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Medical Interpreters in Korea: A Qualitative Study of Medical Tourists' Satisfaction and the Role of Interpreters

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Abstract

Background: As a result of the South Korean government's medical tourism strategies, the number of UAE inbound medical tourists have the highest annual increase rate among the Middle Eastern countries. The need for medical interpreters in such cases is inevitable, especially considering the languages spoken in both countries differs. The work of a medical interpreter affects patient satisfaction, quality of care, and the UAE patients' revisit intention. However, there is a lack of literature that focuses on the role of medical interpreters for the Arabic-speaking medical tourists in South Korea. The purpose of this study is to assess the satisfaction and the experience of UAE medical tourists in South Korea who have used medical interpretation services.

Method: A descriptive exploratory design, including semi-structured interviews, was used in this study to examine factors influencing the satisfaction of UAE patients seeking medical attention in South Korea, who considered travelling exclusively for medical purposes. Eleven UAE medical tourists were selected for the interview using convenience sampling.

Results: Two types of interpreters were revealed by the analysis: interpreters with Arabic as their mother tongue and interpreters with Korean as their mother tongue. Patients emphasized the origin of the interpreters and differentiated between the two types of interpreters' professionalism, abilities, and personal skills. However, due to the huge gap between the two cultures, languages, and religions, the UAE patients mainly preferred the Arabic medical interpreters. Further, each type had certain traits that impacted the medical care process and patients' satisfaction.

Conclusion: This study shows that the South Korean government needs to focus on the training and assessment system for Arabic language interpreters. Additionally, cultural differences training for the interpreters may help to increase UEA patients' satisfaction.

Keywords: *medical tourism, medical interpreter, patient satisfaction, South Korea, UAE*

1. Introduction

Southeast Asian countries pursuing economic expansion and development, such as Thailand, Malaysia, and Singapore, have been targeting medical tourism for economic diversification since the 1997 Asian economic crisis [1, 2]. However, the South Korean ("Korean" from now on) government introduced policies to attract medical tourism in 2005 as a strategic priority [3]. The governments of most oil-producing countries in the Middle East want to send their patients overseas for treatment, supported by a national budget surplus [4, 5]. The Korean government entered into the agreement "*First national-level agreement on acceptance of patients concluded with Abu Dhabi Health Authority*" in 2011 [6] and welcomed Arab (especially UAE) patients seeking medical attention. Since 2011, the number of medical tourists from Gulf Cooperation Council (GCC) countries has been increasing. Between 2010 and 2012, tourists from the Kingdom of Saudi Arabia (KSA) increased from 380 to 1,082, and those from the United Arab Emirates (UAE) increased from 54 to 342 [7]. Interestingly, in a recent

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study, South Korea ("Korea" from now on) ranked 17 out of 30 countries worldwide in terms of attractiveness as a medical tourism destination, and the country captured a higher market share than other medical tourism destinations for specific aspects of medical care, including robotics, oncology, cardiovascular services, and dental care [8]. Medical service quality is an important determinant of tourists' decision to visit a country for treatment, given that they seek medical attention [9, 10]. Korea established some methods to ensure the quality of such services[11-13].

Arabic culture is different from Korean culture, and the languages spoken in both countries also differ[14]. Moreover, using English as a common language cannot be guaranteed since most medical staff in Korea like doctors and nurses do not speak English as they were educated in local institutions [4, 12]. The doctrines of the Muslim religion combined with distinctive GCC traditions places peculiar demands on the Korean medical industry, such as the need for medical interpreters (interpreters from now on), halal food, and prayer rooms. These differences may lead to difficulties in satisfying Arabic medical tourists in Korea [11, 13, 15, 16].

Patients' needs affect (and shape, in some cases) the health care system [17] . Further, in the Korean-Arabic case, communication with the patient plays an important role in improving quality, satisfaction, loyalty, and revisit intention [11, 18]. The work of interpreters, which is to ensure correct and smooth communication between patients and caregivers, affects patient satisfaction, quality of care [18-20], and UAE tourists' intention to revisit Korea as a medical tourist [11]. The interpreter therefore plays a key role in the Korean-Arabic case [11, 13, 21]. Thus, to guarantee quality of care, increase patient satisfaction, and to insure revisit intention, the role of interpreters should be more fully investigated [11].

