beltran Avery, 2001, p.9). Healthcare interpreters are considered to be important intermediaries between powerful organisations and minorities, or healthcare providers and members of the community who seek their services. According to the NSW Government in Australia, 'Professional interpreters must be used in all patient care settings to promote effective communication, ensure quality and safety in patient care and to minimise potential adverse events.' (NSW Ministry of Health, 2017)

However, according to Smirnov, not every person who provides interpreting is a professional healthcare interpreter because non-trained bilingual individuals, typically bilingual friends and family members, staff or volunteers from the community, are often pressed into service as interpreters (Carr,1995, p.271), since healthcare interpreting is a relatively recent practice in community interpreting (Beltran Avery, 2001), and formal training courses and/or qualifications in interpreting and translation for the medical domain are very rare (Angelelli, 2004). The problem here is that healthcare interpreting takes place in settings where individuals discuss the most intimate or private issues in their everyday lives (Hale, 2007). In addition, according to Garber (2000), community interpreters and in the context of this thesis, healthcare interpreters, carry even more risk and more responsibility than conference interpreters, because, without an interpreter, the two main interlocutors cannot communicate and may not be able to correctly diagnose and treat a patient's illness. As the healthcare interpreter plays a crucial role in the healthcare setting, not only because confidential information is conveyed, but because the 'life of [the interpreter's]

client may become a price paid for a poor rendition' (Smirnov, 1997), it is crucial that the interpreter be professionally qualified. Professional interpreter training is one of many ways of reducing this risk. Because a number of the problems mentioned above are related to ethics, roles, and skills needed, training must be theoretically based and guide interpreters in applying the theory to practice. In addition, healthcare interpreters must receive training in anatomy, physiology and pathology (Crezee, 2013; Crezee, Mikkelson & Monzon-Storey, 2015, etc).

In addition to the lack of proper training, another ongoing challenge for the provision of qualified healthcare interpreters is the low status, poor pay and conditions that all community interpreters work under. The fact that they are not professionally trained is not the sole contribution to healthcare interpreters' low status. The status of an interpreter is often decided by the individual or group who uses the interpreting service (Angelelli, 2004). The most important means for an interpreter to earn recognition, though, is by building their skills through education (Roberts, 2000).

Interpreting delivered by professionally trained interpreters has nevertheless gained some status and better levels of remuneration in some contexts (Smirnov, 1997), but is still not on a par with conference interpreting.

Non-professionals in community interpreting, in other words those who did not undergo professional training, are classified as 'bilingual helpers', however, this point could be controversial since the factors that distinguish professional from non-professional interpreters are vague (ibid, 1997). There is a number of features that define a professional, such as the expectation that you will perform a certain job, with remuneration and recognised status, while adhering to specific rules such as a code of ethics. Considering this, non-professionals could be defined by the characteristics that are the contrary of those used to define professional interpreters. Despite this, in some cases non-professionals do not work in accordance with these defining features. For instance, non-professional interpreters can be paid when they are locally recruited as a staff member at a clinic, such as bilingual nurses who are trained on-site. They are hired as staff members, but interpreting can be part of their roles (Antonini et al., 2017). Further discussion on non-professional interpreting will follow in the next section.

Regardless of whether healthcare interpreters are professionals or not, it is true there is still room for improvement in healthcare interpreters' low status. Unfortunately, since interpreters are bound by their code of ethics to maintain confidentiality, there is little chance for healthcare interpreters to compare, discuss and develop their skills in the field through collegial discussions with their fellow interpreters (Gentile, 1995). Therefore, training in healthcare interpreting is

much needed not only to obtain recognition for the work that the interpreters do, but by bettering their skills.

As indicated above, research is one of the components of comprehensiveness (Ozolins, 2000) and despite inspiring less interest from scholars initially, non-professional interpreting has become a subject of interest after it was first recognised as an object of research by Harris when he coined the term 'natural translation': the translation done by a bilingual person who has no professional training (Antonini et al., 2017). Since then, Harris (1980), Malakoff and Hakuta (1991), and Shannon (1987, 1990) have described non-professional interpreting in the same terms as language brokerage or bilingual individuals performing interpretation. There is now a body of research into non-professional interpreting, especially in healthcare settings (Antonini et al., 2017). This is highly relevant to my study since many non-professional interpreters are currently working at hospitals in Korea providing interpreting services to patients who speak languages other than Korean.

In addition to the issues already outlined in relation to community interpreters and interpreter training, the ethical principle of neutrality and detachment is a major challenge, since there is an obligation to avoid aligning with any of the parties (Wadensjö, 1998, p.58). As mentioned earlier, it is inevitable that community interpreting is often conducted in a setting where there is a power imbalance between the main interlocutors. The provision of quality communication in the healthcare setting is directly linked to the protection of minorities. Based on the premise that minority language speakers cannot speak the majority's language and are unfamiliar with the system, there has been an argument that they are disadvantaged in gaining access to services. It follows that interpreters were at times considered as advocates who recognised the power imbalance and tried to close the power gap (Witter-Merithew, 1999; Garber, 2000). This brings us to a discussion of the role of interpreters working in healthcare settings.

Role is one of the ongoing debates in Interpreting Studies (Pöchhacker, 2016). There have been many studies conducted on interpreter-mediated discourse which have uncovered 'participatory' or visible roles undertaken by the interpreter. Many scholars (e.g. Angelelli, 2004; Beltran Avery, 2001; Kaufert and Putsch,1996; Roy, 2000; Rudvin & Tomassini, 2011; Slatyer, 1998; Wadensjö, 1998) have suggested that interpreting involves power and dominance, and since there is a large gap of culture and language between the main interlocutors, it is inevitable that an interpreter serves as a 'cultural broker,' or that she 'explains or mediates' when effective communication is hindered by different cultural or language backgrounds, as stated in the introduction to this thesis. Since interpreters understand the languages and cultures of both parties, they are expected to have

objective viewpoints towards each party and facilitate communication by relaying the intended meaning of the interlocutors (Beltran Avery, 2001). However, it is critical that interpreters understand the fine line between mediating language and culture, and role overload, where the interpreter risks replacing the professional health practitioner.

One of the challenges in interpreting, therefore, is navigating the complex understanding of role and how it varies according to the specific circumstances of the interpreter-mediated encounter. Since Roberts (1997) highlighted that defining role is a crucial component of professional interpreter training, many researchers including Pöchhacker (2000), Angelelli (2004) and Beltran Avery (2001), have undertaken research to examine the role of the healthcare interpreter in greater detail. However, there are many diverging views as to whether the interpreter should be seen as a language helper or advocate or merely a language aide. Some authors have examined the varying roles of an interpreter which commonly proposed an interpreter as 'helper', 'conduit', 'cultural broker', 'bilingual professional', or 'advocate', communication facilitator, and bicultural specialist (e.g. Beltran Avery, 2001; Roy, 2000; Mason & Ren, 2012). This supports the viewpoint of perceiving interpreters as active participants rather than invisible participants or mere 'translation machine'.

Following the seminal work of Wadensjö (1998), who identified two main functions of the interpreter as relaying and coordinating talk, other scholars (e.g. Llewellyn-Jones & Lee, 2013; Roy, 2000; Davidson, 2000 Angelelli, 2004; Slatyer, 1998) have concluded that the interpreter's role is not limited to conveying information, which is a traditional point of view, but that interpreters also need social skills to mediate the communication.

In the early days, it was common for family members, friends of a patient or bilingual staff to interpret communication between healthcare practitioners and patients (Pochhacker, 2000). This was normally *ad hoc* interpreting which involves no training or accreditation (Ozolins, 2000). Now many countries, such as Australia, no longer allow unprofessional interpreters undertaking interpreting services in a healthcare setting. However, in Korea, untrained bilingual hospital staff providing *ad hoc* interpreting services is still common, as seen in the findings of this study.

When conference interpreting was considered the only type of interpreting, it was common for an interpreter to be considered a message 'relayer' (Llewellyn-Jones & Lee, 2013; Wadensjö, 2002) and accuracy has been considered as the most important goal in interpreting by many interpreter organisations (Angelelli, 2004). Interpreting in a conference setting is commonly conducted in a booth which makes interpreters 'invisible' to speakers and audiences. Therefore, there is no room for both interlocutors and interpreters to consider other factors in accurate message delivery.

Healthcare interpreting, on the other hand, is conducted in face-to-face communication, where the meaning of individuals' messages varies depending on their linguistic or cultural backgrounds and the situation where the conversation is taking place.

Healthcare interpreters, are therefore 'visible' participants because the interpreting takes place in a face-to-face context, and interactive communication is the norm. In both cases, the main goal of interpreting is message delivery. Roy (2000) also pointed out that in terms of turn-taking in interpreter-mediated communication, an interpreter takes 'responsibility for the flow and maintenance of the communication' (p.18). In the context of healthcare interpreting, it is acknowledged that the interpreter is not only a 'message relayer' but also a 'coordinator' because the interpreter has responsibility for regulating the interaction between the two main participants (Llewellyn-Jones & Lee, 2013; Wadensjö, 2002). In addition, when two interlocutors do not share the same language and culture, cultural gaps can be a factor impacting on message conversion. It is therefore accepted that a healthcare interpreter is a manager of the cross-cultural, cross linguistic mediated clinical encounter. This last point of view focusses more on a 'facilitating' role during the communication process, as the interpreter needs to be sensitive to the patient's emotional state and convey this fully to the health practitioner. In the context of intimate communication, interlocutors' culture, class, other social backgrounds such as religion, affect their views and opinions. In order to overcome communication barriers which may arise due to cultural differences, the healthcare interpreter should actively consider an individual's unique cultural background to deliver their messages in a more accurate manner. To this end, having a strong theoretical background is needed.

To clarify the previous concepts, the role of the healthcare interpreter can be defined as follows, as healthcare interpreting is considered to be a special form of community interpreting:

> Community-based interpreting is a particular type of interpreting that is carried out in face-to-face encounters or over the telephone between a service provider and their client (such as a doctor and patient, policeman and witness, employment agency and applicant or school principal and parents) often in situations of crisis.

(Mesa, 1997, p. 44)

It has also been documented that the interpreter intervenes in the conversation as a participant in her own right (Wadensjö, 1998; 2002), asking questions of speakers to enhance her understanding and requesting clarification, which is also relevant to the interpreter's visibility,

the interpreter as an active participant, or, in other words, to the expected roles of the interpreter from the service user's perspective.

In this section we have looked into the definition of interpreting, how different scholars define community interpreting, and how this specific type of interpreting has been recognised and provided in different geographic areas in response to need. Following this, we touched on medical interpreting or healthcare interpreting, including the ongoing debate on the healthcare interpreter's role, as the research focusses on community interpreting, especially in the medical context. However, as stated earlier, the provision of community interpreting in Korea is in the early stages and has not received much attention from scholars. Therefore, the next chapter will provide a general background of interpreting studies and practices in Korea, including the characteristics of professional interpreter training, and community interpreting service provision, with a particular focus on healthcare settings.

2.3. The Korean context

As a signatory to the Universal Declaration of Human Rights, the Korean Government is required to abide by Article 25 of the Declaration, which states that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family' (2002, p.7). This includes the provision of services for medical care, sickness and disability in a language that the person can understand.

The Republic of Korea is now witnessing a rapid growth in the number of foreign nationals living there. According to Migration Trend of Korea 2014, the number of non-Korean residents recorded 1.576 million in late 2013, which accounts for 3.3% of the total Korean population, and the average growth rate of migrants was 8.6% between 2003 and 2013. This report stated that if the speed of the increase remains the same in the future, 'the estimated number of migrants would be 2 million in 2018, 3 million in 2028, and 5 million in 2048' (Kang DK., OH JE., Lee CW., Choi S., Youn, 2014). In response to this trend, the government must ensure effective communication with multilingual populations when they interact with public sector institutions, just as in traditional countries of immigration such as Australia, Canada, New Zealand and the United States of America (Ozolins, 2000), where immigration has had a great impact on the healthcare system (Beltran Avery, 2001).

a. Interpreting in Korea

The first graduate school of interpretation and translation in Korea opened 40 years ago at Hankuk University of Foreign Studies in Seoul, and since then, many students have been through professional training at schools of interpretation and translation nationwide, becoming professional interpreters and translators. A distinctive feature of these schools and their programs at graduate and postgraduate level in Korea is that they mainly focus on training, i.e. developing students' 'practical' skills rather than basing a broader educational experience on theory or background disciplinary study (C.J. Jeong, 2011) that could foster a better-rounded professional profile. Furthermore, well-educated individuals with good bilingual language skills performing interpreting and translation are becoming common in Korea, changing traditional interpreting and translation practice (S.M. Kim, 2017). In other words, individuals without any proper or professional interpreting training are performing interpreting or translation based only on their bilingual skills.

Considering the characteristics of interpreter and translator education and trends in Korea, it is hard to expect even a trained healthcare interpreter to have an idea of their professional role, except for having professional-level linguistic skills, as training is focussed only on practical skills rather than being informed by theory and research. However, the interpreter training system is not the sole reason why many non-professionals are performing interpreting in healthcare settings: Korea's unique healthcare system is also a contributing factor, which will be discussed in the next section.

b. The healthcare system in Korea

According to research conducted by the World Health Organization regarding health service delivery in Korea in 2012, there is little encouragement for patients to enter the medical system at the primary care level (general practice), and patients can still receive treatment at a secondary level of service (specialist services such as orthopaedic doctors, including a number of university hospitals) for a condition that could also be managed at primary level (World Health Organization, 2016). For example, without seeing a family medicine doctor or GP to get a referral letter, you can visit any specialists' clinics. This is due to the unique healthcare system and culture surrounding the provision of healthcare in Korea. Article 37 of the Medical Law stipulates that patients can choose experienced and/or specialist doctors for an additional fee (Chun, C. B., Kim, S. Y., Lee, J. Y., & Lee, S. Y., 2009). Coupled with the culture, the fact that the service delivery model is in a deregulated environment, private sector-led, and market-oriented (WHO, 2016) has resulted in clinics and hospitals accepting patients without a referral letter to maximise

their profits (Ock, M. et al., 2014). Hospitals are to provide healthcare services but at the same time to make profits. Understanding the nature of healthcare services in Korea, cost-effectiveness emerges as one of the important factors to consider from the perspective of healthcare organisations, which means that hiring bilingual staff is preferable to hiring professional staff and also professional interpreters.

c. Healthcare interpreting in Korea

As outlined above, healthcare interpreting in the Korean context is in its infancy. Comprehensiveness (Ozolins, 2002), as witnessed in countries like Australia, includes the implementation of strict regulations on the use of untrained or unaccredited interpreters providing language aid services in healthcare settings. Korea could be considered to be at an *ad hoc* stage, with a lack of research, training and professional associations.

Unlike Australia, Korea has not developed regulations on healthcare interpreting (Kwak, 2010). According to research conducted in 2009 to investigate the needs of healthcare interpreting users in Seoul, Korea, 77% of 692 hospitals in Seoul are already providing interpreting services. Of those with no interpreting services, 43% responded that they are interested in providing services (Jeong, 2010), so there is awareness that interpreter services are important.

Unprofessional, bilingual staff who can provide interpreting services are hired by hospitals, and it is noted that their roles include tasks other than interpreting, such as assisting healthcare practitioners, and marketing (Kwak, 2009). Only 5% of Korean hospitals in the survey hire freelance interpreters, and it has been found that the percentage of temporary/permanent staff members in charge of interpreting make up 32% of total staff members (Jeong, 2010). This is because hiring or using competent interpreters depends on how familiar the service users are with the concept of interpreting. If the interpreting service user is used to working with interpreters, they will have a clear idea of the roles and standards for the services, requiring that interpreters demonstrate their competence through experience, qualifications and training. On the other hand, if the user is not used to working with interpreters, they will have no idea about being selective when hiring an interpreter (Mikkelson, 2009). Many users of healthcare interpreting services in Korea have a lack of understanding about what is required of interpreting services. In the early stage of development of community interpreting, it is recognised that 'Although community interpreters are often expected to be bilingual, poor general language proficiency and weak

command of specialised terminology are not uncommon among them.' (Smirnov, 1997) This is where Korea is at now.

As indicated above, most healthcare interpreters in Korea are untrained bilingual staff hired by hospitals. The Korean situation gives support to one of the enduring myths and misconceptions about interpreting: that community interpreters are amateurs with a lack of formal education (Mikkelson, 2009). Under these circumstances, for interpreters to earn recognition for their skills, they first have to develop them (Roberts, 1995).

Aside from their lack of skills or ability to provide quality interpreting services, the problem of vague role boundaries also needs to be touched upon since it is directly linked to power imbalances in this case. In Korea, the roles of a healthcare interpreter are vague due to the fact that the organisations and hospitals, when staffed with bilingual staff members undertaking interpreting work, tend to expect their employees to be multi-taskers rather than an interpreting service provider (Kwak, 2009).This leads to interpreters holding more power than the community of non-dominant language speakers because first, they are hired and protected by hospitals where they can be considered the dominant party in terms of power compared to that of the patients who do not speak Korean, and second, working for certain hospitals as employees means healthcare interpreters will inevitably learn more about the organisations' cultures and systems, which can affect their objective viewpoints and stance.

Against this backdrop, it is crucial to define the role of healthcare interpreters and provide training accordingly to ensure the right of healthcare consumers in Korea to effective communication.

e. Education of healthcare interpreters

Korea has a short history of community interpreting. It is notable that since the Hankuk School of Interpretation and Translation was established in Korea, interpreter training has been mainly focused on conference interpreting (Kwak, 2010). It was only in 2008 that the concept of community interpreting was introduced to Korea, and medical interpreting in 2010 at a conference hosted by the Graduate School of Interpretation and Translation (GSIT). The Korean government has been trying to train healthcare interpreters since 2009 (ibid, 2010), but even though the government is running various medical interpreting education programs, professional interpreting is rarely taking place in healthcare settings (Jeong, 2010).

Of the bilingual staff hired by hospitals in Korea, those who currently provide medical interpreting at hospitals are mostly unprofessional and did not receive professional interpreting

education (Ko, 2004). Unlike other countries, like Australia or the United States of America, there are no regulations on using unprofessional bilingual staff as interpreting service providers (Kwak, 2009), and there are no interpreter codes of ethics specific to Korea.

From July to December in 2009, medical interpreter training was offered with support from the Korean government to provide community interpreting aimed at supporting medical tourists (Kwak, 2010). Under direction from the Ministry of Health and Welfare, the Korean Human Resources Development Institute (KHRDI) taught around 60 trainees, with medical experts and 6 GSIT professors. A total of 200 hours of the training was provided every Saturday, and 60 hours out of the total training was allocated for practical interpreting classes.

The evaluation of the training outcome showed that those who have interpreting experience outperformed the students without an interpreter education background.

