

Efficient Care of Oversea patients in Clinical Practice with a Focus on the Conflict between Healthcare Providers and Interpreters

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Abstract

Purpose: This study aims to dissect the conflict between healthcare professionals and interpreters during overseas patient care.

Patients and methods: For the quantitative and qualitative analysis, 2 in-depth interviews and surveys were conducted with 33 healthcare providers and 37 interpreters.

Results: The presence of conflict between the two groups was confirmed, and was classified into task conflicts, relationship conflicts and process conflicts and other conflicts like culture related and patient-system related conflicts were newly observed in this study. The causes of each included a lack of knowledge of overseas patient culture, the interpreter employment system, and the hospital medical service system.

Conclusion: The roles and responsibilities of healthcare interpreters need to be clearly defined. A more specific educational model on the skill of communicating through an interpreter needs to be developed, and efforts should be made for the improvement of overseas patient medical service systems.

Keywords: conflict, overseas patient, healthcare, provider, interpreter

INTRODUCTION

In Korea, medical tourism has undergone explosive growth after being selected as a National New-Growth Engine industry in 2009. In 2014, the number of overseas patients who visited Korea to receive medical treatment was already more than 260,000, and 24,000 were admitted to hospitals; an average increase of 43.5% from 2009.¹ Government has estimated that 11,000 more jobs (5,000 nurses, 4,000 healthcare interpreters, etc.) will be needed by the year 2020² and is conducting a healthcare interpreter development program under the supervision of the Ministry of Health and Welfare. Against this backdrop, however, there is a crucial shortage in the availability of interpreters compared to the sharply increasing demand. As such, interpreters who do not have the necessary linguistic capabilities, let alone the required medical knowledge, are being sent into the field. Furthermore, healthcare providers do not have a basic understanding of the role of a healthcare interpreter or any experience of collaboration with them, which is causing discord between the two fields. Such disharmony eventually has a negative effect on patient care and creates a system unable to satisfy the patient's expectations, affecting the potential growth of the medical tourism industry. Despite this, studies on the conflict surrounding healthcare interpreters in Korea are rare.³⁻⁵

Studies have been actively conducted in other countries for many years in countries where healthcare interpreters have been utilized for many years but many difficulties in applying

the results of such studies to the situation in Korea. In the US and Australia, healthcare interpreters have evolved and developed as a type of community interpreter in a multicultural society.⁶⁻⁸ However, in Korea, the advent of healthcare interpreters is a relatively recent event, where healthcare interpreting has been developed under the supervision of the government as a form of medical tourism strategically to attract overseas patients. Such a disparity in circumstances leads us to conclude that a study reflecting the local healthcare interpreter environment and viewpoint was required.

As such, this study aimed to evaluate and classify the types of conflict experienced between local healthcare providers and Russian and Arabic interpreters, who are the most active group in the field, and analyze the causes of such conflict. With this basic information, this study's ultimate goal is to propose a harmonious method of collaboration between healthcare providers and interpreters.

MATERIAL AND METHODS

Conflict can be defined as "Conflict has been defined as perceived incompatibilities" or "perceptions by the parties involved that they hold discrepant views or have interpersonal incompatibilities",⁹⁻¹¹ or "one unit of an organization perceiving the failure of its interests by another unit".¹² In this study conflict was defined as being caused by different perceptions (including differences in scope of role and responsibility), and different emotional states related to the conflict such as feeling of stress, tension, animosity or anxiety. Conflicts can be subdivided into 3 types: task conflicts, relationship conflicts and process conflicts.¹³⁻¹⁵ Based on in-depth interviews and results of previous studies, in this study, category criteria for conflicts between healthcare providers and interpreters can be defined as follows:

Task conflict. A conflicting perception of scope and content of responsibilities, due to a different understanding of the roles of the organization members.

Relationship conflict. Emotional conflict due to the method of communication used, such as an authoritative or negative attitude, to communicate with other organization members.

Process conflict. Elements that act as obstacles in performing tasks, such as differences in treatment methods or conflicts of opinion due to cultural differences between the healthcare providers and the patient. Also includes other environmental or institutional factors that interfere with the task of healthcare interpreting.

However, Lee & Kim¹⁶ pointed that Jehn's category were not enough to categorized conflicts between doctors and nurses in Korea. So in this study, conflicts which do not fit any of these categories were categorized as other and then were analyzed.