Medical tourists from the UAE are the second-largest group of medical tourists in Korea [22], with the highest annual increase rate among the Middle Eastern countries (2009-2016, 114.6%) [23]. Furthermore, every UAE medical tourist in Korea has to communicate with the medical team via interpreter [11, 13]. However, there is a lack of studies that focus on the role of interpreters for Arabic-speaking medical tourists in Korea. Thus, the purpose of this study is to assess the satisfaction and the experience of UAE medical tourists in Korea who used medical interpretation services.

1.1 The concept of medical tourism

Health tourism dates back to when the Roman Empire occupied what is currently known as the Middle East. According to documented stories narrated from generation to generation, Romans visited the shores of the Dead Sea to take a "relaxing hot bath" around 25 BC, leading to the introduction of the first spa resort ever documented, followed by a long list of hot spring spas in Europe. This is considered to be the oldest record of health tourism, marking a beginning of long and complex story [24].

Health tourism involves traveling overseas for two different reasons. The first is seeking to improve well-being, which is to find "merely assumed incidental benefits in amenable, relaxing contexts" and includes spas, yoga, or even hiking (wellness tourism). The second is seeking medical intervention for a substantial, long-term outcome (medical tourism) [1]. This type of health tourism (medical tourism) grew in prevalence because of many factors, including high-quality service, lower costs, long waiting time, low international airfare (compared to the total cost of medical attention in the home country), relatively favorable economic exchange rates, and the aging of the baby-boom generation (known to be wealthy)[1, 2]. Malaysia, Thailand, Singapore, and India were among the first medical tourism destinations, with such tourism dating back to the 1970s, when Thailand became a destination for operations for transgender individuals. This continued until the end of the millennium, when internet marketing served as an intermediary between international patients and hospitals [1]. Recently, Gyu Ko argued that medical tourism could become as routine as looking for the best airfare deal [25]. However, despite medical tourism's popularity, it was not until 2006 that it began to be conceptualized and discussed in the academic literature [25, 26].

As an example of the growing importance of medical tourism, in the 2015 medical tourism survey conducted by the Medical Tourism Association, 69 percent of respondents expressed an interest in traveling overseas for health care purposes[27]. In 2011, the growth in medical tourism presented some complexities, policy duplication, and wasting of budgets and human resources. Nevertheless, until 2011, the roles and relationships of the phenomenon's components were not clear, as for any new system; as such, Gyu Ko attempted to build a medical tourism system model [25].

The medical tourism phenomenon has its roots in history and is a current focus in the literature. It is also expected to grow even more in importance and become the main purpose of travel in the future [1]. One day, each plane in the sky might have at least one health tourist.

2. Methods

A descriptive exploratory design, including semi-structured interviews, was used in this study to examine factors influencing patient satisfaction. The study examined UAE patients seeking medical attention in Korea and considered tourists travelling exclusively for medical purposes. It should be noted that this study limited its scope to interpreters only.

2.1 Ethical consideration

The first author visited the UAE embassy, explained the study purpose and implications, method, agreement and withdrawal procedure, and illustrated that anonymity would be guaranteed. Additionally, the first author explained to each patient interviewed the agreement and withdrawal procedure, study purpose and implications, and assured their anonymity. It was also explained that the interview session would be recorded with participant consent, and the participant would be free to end the recording session at any time.

2.2 Sample

We used a convenience sampling method to interview 11 UAE patients who visited Korea for medical attention. All the patients were men, aged between 18 and 49 years. Their length of stay ranged from one month to four years (the four years included some short vacations to UAE), while mean length of stay was ten months. According to the sample guidelines for qualitative studies, this sample is adequate [28].

2.3 Data collection

Through a visit to the UAE embassy in Korea, the first author was introduced to the hotel that accommodated the UAE patients, who shared a common room. Through three visits in February 2017, the patients were introduced to the study and its purposes. The first author conducted a semi-structured interview with each participant in the common room, to ensure consistency. The semi-structured interview guide was written in English and then translated into Arabic. The recordings were transcribed in Arabic and analyzed in Arabic by the first author. Specific questions asked to the participants regarding their experiences with the interpreters. For example, "How helpful was the interpreter?" "How satisfied are you with the interpreter?" and "How was your experience with the interpreters?"

2.4 Data analysis

The transcripts of the interviews were printed in the Arabic language and then repeatedly read multiple times to ensure a comprehensive overview of the information. Then, the first author, whose mother tongue is Arabic, analyzed the responses and entered the data in the NVivo Qualitative Data Analysis Software [29] for coding. Then, the data were divided into categories and coded; codes with similar meanings were grouped together. The process was repeated until no new data or information emerged.