Since medical tourism is robust in Korea, the Korean government has been trying to train medical interpreters (Kwak, 2010). However, the training has been focused on nurturing healthcare interpreters in the 'medical tourism' era, which inevitably set their role more as coordinators, about a unique form of a health care interpreter, which is often referred to as a medical coordinator rather than simply as an interpreter. To briefly explain the term commonly used in Korea, 'medical coordinator' refers to someone who designs medical trips, organises services, escorts service users, provides consultations, and helps users finish the entire process with success. To summarise, they play five roles: designer, organiser, escort, consultant, and planner (H.S.Yoon, S.W.Cho, & V. Sugumaran, 2011). As the roles overlap with those of bilingual staff who serve as interpreters, they are often called medical coordinators instead of medical interpreters. Coupled with this, the organisations and hospitals which employ untrained bilingual staff as interpreters, tend to expect their employees to be multi-taskers rather than only interpreting service providers. This has resulted in a broadening of the role of the healthcare interpreter as a medical coordinator.

f. Potential risks

Among the findings of a healthcare interpreting study, the presence of an interpreter was found to reduce the potential for critical incidents, increase length of stay, outpatient visits and sick days (Hewitt, 2000). In 2013, a medical accident saw a Polish woman have her uterus removed due to miscommunication. The consultation was interpreted by her husband. This shows how quality interpreting is crucial in healthcare settings. Providing quality interpreting services could

therefore serve as one of the strategies to ensure the success of the new trend of medical tourism in Korea and attract new patients, or increase the number of patients' follow-up visits. To this end, it is crucial that all interpreters abide by a code of ethics to perform 'quality' interpreting.

In Korea, there is no overarching organisation nor code of ethics tailored to Korea. Many scholars, including Webb (2009), have stressed the importance of the neutrality of the interpreter. It is stated in the AUSIT code of ethics that an interpreter should be someone who does not favour any of the participants in the communication. An interpreter can assist one of the parties to reach their goal in the conversation, whether consciously or unconsciously (Webb, 2009), and thus lose neutrality. As stated above, the majority of healthcare interpreters who provide interpreting services at hospitals are hired by those hospitals, and many are staff members with roles other than interpreting (Jeong, 2010). For example, medical staff like nurses can serve as healthcare interpreters. This means most of the healthcare interpreters at the hospitals know their systems well, and are familiar with the settings, which may lead to a violation of neutrality and the temptation to blur role boundaries. There are also underlying risks of using interpreters with dual roles, such as nurses as interpreters, and un-trained healthcare interpreters. Elderkin-Thompson, Silver, and Waitzkin (2001) suggested that interpreting errors are witnessed when nurses provided information congruent with clinical expectations rather than that of the patients. Nurse-interpreters and other untrained healthcare interpreters create communication errors. Ebden and colleagues found that non-trained, *ad hoc* staff interpreters may misinterpret or omit questions by physicians (Ebden, Carey, Bhatt & Harrison, 1988; Aranguri, Davidson & Ramirez, 2006).

In this literature review I have provided the background and rationale for the case study that will be described in the following two chapters. As stated previously, the context for community interpreting and in particular healthcare interpreting in Korea is quite different to that of other countries with more developed structures and services, and could be considered to align with Ozolins' (2000) definition of *ad hoc* interpreting. This poses a problem for those interpreters and bilingual staff members who have not had the benefit of training, who may misconstrue their role, provide incorrect or inadequate interpreting, or lack sufficient command of both languages.

Chapter 3. Methodology

In view of the evolving nature of the healthcare interpreting sector in South Korea and the lack of research that describes current practices, this study aims to explore the occurrence of linguistic and cultural barriers between practitioners and their patients in face-to-face, interpreter-mediated communication that are likely to have an impact on health outcomes, and to define the roles of healthcare interpreters in the Korean context. To this end, a case study was conducted at a university hospital in Seoul, Korea. Due to the limited scope of a Master by Research project (9 months duration and a 20,000 word thesis), I decided to choose one hospital only and conduct a case study within the context of that institution. The case study used a mixed-methods approach incorporating surveys, interviews and participant observation. Healthcare practitioners, patients and interpreters were surveyed to capture their views, attitudes and experience of interpreting, and healthcare practitioners and interpreters were interviewed. An ethnographic approach was taken to examine practices within the institution through non-participant observation. In this chapter, I will provide a rationale for the methodological approach taken, and describe the methods and procedures used in the study.

At the outset, my primary focus was to investigate the degree of satisfaction of healthcare practitioners and their medical tourism patients in their experience of interpreting. However, it became apparent during my initial observations that the original target population using interpreters was not medical tourists, but foreigners residing in Korea, and the interpreters were employed in dual roles. These two factors meant that the nature of the interpreter-mediated communication was likely to be different to what I had expected, so the main focus shifted from examining user satisfaction to a descriptive examination of the roles and practices of the interpreters in order to firstly define healthcare interpreting practice in the Korean context.

The aims of the research, therefore, were to:

- profile the interpreters working in a healthcare setting in Korea

- profile the users of interpreter services (healthcare practitioners and their patients)

- identify the roles and practices of interpreters working in a healthcare setting in Korea

- determine the level of satisfaction of users of interpreting services and the reasons for their stated level of satisfaction

In order to achieve the aims of the study the following research questions were formulated:

1. Who are the interpreters?

2. What roles and practices are being carried out by interpreters?

3. Who are the users of the interpreting services?

4. What are the role expectations from the service users?

5. Are the interpreters' clients satisfied with the services they are receiving? And if so, what are the factors that contribute to their satisfaction?

In the following sections, I will describe the methodological premises behind the choice of methods and outline the design of the research instruments used in the study.

3.1. Case study

The main purposes of conducting a case study are to first portray, analyse and interpret the uniqueness of real individuals and situations through accessible accounts, secondly to catch the complexity and situatedness of behaviour, and to present and represent reality to give a sense of 'being there'. The case study also provides unique examples of real people in real situations, enabling readers to understand ideas more clearly than simply by presenting them with abstract theories or principles (Cohen, Manion & Morrison, 2000).

According to Hitchcock and Hughes (1995:322), case studies will be defined by the individuals and groups involved. Therefore, researchers should avoid selective reporting or supporting a particular conclusion. Another distinctive characteristic of case study research is the selection of information. It is significance rather than frequency that gives 'the researcher an insight into the real dynamics of situations' (ibid, 1995). For example, even though it is not frequent nor representative, one case can be highly critical and crucial to the researcher to understand the case study in its entirety.

While the nature and scope of this study (like most small-scale case studies) does not allow for any generalisations to be made based on statistical analysis, it is possible to see the relevance of the findings for similar institutions with similar participant profiles – in this case for a similar hospital setting in another context.

As the main aim of this study is to explore the reality of interpreting in a healthcare setting specifically in Korea, a case study was conducted at a hospital where an international healthcare centre is located, and which uses both trained and untrained interpreters, with the aim of achieving an in-depth understanding of a specific instance of the provision of healthcare

interpreting. The reason this hospital was selected as a research site is because of easier access to every group in the interpreter-mediated healthcare communication: patients, healthcare practitioners, administrative staff and the interpreters themselves. While a case study was undertaken, participant observation, surveys, and interviews were conducted.

3.2. Participant observation

There are a few advantages of participant observation as suggested by Bailey (1978). Firstly, when collecting data on non-verbal behaviour, observation is better than experiments or surveys. As the research is highly related to the quality of communication, which involves both verbal and non-verbal elements, the observation took place to capture the overall picture of communication or communication-based interlocutor interaction. The second upside of participant observation is that, as the observation normally takes place over a certain period of time, the researcher can build informal and close relationships with the participants the researcher is observing. The important thing during the observation is to record it comprehensively (Cohen, 2000).

Observational data gives the researcher an opportunity to monitor what is happening in real life situations. There are three types of observations: highly structured, semi-structured, and unstructured. The difference lies in how clear the researcher's idea is of what he/she is looking for. In the case of highly structured observation, the researcher will have hypotheses, and the observation will take place to find support for the hypotheses. Semi-structured observation will require interpreting the data before coming up with a suggestion or explanation of the situation. In this research, unstructured participant observation was conducted at the hospital in addition to the surveys, in order to better understand the context in which the interpreting took place, for example, what other tasks were the interpreters engaged in, how were they recruited, and how they interacted with the patients (outside the interpreting assignments). No observational checklists were used for this purpose as the aim was to be open to observing all relevant activities. I had planned to undertake observations of interpreter-mediated consultations, but because of the difficulty of obtaining consent from the patients due to their reluctance in having an unknown third-party present during very personal and intimate interactions, I was unable to observe any of the patient-healthcare interactions.

3.3. Survey

Surveys are generally conducted to 'gather data at a particular point in time with the intention of describing the nature of existing conditions, or identifying standards against which existing conditions can be compared' (Cohen, et.al., 2013, p.169). This thesis reports on a small-scale study carried out by a single researcher, so the advantage of a survey via questionnaires is its efficiency in obtaining snapshots of the target population with as large a population as possible. The biggest advantages are that it can be conducted without the researcher being on site, and that the analysis is relatively straightforward (Wilson and McLean, 1994). However, the downside is the time-consuming process in developing, piloting, and revising the questionnaires to ensure that the items are clear and objective.

When developing a questionnaire, ethical issues must be considered, since the questionnaire requires respondents to give up their own time to complete it, and it introduces the possibility of threats on or invasion of their privacy. Respondents should therefore not be coerced into answering the questionnaire (Cohen et al., 2013).

3.3.1. Design of the survey questions

There are different types of question and response modes in the questionnaire: dichotomous questions, multiple choice questions, rating scales and open-ended questions. I will briefly discuss the advantages and disadvantages of each question type.

1. Dichotomous questions

Dichotomous questions require yes/no responses. The advantages of this type of question are that you can code the answers quickly, and they are useful for setting up the subsequent questions (item logic). However, they need to be used in an appropriate way because they are not suitable for complex questions that cannot be simply answered with 'yes' or 'no'. Furthermore, Youngman (1984:163) pointed out that people are more comfortable with agreeing with a statement, so these items could 'build in respondent bias'. Using dichotomous questions such as gender and type of schooling enabled me to collect nominal data on demographic profiles, for example.

2. Rating scales

Rating scales are used for evaluative questions. Respondents can either place their response on a Likert scale, or use a sliding scale to indicate their views.

3. Multiple choice questions

Multiple choice questions can be used to get an idea of responses to more complex questions. It is important to remember that the categories should cover the possible range of responses, and also indicate the mode of the question – a single answer mode or a multiple answer mode.

One of the challenges of questionnaires is that different respondents might 'interpret the same words differently', which means the researcher's intention and respondents' interpreting could be different (Cohen et al., 2007). Multiple choice questions are quick to complete, and easy to code. However, at the same time they do not allow respondents to add any remarks. Oppenheim (1992:115) pointed out that 'there is a risk the categories might not be exhaustive and there might be bias in them.' Therefore, I have structured multiple choice questions to include an 'other' category and comment box.

3. Open-ended questions

Open-ended questions are a useful tool for smaller scale research, enabling the researcher to gather information that may not have been caught in closed questions. However, the downside of the open-ended question is that the responses can be difficult to code.

The sections of the surveys included:

1. Demographic profile

In this section of the questionnaire, respondents were asked to provide details of their profile: gender, age, the highest level of education completed, country of birth and country of residence.

2. Linguistic profile

Here, respondents were asked about their linguistic background. They were asked to state their first, second, and dominant language, language qualifications, and languages they used in interpreter-mediated communication.

3. Evaluation of interpreting services (for healthcare practitioners and patients)

The respondents were asked to answer questions regarding their experience of the interpreting services they used, which are provided by the hospital. This section includes the level of satisfaction, factors contributing to their (dis)satisfaction, and general questions on the nature of healthcare interpreting and interpreters.

3.3.2. Survey Pilot

Once the items had been drafted, the questionnaires for healthcare practitioners were translated as the participants' first language is Korean. Potential participants were identified and the questionnaires for all three parties were informally piloted to determine whether the items contained bias and were clear. Because of the concern about the power of the study and the need to obtain as many responses as possible, the surveys were not able to be formally piloted with members of the representative participant groups. Each survey was, therefore, trialled with a respondent representing the target participant group. The pilot took place in April 2017, prior to submission of the ethics application. Minimal revisions were deemed necessary.

The surveys were created using the survey tool Survey Monkey to enable both online data collection and the printing of hard copies for those respondents who preferred this format.

3.4. Interviews

Interviews can be used to collect pure information, control transactions with bias by interviewing a few different participants with different biases, and to share features of everyday life (Cohen et al., 2013). The researcher can evaluate a respondent, test or build a hypothesis, and even gather data in a survey situation. However, different respondents can come up with different answers as they can understand or perceive meaning in their own unique way. Another disadvantage of the interview is that the respondent can feel uncomfortable if the question is too deep (ibid, 2013).

In this study, semi-structured interviews were conducted with staff. The interviews were expected to last up to 60 minutes.

3.5. Ethics

As this research involved human subjects (practitioners, interpreters, and patients), obtaining ethics approval was mandatory. The questionnaire and consent forms were written in English as the researcher was informed that the hospital where the case study was going to take place uses English with any patients who visit the International Healthcare Center. However, the forms for healthcare practitioners were provided both in English and Korean on the assumption that some participants may not be able to read or write, or fully understand English. After providing the piloted surveys and consent forms, as well as explaining the potential risks for the participants to the Medical Sciences Human Research Ethics Committee for evaluation, the study was delayed by a review by the full ethics committee due to the special provisions for research undertaken in a medical context.

3.6. Procedure

After receiving approval from the Macquarie University Human Research Ethics Committee (included in Appendix 1) on the 20th of June, 2017, I travelled to Korea to collect data at the participating hospital. The surveys were administered to all three participant groups: healthcare practitioners, interpreters, and patients. The questionnaire link was sent online to healthcare practitioners and interpreters so that they could choose to participate in the research voluntarily without any coercion from the researcher or the hospital. However, a few healthcare practitioners (nurses) and receptionists preferred a hard copy version of the questionnaire. Their responses were collected on hard copies and entered into Survey Monkey manually. As there were no electronic devices for patients to use at the hospital, patients were asked to answer the questionnaire in hard copy. The data collection took place for a month, from 1st to 31st August, 2017. The data collected from the patients were also entered into Survey Monkey manually every day as they were completed. As patients were asked to participate in the research in person at the International Healthcare Center, the researcher provided the consent form and explained the purpose of the research. Only those who agreed to take part in the study completed the

questionnaire. Any questions from patients were answered by the researcher on site. Distributing the survey questionnaire was quick and easy as there was an online platform and patients were able to fill out the questionnaire while waiting for their consultations. However, it was more difficult to attract participants for the interview, since it takes longer to fully respond to the questions and interviews may venture onto sensitive topics. There were only two participants who agreed to be interviewed; one took place in a written form, and another during the lunch break outside the hospital to ensure confidentiality. The first participant wanted research questions beforehand in a written form so that she could have enough time to think about her answers and provide them. She was supposed to be interviewed in person, but it was impossible to find a suitable time, and she therefore submitted her responses in a written form.

3.7. Sampling

If researchers plan to use some form of statistical analysis on their data, a sample size of thirty is held by many to be the minimum number of cases (Cohen, et.al., 2000, p.102). Since research was taking place in a healthcare setting where individuals discuss personal issues (Hale, 2007), I had to consider the possibility of not getting consent from patients. Furthermore, due to the short time frame for the Master of Research and the long time frame required for full ethics approval, I was constrained to collecting data during the holiday season, when the hospital witnesses the lowest number of foreign patient visits. Thus, I chose convenience sampling, also called 'accidental' or 'opportunity sampling' (Cohen et al., 2000). Convenience sampling is used for a case study and 'chooses the nearest individuals to serve as respondents and continuing that process until the required sample size has been obtained' – in this case a minimum of 30 responses (Cohen, et.al., 2000, p.102).

In this chapter, I have briefly outlined the main research methods used and explained their advantages and disadvantages in the context of the present study. I have also described the development and administration of each of the methods. The following chapter reports the results of the data collection.

Chapter 4. Results and Data analysis

In this section, I will report the results of data collected from the observation, survey questionnaires from each group, and interview. I will explain first the methods use to analyse the data, and second the results of the analysis.

4.1. Analysis

The survey produced both quantitative and qualitative data (as outlined above in the description of the different item types). Along with the survey, additional interviews related to the survey, and independent interviews on the experiment were conducted. The reason interview was chosen as one of the research methods is because it is suitable for testing or developing my hypotheses, and gathering information in an experimental situation (Cohen, 2013). To analyse the interview, the recorded interview was transcribed and the resulting data analysed by categorising different themes emerging from the data. The categories were then reduced by counting the frequency of occurrence. Due to the small number of participants in the interview, the data was analysed manually.

The statistical software SPSS was used to analyse the quantitative data. Before entering the survey data into SPSS, it was exported from Survey Monkey into Excel and cleaned to eliminate ambiguous responses and reword others for consistency and coding (e.g. when asked to state their country of residence, some respondents wrote 'Korea', others 'South Korea', 'Republic of Korea', etc.). To address the completeness of responses, missing answers could sometimes be cross-checked from other sections of the survey. For example, when excluding receptionists from the healthcare practitioners' group, one respondent did not answer the question 'In which department do you work?'. The response was obtained by cross-checking with the response to 'What is your primary work activity?' which includes 'Payment & Administrative work' in the responses. It was therefore possible to provide a response to the question 'In which department do you work?'

The total number of responses to the survey was not sufficient to undertake a complex statistical analysis exploring the relationships between the subgroups. As advised by the faculty statistician, I did this qualitatively by cross referencing the associations between different responses.

4.2. Results

A total of 106 participants took part in the surveys: 34 healthcare practitioners, eight receptionists who can read and write Korean, four healthcare interpreters hired by the hospital, and 60 patients who visited the International Healthcare Center and are able to read and write English. Only two respondents participated in the interviews. Both are from the International Healthcare Center: one was working as an interpreter, the other as a coordinator.

In the following sections, I will report on the results for each of the sources of data (participant observation, surveys and interviews) starting with the participant observation which serves to contextualise the study.

4.3. Participant observation

When I arrived at the Center, I was provided with an office and a desk. I was present from 9am to 5pm, five days a week. This provided me with ample opportunity to carry out the participant observation. I took an ethnographic approach and sought to document my observations about how foreign patients, interpreters and healthcare practitioners carried out their work and interacted with each other.

There were three Family Medicine health practitioners working at the Center who spoke languages other than Korean. To be specific, one speaks English, French, and Spanish, another speaks English, and the other Spanish. As in many countries, the patients who visited the Center were seeing the practitioners first, and were then directed to see specialists working in different departments at the hospital when necessary. However, a number of patients who showed clear symptoms were triaged and often sent to the specialists directly without seeing a Family Medicine doctor at the Center first. The main language used at the Center is English, but Japanese, Chinese, Russian, Spanish were also provided when needed or requested. Most of the interpreters were playing dual roles as nurses (*n=2*), receptionists, bilingual staff, and medical coordinators (*n=4*). In the morning, seven staff work at the Center: four mainly provide interpreting services, and two nurses play receptionist and gatekeeper roles, guiding patients to specialists directly. They also sometimes provide interpreting services when the number of patients exceeds four. The last is a medical coordinator who mostly deals with administrative work such as insurance matters.

