

The Socio-Legal and Training Landscape of Healthcare Interpreting in Korea: From the Viewpoint of Medical Tourism

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1. Introduction

The term "healthcare interpreting"¹⁾ refers to interpreting performed in "medical settings [that] include private practice, hospital settings and consultations with other health care professionals, such as speech pathologists, dieticians or physiotherapists" (Hale 36). It often takes place to facilitate communication between medical professionals and patients who have no or limited proficiency in the majority language(s). Interpreters working in medical settings are called healthcare interpreters.

1) In this paper, the term *healthcare interpreting (interpreter)* is used interchangeably with *medical interpreting (interpreter)*.

Healthcare interpreter services are of vital importance to the health and safety of patients. As reported in *The New York Times*,²⁾ the absence of 'competent' interpreter services may cause quality chasm in healthcare and have life-threatening consequences. That explains why countries with ethnically and racially diverse populations have recently done much to improve their healthcare interpreter services. The work of supporting such services seems to be centered largely on legal and training areas.

In Korea, however, healthcare interpreting has not been the topic of ample discussion until a few years ago. Language Assistance Services (LAS) in hospitals and clinics have been limited and educational opportunities allowing for specialization were hardly provided. In addition, policy priority on the part of the government was not given to increasing access to quality care for patients with limited Korean proficiency, so that healthcare providers were not hard pressured to establish a LAS system.

In such a situation, the domain of medical interpreting has suddenly begun to receive recognition in Korea for two reasons. First, medical tourism³⁾ has emerged as one of the biggest cash cows, with the government aiming to turn the nation into a major medical tourism hub in Asia. The incumbent government designated the healthcare sector as a new 'growth engine' in early

2) The New York Times. (July 26, 2004). *Caught in the Health Care Maze: A Korean Family's Story*. Moon Chul-Sun, a Korean carpenter who arrived in the US on a tourist visa, played soccer at a local school in Queens. He sustained head injuries during the game and returned home early. At midnight he was taken to the emergency room at a nearby medical center because of a severe headache. The real problem is that he did not receive medical treatment required to save his life due to the absence of a 'qualified' medical interpreter.

3) Connell notes that medical tourism is a form of tourism that "is deliberately linked to direct medical intervention and outcomes are expected to be substantial and long term" (1094). According to Seo et al., however, some researchers prefer to use the term *medical travel*, which is loosely defined as crossing the border to receive medical care and services, arguing that medical tourism is just a combination of tourism and medical care (57-60). Such a distinction will not be made in this paper.

2009, deciding to support it financially and administratively. Healthcare interpreter services are seen not as 'good-to-have' extras but as a prerequisite to enhancing the competitiveness of the medical tourism industry. Second, the proverbial ethnically homogeneous Korea is increasingly urged to establish a substantive LAS system in medical settings due to growing influxes of people from other countries. According to government data,⁴⁾ the proportion of foreign nationals in the entire population has risen about 0.5 percent every five years since 1990, and the number of foreign nationals living in the nation surpassed the one-million mark in August 2007.

After all, medical interpreting has become an issue that requires an extensive reality check and serious discussion. Among others, socio-legal policies and training programs related to healthcare interpreting are thought of as the first territory to be explored because they have a direct bearing on the quality of LAS in medical settings.

It is important to note, however, that in the case of Korea, matters about medical interpreting need to be addressed in a different way (at least for now) because societal discussion about healthcare interpreter services are focused mostly on 'inbound' medical tourists who can afford sophisticated medical care and services. This stands in marked contrast to the situation of other countries in which medical interpreting is frequently construed as a kind of community interpreting (or public service interpreting) that is aimed to eliminate healthcare disparities facing minority citizens. In this respect the present paper deals with healthcare interpreting in Korea largely from the viewpoint of medical tourism, with the focus of interest in its socio-legal and training aspects.