3. Result

Two types of interpreters were revealed by the analysis: native interpreters with Arabic as their mother tongue (of Arabic origin; they will be referred to as "Arabic interpreters" from now on) and interpreters with Korean as their mother tongue who studied Arabic language in local institutions (local interpreters; they will be referred to as "local interpreters" from now on). Patients emphasized the origin of the interpreters and differentiated between the two types of interpreters' professionalism, abilities, and personal skills. However, each type had certain traits, both positive and negative, that could be identified from the discussion and which impacted the health care process and patients' preferences (see Figure 1).

3.1 Local interpreters ease the health care process

Local interpreters were found to be more commonly used than Arabic interpreters, as some hospitals do not provide Arabic interpreters, so many of the patients' comments focused on local interpreters. The local interpreter as described by the UAE patients is a Korean citizen who studied the Arabic language "Fusha" in local institutions. Fusha (pronounced Fus-ha) is the original form of Arabic language, which is the root of all current dialects [30-32]).

Fluency is essential for the interpreter to convey the physician's and patient's messages to each other, without changing the meaning [33]. If this is done professionally, it will provide relief to the patient and improve the quality of care and satisfaction [18]. Some patients described the empathy and the fast services provided by the local interpreters. One patient said: *"They are fast, and they care for us quite well."* Another patient described the fluency of local interpreters saying: *"The local interprets, masha'allah they speak fluently."*

3.2 Local interpreters complicate the health care process

Fluency in any language is a crucial part to deliver the desired message correctly and in an appropriate manner; however, as a patient, it is crucial to understand what the caregiver is saying. Some patients indicated a lack of fluency of local interpreters. One patient said:

> *The interpreter described to me the operation process that I will go through; I was told that I will be injected in my pelvis. After that, I got back home telling my family about the process, they were shocked asking me 'Why in your pelvis, isn't it weird' and I had a family member who is a physician, who said, 'That is wrong, I think they meant your back not your pelvis.' At the end, my relative was right; the injection was in my back.*

Lack of fluency was noticed by the patients in many ways. Another patient referred to the local interpreters' lack of fluency and told about a situation during a physician clinic appointment during which the interpreter did not completely convey the doctor's message: *"The physician spoke for a long time, but the interpreter conveyed short messages. Even the physician didn't seem to like it."*

The Arabic language has many dialects, depending on the geographical region; however, many Arabic people understand Fusha, which is the root of all current dialects [30-32] . Nevertheless, it was neither preferred nor understandable for some patients. One patient said: *"Regarding the Korean interpreters who are speaking Fusha, they do not speak fluently or correctly."* Another patient said that he could not understand what the interpreter was saying: *"I couldn't understand some words until I asked the interpreter to repeat them in a different way."* Another patient suggested that if the interpreters could learn how to speak dialects, it would be more understandable for the patients and their relatives: *"As Korean interpreters, I would prefer if they could learn dialects; they could practice it with the patients. In fact, most people do not understand when you speak Fusha, and they will understand better if you speak their dialect."*

Culture controls the way we communicate and interact. Another patient indicated how the cultural difference affected his son's morale; he did not want his son to know about the details of his condition: *"The interpreter translated everything in front of the patient, I didn't want him to know about his disease; he should have taken me outside and told me instead of saying it in front of an 8-year-old boy."*

3.3 Arabic interpreters are preferred by UAE patients

UAE patients preferred to deal with Arabic interpreters, perhaps because of two reasons: dialects and cultural similarities. The Arabic language has multiple and different dialects, and almost every Arabic country has a different dialect [14]. Further, engaging with an Arabic interpreter was perceived as more comfortable and appeared to be the preferred choice if available (as not all hospitals provide Arabic interpreters). One patient said, comparing his current engagement with local interpreters to his previous engagements with Arabic interpreters: *"I used to be more comfortable with the Arabic interpreters."* Another patient described his Arabic interpreter in terms of happiness and pride, indicating that he was the best interpreter he had come across: *"My interpreter is from an Arabic country, Alhamdulillah, this one is perfect, the best among all the other interpreters that the hospital provides."* One patient described a situation that he believed would have been easier to deal with if he had had an Arabic interpreter*: "If I had had Arabic interpreter, he would calmly tell me 'They will do bla bla etc.,' and he would try to calm me down himself*".