During the month that I was observing the Center, I did not witness 'proper' healthcare interpreting taking place due to the fact that doctors working at the Center were able to speak

English and communicate with foreign patients without the help of interpreters. Even though their level of English language proficiency was not assessed, these doctors self-reported their competence. This led the interpreters rather play a 'language helper' role. Their main job was to accompany the patients to other departments, treatment rooms, or the pathology lab, help them with payments, and provide simple instructions on how to take the prescribed medicines. When the specialists asked interpreters to interpret the consultation, they performed 'interpreting' in the consulting room, including interpreting the operation/treatment process and side effects, and carried out sight interpretation of consent forms or helped patients fill in the admission forms. However, there are cases where they only sight interpreted the list of precautions given to the patients from the specialists.

In the afternoon, two of the seven leave the International Healthcare Center and move to their office to focus on administrative work. It seems that they are trying to establish a boundary for each of their roles and allocate each staff member a specific task related to that role.

4.4. Survey results by participant group

4.4.1. Group 1– Healthcare practitioners: Doctors & nurses (*n=34*); Receptionists (*n=8*)

As medical staff included not only healthcare practitioners but receptionists, and both groups use interpreting services, the survey was conducted with both groups. To get a broad idea of the interpreting service provided by the hospital, charts will include data from both parties. However, data related to interpreter-mediated, patient-healthcare practitioner (doctors and nurses) communication is more critical and more directly related to the research questions. Therefore, detailed analysis of Group 1 will include that of healthcare practitioners exclusively.
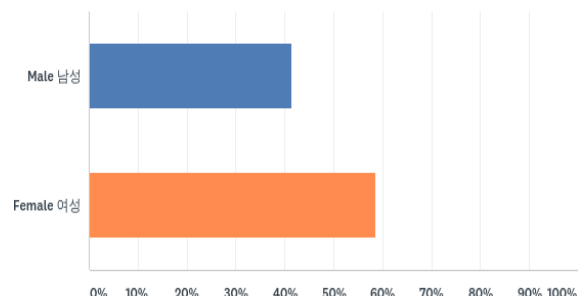

Figure 2 Q 1. What is your gender?

Of the 34 healthcare practitioners excluding receptionists, 17 were male, 16 were female, and one did not specify the gender. Twelve respondents were aged between 40 and 49 years of age,

nine between 30 and 39 years of age, twelve between 20 and 29 years of age, and one did not specify. In terms of formal education received, nine had completed PhDs, two Master's degrees and 23 undergraduate degrees. All 34 participants were born in Korea and are still living in the country. Four respondents commenced but did not complete the survey. In the summary of results below, the number of respondents is 30 unless otherwise specified.

Among the 34 healthcare practitioners, twelve are in the Department of Family Medicine, three in Ear Nose and Throat, three in Ophthalmology, two in Gastroenterology, two in Orthopaedics, and one in each of Cardiology, Obstetrics and Gynaecology, Internal Medicine, Infectious Diseases, Intensive Care Unit, Pediatrics, Surgery, and Urology. Four did not specify the department they work in.

Four doctors started their career between 1990 and 1999, and the most recent starters (*n=20*) commenced work within a five-year period between 2013 to 2016. The cohort of doctors was therefore experienced in their professional practice.

Questions 8, 9, 10 & 11 relate to the healthcare practitioners' experience of their work and in particular about their workload.
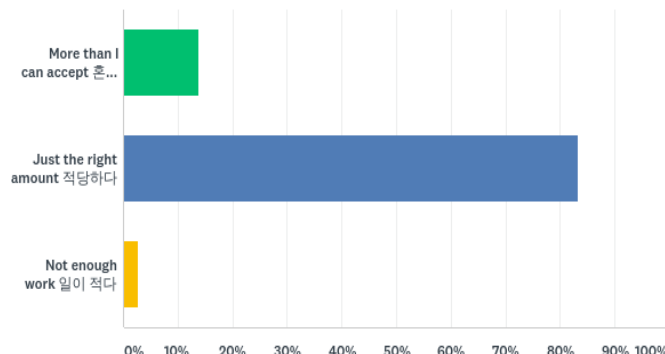

Figure 3 Health practitioner survey Q 8. Do you have adequate work?

When asked 'Do you consider your workload to be adequate?', only one person answered that they did not have enough work, and three answered they have more work than they can accept. The other 26 responded that the workload is just right, and the rest (*n=4*) did not provide an answer. However, to the question that asks about their level of satisfaction, two out of three participants who answered that their work load is more than they can cope with said they are very satisfied, and the other answered satisfied. The person who said there's not enough work answered very satisfied. Among the 26 participants who answered that their workload is just right, five of them answered that they

were very satisfied with their work as healthcare practitioners, fifteen were satisfied, and six were neither satisfied nor dissatisfied. It is notable that no one provided negative answers ('dissatisfied'), which will be commented on in the discussion section of the thesis.

Of the 30 respondents who completed the survey, eleven answered that their primary work activity is consultation, and twelve, treatment. Of the seven who answered 'other', four stated that their work activity was 'assisting with treatment', and one person each in 'research', 'teaching' (including consultation and treatment), 'consulting', 'payment and administrative work', and 'comprehensive treatment'.

The question about the number of hours that respondents estimated that they worked in a week relates to their feelings of satisfaction with their workload, on the assumption that if doctors estimate that they work many hours per week, they may be less satisfied with their workload. Of the 30 respondents, the largest group of eleven people work between 40 and 50 hours, and ten respondents work up to 100 hours a week. There is one person who is on call, which means there is no set times of work and workload varies depending on need. The interesting part here is that most of the doctors described their workload as adequate, yet almost half of the participants work more than 50 hours a week, including those who work 100 hours a week. These hours could hardly be qualified as satisfactory, so it was surprising no one provided negative answers (here, 'dissatisfied').

In response to Question 12 about the length of time spent in consultation or treatment per patient, ten healthcare practitioners said they spent five minutes or less per patient, with ten responding that they spent between five to ten minutes, five spend ten to fifteen minutes, and five spend 20 minutes, 25 minutes, 30 minutes, 60 minutes, and 180 minutes respectively.

Questions 13 and 14 sought to understand how well the healthcare practitioners understood the role of effective health-practitioner-patient communication, including their communication with foreigners, by asking about the training the doctors have received in this respect, and more specifically about their training in communicating with foreigners.
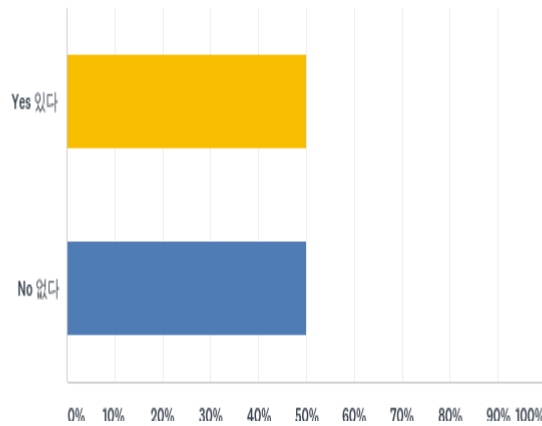
Figure 4 Health practitioner survey Q 13. Did you receive training regarding effective health practitioner-patient communication?
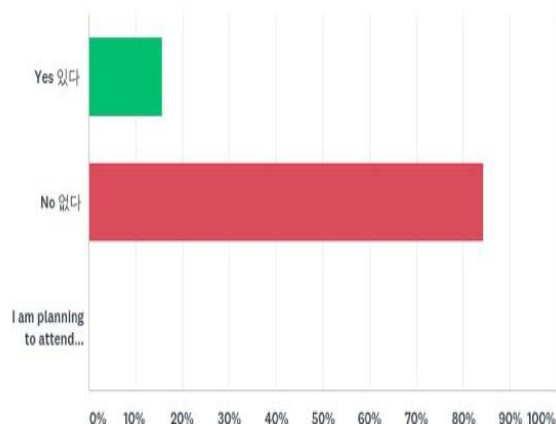

Figure 5 Health practitioner survey Q 14. Did you receive training regarding effective ways to communicate with foreign patients?

Among those who have received training regarding effective health practitioner-patient communication (Q.13), only five answered that they have received training regarding effective ways to communicate with foreign patients (Q.14). The interesting part is that those who have not received training in effective health practitioner-patient communication did not receive training in how to communicate effectively with foreign patients either.

	Received training regarding effective ways to communicate with foreign patients	Have not received training regarding effective ways to communicate with foreign patients
Received training regarding effective health practitioner- patient communication	5	10
Have not received training regarding effective health practitioner-patient communication	0	15

Table 1 Training status on effective communication with patients

One who received training in both also commented that training helps gain patient handling skills.

Questions 15 & 16 relate to the respondents' experience with foreign patients. Among those who have not received any training regarding effective communication with (foreign) patients, only two respondents never treat foreign patients, and another thirteen treat an average of 6.8[2] foreign patients per week. Among those who only received training regarding effective health practitioner-patient communication and no training in effective ways to communicate with foreign patients, only one does not treat foreign patients. The others treat an average of 12.9 foreign patients per week. Of those who received both types of training, only one does not treat any foreign patients, and only two respondents treat between one to five foreign patients, one respondent 25 patients, and one 100 patients.

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[2] The figures here were obtained through the use of a sliding scale in the survey, which explains the decimal points when referring to patient numbers.
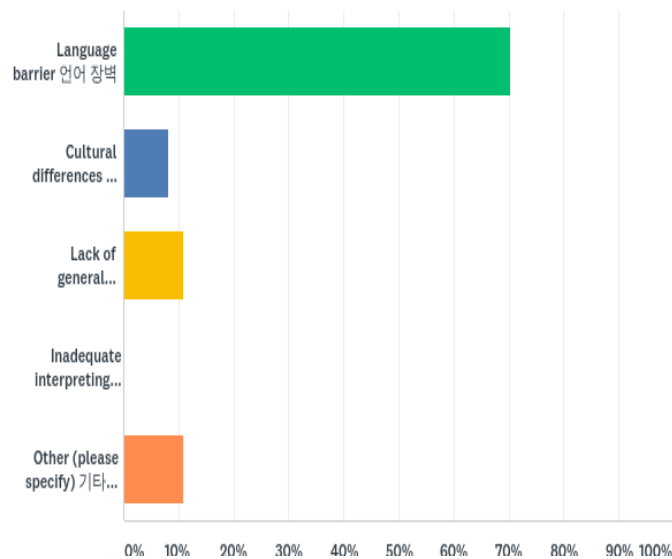
Figure 6 Health practitioner survey Q 16. What are the difficulties you face when dealing with foreign patients?

To the question about the difficulties practitioners face when dealing with foreign patients (Q 16), nineteen participants (63.3%)[3] answered 'language barrier', three (10%) 'lack of general knowledge regarding effective communication with foreign patients', and three (10%) 'cultural differences'. Among those who answered 'other' (four respondents, 13%), one answered both 'language barrier' and 'cultural differences', one answered 'language barrier' and 'inadequate interpreting services', one answered 'foreign patients' lack of understanding about the Korean healthcare system leads to tendency of thinking they can receive the same treatments as they have in their countries', and one answered 'general stress from communicating'.

Questions 17, 18, 19, 20 & 21 relate to the respondents' experience with the interpreting services.
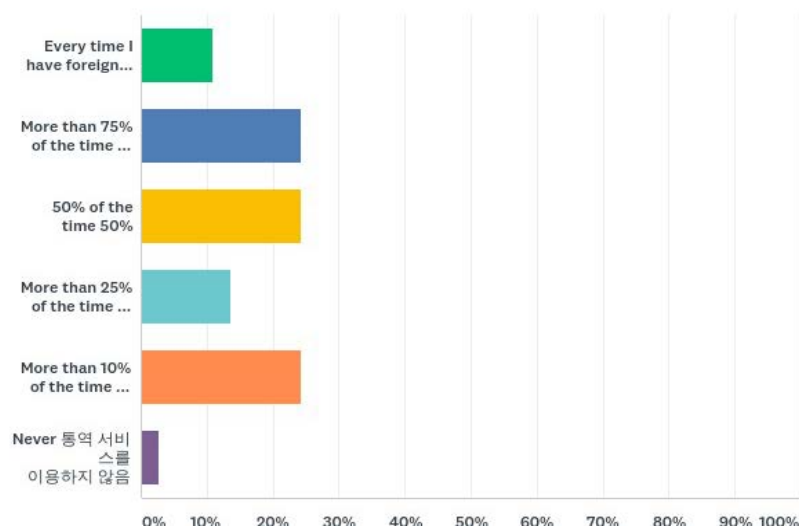
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[3] Respondents could choose multiple responses.

Figure 7 Health practitioner survey Q 17. How often do you use interpreting services?

Forty-six point six per cent (*n=14*) of healthcare practitioners use interpreting services more than 50% of the time that they are dealing with foreign patients. Fifty per cent (*n=15*) use interpreting services less than 50% of the time or do not use the service, while the remaining interviewees 3.3% (*n=1*) did not specify.
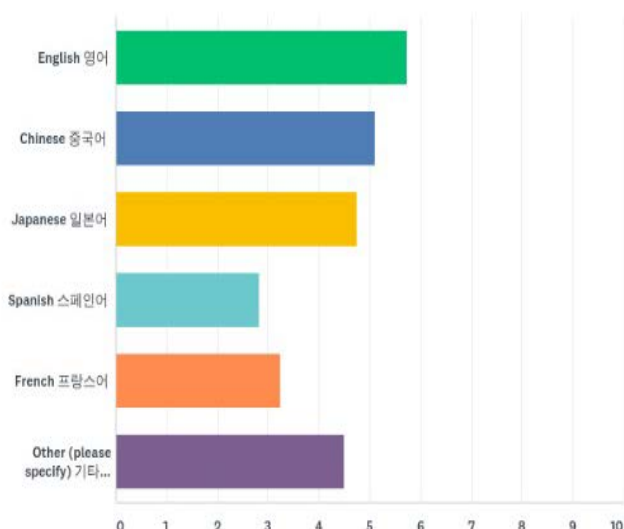

Figure 8 Health practitioner survey Q 18. In which language do you use interpreting services the most?

The most commonly used language for interpreting was English: all healthcare practitioners who always use interpreting services answered that English was the most commonly used language, and this was same for those who use interpreting services more than 75% of the time when treating foreign patients. The next most commonly used language was Chinese (*n=3*), followed by Japanese (*n=2*).
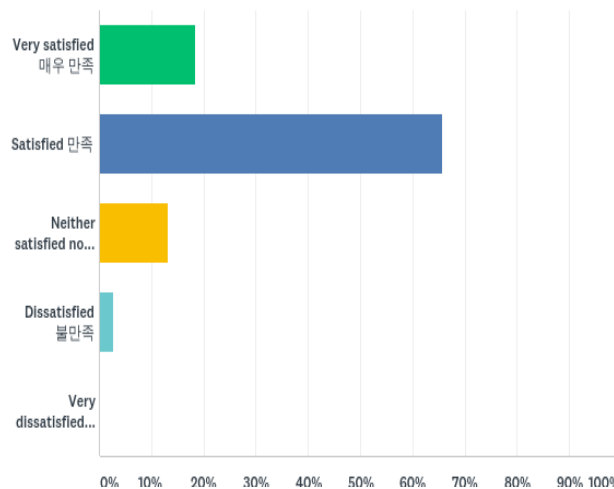
Figure 9 Health practitioner survey Q 19. Are you satisfied with the interpreting service?

Of the 30 healthcare practitioners who used interpreting services, 79.9% (*n=24*) were satisfied with the service, while another 19.9% (*n=6*) stated being 'neither satisfied nor dissatisfied', or 'dissatisfied'. To be more specific, of the three interviewees who used interpreting services every time they communicated with foreign patients, two were satisfied with the service, while one respondent answered that he/she was neither satisfied nor dissatisfied. Of the five who used the service more than 75% of the time they had foreign patients, three were satisfied, one was neither satisfied nor dissatisfied, and another was dissatisfied with the service. Of the six who used the service more than 50% of the time they had foreign patients, five were satisfied, and one was neither satisfied nor dissatisfied.

Of the sixteen who used the service less than 50% of the time they had foreign patients, most (*n=14*) were satisfied, while only three were neither satisfied nor dissatisfied.

Figure 10 Health practitioner survey Q 20. If you are (very) satisfied with the interpreting service, what are the reasons for your satisfaction?

When asked what contributed to their satisfaction with the interpreting service, of the 24 respondents who answered that they were satisfied ('very satisfied' and 'satisfied'), 21 answered that it helps them communicate better with patients, one answered that it reduces the time of the consultation, while two did not specify. However, of those who answered 'satisfied' (*n=19*), eight gave reasons why they were not *very* satisfied: six pointed out that it results in longer consultation times, one cannot bridge cultural differences, and the other cannot be sure whether the interpreting is accurate or not.
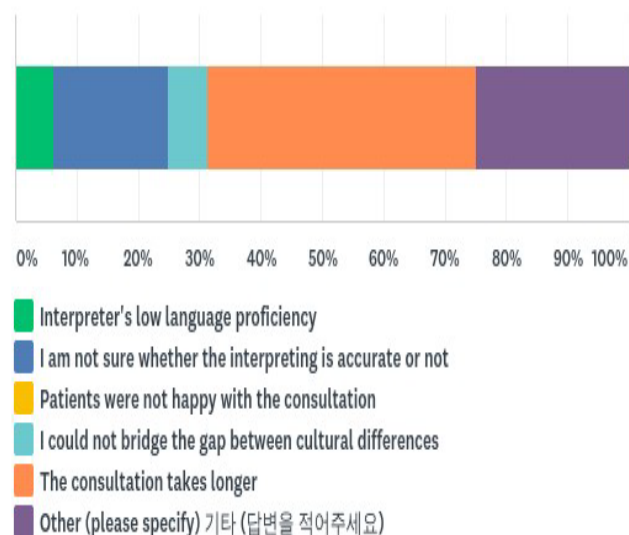

Figure 11 Health practitioner survey Q 21. Why are you dissatisfied with the interpreting service?