4) Ministry of Justice. 2007. *KIS Statistics 2007*. Retrieved on May 20, 2009 from <http://www.immigration.go.kr>

2. Previous Research into Healthcare Interpreting

Healthcare interpreting was once one of the least researched areas in the discipline of interpreting studies. However, the visibility of healthcare interpreting research began to increase in the early 1990s largely thanks to Cecilia Wadensjö (1992, cited in Pöchhacker and Shlesinger 2007), who presented a corpus of Russian-Swedish dialogue interpreting in 13 medical encounters. Her work was described as "something of a 'rough diamond'" (Pöchhacker and Shlesinger 2002 354), inspiring a wide array of studies on interpreting performed in medical settings. However, it was not until in the mid-1990s that the topic of medical interpreting started to gain international attention. In June 1995, the First Critical Link Conference was held in Toronto, Canada to discuss various issues about community interpreting (including medical interpreting). Since then, medical interpreting has emerged as a field of research in its own right, not to mention a "prevalent field of practice for interpreters in the community" (Pöchhacker and Shlesinger 2007 1).

One of the most oft-researched subjects in this domain of inquiry relates to a particular type of 'communicative event' characterized by the delivery of interpreting services. In this case, researchers analyze the interpreter's roles, responsibilities and/or behaviors, viewing interpreter-mediated communication as 'textual' or 'discursive' process (e.g. Wadensjö 1998; Davidson 2000; Angelelli 2003; Angelelli 2004; Hsieh 2008). Wadensjö's (1998) widely lauded work, for example, deals with the responsibilities and expectations of the interpreter in doctor-patient interactions and Angelelli's (2004) ethnographic study of bilingual medical interactions illustrates that the interpreter actively influences medical encounters instead of playing a default and invisible role.

While this type of research seems to relatively abound in this field, it is true that 'socio-professional' and 'institutional' facets of healthcare interpreting have not received great attention. It is presumably because in most countries, healthcare interpreter services have not been institutionalized and laypeople

(and even medical practitioners) have a lack of understanding of 'medical interpreting as a profession.'

The main subjects of this study, i.e. the socio-legal conditions of medical interpreter services and interpreter training programs in Korea, are characteristic of socio-professional and institutional elements. In this paper, the two subjects will be highlighted, given the potential effects of healthcare legislation and training on the overall perceptions of the 'profession' and on the quality of interpreting services.

2.1 Socio-Legal Conditions: With Emphasis on the US Case

As regards healthcare interpreting, it may be difficult to go further than the United States,⁵⁾ a linguistically diverse country where the barrier between public language and minority languages has been a perennial issue in people's daily lives. As language services were historically provided, albeit not systematically, in the US, Americans have increasingly perceived access to the dominant language as their fundamental rights. Now the US has in place legislation on language access at both federal and state levels. Considering that US's policies on healthcare interpreting have been discussed for more than a decade (See, for example, Fortier 1997 and Chen et al. 2007), it is meaningful to deliberate on the case of the US, especially its legal requirements.

According to Jacobs et al. (2004), US legal instruments on healthcare interpreting at the federal level include Title VI of the Civil Rights Act of 1964, the Hill-Burton Act of 1946, the Emergency Medical Treatment and Active Labor Act, and the Executive Order 13166 (issued in 2000 by President

5) The US healthcare interpreter system has been developed to such an extent that there are efforts underway to establish a national certification system. The National Board of Certification for Medical Interpreters is now "entering a new phase of the national medical interpreter certification process" (National Board of Certification for Medical Interpreters, 2009, June 8).

Clinton). Among these, Title VI of the Civil Rights Act⁶⁾ seems to constitute the crux of the nation's language law.

At the state level, the number and type of statutory requirements vary from state to state, "with some having none, and others having up to 23 (California)" (Jacobs et al. 87). California, in particular, is now seen to be at the forefront of healthcare interpreter services, especially in terms of statutory requirements. Due to its demographic conditions, California has been under greater pressure than any other state to develop legal responsibilities for delivering LAS in medical settings. According to Dower (2003), a fifth of Californians are considered Limited English Proficient (LEP) and over 200 languages are now spoken in the state.