Study Design

This is a mixed-method study in which the different types of conflict between healthcare providers and interpreters were quantitatively measured, and the content qualitatively analyzed. For this purpose, in depth interviews were performed with 3 healthcare interpreters and 1 professional healthcare provider. Based on these results, a survey was prepared. The survey was conducted for 20 days by 150 healthcare providers and interpreters who had experience in treating overseas patients in the five largest hospitals visited by overseas patients in Korea. Surveys were self-conducted, and data collection was performed by three people familiar with the purpose of the study, the questions posed by the study, the method of response, and collection methods. 73 were collected (48.6%). Among them, a total of 70 surveys (33 providers and 37 interpreters) were analyzed excluding 3 improperly or partially recorded answers.

Participants

The number of subjects needed for this study was calculated with the G* power 3.1.2 program. Using a statistical power of $(1-\beta) = .80$, a significance level of $(\alpha) = .05$, and an effect size of $(d) = .50$, the calculated minimum sample size per group was 28, but after taking the dropout rate into account, the final number was calculated as 33 per group.

Data analysis

Interview data was collected by the researcher and content analysis was performed. Meaningful statements were extracted from in-depth interviews and survey short-answer questions, and common elements related to conflict were collected and categorized in order of frequency. Analyzed results were validated by a qualitative study expert. Data analysis was conducted using IBM SPSS Statistics 22 and SAS 9.4. Actual values, median, percentage, and standard deviation were calculated for subject demographics. For questions posed to both healthcare providers and interpreters, a test of homogeneity (Fisher's exact test) was performed to see whether the ratio of positive or negative answers was equal. The significance level used was $p < 0.05$.

RESULTS

Demographic characteristics

The Demographic characteristics are shown in <Table 1 & Table 2>.

Table 1: Demographic Characteristic of Medical Providers

(n=33)

Characteristics	Categories	N(%)	M±SD
Gender	Male	6(18.2%)	
	Female	27(81.8%)	
Age	20s	13(39.4%)	33.62±7.24
	30s	12(36.4%)	
	40s	8(24.2%)	
Occupation	Nurse	27(81.8%)	
	Doctor	6(18.2%)	
Work experience (years)	Less than 3	5(15.2%)	
	3-5	8(24.2%)	
	5-10	7(21.2%)	
	More than 10	13(39.4%)	

Table 2: Demographic Characteristics of Medical Interpreter

(N=37)

Characteristics	Categories	n(%)	M±SD
Gender	Male	4(10.8)	
	Female	33(89.2)	
Age	20s	21(56.8)	30.61±6.02
	30s	11(29.7)	
	40s	5(13.5)	
Language	Arabic	27(81.8)	
	Russian	6(18.2)	
Institution	Freelancer	13(35.0)	
	Translation Graduate school Center	8(21.6)	
	Hospital	6(16.2)	
Translation experience	Less than 10 times	8(27)	2.02±1.11
	10~ 50 times	7(18.9)	
	More than 50 times	20(54.1)	

Conflict between healthcare providers and interpreters

41.9% of the nurses and doctors, almost half of the respondents, and 32.4% of the healthcare interpreters replied that they had experienced conflict, confirming that conflict is present between the 2 groups. Of the healthcare providers questioned, respondents selected “difficulty in contacting and securing an interpreter” as the most common cause of conflict (64.0%), with “poor interpreting ability” (25.8%), “appearance and attitude” (12.9%), “lack of cultural understanding” (6.5%), “interpreting fees” (9.7%), and other reasons (19.4%) also chosen. Other opinions included

repetitive explanations due to a frequent change in interpreter, tardiness, absence with no advanced notice and refusal to translate by phone or in person. For the healthcare interpreters questioned, most answers highlighted excessive work load and an uncooperative attitude or negative manner from healthcare providers.