Those who answered they were not satisfied were directed to an additional question by the item logic to specify the reasons why. Of the six respondents, two answered that they are not sure whether the interpreting is accurate or not; two that the consultation takes longer; and one was both unsure whether the interpreting was accurate or not, and could not bridge the cultural differences. The one who answered 'dissatisfied' stated that his dissatisfaction was due to the interpreter's low language proficiency in English. It turns out to be the interpreters' limited ability to carry out their roles that contributed to dissatisfaction (*n=4*), and the nature of the interpreting (*n=2*) which makes the consultation take longer.
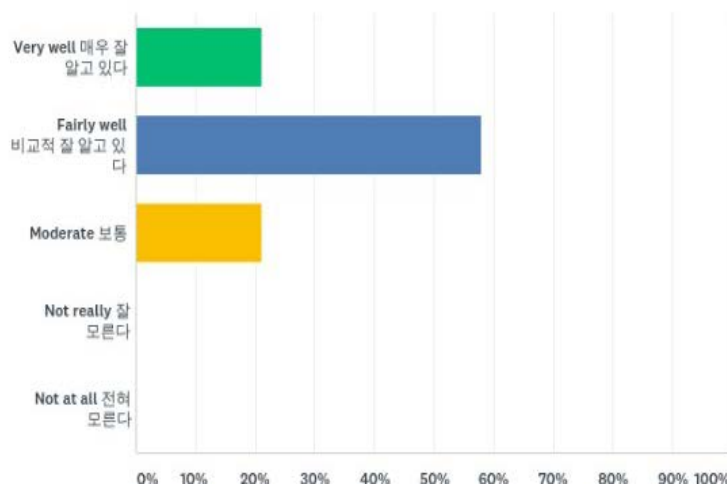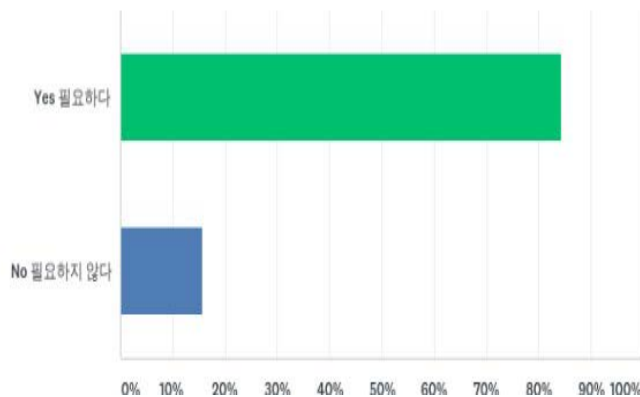

Figure 12 Health practitioner survey Q 22. Are you well aware of interpreter's role?

Most of the respondents answered that they know what the interpreters' roles are. To be specific six answered 'very well', sixteen 'fairly well', and eight 'moderate'.

Figure 13 Health practitioner survey Q 23. Do you think you need training regarding interpreter-mediated communication?

Only five of the 30 respondents answered that they do not need training in interpreter-mediated communication, and the rest (*n=25*) answered that they do. There were also five respondents (all use the interpreting service with the foreign patients) who commented on why they need training in interpreter-mediated communication.

Three considered that training is needed because it helps the communication with foreign patients (R2, 3, and 4). One of those is satisfied with the service due to the fact that it helps them communicate better. However, this person stated that the reason why they were not 'very satisfied' with the interpreting service is the fact that the consultation takes longer: 'Considering there is a delay in their responses, it is unnatural compared to that of general patient-healthcare practitioner communication.' Another who was satisfied stated that 'Even though you are not good at speaking English, there should be communication made before they go to the International Healthcare Center, so that you can build trust with the patient and reduce the time.' R1 (who uses interpreting services more than 50% of the time when treating foreign patients and is very satisfied with the service because she thinks it helps with communicating with patients) answered that 'The number of foreign patients is increasing and [interpreters help] to bridge the cultural differences.' R5 is dissatisfied with the interpreting service because of the interpreter's low language proficiency. He also answered that the training is essential, pinpointing that 'the quality and accuracy of the communication leads to adequate treatment.'

4.4.2. Group 2 – Staff members/interpreters working at International Healthcare Center hired by the hospital.

A total of four staff members at the International Healthcare Center (Jiyeon, Kyunghun, Eunmi, Alisher) who are able to read and write English participated in the survey. For this group, because we are interested in the profile of the interpreters working at the Centre, it was decided to provide individual profiles, exploring backgrounds and perceptions of their roles based on survey responses. The small number of participants in this group meant that quantification of results was meaningless.

Jiyeon is a nurse and the other three (Kyunghun, Eunmi, Alisher) are staff interpreters hired by the hospital who also carry out other duties. All four staff members are female; three are in their 20s, Jiyeon is in her 30s, and all live in Korea. Of the four respondents, three (Jiyeon, Kyunghun and Eunmi) were born in Korea, and one (Alisher) was born in Uzbekistan.

Jiyeon sees herself as a bilingual worker combining her nursing duties with her interpreting. She is a Korean national with Korean as her first and dominant language, and English as her second language. She received her education in Korean and uses Korean at home. She does not have any language qualifications but her working languages as an interpreter are both Korean and English. She has an undergraduate degree in nursing. She never received any interpreter education or training, nor any healthcare interpreting training, but studied nursing in Australia. In her work, she uses sight translation, telephone interpreting, and consecutive interpreting. She does not consider herself to be like the other interpreters who participated in the research, but identifies more strongly as a nurse. She considers that cultural differences are the most important barrier that she faces when performing her interpreting, but has not discussed this barrier before participating in the research. She uses the third person when interpreting. She does not explain general information about interpreter-mediated communication to health practitioners and patients, but sometimes explains cultural differences to both parties. She does not take notes but she interrupts when one interlocuter talks too long so that she can interpret. She has never attended any classes or seminars related to healthcare interpreting because she does not think she needs it, and does not think she needs any (further) training in healthcare interpreting. However, she considers that other healthcare practitioners or staff members need to receive training to work with healthcare interpreters in order to achieve better communication.

Eunmi sees herself as a bilingual worker. Her highest level of education is postgraduate study. She was born in Korea and still lives in the same country. Her first language is Korean and her second language is English. She received her education in Korean. She did not answer what her

dominant language is, but she uses Korean at home, and has Korean language qualifications. Her working languages are both Korean and English. The type of interpreter education or training she completed was on-the-job training while working as a healthcare interpreter. The duration of the training was less than one semester (one semester is normally approximately twelve weeks in Korea). She indicated that she provides simultaneous interpreting to the patients. She considers herself a medical coordinator, and medical terminology is the barrier she faces when performing interpreting. However, she was informed of this difficulty prior to commencing her work as an interpreter. She uses both first and third person when she is interpreting. She explains interpreter-mediated communication and cultural differences to health practitioners and patients. She takes notes when she is performing interpreting, and she interrupts to interpret (within her capability) when one party talks too long. She has never attended any classes or seminars related to healthcare interpreting, but believes further training regarding healthcare interpreting is needed. She also thinks other healthcare practitioners or staff members need to receive training to work with healthcare interpreters but did not specify the reason.

  Kyunghun also sees herself as a bilingual worker. The highest level of education that she has achieved is undergraduate study. She was born in Korea and still lives in Seoul. Her first language is Korean but she did not specify her second or third languages. She uses Korean at home and has language qualifications in Chinese. She obtained HSK (Chinese language) accreditation in 2017. Her working languages are Korean, English, and Chinese. She also received on-the-job training in healthcare interpreting, but the duration of the training was one to two years, which is longer than Eunmi's. She provides sight translation, telephone interpreting, simultaneous interpreting, and consecutive interpreting. In addition to her role as a bilingual worker, she also considers herself as a healthcare interpreter, administrative staff member, help mate, and cultural broker. She mentioned that the greatest difficulty that she faces when performing interpreting is cultural differences, and has partially discussed this challenge in interpreting classes at university. When she interprets, she uses the third person. She explains interpreter-mediated communication to health practitioners and patients, but explains cultural differences to both parties only sometimes. She takes notes, and interrupts the conversation if necessary so that she can interpret. She has attended 20 different classes related to healthcare interpreting, and found them useful. However, she thinks she still needs further training regarding healthcare interpreting, and believes other healthcare practitioners and staff should receive training in order for them to work effectively with healthcare interpreters.

Alisher sees herself as a bilingual worker. The highest level of education that she has attained is postgraduate study. She was born in Uzbekistan but now lives in Korea. She has lived in Korea for three years. She defined her first language as Uzbek and her second language as Russian, but also responded that her dominant languages are English and Korean. She received her primary and secondary education in Russian, and tertiary education in both Russian and English. She uses Russian and Uzbek at home. She has English language qualifications, and Uzbek, Russian, Korean and English are her working languages. She has never received interpreter education or training but has practical experience in community interpreting for her friends. She answered that the length of her experience is less than one semester. She does consecutive interpreting, and considers herself a healthcare interpreter. She also stated that medical terminology is the greatest barrier she faces when performing interpreting, and has been informed of this difficulty. When she interprets, she uses the third person. She explains interpreter-mediated communication and cultural differences to health practitioners and patients. She also takes notes and interrupts when one party talks too long to interpret. She has attended 52 sessions of healthcare interpreting classes or seminars, and found them useful. However, she also thinks she needs further training in healthcare interpreting, and believes that healthcare practitioners and other staff need to be trained to work with healthcare interpreters.

4.4.3. Group 3 – Patients who visited the International Healthcare Center

Sixty patients who are able to read and write English completed the patient survey. Of the 60 patients, 35 are male and 25 are female. There were five participants between 15 and 19 years of age who are students, and 17 between the ages of 20 and 29 who are mostly students ($n=9$) or English teachers ($n=4$). The rest were an athlete, a press representative, and an accountant. There were 22 respondents between 30 and 39 years of age, and of these, eight are self-employed in their own business, five are English teachers, four are housewives, two are working for the government, and the remaining three are a professor, student, and a missionary. There were nine between 40 and 49 years of age: four are working for the government, two are teachers, two are in business, and one is a professor. There were five between 50 and 59 years of age: two are in business, one is working for the US government, one is an English teacher, and one has retired. The remaining two are between 60 and 69 years of age and both are in business. Of the all the participants, 36 are currently living in Korea, six in the USA, five in Malaysia, and twelve in

other countries including India, Canada, Spain, and so on. All except sixteen participants (*n=44*) are currently living in a country other than their country of birth.

Of the 60 patients, 61.6% (*n=37*) of them answered that the primary purpose of their visit to Korea is work, 16.67% (*n=10*) study and 13.33% (*n=8*) travel (Fig. 15). One participant answered both study and work, one is a permanent resident in Korea, and the other three answered that they are in Korea because of their spouse's or parents' work. It is surprising that during the time the survey was conducted, no patients came to Korea for the purpose of medical tourism. The government-run healthcare interpreter training was developed with the purpose of meeting the demands of medical tourists, and the results contradict this.
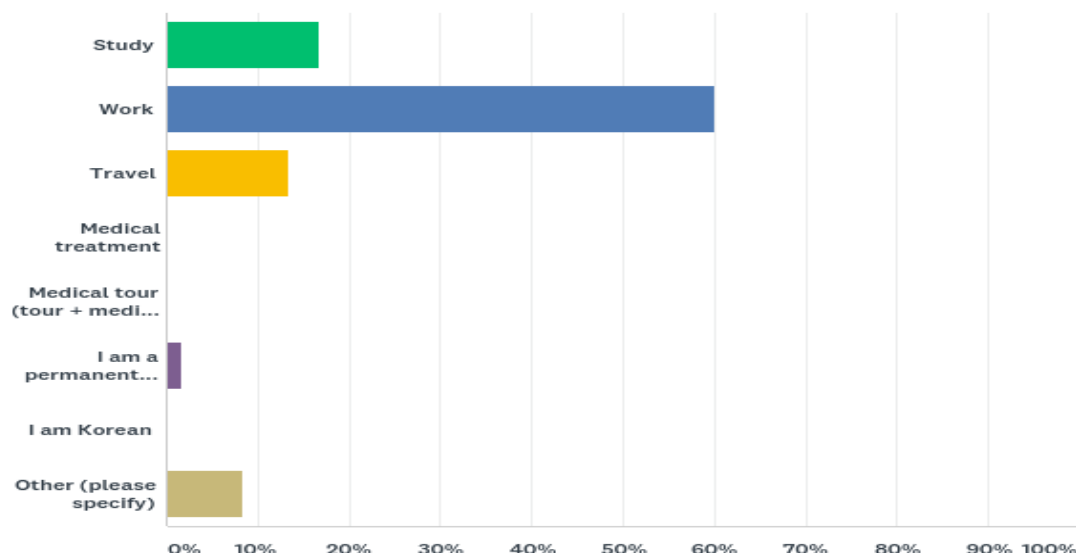

Figure 14 Patient survey Q 7. What is the main purpose of your visit to Korea?
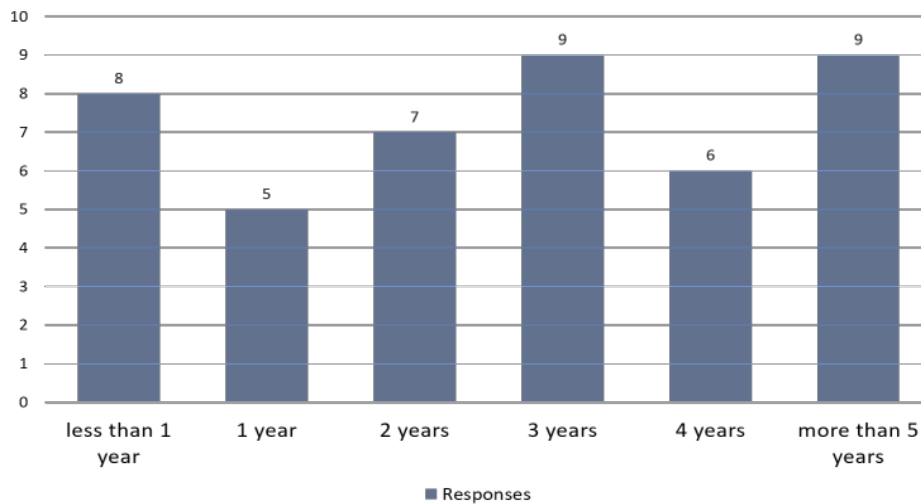
Figure 15 Patient survey Q 2. How long are you staying in Korea?

In response to the question about the length of their residency in Korea, eight indicated that they were staying less than a year. Five of those were staying less than six months in Korea (two participants indicated that they were staying for eighteen days and three weeks, respectively) and three up to a year. Twenty-seven indicated that they were staying between one and five years, and nine more than five years. Of those staying more than five years, two are staying more than six years, one more than nine years, and four more than ten years, including one person who answered 30 years. The other eleven did not specify the duration.

Question 9 asks the reason(s) why the patient chose this specific hospital for their treatment, and as there could be more than one factor that contributed to their decision, respondents could provide multiple answers.
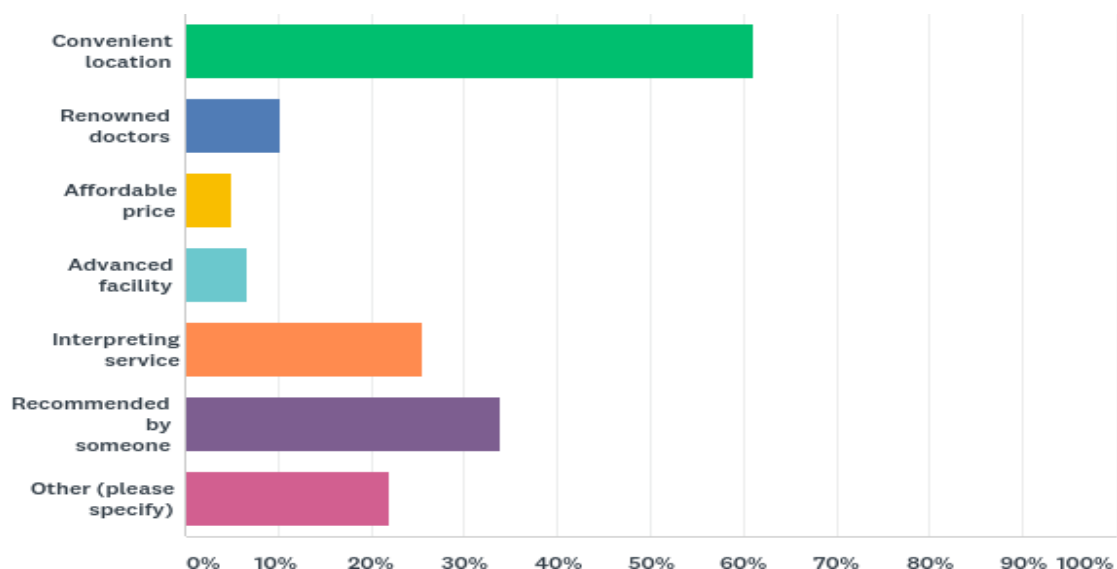
Figure 16 Patient survey Q 9. Why did you choose this particular hospital?

Sixty-six point six per cent (*n=37*) answered 'convenient location', 33.9% (*n=20*) 'recommended by someone', 26.6% (*n=16*) 'interpreting service', followed by 'renowned doctors' (*n=6*), 'advanced facility' (n=4), and 'affordable price' (*n=4*). Seven responded 'other'. Three of these specified the reason as 'good service'/ 'friendly community', two 'international clinic' (English speaking), one 'good reputation judging by internet search', another answered 'previous visit', and the other 'easier to claim for medical fees'. There were 27 people who answered that the clinic had been recommended by someone, and of these, five responded that the hospital was on their embassy authorised hospital list (which means that they cover embassy officers and their dependents), three were told by their insurance company to visit this specific hospital, and one said that a clinic referred him/her to the hospital. Except for these external reasons, answers from those who were recommended by their acquaintances varied.

Fifty-five respondents indicated that they would recommend the hospital to others. Of the 55, eleven answered because there is the International Healthcare Center, and the communication was in English, including two people who answered that the doctors can speak English. Another specifically responded 'good interpreter'. Thirteen respondents wanted to recommend the hospital because of the good service, or because it was foreigner-friendly. The remaining nine responded 'staff' (*n=3*) or 'professional healthcare practitioners' (*n=6*), and three specified 'reasonable price'. Also, there were two respondents who answered 'maybe' without any specific reasons, and '50-50' due to inconsistent service.

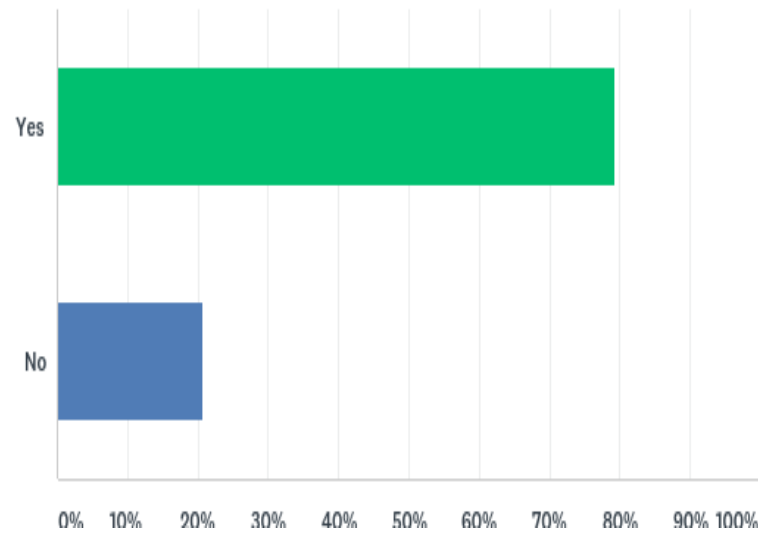Question 15, 16, 17, 18 & 19 ask about interpreting service experience.