More recently, California's legislative efforts to achieve accessibility to language assistance have been reinforced. On January 1, 2009, the Department of Managed Health Care (DMHC) regulation came into effect, requiring that health plans establish a language assistance program (LAP) for LEP enrollees. It is considered a "first-in-the-nation law aimed at dismantling the language barriers that get in the way of good medicine" (Calvan 2009). Similarly, California's Department of Insurance (CDI) regulation provides that starting from April 1, 2009, health insurers implement LAP services in accordance with Sections 10133.8 and 10133.9. With regard to interpreting services, the DMHC provides that "health plans must establish processes and standards for providing enrollee access to interpretation services at no charge" and the CDI requires that "health insurers must provide [the] insured with timely access to interpretation services at no charge."⁷⁾

6) "No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" Title VI of the Civil Rights Act of 1964. 42 U.S.C.; §1964.

7) A Comparison of DMHC & CDI SB 853 Requirements. Retrieved on May 10, 2009 from <http://www.sb853.com/pdf/Regulations-Table.pdf>

However, these legal requirements have not given Californians 'guaranteed access' to good interpreters. According to Grubbs et al., awareness in LEP populations of language law is not associated with the utilization of medical interpreters and "system and provider-level barriers to language access appear to override patient ability to self-advocate" (687). This means that there are (inevitable) tensions between legal ideals and reality in California's medical settings, so there is still room for the meaningful delivery of LAS for LEP patients.

2.2 Training and Education

Medical interpreter training and education have been discussed from diverse vantage points. In some cases, a particular type of issue about healthcare interpreters has been analyzed with a brief comment about general approach to training. For example, Clifford asserts that future training programs should "focus squarely on the complexity of the role of the [medical] interpreter" (243), saying that the medical interpreter can play an interventionist role appropriately only when he or she has expertise in three key areas, namely 'culture-based communication preferences,' 'ethical principles in cross-cultural healthcare,' and 'levels of trust between practitioners and interpreters.'

Also there are interesting studies which center on the education of 'healthcare providers' in how to work effectively with interpreters. Tebble (2003) describes training materials, workshop programs and strategies, all of which interns can use to familiarize themselves with the use of interpreters. Candlin and Candlin (2003) mentions that medical practitioner training in the use of interpreters is badly needed, especially for new doctors. And Angelelli (2004) emphasizes the need for educating healthcare providers, arguing that "their education include some exposure to cross-cultural communication through interpreters" (136). All these studies suggest that interpreter services are actually underused in the field, and that the better use can be made of

interpreters when education is also provided for 'service users.'

While it seemed rare that the contents of interpreter training are discussed in detail, there are some notable exceptions. Angelelli (2006) argues that healthcare interpreter training include at least six curriculum components: cognitive processing, interpersonal (interpreter role), linguistics, professional, setting-specific, and socio-cultural. She attempts to develop a comprehensive model on the basis of the principles of teaching tailored to healthcare interpreting, while discussing course sequence, language enhancement for medical interpreters, practicum, and interpreting strategies. Valero-Garcés (2008) analyzes various aspects of interpreter training based on a corpus of simulated role plays and explores the effects of such training in the workplace through student interpreters' comments. Her findings seem to be useful for three different participants, viz., trainers, healthcare providers and interpreters, because both simulated role plays and student interpreters' comments are well reflective of the characteristics of an interpreter-mediated communicative event.

Some other studies address healthcare interpreting in association with community interpreting or public service interpreting (PSI). Hale (2007), for example, assigns about 30 pages (Part 2. Interdisciplinarity: Community Interpreting in the Medical Context) to the subject of medical interpreting in order to discuss matters including medical interpreter roles, questioning styles in medical consultations, and patients' compliance with medical instructions. In terms of training, however, she does not deal with the intricacies of healthcare interpreter training. This similarly applies to Corsellis (2008) which addresses PSI in a comprehensive way. Still, there are useful resources in both studies: the former provides web-based glossaries and internet resources on medical interpreting courses; the latter touches upon course design/content and explores the way in which PSI education should be provided.

Lastly there are commissioned studies which attempt to portray the training landscape. Among them, at least three are worthy of mention here. First, Kinsey et al. (2004) provides a quick overview of healthcare interpreting in

California and summarizes different stages of interpreter training. This study offers practicing interpreters access to a variety of resources including medical glossary, information on field-specific interpreter organizations, and the contact points and venues of training programs available.