Conflict types

The measured frequency of conflicts and detailed causes of each were shown in

Table 3: Types and causes of conflict between the medical providers and interpreters

(N=70)

Type	Cause	Medical providers	N	Interpreters	N
Task	Role Ambiguity	Other works requested than interpreting (e.g. administrative work, resolution of complaints, patient care, tour, etc.)	52	Other works requested than interpreting (e.g. administrative work, resolution of complaints, patient care, tour, etc.)	87
Relationship	Attitude	Lack of responsibility (21)	32	Negative attitude (e.g. high-handedness, shouting, rudeness, irritation) (33)	45
		Requests for information (11)		Uncooperative attitude (e.g. refusal to provide information) (12)	
Process	Communication	Medical knowledge (22)	38	Medical staff communication skills (35)	39
		Language ability (14)		Translation capability (4)	
		Hospital knowledge (2)			
Others	Culture			Understanding for other cultures	10
	Patient-system	Delayed treatment consultation due to the translator's schedule (31)	39	Unfair treatment (no reimbursement of travel expenses) (25)	63
		Frequent change of translator (40)		Frequent change of translator (13)	
		Overpriced translation fees (3)		Underpriced translation fees (11)	
Lack of professional translators (e.g. temporary translators such as patient relatives or medical personnel) (1)	Hospital environment (e.g. waiting period, lack of facilities) (4)				

*multiple response

Analysis of the collected completed questionnaires found all conflict types described by Jehn to be present. Task conflicts showed the highest frequency, followed by relationship conflicts, and process conflicts. And other conflicts categorized as cultural conflicts and patient-system conflicts were newly observed in this study.

Task conflicts

The fundamental reason for the excessive work load placed on healthcare interpreters is the difference in perception of the role by each group.

Table 4: Perception of Medical Providers and Medical Interpreters of the Role of a Medical Interpreter

(N=70)

Category	Medical Providers (n=33) n (%)	Medical Interpreters (n=37) n (%)
Professional interpreter	19(57.6)	29(78.4)
Paramedical	4(12.1)	4(10.8)
Hospital employee	10(30.3)	3(8.1)
Volunteer	0(0)	1(2.7)

As seen in the <Table 4>, both groups have an ambiguous perception of the healthcare interpreter role. While most interpreters responded that interpreting during consultation was the role of the healthcare interpreter, healthcare providers replied that interpreting was to be given during: treatment consultation (n=26); surgery and critical patient care (n=10); and clinical rounds (n=9). Other responses included a role in the interpreting of drug-related (n=9), administration (n=7), and admission/discharge procedures (n=3). These results demonstrate that healthcare providers perceive the role of a healthcare interpreter as covering a broad spectrum of tasks outside of their official job description.

Also, similar tendencies can be observed in the answers to the questions addressed to healthcare providers of what they demanded from the healthcare interpreters they had worked with. The most frequent answer was resolution of patient complaints (n=18), followed by administrative work (n=10), care of the patient guardian (n=7), patient transfer (n=6), and tourism guidance (n=3), amongst others. In contrast, healthcare interpreters answered that they were additionally requested to assist with: resolution of healthcare service related complaints (n=30), care of the patient guardian (n=7), patient transfer (n=20), patient care (n=4), and free translation (18), amongst others. This demonstrates that healthcare interpreters are performing roles that encompass a broader range of tasks, including caring for patients.

Relationship conflicts

Uncooperative attitude. Normally, interpreters receive information from clients prior to interpreting. If they do not receive any information, they are trained to request some actively in order to elevate the quality of the interpreting. As such 78.4% of interpreters stated that they requested information from the hospital prior to interpreting, but 29.7% stated that they were not able to receive any. With regard to this, 66.7% of providers replied that they were willing to provide this information, but 33.3% did not feel willing to provide information to interpreters. That is, despite the fact that the information was crucial for interpreting, if interpreters did not request for it 'actively', many were not able to receive any support.

Negative manners of speaking. Interpreters feel offended by healthcare providers' negative manner of speaking. The following are examples related to their negative manner of speaking:

- *Some providers ask me in a really irritated voice to explain the situation to the patient..*
- *In the hospital everyone calls each other with a title of respect 'sangsaengnim,' but they talk down to me calling me a common title 'ssi' and when speaking to a third party, they say "the interpreter's here."*
- *People in the hospital tend to disregard those who are not nurses or doctors.*

Process conflicts

Lack of communication skills. For the question of <Healthcare providers speak with an understanding of the interpreter's thoughts and needs>, 75.8% of the healthcare providers replied that they did, and 67.6% of the interpreters replied that they did not, and the results of the Fisher's exact test showed that the perception of both groups were highly dissimilar ($p < 0.01$).

For <(Regarding tests, drug administration, and treatment), The interpreter was given an explanation that was easy to understand>, 93.9% of healthcare providers answered 'yes', and 59.5% of healthcare interpreters replied 'no', demonstrating a clear discrepancy in perception between the two groups ($p < 0.01$).