Figure 17 Patient survey Q 15. Did you use the interpreting service provided by the hospital?
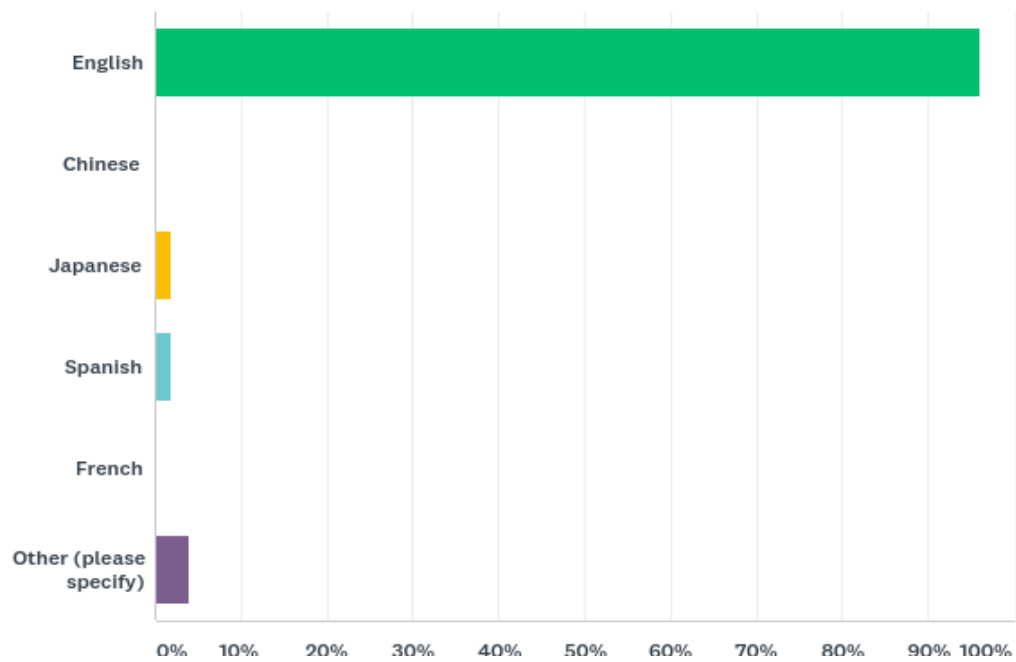

Figure 18 Patient survey Q 16. In which language did you use the interpreting service?

Of the total of 60 respondents, 79.31% (*n=46*) used the interpreting service provided by the hospital and 20.69% (*n=12*) did not; the majority of them used the service in English (*n=43*), except for three people who also received the service in Japanese, Russian, and Spanish. Sixty-five point two per cent (*n=30*) received the service in their first language (Fig. 20).
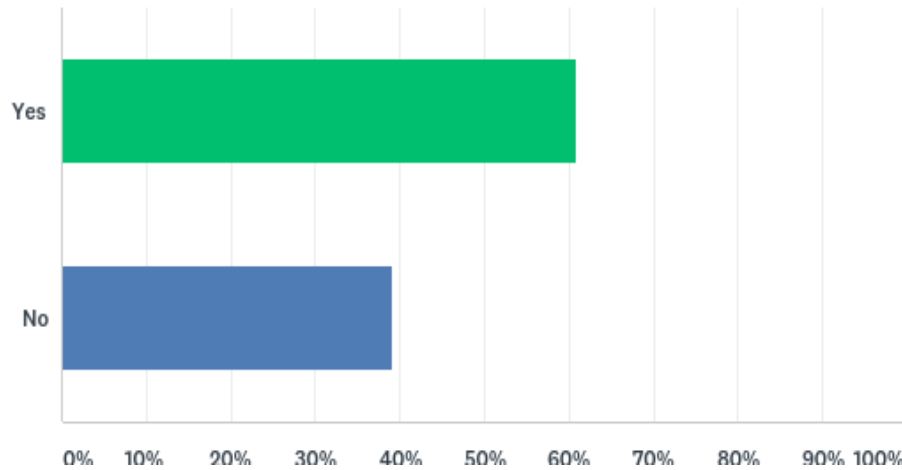

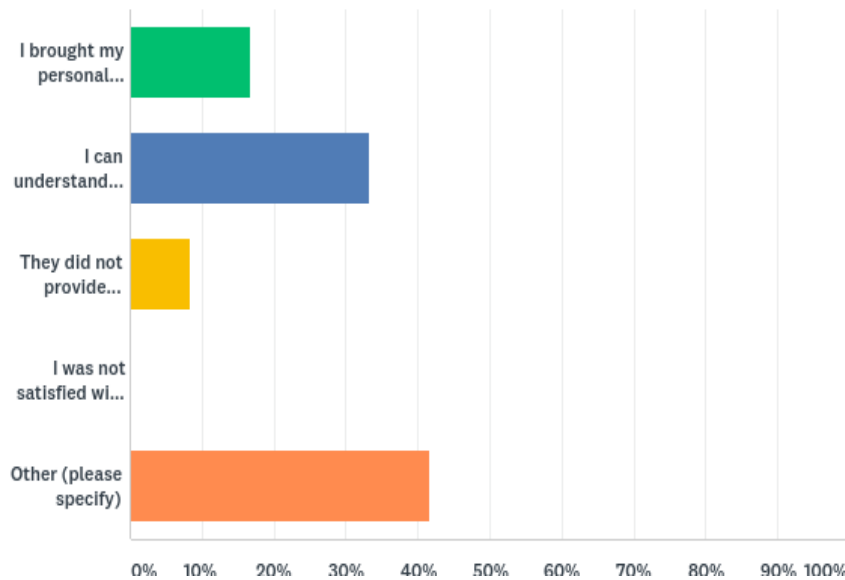*Figure 19 Patient survey Q 17. Was the interpreting performed in your first language?*

Figure 20 Patient survey Q 18. Why did you not get the interpreting service in your first language?
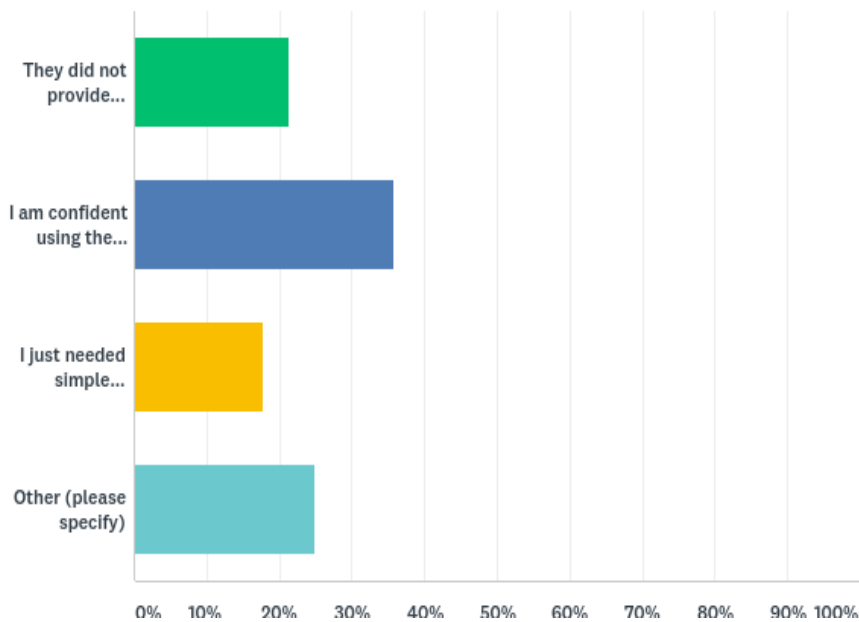
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Figure 21 Patient survey Q 19. Why did you not use the interpreting service provided by the hospital?

Of the sixteen respondents who did not receive the interpreting service in their first language, nine responded that the hospital did not provide interpreting service in their first language, four that they were confident using the language the interpreting service was performed in, and another two responded that they just needed simple assistance rather than the interpreting service.

Of the sixteen respondents, four did not use the interpreting service because they were confident using the language the service was performed in, and of the four, two brought personal interpreters (their friends) (see Fig. 23), and two responded 'because doctors speak English'. Another two responded that they just needed simple assistance rather than the interpreting service: one said that the doctor speaks English, one brought a personal interpreter (nephew). Furthermore, one responded that the interpreting is not needed, another can understand Korean, and the other responded that no communication was necessary.

Question 20 & 21 relate to respondents' personal interpreters.
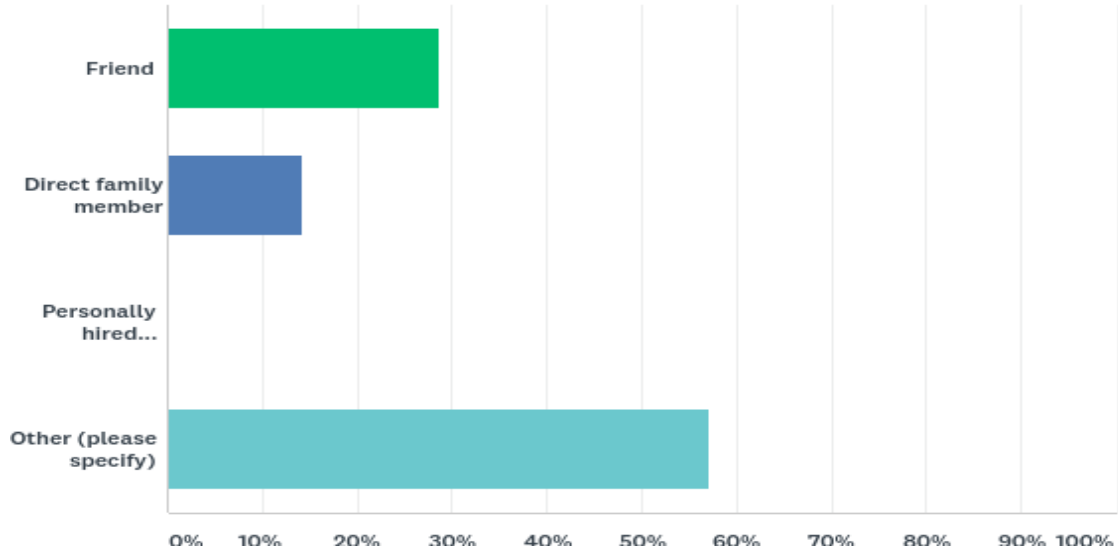
Figure 23 Patient survey Q 20. Who did you bring to interpret your consultation?
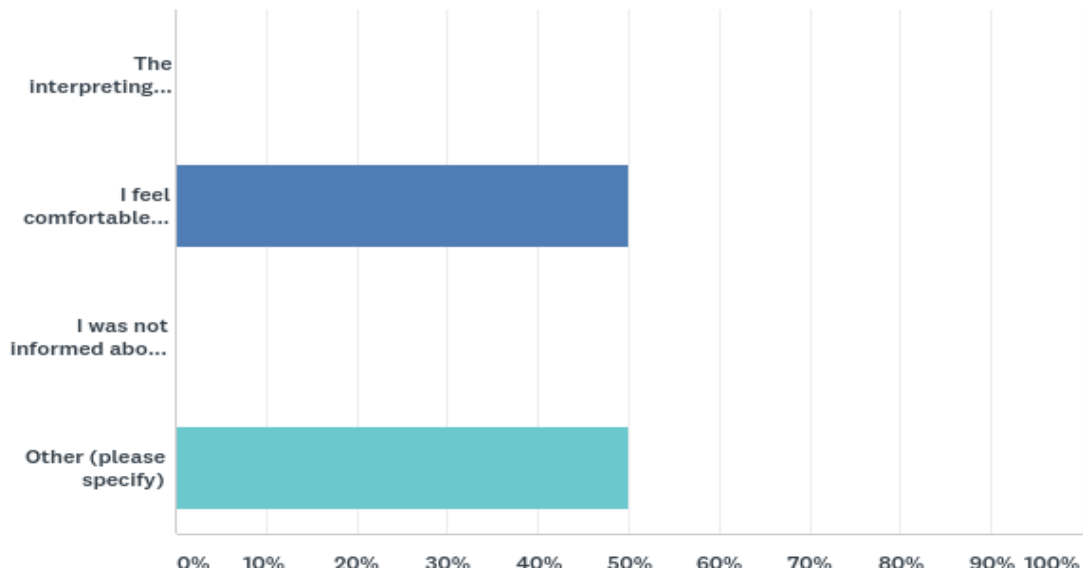
Figure 24 Patient survey Q 21. Why did you bring your personal interpreter?

Of the three who brought their personal interpreters, two felt comfortable with the person, and one answered that the person accompanied him/her to the Center and he happened to speak Korean (Fig. 24).

Question 22, 23 & 24 ask about the respondents' levels of satisfaction in the interpreting
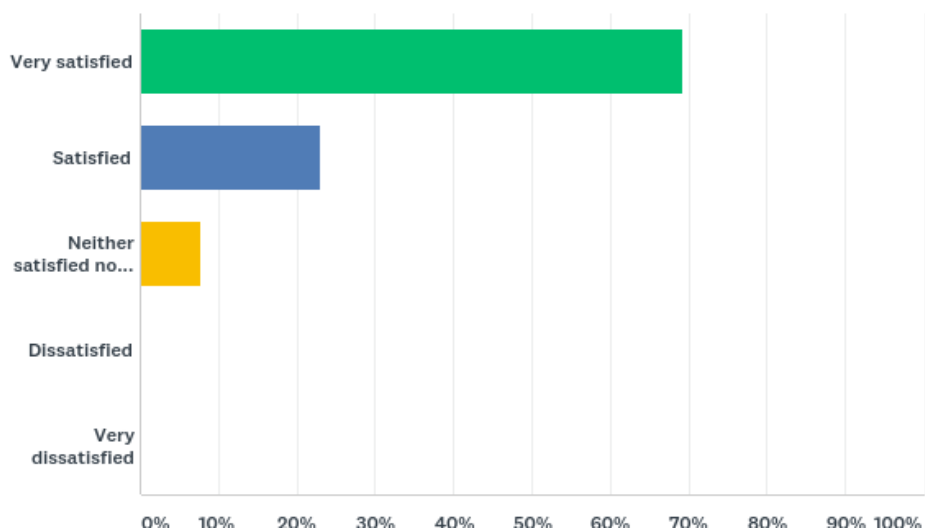
services.

Figure 23 Patient survey Q 22. Are you satisfied with the hospital-provided interpreting service?
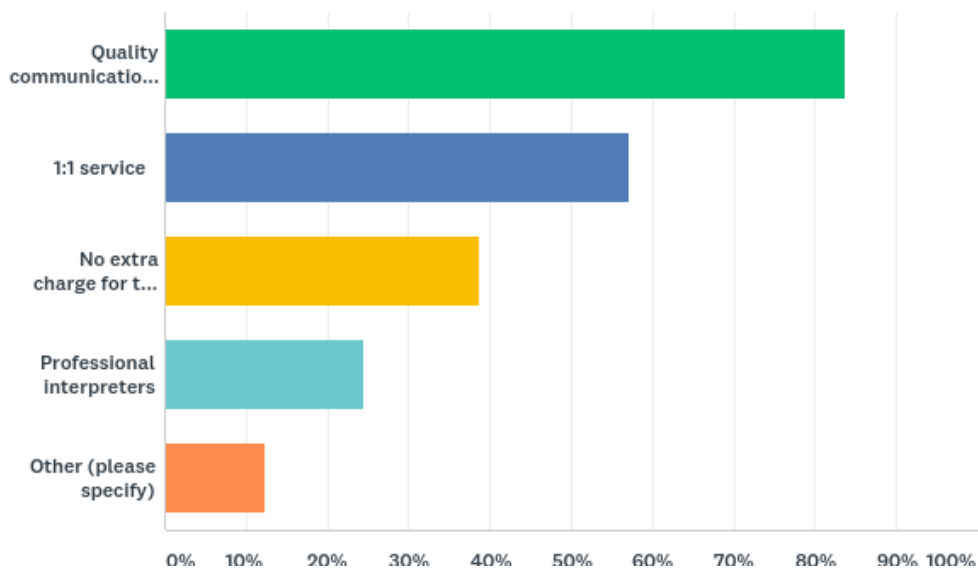
Figure 24 Patient survey Q 23. What are the factors that contributed to your satisfaction?
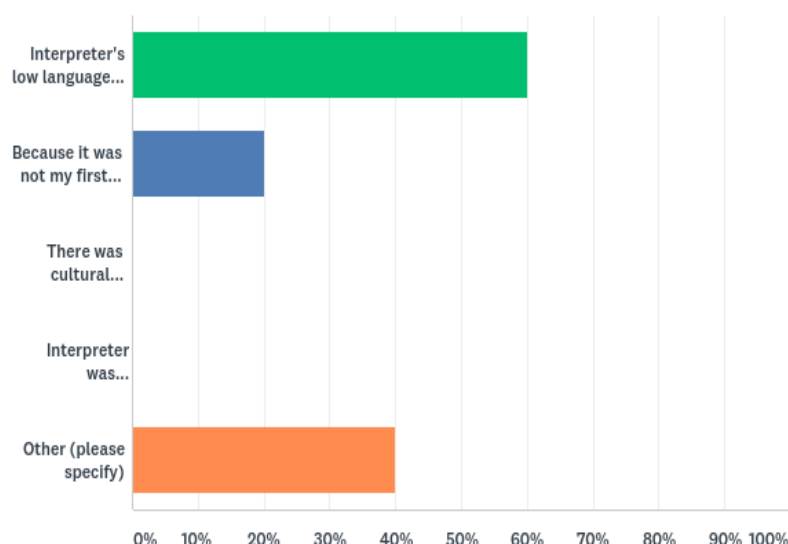
Figure 25 Patient survey Q 24. Why are you dissatisfied with the interpreting service provided by the hospital?

Of the 46 who used the interpreting service provided by the hospital, 42 were 'satisfied', 31 'very satisfied' and eleven 'satisfied'. The remaining three were 'neither satisfied nor dissatisfied'.