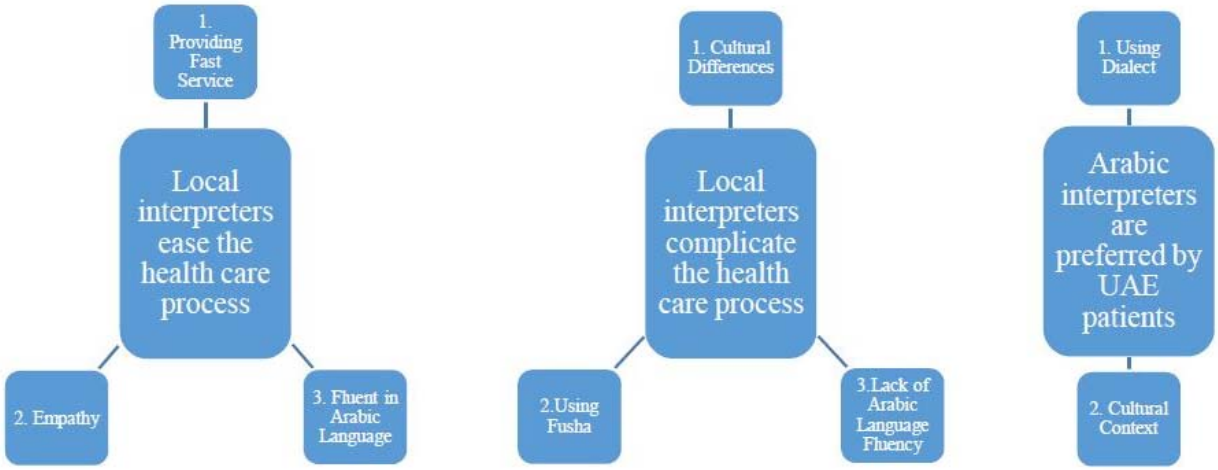

Figure 1. Three categories with eight sub-causes found through data analysis

4. Discussion

Communication is a crucial component when different cultures, languages, and religions interact for mutual benefit. As the Korean government aims to increase the number of the medical tourists, taking into account the Middle Eastern market [3, 7, 13], it faces issues arising from sociocultural differences like lifestyle, availability of halal food, language, etc. [13, 21]. The government had to act, considering that miscommunication is the leading cause of customer dissatisfaction. The decision to use local human resources as interpreters was an astute solution for this issue and that of the shortage of interpreters [12, 13].

This paper presents a first-hand account of the interpreter issues faced by UAE medical tourists in Korea. Arabic-speaking patients in Korea have often been excluded from research, this could be because of the communication barrier and their inability to speak the local language. However, except for one recent study [11], which argues UAE overall satisfaction, to the best of the authors' knowledge, no previous study has discussed medical tourists' satisfaction and its relationship to the role of interpreters. Several articles have discussed the role of interpreters in the context of Arabic-speaking migrants or residents living in English-speaking countries who have limited English proficiency, e.g., [18-20, 32, 34-36].

Based on the patients' examples and their positive or negative statements, our study found that

patients differentiate between interpreters by their origin. Patients made direct, immediate, and strong positive statements regarding their satisfaction with Arabic interpreters and were always confident of their professional interpretative abilities.

On the contrary, the patients' choice of words reflected their negative attitude toward local interpreters and especially questioned their professional interpretation (fluency) in Arabic, which could impact the quality of health care [18-20, 37, 38].

The patients' preference in the type of interpreter was based on mother tongue. This finding is expected, since there is a huge gap between the two cultures, besides the relative availability of Arabic interpreters (who mainly speak different dialects than the local interpreters and the patients themselves). Arabic has multiple distinct regional dialects, whereas local interpreters use the formal Arabic Fusha [14, 30, 32]. While every Arabic person understands Fusha, modern dialects are more convenient to use, easier to understand, and better suited to express emotions, feelings, concerns, pain, and describing situations and circumstances [30, 32, 39, 40]. Therefore, using Fusha is perceived as problematic by patients. Nonetheless, UAE medical tourism patients use local interpreters to facilitate the process of medical care. While professional interpreters in general are usually bilingual and interpret into their mother tongue, which is the same as the patients' language [32, 34, 39, 40], in Korea, the local interpreters are translating into a language that is not their mother tongue. This has not been found in previous studies.