For <The staff readily answered any questions from the interpreter without showing anger or irritation>, 100% of the healthcare providers replied 'yes', while 67.6% of interpreters replied 'no'. This is also a very conflicting result between the two groups ($p < 0.01$).

For <Only 2 to 3 sentences are spoken at one time with consideration for the interpreter>, 74.2% of the healthcare providers replied 'yes', and 43.2% of the interpreters replied 'no' (therefore reflecting that 56.8% answered 'yes'). The

Fisher's exact test showed that there was no statistically significant difference between the opinions of the two groups. This demonstrates that, contrary to expectation, there is an awareness of consideration for the healthcare interpreter during communication.

To summarize the results above, while most healthcare providers perceive that they are attentive to the needs of healthcare interpreters, the majority of such interpreters do not agree.

Lack of experience or understanding of interpreter mediated communication. Interpreters are trained to speak in the first person perspective, not the third person perspective. Because of this, although the interpreter is speaking as a representative for the patient, healthcare providers can misinterpret this as the interpreter speaking.

- *I kept translating what the patient was saying, but the doctor acted as if I was the one who was asking the questions and became irritated with me. Finally, he asked for a coordinator from the International Healthcare Center.*

- *There are some cases in which the doctor gets angry with the interpreter for asking questions, when the fact is that the questions are being asked by the patient, and the interpreter is merely doing her job by translating what the patient says.*

This discrepancy could be accounted for by a lack of experience or understanding of interpreter mediated communication.

Other conflicts

Culture related conflicts. Conflicts that were highlighted also included those due to cultural differences, including medical culture and religion. Healthcare providers, who were not aware of such differences, often expressed their frustration or displeasure to the healthcare interpreters. The interpreters also experienced conflict due to patients who lacked an understanding of the Korean medical and hospital culture. Specific examples are as follows:

- *There were problems related to local folk remedies and religion.*

- *Male patients from the Arab world often tried to order a nurse to do something normally performed by a nurse's aide.*

- *Calling a nurse 'SISTER' is a way of expressing friendliness in their country, but Korean nurses say that they are offended by this.*

- *Patients from the Arab world are admitted to the VIP room, which places a huge burden on the attending nurses. They continue to endure the difficulties until they are no longer able to hide their hostility.*

Patient- system related conflicts. Within patient and hospital systems, in many cases, the cause of conflict is due to one independent factor. However, in this study, often two factors were seen as one combined factor. In particular, as previously mentioned, the patient-system factor, despite the fact that it is an indirect factor in the conflict between healthcare providers and interpreters, is often perceived by the healthcare providers as directly related to the interpreter's attitude, and because of this is especially problematic. More specifically, patients who were not familiar with the differences between the medical system of their native country and that of Korea, continuously asked questions or made excessive requests, thereby causing additional conflict between the healthcare providers and healthcare interpreters. As for the system factor, problems in the interpreter employment and management system, such as frequent change of interpreters or overlapping interpreting, as well as problems in the local hospital system, such as a lack of consultation time, lack of explanations from healthcare professionals, or prolonged waiting periods, were a cause of conflict between the healthcare providers and the healthcare interpreters.

- *During rounds, similar advice is given repeatedly, and because the interpreter was changed every time, the doctor had to give the same explanation again and again, causing him to become annoyed and irritable.*

- *When there are not enough interpreters, if there are sudden rounds or if an admitted patient is suddenly sent to the outpatient clinic, the interpreter has to finish up what he/she was doing or just get up and leave according to whatever priority is given to each case, and even if he/she tries to be as quick as he/she can, there are times when he/she is late. The healthcare providers often get angry at the interpreter for making them wait.*

- *For university hospitals, oftentimes the waiting period is very long and the actual consultation time is very short. Russian patients who have paid a great deal to come from a long way away have high expectations, and often express their dissatisfaction overtly if they do not receive good treatment.*

- *A doctor with a tight consultation schedule received continuous questions and requests from an Arabic patient, which caused further delays in the schedule. The doctor did not give clear answers to the patient, so the patient kept on repeating his questions. Finally, the doctor asked me to escort the patient from the room.*

DISCUSSION

This study aimed to evaluate the conflict between healthcare providers and healthcare interpreters, and classify such conflicts into categories in order to analyze the causes and propose methods of resolution. The presence of conflict between the two groups was confirmed, and was classified into task conflicts, relationship conflicts, process conflicts and

other conflicts like culture related and patient-system related conflicts.