Of the 42 who were satisfied with the service, 80.95% (*n=34*) nominated 'quality communication with medical staff', 54.76% (*n=23*) 'one-on-one service', 40.47% (*n=17*) 'no extra charge for the service', and 28.57% (*n=12*) 'professional interpreters' as the reasons for their satisfaction.[4] There were six respondents who also left a comment about the good service provided by the interpreters. However, there was one who was generally satisfied with the service but who commented on his dissatisfaction with 'the inconsistent quality of the service'. On the other hand, two of the three of those who are 'neither satisfied nor dissatisfied' responded that the interpreter's low language proficiency contributed to their dissatisfaction on the interpreting service.

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[4] Respondents were allowed to provide multiple answers; therefore, the total percentage exceeds 100%.
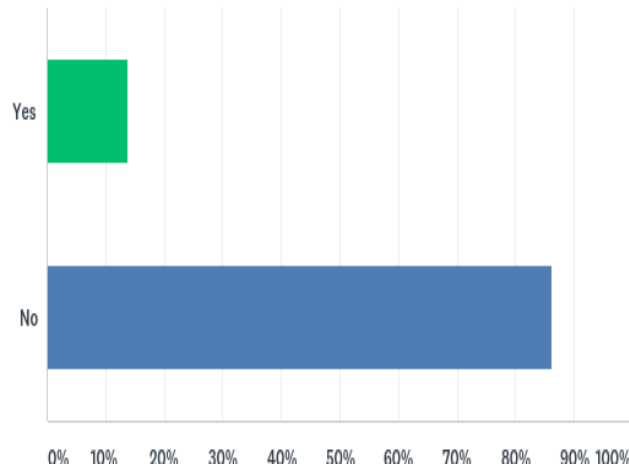
Figure 26 Patient survey Q 25. Are you uncomfortable with the presence of the interpreter during your consultation?
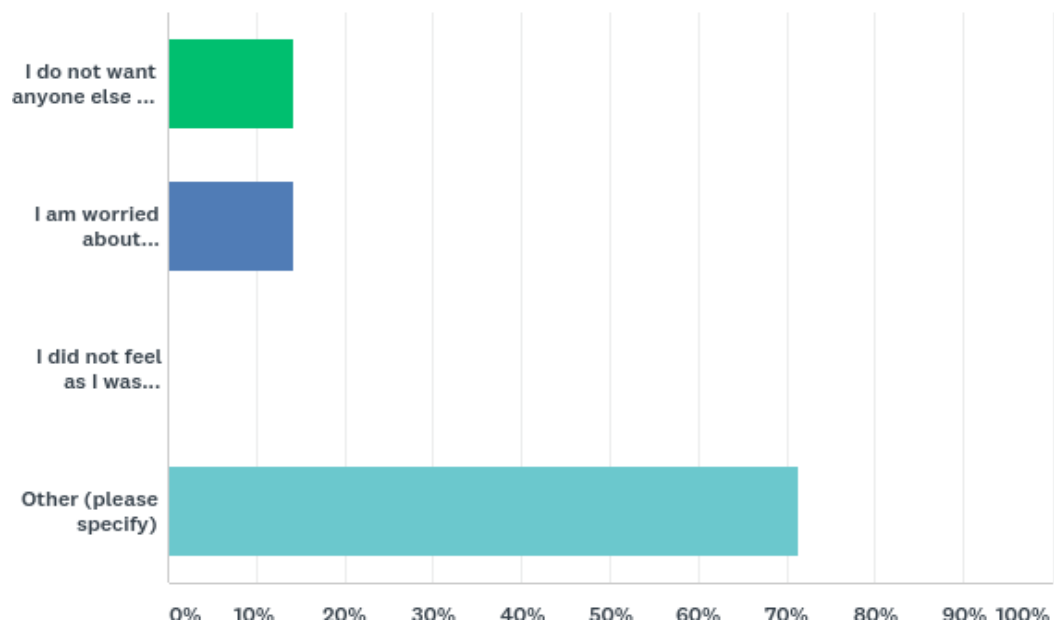
Figure 27 Patient survey Q 26. Why do you feel uncomfortable?

The vast majority, 86.27% (*n=44*) did not feel uncomfortable with the presence of the interpreter during their consultation, but 7 (*n=7*) did feel uncomfortable (Fig.28).

As a follow up question to those who felt uncomfortable with the presence of the interpreter during their consultation, two respondents (R1 & R2) believe interpreting is not needed if doctors

and patients understand each other, and another two (R3 & R5) do not want anyone else to know about their medical conditions. R5 and the remaining respondent (R4) preferred direct communication with the practitioner to interpreter-mediated communication.

4.5. Interviews

The interviews with staff members at the International Healthcare Center were conducted to collect broader and deeper views from individuals. The objectives of the interviews are listening to each groups' (healthcare practitioners and interpreters) perspective on interpreters' roles. However, because the interview was time consuming, only two staff members were available.

Participant 1 was a healthcare interpreter hired by the hospital, with experience in receiving (community) interpreter training. The interview with her aimed to explore the difficulties interpreters face in practice, especially focussing on the respondent's view on the interpreter's roles and community interpreter training. When asked about training opportunities and their benefits, she indicated that she has taken many interpreting classes, including community interpreting classes, at a university level. The benefit of having taken these classes is a heightened awareness of the concept of community interpreting. The class gave her the opportunity to learn about community interpreting, and to intern at the hospital, which led her to work there.

The class she took was only one semester long, but she learned medical terminology, the differences between non-community interpreting and community interpreting, the challenges or aspects she needed to pay attention to when interpreting, attitudes towards interpreting, and healthcare practitioner and patients' needs. Knowing these, she was able to adapt to a healthcare interpreting setting quite easily.

When working with professionals who do not have training in working with interpreters, this interpreter responded that firstly, when patients in whose languages interpreting services are not provided, they use phone interpreting services. Most of the phone interpreters are volunteers. In these cases, interpreting prolongs the consultation time. The main reason for this is that these interpreters have less understanding of patients' and healthcare practitioners' needs. When delivering an utterance, you need a clear understanding of the speaker's intentions in order use an appropriate expression, or you have to probe to get an idea of the meaning. Also, interpreter's mediation is necessary when one interlocutor speaks for too long, but this normally does not take place. Lack of knowledge and medical terms contribute to problems with communication.

Secondly, when training short-term interns, or volunteer workers, she can tell the differences between them and people who had professional training in terms of their abilities to adapt to and understand a healthcare setting. Those who have taken community interpreting classes or government-run healthcare interpreting courses better understand how to assist and interpret in this particular setting.

Lastly, healthcare practitioners, especially doctors, have basic English skills as the medical terms or books they use are mostly in English. However, when looking into cases where effective communication did not take place, failure to understand the cultural differences or capture patients' needs are the most common reasons for poor communication. I think this is because distinctive features of community interpreting (compared to non-community interpreting) were overlooked (e.g. the interactive aspects and participant roles).

When asked whether an English speaker would be capable of interpreting, she responded that it was possible, but not in an effective and successful way. Foreign patients with English-speaking guardians sometimes required an interpreter. When interpreting, having background knowledge is very important. Lack of medical knowledge or understanding of different cultural or healthcare settings could bring about poor interpreting. You can interpret successfully only when you fully understand the intention of the interlocutors under a certain situation.

The interview with Participant 1 clearly shows that she believes having bilingual competence alone is not sufficient to perform medical interpreting.

Participant 2 was a staff member working at the International Healthcare Center hired by the hospital. She did not have the time to attend an interview. Instead she responded in writing to the semi-structured interview questions.

The written interview with this staff member, also called a medical coordinator, aimed to investigate the structure of language aid services at International Healthcare Center and the difficulties staff members encounter.

She was firstly asked what she considered to be the difference between a healthcare interpreter and a medical coordinator. In her view the main difference is their roles; an interpreter is the term for a staff member who provides services related to 'language', on the other hand, a medical coordinator is a staff member who provides liaison services but also takes part in administrative work.

She believed that the roles of the language service providers are not limited to language service provision. Until recently, all staff members were considered full-time employees who can also

provide interpreting services. However, in these days, the Center was trying to give different staff members different roles. For example, Participant 2 was now mostly dealing with administrative work,which included managing staff members of the Center, training new interns, and promoting the International Healthcare Center by running many different projects. In the future, she hoped to bring about systemic changes so that healthcare interpreters can focus on their interpreting roles, and other staff members on other administrative or reception work.

Both healthcare practitioners and patients considered the quality of communication the most important factor that contributes to a satisfactory interpreting service. Also, the accuracy of the interpreting and language proficiency of the interpreters are seen as qualifications that define the quality of interpreting, as they are the reasons that respondents gave for dissatisfaction. However, the fact that patients ranked good service as the second factor that contributed to their satisfaction, which includes one-on-one, personalised service, foreign patient-friendly atmosphere, and no extra charge for the interpreting service, shows that healthcare interpreters need more than bilingual competence to bring about a certain level of satisfaction.

Coupled with the expectation they have for interpreters, and the difficulties that healthcare practitioners face when communicating with foreign patients (language barriers, lack of general knowledge regarding effective communication with foreign patients, and cultural differences), expected healthcare interpreters' roles among health practitioners can be interpreted as a communication facilitator, cultural broker, and a language expert/language aid.

Meanwhile, the patients see interpreters as communication facilitators and service providers or staff hired by the hospital (because they see the quality of general service as an important factor contributing to their satisfaction). However, of the four staff members undertaking interpreting, all identify more with their roles as medical coordinator, healthcare interpreter or bilingual nurse. It is surprising that only one of the staff members described herself not only as a healthcare interpreter, but also as an administrative staff member, help mate, and cultural broker, which are the roles that interpreting service users expect.

Chapter 5. Discussion and conclusion

The aims of this study were firstly, to provide a profile of interpreters working in healthcare settings in Korea and the users of interpreter services; secondly, to identify the roles and practices of interpreters working in healthcare settings in Korea; and lastly, to determine the level of satisfaction of users of interpreting services.

I set out to examine healthcare interpreting in the Korean context on the assumption that

a. the users would be medical tourists, and

b. the interpreters would have been non-professional interpreters without qualifications or training.

However, after conducting the participant observation, it became clear that the users were, in fact, mostly foreign residents of Korea and this was confirmed by the survey results. Therefore, I can conclude that the government initiatives to train interpreters for medical tourism are not adapted to the actual market.

My second assumption was confirmed: the majority of the interpreters were non-professional, but what I had not expected was that they were playing dual roles in the institution with the associated potential for role overload. The interpreters were all employed by the Center to undertake interpreting duties in addition to other administrative roles. Despite the availability of training, these interpreters were principally identified as coordinators and therefore did not perceive a need to undertake training for the interpreting they did as a secondary professional role. Only one, who identified herself primarily as an interpreter, had received training.

However, they all considered that health practitioners and other staff members should undertake training to work successfully with interpreters. The problem here is that the results show that if healthcare practitioners are not interested in general practitioner-patient communication training, it is highly likely that they will not attend other types of communication-related training, which conflicts with the interpreters' beliefs about the need for specialised training. The current working environment of healthcare interpreters, and the lack of clear policies or training regimes, contribute to the lack of understanding of how healthcare interpreters should conduct their professional work as interpreters, as well as how healthcare practitioners could work with interpreters in a harmonious way.

For these interpreters, medical terminology and cultural differences are the principal difficulties that they face when interpreting. This could explain the stated dissatisfaction of the healthcare providers with the interpreting service related to the interpreters' low language proficiency and

consequent difficulty with the specialised medical terminology, as well as their uncertainty about whether the interpreting is accurate or not. It seems that healthcare practitioners are satisfied overall with the level of service provided by the staff interpreters, as they feel that the interpreters enable better communication with their patients, but they are concerned about quality as stated above. Considering the fact that the difficulties they experience in communication with foreign patients are language barriers and cultural differences, which are directly linked to the quality of communication, it is timely to provide quality interpreter training and communication training to nurture professional healthcare interpreters, since interpreting is emerging as a professional practice in this setting. This will encourage interpreting service users' better understanding of the contribution that interpreters can make to enable effective communication between practitioners and their foreign patients. To this end, market demand oriented programs should be provided after defining the roles and demonstrating the importance of using professional healthcare interpreters.

5.1. Discussion

a. Healthcare practitioners

Even though the total number of respondents was only 30, considering that the hospital where the research was conducted is one of the renowned university hospitals in South Korea, with 30 clinics, 130 health professionals, and more than 1,200 staff, and the healthcare practitioners who did participate in the survey are all experienced practitioners with at least two years experience, the result can be considered a reliable picture of the current status of healthcare interpreting practice in Korea.

First of all, it was notable that the majority of participants answered the questions with a positive bias. For example, if the question is about the level of satisfaction, they tend to answer 'very satisfied', 'satisfied', or 'neither satisfied nor dissatisfied'. However, when they provided the reasons for their response, they supported a view of not being 'very' satisfied. What I concluded was, therefore, instead of looking at the numbers, paying attention to the specific reasons for their answers will give more accurate results. Another example relates to the question about workload. Once again, the majority indicated that they are able to cope with their workload, however, when asked the level of satisfaction, all six who answered 'neither satisfied nor dissatisfied' also stated that they have an adequate number of hours of work. Surprisingly, practitioners who answered that their workload is more than they can accept or is not enough showed that they are satisfied with their work as healthcare practitioners. This shows that when

asked for their personal views about something, their answers may not be very accurate, and the levels of satisfaction reported in the survey may also not be as positive as they appear. The detailed responses from the survey of healthcare practitioners are provided above in Chapter 4. Therefore, in this section I will examine the responses that relate to communication between the practitioners and (foreign) patients in more depth.

It was interesting that the ratio of practitioners who received training regarding effective health practitioner-patient communication, and those who did not, was exactly 50:50. Even more surprising was that none of those who had not received any training related to health practitioner-patient communication did not receive any training regarding effective ways to communicate with foreign patients either. As communication with foreign patients may be a subcategory of communication between practitioners and patients in general, it makes sense that only those who have a background of receiving training in communication have a higher chance of getting any training regarding communicating with foreign patients. An additional point of interest is the fact that the provision of training does not relate to the year the practitioners graduated or started their career, nor to the level of education completed. However, three of the four who started their career in the 1990s, and less than half (*n=10*) of those who started working later than 2000, received the training in effective communication between healthcare practitioners and patients. This tells us that there is a general lack of awareness of the necessity of a theoretical approach to the quality of communication. The problem here is that except for three healthcare practitioners, the rest actually do deal with foreign patients, and 63.3% of them (*n=19*) face 'language barriers' when dealing with them. If not, they encounter difficulties due to their 'lack of understanding of effective communication skills'. There was actually one healthcare practitioner who answered that the difficulty also comes from interpreter-mediated communication because the interpreting services were inadequate. This result shows that it is not only the healthcare practitioners who are not familiar with communicating with foreign patients on the matter of cultural differences, but some interpreters they work with may also not be able to perform quality interpreting, as the healthcare practitioner specifically pinpointed the reason for inadequate interpreting service.

Following this result, they were asked to answer questions regarding the interpreting service. Not surprisingly, most of them answered they are (very) satisfied with the service, but there was one respondent who answered 'dissatisfied', indicating that it was because of 'interpreters' low language proficiency'. This is very interesting because, as stated above, most of the respondents tend not to answer any questions in a negative way, but this one person showed dissatisfaction towards the interpreting service, specifying that the quality of the interpreting was lower than he

expected. Furthermore, a few of those who were satisfied with the interpreting service mentioned that they are not 'very' satisfied because 'they do not know whether the interpreting is accurate or not', and even interpreter-mediated communication 'cannot bridge the gap of cultural differences'. In other words, there are doubts about the interpreters' language skills (which is the most basic and important skill to have as an interpreter), and a reliance on the interpreter as a cultural mediator.

Furthermore, most of the participants indicated that they need training regarding interpreter-mediated communication. A few specifically explained that they feel interpreter-mediated communication is unnatural due to delays in communication; another expected interpreters (or bilingual staff members) to build trust with patients and reduce the time, tasks that are not the usual responsibility of interpreters. Others answered that it was because they need to bridge the cultural gaps, and improve the quality and accuracy of the communication. The result shows that a few healthcare practitioners see interpreters as cultural brokers, mediators (who builds trust), and language experts. However, at this stage, the definition and prerequisites for quality interpreting and healthcare interpreter cannot be defined, as interpreter-related questionnaires were not included in the survey. Their opinions about whether interpreters need to be trained or not, or need to obtain any accreditation, have not been explored, and therefore it is still uncertain as to whether bilingual workers who often perform interpreting can be referred to as 'healthcare interpreters' rather than 'non-professional interpreters'.

b. Staff members

Four staff members participated in the survey as interpreting staff, but the nurse identified herself more as a nurse than a bilingual worker or interpreter. Other staff members defined themselves as 'medical coordinators', 'healthcare interpreters', or 'healthcare interpreters, administrative staff members, help mates, and cultural brokers', which shows each individual sees themselves differently. The more interesting part is that even though they received on-the-job training (a short orientation introducing their roles, general background of healthcare interpreting, and potential barriers they may face) or had work experience as an interpreter, their professional technical skills varied (e.g. if they take notes or use first or third person). In other words, there is no consistency in the way they deliver the interpreting service. This can potentially cause confusion to service users about how to best work with interpreters. Furthermore, in terms of the difficulties they experience when performing interpreting, cultural differences and medical terminology turn out to be the two biggest barriers. To summarise, in order to maintain consistency and improve the quality of the interpreting service, uniform training, including basic

interpreting skills, and especially medical terminology and cultural differences, needs to be provided. Also, considering the fact that each interpreter uses different persons, the result tells us that even interpreters themselves do not have clear definition or idea of healthcare interpreting, as some of them are using the first person, which could be interpreted as interpreters considering themselves 'translation machines', and others are using the third person (or indirect or reported speech), which means they see themselves as active participants in communication. One of the reasons that healthcare interpreters use different persons could be the fact healthcare interpreting in the Korean context is ill-defined and the roles of the interpreters are still vague. In order to resolve this issue, defining healthcare interpreting for the Korean context should come first.

c. Patients

The data collected from the patients who used the International Healthcare Center was the most interesting part to analyse not only because the result was different to what I had expected, but the result itself suggests further research on this topic is needed. It was surprising and interesting to find, that during the period in which the research was conducted, there were no patients who were visiting Korea for the purpose of medical tourism. Most of the participants were long term visitors to or residents of Korea, residing there for at least a year for the purpose of their work or study. This suggests firstly that medical tourism targeted interpreter training could be redirected to general medical interpreter training, and secondly, that the Korean government needs to provide more community interpreter training to provide language support to non-Korean speaking background communities in all domains (such as legal or welfare). The second interesting part was the reasons for the patients to choose this particular hospital. Most of the patients in the study prioritised convenience and reputation over communication quality, giving 'convenient location' as the primary reason they chose the hospital. Furthermore, a few people visited this hospital because their work or insurance covered their medical costs at this specific hospital. Even though 'interpreting service' ranked third, the answers provided in the subsequent question supported the conclusion that patients do not consider the quality of communication or interpreting in choosing a hospital, as long as they are able to communicate well enough with administrative staff and healthcare practitioners. They put friendly atmosphere or quality of service above communication, followed by the professionalism of the practitioners and the price. Despite this, almost 80% of the patients who visited the International Healthcare Center stated that they used the interpreting service. However, patients' notions of 'interpreting' may vary because in some cases, they just received language support, such as bilingual staff members helping them with payments and

administrative processes, or accompanying them to other departments to see specialists. As an observer and an interpreter, I define 'interpreting' as the language mediation that takes place in a consulting room, rather than the bilingual support involved in telling patients the price in English or giving them directions. I discovered that understanding of the term 'interpreting' needs to be explored from the users' perspective in order to better understand their views, expectations, and needs, which could later affect interpreter training.