Interpretation into an unfamiliar dialect is also found to be uncomfortable to the extent of being incomprehensible for some patients, especially in the health care context [14, 33]. However, our findings indicate that most of the patients preferred interpreting into a modern dialect even if it was not the same dialect they speak. This might be because these are easier to understand than Fusha [30, 32, 33].

Ethnic origin and religious background are found to be important factors in professional medical interpretation [33]. This could be why the patients preferred the Arabic interpreters; however, UAE patients also gave positive feedback regarding the local interpreters. Further, more training on the patients' culture, Islam, and daily lifestyle could help increase the satisfaction among UAE patients with local interpreters [16, 41].

An unsureness about whether the information was correctly interpreted was another consistent finding among Arabic-speaking migrants in the interpreters qualitative study [32]. Glenn Flores, in his study of interpreters errors, found that the most common error type was omission [20]. In a recent study that used the same method as ours, patients narrated that in their interactions, physicians spoke for a long time, whereas the interpreter translated in only a few words, which gave the patients a feeling of insecurity [42]. Similarly, we studied the same phenomena in our study and attributed it to several factors such as lack of training or inadequate interpreting skills. Some medical interpretation guidelines also instruct the health care staff to aid the interpreter by speaking directly to the patient slowly in short sentences, in sequence, and also insist on sentence-by-sentence interpretation [33, 43].

Further, even though there is a large number of female local interpreters, contrary to the Arabic-speaking migrants qualitative study, gender was not an issue and was never brought up as an issue to discuss [32]. This could be due to our sample, which was limited to only male patients.

In this study, many patients described their daily cultural and professional contact, situations, dilemmas, and the sensitive issues they faced with the interpreters during their experience in Korean hospitals. A greater understanding of these issues could help both the interpreters and the UAE patients avoid these issues in the future, as they could affect the quality of care and help enhance satisfaction [18, 20, 40].

Most of the patient preferred Arabic interpreters, and even though local interpreters were less

preferred, this did not preclude positive feedback about local interpreters. This could be indicative of the level of professionalism of some local interpreters. The link between interpreter's professionalism, their role in the health care system, and patient satisfaction have been well documented [38, 43-45]. Likewise, to increase the quality of service and provide the maximum benefit for the patients and their families, in consideration of the huge gap between the two cultures, focusing on understanding the Muslim patients' culture as part of the Korean medical tourism model requires more attention and investigation [15, 16, 18, 20, 41].

As the Korean government planned to train and certify professional interpreters a long time ago and has allocated a budget for this, it seems that there is still more that needs to be done regarding Arabic language interpreters [12].

In light of the scarcity of native interpreters of Arabic in Korea, the Korean government's solution of providing local interpreters is arguably clever. Despite the substantial cultural differences, which inevitably create sensitive situations between patients and local interpreters, the interpreters become more familiar with the patients' culture, and the patients also learn about Korean culture through the daily use of medical services; therefore, this gap might decrease in the future.

The strength of this paper is that the patients were able to respond to the researchers' questions in their mother language, which allowed them to comfortably and accurately express their feelings and points of view. Further, this use of Arabic during the study helped improve the quality of the extracted information and avoided any misinterpretation of the data [30, 46, 47].

5. Conclusion

As the Korean government has promoted its strategy of attracting medical tourists from Middle Eastern Arabic-speaking countries, the need for a training and assessment system for the Arabic language interpreters, both Arabic and local, is inevitable. The health care process involves teamwork, and thus some training for health care team members, such as physicians and nurses, on how to deal with medical tourism patients who use interpreters would also be helpful. This could include suggestions like speaking directly to the patient, slowly, in short sentences, in sequence, and also insisting on sentence-by-sentence interpretation.

Training focused on the medical tourists 'culture would also be helpful for the interpreters, especially the local ones. This training could include content on Middle Eastern common cultural context and how to interact with a Muslim person regarding religious practices, social beliefs, common behaviors, and the like. Moreover, as it is normal for patients to have negative emotions during treatment, the interpreter training should consider this by including behavioral courses.

This study had some limitations. The sample included only male UAE medical tourists, which might impact the results because of the omission of the female point of view in this study. A recommendation for future researchers is to include a female interviewer who might ease interviewing female UAE or other Middle Eastern medical tourists, especially considering that we were limited in interviewing female patients because our study interviewer was male. Additionally, adding other Middle Eastern countries might would be important in future studies. Finally, this study is the first of a series, and the role of other non-medical service factors will be included in future research.

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