First, for task conflicts, ambiguity in the healthcare interpreter's role was the main cause, which led to an excessive work load, fueling all participants' dissatisfaction at a healthcare interpreting setting. In order to resolve this problem, the role of interpreter must be clearly defined and then further education is required on what the role of the healthcare interpreter entails for healthcare providers and patients.

Second, mutual professional respect between healthcare providers and healthcare interpreters is needed in order to reduce relationship conflict. Healthcare providers complained of the irresponsible attitude of the interpreters, and interpreters complained of the uncooperative or rude attitude of the healthcare providers. However, one thing to take note is that the healthcare interpreters were often late to appointments due to overscheduling. From this we deduce that the fundamental cause of the irresponsible attitude pointed out by the healthcare providers was a system-wide problem. Thus, interpreters need to actively speak out in regard to such system problems in order to prevent unnecessary conflict, and the hospital should improve the system to manage a sufficient number of interpreters and their schedules.

Third, this study highlighted the necessity of training to resolve communication conflicts. Training in medical knowledge and hospital systems is needed to reinforce the healthcare interpreter's professionalism, and the healthcare providers also require training on communication skills through an interpreter. Regarding interpreter training, increased priority should be given to medical knowledge education. Another measure could be for hospitals to provide orientation sessions for healthcare interpreters on hospital-specific healthcare service systems. Regarding education for healthcare providers, there is a need for programs focusing on communication skills to work with interpreters. It is necessary to elaborate guidelines for healthcare providers to follow during healthcare interpreting, such as refraining from the use of professional terminology because there are no such guidelines available in Korea.

Forth, cultural education for healthcare providers and interpreters is needed. While interpreters have pointed out that oversea patients lack an understanding of Korean medical culture, and that healthcare providers lack an understanding of foreign medical culture, this was only highlighted by a few of the healthcare providers we surveyed. Upon analysis of the in-depth interviews or the short-answer survey questions, there is a significant amount of conflict caused by such cultural differences. The reason that the majority of healthcare providers failed to point out cultural factors as a cause of conflict may be that they did not perceive the conflict to be due to cultural differences, but may have thought that it was due to the patient attitude.

Fifth, the healthcare interpreting system must be improved. A great deal of the complaints made by healthcare providers on the attitude or responsibility of the healthcare interpreters was due to system problems. For instance, treatment delay due to overscheduling, lack of systems to balance interpreter supply and demand, frequent interpreter changes, free translation requests, long waiting periods, and no reimbursement for travel expenses, amongst others were all raised as causes of conflict due to hospital systems. Although they are not primary triggers of conflict, they do act as secondary factors that interfere with a successful healthcare interpreting environment.

This study also identified a need for discussion of the resolution of conflict between, not only healthcare providers and healthcare interpreters, but also conflict with patients as well. This patient-conflict was not anticipated at the beginning of the study, but many of the complaints raised by healthcare providers on the attitude of the healthcare interpreters were actually due to the patients. The healthcare providers judged that consultation prolongation due to patient questions, patients asking repetitive questions, a high volume of patient requests, and an inability of the patient to understand professional medical terms, were due to the interpreter's attitude and raised complaints in this respect. Therefore, there is a need for healthcare providers and healthcare interpreters to cooperate in resolving conflicts with the patient.

CONCLUSION

This mixed-methods study identified the types of conflict between healthcare providers and interpreters and their causes, and solutions. Overall, the roles and responsibilities of healthcare interpreters, who play a central role in the medical tourism industry, need to be clearly defined. As well as this, there needs to be mutual professional respect between the healthcare providers and the healthcare interpreters. A more specific educational model on the skill of interpreter mediated communication needs to be developed, and efforts should be made for the improvement of oversea patient medical service systems, such as interpreter employment systems and their management.

The limits of this study are that only healthcare providers and healthcare interpreters were included as subjects. A more comprehensive study including healthcare technicians, administrators, coordinators, International Healthcare Center employees, and all personnel related to the treatment of oversea patients, is needed for a more complete evaluation of oversea patient satisfaction.

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The ethical committee of the institutional review board (IRB) at * University approved all of the study procedures (IRB: ***-15-017-2). Participants were offered an opportunity to ask any questions and were told that they could end their participation at any time. Participants were asked to sign an informed consent document.

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