Even though the patients' definitions of interpreting were broader than expected (for instance, they considered someone using another language to give simple instructions to a non-Korean speaking person as interpreting, just as Angelelli (2004) defined community interpreting as a tool for minority language users communicate with dominant language users in everyday communication), the result also shows the contradictory view that patients consider an act of interpreting something special. For example, to questions about why they did not use the interpreting service, or use the service in a language that is not their first language, except in the case when interpreting in their first language was not provided by the hospital, patients responded that they could understand or communicate using the language the interpreting or consultation and treatment was performed in, or that they just needed simple assistance rather than interpreting. From this point of view, it is clear that if the communication takes place and both parties can understand each other to a satisfactory level, professional language support is not seen to be needed. Another perspective is that quality communication does not matter to the patients, or is not reliant on the level of language proficiency, as there are a few patients who brought their friends or family members as their personal interpreters. This is especially true in the case of the patient whose nephew performed interpreting for them: the patient stated that, fortunately, the nephew happened to speak Korean, and that was the reason he could help as a non-professional interpreter. Responses to questions in the latter part of the survey again emphasise that the quality of the communication is not really important for patients. Patients were satisfied with being able to communicate with staff, and receiving one-on-one or friendly service. Price (no extra charge for interpreting service) and the existence of professional interpreters did also contribute to their satisfaction, but were not the main reason for it. Also, survey questions did not ask respondents to state which interpreter performed interpreting for them, so we cannot tell whether non-professional interpreters could also be considered as professional as trained interpreters, or whether they can be distinguished from professional interpreters by the users. However, when it comes to dissatisfaction, interpreters' low language proficiency was the main reason for patients' dissatisfaction. Again, from the survey we cannot tell which staff member interpreted each case: it

is not clear whether the interpreter with low language proficiency is non-professional or a trained interpreter, even though neither case is ideal in healthcare interpreting settings. Some patients also feel uncomfortable with the presence of an interpreter due to confidentiality, or the directness of the communication, as they prefer direct conversation with the health practitioners rather than using someone else's voice. This shows a number of interpreting service users are not aware of the fact that interpreters must abide by ethical principles including confidentiality in their code of ethics, or employ basic characteristics of interpreting, which includes the use of the first person when performing interpreting. Also, the users do not place a priority on the quality of the communication. To summarise, patients generally feel satisfaction when they are able to communicate with healthcare practitioners (directly), and it does not have to be quality communication. This leads to patients not using interpreting services, or using it only in a limited way for specific situations. However, the definition of interpreting varies from one patient to another. Therefore, defining interpreting should come before the in-depth research in healthcare interpreting in Korea

d. Overall discussion

According to the data collected from the case study, there was no consensus on how the term 'interpreting' is understood and used among service users and interpreters. For example, some considered any activity that took place in English as an act of interpreting, while others limited the term to interpreting performed in a consulting room where there were three parties – healthcare practitioners, patients, and interpreters – participating in the communication. To clearly define what healthcare interpreting is, and furthermore, to set a role boundary to prevent a heavy workload for interpreters, categorising activities into different types should come first, and that could lead us to define the term 'healthcare interpreting' at the same time as setting a role boundary.

The next step will be training or education. The training must include interpreters' roles, a code of ethics, and skills required to perform quality interpreting. Not only interpreters but also service users should be trained to be familiar with the concept and understand the code of ethics to make sure they receive the service at an acceptable standard, without feeling that their personal medical records are insecure, or being uncomfortable with the presence of the interpreter.

However, setting role boundaries may pose a burden to hospitals where cost-effectiveness is important to run their businesses, since they might need to replace a few untrained bilingual staff with trained or professional interpreters. In other words, they need to hire more people to share a

workload that used to be handled by one bilingual staff member. Even though hiring professional interpreters may reduce the risk of medical incidents and length of stay, and increase the satisfaction of patients and practitioners, the cost-effectiveness needs further research in the Korean context, since it has a unique healthcare system that is different to other countries. If hiring professional interpreters brings about better cost-effectiveness, then hospitals can come up with new policies. To this end, the government also needs to implement laws to protect both interpreters' and service users' rights by setting a code of ethics tailored to the Korean context.

5.2. Limitations

This case study conducted in one hospital enabled us to collect a small number of responses to our surveys. The number of participants was limited due to the research being conducted during the holiday period (an unavoidable occurrence due to the short time frame of the Master of Research). Also, as the research was conducted in a healthcare setting, some participants felt uncomfortable sharing their experience due to the personal nature of the consultations. It was therefore difficult to collect observations of interpreter-mediated interactions as had originally been planned. The small numbers meant that the test of significance was difficult, and the associations between factors had to be carried out qualitatively.

5.3 Further research

To better define healthcare interpreting in the Korean context, further investigation into how the roles of healthcare interpreters play out is necessary, perhaps over several institutions for a longer period of time. As interpreter training is based on the market needs (Angelelli, 2004), it is important to understand the viewpoint of interpreting service users, as well as knowing how interpreters define their roles in order to bridge the gap between interpreting providers and users, and theory and real-life situation. To this end, further research with in-depth case studies of practice, observation of interpreters working, and surveying is essential to collect broader data from both patients and interpreters, focussing on defining healthcare interpreting in Korea.

5.4. Concluding remarks

Since healthcare interpreting is still an ill-defined concept in Korea and a practice that is in its infancy, the roles of interpreters and the prerequisites to professional practice remain vague.

What are the characteristics that distinguish bilingual staff members and healthcare interpreters? To answer this question, the roles of healthcare interpreters in other countries were discussed in the literature review, and a case study at a hospital in Korea was conducted to explore the status quo of healthcare interpreting in Korea. The expected roles of a healthcare interpreter were found to be 'communication facilitator', 'cultural broker', 'language expert', and a staff member of the hospital, even though a few interpreting service users do not trust the accuracy of the interpreting due to the low proficiency of the interpreters. This calls upon an interpreter to earn recognition by developing the relevant skills. As Bell (1997) highlighted, the appropriate level of bilingual skills, background knowledge in both languages, qualifications, and appropriate training will be required to gain a reputation for the quality of their interpreting performance. However, as mentioned above, Angelelli (2004) considers that interpreter training must be provided to meet the current needs of the market. To discover the consumer's needs, further research into the expectations and needs of patients toward healthcare interpreters in Korea is required. Also, as non-professional interpreting and translation-related research is gaining attention and being conducted from various perspectives in many countries (Antonini et al., 2017), it is timely for Korea to conduct research on non-professional healthcare interpreting, since Korea is still at an *ad hoc* stage according to Ozolins' (2000) continuum of responsiveness. When both consumer needs and interpreter's roles are defined, and the importance of using professional or trained healthcare interpreters gains attention, mapping healthcare interpreter training should follow. A better understanding of the needs and profiles of the profession could potentially have a positive impact on the training of healthcare interpreting in Korea, setting the foundation of the provision of quality interpreting services within the country, where the government and the society no longer accept unaccredited or non-professional interpreters. When *ad hoc* interpreting is replaced by professional interpreters except in emergencies, Korea will become one of the countries which attain Ozolins' (2000) category of 'comprehensiveness'.

References

Angelelli, C. V. (2004a). *Medical interpreting and cross-cultural communication*. Cambridge University Press.Angelelli, C. (2004b). *Revisiting the interpreter's role: a study of conference, court, and medical interpreters in Canada, Mexico, and the United States* (Vol. 55). Amsterdam: John Benjamins Publishing.

Antonini, R., Cirillo, L., Rossato, L., & Torresi, I. (Eds.). (2017). Non-professional interpreting and translation: state of the art and future of an emerging field of research. Amsterdam: John Benjamins.

Australian Commission on Safety and Quality in Healthcare. (2012, 5 5). Review of patient experience and satisfaction surveys conducted within public and private hospitals in Australia. Australian Commission on Safety and Quality in Healthcare.

Bell, S. J. (1997). The Challenges of Setting and Monitoring the Standards of Community Interpreting: An Australian Perspective. In S. E. Carr, R. Roberts, A. Dufour, & D. Steyn (Eds.), *Critical Link : Interpreters in the Community* (Vol. 19, pp. 93-108). Amsterdam: John Benjamins Publishing Company.

Beltran Avery, M.P. (2001). The role of the health care interpreter: An evolving dialogue. *National Council on Interpreting in Health Care*.

Carr, S. E., Roberts, R. P., Dufour, A., & Steyn, D. (Eds.). (1997). *The Critical Link: Interpreters in the Community: Papers from the 1st international conference on interpreting in legal, health and social service settings, Geneva Park, Canada, 1 4 June 1995* (Vol. 19). Amsterdam: John Benjamins Publishing.

Chun, C. B., Kim, S. Y., Lee, J. Y., & Lee, S. Y. (2009). Health systems in transition: Republic of Korea: health system review 2009. In Health systems in transition: Republic of Korea: health system review 2009 (pp. 183-183).

Cohen, L., Manion, L., & Morrison, K. (2013). Research methods in education. Routledge.

Crezee, I., Oh, Gene Kwan, Tetteroo, Paul, & New Horizons Advisory Services. (1998). *Interpreting for community settings* Auckland, N.Z.: New Horizons Advisory Services.

Davidson, Brad (1998). Interpreting Medical Discourse: A study of cross-linguistic communication in the hospital clinic. PhD thesis, Stanford University.

Davidson, B. (2000). The interpreter as institutional gatekeeper: The social-linguistic role of interpreters in Spanish-English medical discourse. *Journal of sociolinguistics*, *4*(3), 379-405.

Dong Kwan Kang. (2014). Migration Trend of Korea, 2014. Goyang-si: The Migration Research and Training Centre of the International Organization for Migration.

Ebden, P., Bhatt, A., Carey, O., & Harrison, B. (1988). The bilingual consultation. *The Lancet*, *331*(8581), 347.

Elderkin-Thompson, V., Silver, R. C., & Waitzkin, H. (2001). When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting. *Social science & medicine*, *52*(9), 1343-1358.

Garber, N. (2000). Community Interpretation: a personal view. In Roberts, R. P., Carr, S. E., & Abraham, D. (Eds.). *Critical link 2: interpreters in the community. Selected papers from the second international conference on interpreting in legal, health and social service settings*, Vancouver, BC, Canada, 19-23 May 1998.

Gentile, A. (1997). Community interpreting or not? Practices, standards and accreditation. In S. Carr, R. Roberts, A.Dufour & D. Steyn (Eds.), *The Critical Link. Interpreters in the community.* Amsterdam & Philadelphia: John Benjamins

George Washington University Medical Center. (n.d.). Interpreter Satisfaction Survey. Retrieved from Robert Wood Johnson Foundation: http://www.rwjf.org/en/library/research/2007/03/interpreter-satisfaction-survey.html

Gynaecoloog verwijderde ongewild baarmoeder Poolse vrouw. (2018). *1Limburg | Nieuws en sport uit Limburg*. Retrieved 13 March 2018, from https://www.1limburg.nl/gynaecoloog-verwijderde-ongewild-baarmoeder-poolse-vrouw

Hale, S. (2007). *Community Interpreting.* Basingstoke: Palgrave Macmillan.

Harris. B. (1997) Foreword: A landmark in the Evolution of Interpreting. In Carr, S. E., Roberts, R. P., & Dufour, A. (Eds.). (1997). *Critical link : interpreters in the community:papers from the 1st international conference on interpreting in legal, health and social service settings, geneva park, canada, 1–4 june 1995*. Retrieved from https://ebookcentral- proquest-com.simsrad.net.ocs.mq.edu.au

Hampers, L. C., & McNulty, J. E. (2002). Professional Interpreters and Bilingual Physicians in a Pediatric Emergency Department: Effect on Resource Utilization. *Archives of Pediatrics & Adolescent Medicine, 156*(11), 1108-1113. doi:10.1001/archpedi.156.11.1108

Helble, M. (2010, November 26). The movement of patients across borders: challenges and opportunities for public health. Bulletin of the World Health Organization, 89(1), pp. 68-72.

Hertog, E. (2006). Introduction. Taking stock: research and methodology in community interpreting. *Linguistica Antverpiensia*., 2006, (5).

Hewitt, M. (2000). Interpreting the volume-outcome relationship in the context of healthcare quality: workshop summary. Washington, D.C.: Institute of Medicine.

Holmes, J. S. (2000). The name and nature of translation studies. In Pöchhacker, F., & Shlesinger, M. (Eds.). (2002). *The interpreting studies reader*. Psychology Press.

Hu, D. J., & Covell, R. M. (1986). Healthcare usage by Hispanic outpatients as function of primary language. *The Western journal of medicine, 144*(4), 490.

Jeong, C. J. (2010). Research on Korean Medical Interpreting: Based on Market Needs Analysis.(pp. 151-172). The Korean Association of Translation Studies.

Kaczmarek. L. (2016). Towards a broader approach to the community interpreter's role. *Interpreting, 18*(1), 57-88.

Kalina, S. (2011). In Kainz, C., Prunč, E., & Schögler, R. (Eds.), Modelling the Field of Community Interpreting: questions of methodology in research and training (Vol. 6) (pp.45-65). LIT Verlag Münster.

Kang DK., OH JE., Lee CW., Choi S., Youn (2014). Migration Trend of Korea, 2014(IOM MRTC Collection of Migration Policy Research No. 05)

Kaufert, J. M., & Putsch, R. W. (1996). Communication through interpreters in healthcare: ethical dilemmas arising from differences in class, culture, language, and power.

Kim, A. E., & Park, I. (2006). Changing trends of work in South Korea: The rapid growth of underemployment and job insecurity. Asian Survey, 46(3), 437-456.

Ko, Y.-M. (2004). Theoretical characteristics of dialogue interpreting and education of dialogue interpreters.

Korea Tourism Organization. (n.d.). Why Korea? Retrieved from Visit Medical Korea: http://english.visitmedicalkorea.com/eng/medicalTreatments/medicalTreatments01/medicalTreatments01_1.jsp;jsessionid=M0R9hicgb4n08jDZcGmhxcszc1J9VorG71Vaas082wAID5ipq8hGAUOc2hl9BIzE.corent-0428_servlet_engine1

Kwak Joong Cheol. (2010). A Study on the Training of Korea's 1st Medical Interpreters in 2009. The Journal of Translation Studies, 11(1), 7-43.

Leanza, Y. (2005). Roles of community interpreters in pediatrics as seen by interpreters, physicians and researchers. In F. Pö chhacker & M. Shlesinger (Eds.), *Healthcare*

interpreting : discourse and interaction (Vol. 9, pp. 11-34). Amsterdam ; Philadelphia John Benjamins.

Lee Sang-Bin. (2009). The Socio-Legal and Training Landscape of Healthcare Interpreting in Korea : From the Viewpoint of Medical Tourism. The Journal of Translation Studies, 10(4), 139-178.

Llewellyn-Jones, P., & Lee, R. G. (2014). Redefining the role of the community interpreter: The concept of role-space. *SLI Press*.

Magill, D., & De Jong, K. (2016). Interview with Kim de Jong, interpreting and translation service. International Journal of Interpreter Education, 8(1), 57–66.

Mason, I., & Ren, W. (2012). Power in face-to-face interpreting events. *Translation and Interpreting Studies, 7*(2), 233-252.

Mesa, A.-M. (1997). *L'interprète culturel: un professionnel apprécié* . Montreal: Régie Régionale de la santé et des services sociaux.

Mikkelson, H. (2009). Interpreting is interpreting – Or is it?. In Originally presented at the GSTI 30th Anniversary Conference.

National Council on Interpreting in Healthcare. (2011, 04). National Standards for Healthcare Interpreter Training Programs.

NSW Healthcare Interpreter Services (NSW HCIS). (n.d.). Interpreting in Healthcare – Guidelines for Interpreters 2014. NSW.

NSW Ministry of Health. (2017, July 31). *Healthcare interpreting and translating services*. Retrieved from http://www.health.nsw.gov.au/multicultural/Pages/Healthcare- Interpreting-and-Translating-Services.aspx

Ozolins, U. (1998). *Interpreting and Translating in Australia: Current Issues and International Comparisons*. Language Australia, GPO Box 372 F, Melbourne, Victoria, Australia 3001.

Ozolins, U. (2000). Communication needs and interpreting in multilingual settings: The international spectrum of response. In R. P. Roberts, S. E. Carr, D. Abraham, & A. Dufour (Eds.), *Critical Link 2 : Interpreters in the Community* (pp. 21-33): John Benjamins Publishing Company.

Perez, I. (2012). Interpreting in the community and workplace: A practical teaching guide Basingstoke: Palgrave Macmillan [Book Review]. *Translation & Interpreting, The, 4*(1), 99.

Pérez-González, L., & Susam-Saraeva, Ş. (2012). Non-professionals translating and interpreting: Participatory and engaged perspectives. *The Translator, 18*(2), 149-165

Pöchhacker, F., & Shlesinger, M. (Eds.). (2002). The interpreting studies reader. Psychology Press.

Pöchhacker, F., & Shlesinger, M. (2007). *Healthcare interpreting : discourse and interaction / edited by Franz Pö chhacker, Miriam Shlesinger.* Amsterdam

Pöchhacker, F. (2016). *Introducing interpreting studies*. Routledge.

Roberts, R. (1997). Community interpreting today and tomorrow. In S. Carr, R. Roberts, A. Dufour & D. Steyn (Eds.), The critical link: Interpreters in the community. Amsterdam: John Benjamins, 7–25.

Roberts, R. P., Carr, S. E., & Abraham, D. (Eds.). (2000). Critical link 2: interpreters in the community. Selected papers from the second international conference on interpreting in legal, health and social service settings, Vancouver, bc, Canada, 19–23 May 1998.

Roy, C. B. (2002). The problem with definitions, descriptions, and the role metaphors of interpreters. In F. Pö chhacker & M. Shlesinger (Eds.), *The interpreting studies reader / edited by Franz Pö chhacker and Miriam Shlesinger.* New York: New York : Routledge.

Rudvin, M. (2006). Negotiating linguistic and cultural identities in interpreter-mediated communication for public health services. BENJAMINS TRANSLATION LIBRARY, 67, 181.

Rudvin, M., & Tomassini, E. (2011). Interpreting in the Community and Workplace. Basingstoke: Palgrave Macmillan.

Sarver, J., & Baker, D. W. (2000). Effect of Language Barriers on Follow-up Appointments After an Emergency Department Visit. *Journal of General Internal Medicine, 15*(4), 256-264. doi:10.1111/j.1525-1497.2000.06469.x

Slade, D., Woodward-Kron, R., Stein-Parbury, J., Scheeres, H., Widin, J., Smith, V. & Macqueen, S. (2011). CHEC: Communication for health in emergency contexts. Final Report July.

Slatyer, H. (1998). *The role of the healthcare interpreter: Reconciling codes of ethics with interpreting practice.* (MA Dissertation), Macquarie University.

Smirnov, S. (1997). An overview of liaison interpreting. *Perspectives: Studies in Translatology, 5*(2), 211-226.

Stolley, K (2012). *Medical tourism: A reference handbook.* ABC-CLIO. ABC-CLIO.

Takeda, K., & Baigorri-Jalón, J. (Eds.). (2016). *New insights in the history of interpreting* (Vol. 122). John Benjamins Publishing Company.

The Disparities Solutions Center, M. I. (2012, 9). Hospitals, Improving Patient Safety Systems for Patients With Limited English Proficiency: A Guide for Hospitals. Retrieved from Agency for Healthcare Research and Quality: http://www.ahrq.gov/professionals/systems/hospital/lepguide/index.html

The Universal Declaration of Human Rights. (1948). Paris: United Nations General Assembly

Uchida, Y. (2015). Medical Tourism or 'Medical Examination and Treatment Abroad': An Economic Study of the Phenomenon. In K. V. Malcolm Cooper, Current Issues and Emerging Trends in Medical Tourism (p. 18). Medical Information Science Reference (an imprint of IGI Global).

Wadensjö, C. (1995). Dialogue interpreting and the distribution of responsibility. HERMES-*Journal of Language and Communication in Business, 8* (14), 111-129.

Wadensjö, C. (1998). *Interpreting as interaction.* Longman: London.

Witter-Merithew, A. (1999). From benevolent care-taker to ally: The evolving role of sign language interpreters in the United States of America. *Gebärdensprachdolmetschen: Dokumentation der Magdeburger Fachtagung (Theorie und Praxis 4), Hamburg: Verl hörgeschädigte kinder*, 55-64.

Woloshin, S., Bickell, N. A., Schwartz, L. M., Gany, F., & Welch, H. G. (1995). Language barriers in medicine in the United States. Jama, 273(9), 724-728.

Appendixes

Appendix 1. Ethics Approval letter

8 June 2017

Dear Dr Slatyer

Reference No: 5201700431

Title: *Mediated communication in bi and multilingual health*

Thank you for submitting the above application for ethical and scientific review. Your application was considered by the Macquarie University Human Research Ethics Committee (HREC (Medical Sciences)).

I am pleased to advise that ethical and scientific approval has been granted for this project to be conducted at:

  • Macquarie University

This research meets the requirements set out in the National Statement on Ethical Conduct in Human Research (2007 – Updated May 2015) (the National Statement).

Standard Conditions of Approval:

1. Continuing compliance with the requirements of the National Statement, which is available at the following website:

http://www.nhmrc.gov.au/book/national-statement-ethical-conduct-human-research

2. This approval is valid for five (5) years, subject to the submission of annual reports. Please submit your reports on the anniversary of the approval for this protocol.

3. All adverse events, including events which might affect the continued ethical and scientific acceptability of the project, must be reported to the HREC within 72 hours.

4. Proposed changes to the protocol and associated documents must be submitted to the

Committee for approval before implementation.

It is the responsibility of the Chief investigator to retain a copy of all documentation related to this project and to forward a copy of this approval letter to all personnel listed on the project.

Should you have any queries regarding your project, please contact the Ethics Secretariat on 9850 4194 or by email ethics.secretariat@mq.edu.au

The HREC (Medical Sciences) Terms of Reference and Standard Operating Procedures are available from the Research Office website at:

http://www.research.mq.edu.au/for/researchers/how_to_obtain_ethics_approval/human _research_ethics

The HREC (Medical Sciences) wishes you every success in your research.

Yours sincerely

Professor Tony Eyers

Chair, Macquarie University Human Research Ethics Committee (Medical Sciences)

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (2007) and the CPMP/ICH Note for Guidance on Good Clinical Practice.

Appendix 2. Surveys

2.1. Healthcare Practitioners

This section is about your personal background 인적사항을 묻는 항목입니다

1. Demographic profile 인적사항

1. Gender 성별

- Male 남성
- Female 여성

2. Age 나이

3. Your highest level of education completed 학력

- School certificate 중등 교육 수료
- Higher school certificate 고등학교 졸업
- University Degree 학사 졸업
- Other (please specify) 기타 (답변을 적어주세요)

4. In which suburb do you live (postcode)? 현재 거주 지역 (우편번호)

5. What is your country of birth? 출생국가

Nature of work 직업환경

6. In which department do you work? 병원 내 무슨 과에서 근무중이십니까?

- Family Medicine 가정의학과
- Endocrinology 내분비대사내과
- Radiation Oncology 방사선종양학과
- Urology 비뇨기과
- Plastic Surgery 성형외과
- Neurosurgery 신경외과
- Cardiology 심장내과
- Radiology 영상의학과
- Pathology 병리과
- Obstetrics and Gynecology 산부인과
- Pediatrics 소아청소년과
- Neurology 신경과
- Surgery 외과
- Gastroenterology 소화기내과
- Emergency Medicine 응급의학과
- Dentistry 치과
- Dermatology 피부과
- Cardiovascular and Thoracic Surgery 흉부외과

- Receptionist 원무과
- Other (please specify) 기타 (답변을 적어주세요)

7. What year did you start your career? 근무 시작 연도를 적어주세요

8. Do you have adequate work? 근무량은 적당한가요?
- More than I can accept 혼자서 감당할 수 없는 양이다
- Just the right amount 적당하다
- Not enough work 일이 적다

9. How satisfied are you with your work as a health practitioner? 본인 직업(의료진)에 만족하시나요?
- Very satisfied 매우 만족
- Satisfied 만족
- Neither satisfied nor dissatisfied 보통
- Dissatisfied 불만족
- Very dissatisfied 매우 불만족

  If dissatisfied, what would you like to be different? 불만족, 매우 불만족이라고 답한 분은 작성해주세요. 불만족스러운 부분이 있다면, 어떤 것을 바꾸고 싶으신가요?

10. Your primary work activity is 본인의 주요 업무는
- Consultation 상담
- Treatment 처치,치료
- Health technician 의료 기사
- Payment & Administrative work 수납 및 행정 관련
- Other (please specify) 기타 (답변을 적어주세요)

11. How many hours per week do you work? 일주일에 평균 몇 시간 근무하시나요?

12. How much time do you spend for consultations or treatment per patient? 환자 1 명 당 상담 혹은 처치,

  치료 평균 소요 시간은 몇 분인가요? (환자 1 명당 소요되는 평균 업무 시간)

13. Did you receive training regarding effective health practitioner-patient communication? 효과적인 의료
  진-환자 커뮤니케이션에 관련된 훈련을 받은 경험이 있으신가요?
- Yes 있다
- No 없다

14. Did you receive training regarding effective ways to communicate with foreign patients?
외국 환자와

의 효과적 커뮤니케이션에 관련된 훈련을 받은 경험이 있으신가요?

- o Yes 있다
- o No 없다
- o I am planning to attend seminars or classes 관련 세미나 혹은 수업을 들을 예정이다

Please specify why you are planning to receive training 관련 수업을 들으려는 이유를
적어주세요

15. How many foreign patients do you get per week (approximately)? 일주일 동안 평균 몇
명의 외국인환자를 대하나요?

16. What are the difficulties you face when dealing with foreign patients? 외국인 환자를 대할
경우 가장 어려운 점은 무엇인가요?

- o Language barrier 언어 장벽
- o Cultural differences 문화 차이
- o Lack of general knowledge regarding effective communication with foreign patients
외국인 환자와의 커뮤니케이션에 대한 지
- o 식 부족
- o Inadequate interpreting services 부적절한 통역 서비스
- o Other (please specify) 기타 (답변을 적어주세요)

17. How often do you use interpreting services? 통역 서비스 이용 빈도수

- o Every time I have foreign patients 외국인 환자가 올 때 마다
- o More than 75% of the time 75% 이상
- o 50% of the time 50%
- o More than 25% of the time 25% 이상
- o More than 10% of the time 10% 이상
- o Never 통역 서비스를 이용하지 않음

18. In which language do you use interpreting services the most? 통역서비스를 가장 많이
이용하는 언어 는?

- o English 영어
- o Chinese 중국어
- o Japanese 일본어
- o Spanish 스페인어

- French 프랑스어
- Other (please specify) 기타 (답변을 적어주세요)

19. Are you satisfied with the interpreting service? 통역 서비스에 만족하시나요?
   - Very satisfied 매우 만족
   - Satisfied 만족
   - Neither satisfied nor dissatisfied 보통
   - Dissatisfied 불만족
   - Very dissatisfied 매우 불만족

20. If you are (very) satisfied with the interpreting service, what are the reasons for your satisfaction? (매우) 만족인 이유는 무엇인가요? (19 번에 매우 만족 만족 하신 분만 답변)
   - Helps me communicate better with patients 환자와의 의사소통을 원활하게 해 주기 때문
   - Reduces time of consultation 상담 (치료, 처치) 시간을 줄여주기 때문
   - I feel less burden conveying bad news to patients 환자에게 안 좋은 소식을 전할 때 부담감을 줄여주기 때문
   - Other (please specify) 기타 (답변을 적어주세요)

21. Why are you dissatisfied with the interpreting service? 통역 서비스에 불만족 하는 이유는 무엇인가요? (19 번에 불만족, 매우 불만족 하신 분만 답변)
   - Interpreter's low language proficiency 통역사의 언어 실력이 부족하기 때문
   - I am not sure whether the interpreting is accurate or not 통역이 정확한 지 알 수 없기 때문
   - Patients were not happy with the consultation 환자가 상담(처치,치료)에 불만족스러워 했기 때문
   - I could not bridge the gap between cultural differences 문화적 차이를 좁히지 못했기 때문
   - The consultation takes longer 상담 시간이 길어지기 때문
   - Other (please specify) 기타 (답변을 적어주세요)

22. Are you well aware of interpreter's role? 통역사의 역할이 무엇인 지 잘 알고 계신가요?
   - Very well 매우 잘 알고 있다
   - Fairly well 비교적 잘 알고 있다

- o Moderate 보통
- o Not really 잘 모른다
- o Not at all 전혀 모른다
  - o

23. Do you think you need training regarding interpreter-mediated communication? 통역사가 개입된 커뮤니케이션을 어떻게 해야 하는 지 배울 필요가 있다고 생각하시나요?

- o Yes 필요하다
- o No 필요하지 않다

Please specify why 이유를 적어주세요

Thank you for your cooperation 협조해 주셔서 감사합니다
If you would agree to answer some further questions or would like to receive results of this study, please write your contact information below 향후 추가 질문에 응해주실 분 혹은 본 연구 결과를 받아보고 싶으신 분은 아래에 연락처를 적어주세요

24. Please select
- o I am willing to discuss these issues further 추후 인터뷰에 응할 생각이 있다
- o Please send me information about the results of the study 연구 결과를 받고 싶다

25. Contact information 연락처를 적어주세요

- o Name 성함
- o Email 이메일
- o Phone 전화번호
  - o

2.2. Patients

This section is about your personal

background Demographic information

1. Gender
- o Male
- o Female
- o Other

2. Age

3. Occupation

4. Your highest level of education completed

- o Primary school

- o Middle school

- o High school

- o Higher school certificate

- o University Degree

- o Other (please specify)

5. In which country do you live?

6. What is your country of birth?

General background of your visit

7. What is the main purpose of your visit to Korea?

- o Study

- o Work

- o Travel

- o Medical treatment

- o Medical tour (tour + medical treatment)

- o I am a permanent resident

- o I am Korean

- o Other (please specify)

8. How long are you staying in Korea?

9. Why did you choose Soonchunhyang University Hospital Seoul?

- o Convenient location

- o Renowned doctors

- o Affordable price

- o Advanced facility

- o Interpreting service

o   Recommended by someone

o   Other (please specify)

10. If someone recommended this hospital, what was the reason he/she recommended this hospital?

11. Do you wish to recommend the hospital to others? Why or why not?

Linguistic background

12. Which is your

First language

Second language

Third language

13. In which language did you receive your

Primary education

   Secondary

education Tertiary

education

14. Which language(s) do you currently use at home?

Interpreting service

15. Did you use the interpreting service provided by the hospital?

- o   Yes

- o   No

16. In which language did you use the interpreting service?

- o   English

- o   Chinese

- o   Japanese

- o   Spanish

- o   French

- o   Other (please specify)

17. Was the interpreting performed in your first language?

- o   Yes

- o   No

18. Why did you not get the interpreting service in your first language?

- o   They did not provide interpreting service in my first language

- o   I am confident using the language the interpreting service was performed in

- o   I just needed simple assistance rather than interpreting service

- o   Other (please specify)

19. Why did you not use the interpreting service provided by the hospital?

- o   I brought my personal interpreter

- o   I can understand Korean

- They did not provide interpreting service in my language

- I was not satisfied with the previous interpreting service

- Other (please specify)

20. Who did you bring to interpret your consultation?

   - Friend

   - Direct family member

   - Personally hired interpreter

   - Other (please specify)

21. Why did you bring your personal interpreter?

   - The interpreting quality is guaranteed

   - I feel comfortable with the person

   - I was not informed about the interpreting service provided by the hospital

   - Other (please specify)

22. Are you satisfied with the hospital-provided interpreting service?

   - Very satisfied

   - Satisfied

   - Neither satisfied nor dissatisfied

   - Dissatisfied

   - Very dissatisfied

23. What are the factors that contributed to your satisfaction?

   - Quality communication with medical staffs

   - 1:1 service

   - No extra charge for the service

   - Professional interpreters

   - Other (please specify)

24. Why are you dissatisfied with the interpreting service provided by the hospital?

   o   Interpreter's low language proficiency

   o   Because it was not my first language

   o   There was cultural breakdown

   o   Interpreter was unprofessional

   o   Other (please specify)

25. Are you uncomfortable with the presence of the interpreter during your consultation?

- o Yes

- o No

26. Why do you feel uncomfortable?

- o I do not want anyone else to know about my medical condition

- o I am worried about confidentiality

- o I did not feel as I was communicating directly with the healthcare practitioners

- o Other (please specify)

Thank you for your cooperation

If you would agree to answer some further questions or would like to receive results of this study, please write your contact information below

27. Please select

- o I am willing to discuss these issues further

- o Please send me information about the results of the study

28. Contact information

Name

  Ema

il

Phone

2.3. Interpreters

Demographic Profile

This section is about your personal background

1. Gender

- o Male

- o Female

o   Other

2. Age

3. Your highest level of education completed

   o   Less than high school

   o   High school

   o   Technical/professional qualification

- Undergraduate

- Postgraduate

- Doctorate

- Other (please specify)

4. In which region do you live (postcode)?

5. What is your country of birth?

6. Number of years you have lived in Korea

Linguistic profile

7. Which is your

First language

Second language

　Dominant language(s)

8. In which language did you receive your

Primary education

　Secondary

education Tertiary

education

9. Which language(s) do you currently use at home?

10. What are your language qualifications?

11. What is (are) your working language(s)?

12. Are you a bilingual worker (tour guide, or etc.)?

- Yes

- No

Translation & Interpreting related qualifications

What are the qualifications you hold?

13. Interpreter education/training type completed

- Intensive short course

- o Technical/professional qualification

- o Undergraduate program

- o Postgraduate program

- o Certification course

- o On-the-job training

o   Practical experience interpreting for friends, etc.

o   Other (please specify)

14. Education/training in the following types of interpreting

o   Community

o   Conference

o   Court

o   Healthcare

o   Telephone

o   General

o   Other (please specify)

15. Duration of interpreter education/training

o   None

o   1 or more workshops (1day or less)

o   1 or more workshops (more than 1day)

o   Less than 1 semester

o   1 semester - 1 year

o   1-2 years

o   Over 2 years

o   Other (please specify)

16. If you have any accreditation as an interpreter, please specify

o   Type of accreditation

o   Year qualified

o   Language direction

Interpreting tasks

The nature of interpreter-mediated communication in healthcare settings

17. Which of the following forms of interpreting you have you provided to patients?

- o Consecutive interpreting

- o Simultaneous interpreting

- o Telephone interpreting

- o Sight translation

- o Other (please specify)

18. Do you consider yourself as

  o Healthcare interpreter

  o Administrative staff

  o Help mate

  o Cultural broker

  o Other (please specify)

19. What are the barrier(s) you face when performing interpreting at the hospital?

  o General English

  o Medical terminology

  o Cultural differences

  o Overwhelming workload

  o Pressure

  o Other (please specify)

20. Have you ever been informed about potential difficulties (including the barriers you answered above)?

  o Yes

  o No

  o Partially

  o Other (please specify)

21. While you are interpreting health practitioner-patient communication, do you use

  o 1st person

  o 3rd person

  o Both

  o Neither

  o Other (please specify)

22. Do you explain about interpreter-mediated communication to health practitioners and patients (where to sit, how to make eye-contact, etc.)?

- o Yes
- o No
- o Sometimes

23. Do you explain cultural differences to both participants?

- o Yes

- o No

- o Sometimes

24. Do you take notes?

- o Yes

- o No

- o Sometimes

25. Do you interrupt when one party talks too long, so that you can interpret?

- o Yes

- o No

26. Have you ever attended any classes or seminars related to healthcare interpreting?

- o Yes

- o No

27. How many times have you attended?

28. Did you find them useful?

- o Yes

- o No

- o Please specify why

29. If you have not, why not?

- o There were no classes or seminars

- o I was not aware of the existence of any classes or seminars

- o I was not qualified to attend any of them

- o I did not have time

- o The fee was too expensive

- o I did not think I need to

o   Other (please specify)

o   If yes, please specify what you want/need to learn about

30. Do you think you need (further) training regarding healthcare interpreting?

o   Yes

o   No

o   Please specify why

31. Do you think other healthcare practitioners or staff need to be trained to work with healthcare

interpreters?

- o Yes

- o No

Thank you for your time and cooperation

If you would agree to answer further questions or would like to receive results of this study, please write your contact information below.

32. Please select

- o I am willing to discuss these issues further

- o Please send me information about the results of the study

33. Contact information

- o Name

- o Email

- o Phone

Appendix 3. Semi-structured interview questions

1. Have you ever taken community interpreting classes?

2. How did that help/influence you working as a medical interpreter/coordinator?

3. Do you find it difficult to work with those who did not have training?

4. Do you think language proficiency alone is sufficient to perform medical interpreting??