Second, NCIHC (2002) attempts to provide models for the provision of medical interpreter training. It defines the major characteristics of healthcare interpreter training programs and categorizes the programs into five, i.e. (a) academic training programs; (b) bilingual healthcare employee training programs; (c) community training programs; (d) intensive training of at least 40 hours; and (e) agency training programs. This study demonstrates the merits and demerits of each category of programs, concluding with "criteria necessary to evaluate the adequacy of a training program" and the "work plan for creating standards for training" (10).

Third, Roat (2003) analyzes trends in interpreter training in California based on a written survey. This study provides a comprehensive compendium of training programs which includes various parameters such as screening, course content/materials, competency testing, unique aspects of a given program, and criteria for trainers. It seems to be a useful resource to both individuals and groups who seek medical interpreter training.

3. Healthcare Interpreting in Korea

When it comes to healthcare interpreting, Korea is still in its infancy. Educational opportunities are insufficient and legislation on language access is difficult to identify. It is hard to imagine a national association for healthcare interpreters which would participate in various activities including training. Systems of certification seem just wishful thinking. It was not until a couple of years ago that the subject of healthcare interpreting began to be discussed in earnest.

It is important to note that the recent developments in healthcare interpreting in Korea are unique in that they are driven by the growth of medical tourism. In the pages that follow, I will delineate the socio-legal and training landscape of healthcare interpreting in Korea, not least in connection with medical tourism, and then I will make some suggestions about how to develop the nation's LAS in medical settings.

3.1 The Socio-Legal Aspects of Medical Interpreting

Currently, healthcare interpreting in Korea is seen largely as a type of liaison interpreting performed to cater to the needs of international medical travellers. This is quite distinct from what has been normally defined as 'healthcare interpreting,' a particular area of PSI which enables those who lack fluency in the dominant language to gain 'full and equal' access to medical care and services. In the case of Korea, the conventional view that the dynamics of medical interpreting is linked with streams of migration needs to be revisited.

The recent growth of interest in healthcare interpreting in Korea⁸⁾ coincides with the expansion of the medical travel market. According to the Korea Health Industry Development Institute (KHIDI), the number of foreigners visiting Korea for medical purposes increased from 16,000 in 2007 to more than 40,000 in 2008 (cited in Cho 2009, April 13). A survey of 21 hospitals affiliated with the Council for Korea Medicine Overseas Promotion (CKMP) reveals that the number of foreign patients in the first four months of 2009 rose by 32.1 percent year-on-year (MIHWAF 2009). Foreign media companies reported that Korea is emerging as one of the top destinations for medical

8) Interest in medical tourism is such that from April 1 to June 30, 2009, over 450 news articles whose titles contain the term 의료관광 [medical tourism] were published domestically. The figure was acquired through a web search on *Naver* (www.naver.com), one of the nation's biggest search engines.

travel (See, for example, Choe 2008, November 16 and AFP 2006, April 10).

The sudden boom in medical tourism has been fueled partly by the government, which strongly believes that medical travel will bring in a great sum of money for domestic hospitals and the economy at large. The Ministry for Health, Welfare and Family Affairs (MIHWAF) estimates that a foreigner coming to Korea for medical care pays an average of US\$3,000 in medical bills, four times larger than a Korean national (This does not include the amount of money spent by people accompanied by the patient). As such the government seeks to promote the healthcare sector and to develop interpreter services as a crucial means to enhance the nation's competitiveness in medical tourism. The government's commitment to the healthcare sector is also reflected in its budgetary plan. According to Gwan (2009, March 30), the 2009 supplementary budget for attracting international medical travellers sextupled to more than US\$4 million, out of which US\$400,000 and US\$23,000 were allocated for the training of professional healthcare interpreters and medical tour coordinators, respectively.

Against this backdrop, the health ministry has worked to set forth a road map aimed to foster 'professional' healthcare interpreters and medical tourism businesses. A health official's comments that follow⁹⁾ demonstrate the government's view of healthcare interpreters and its long-term plan for training and certification.

9) In Korea, an average citizen can apply for public services through a ministry website. If a civil application is received, an official in charge is required to address the matter concerned in one way or another and to inform the applicant of the results. The applicant is also informed of the name, contact points and title of the responsible official so that he or she can directly seek further information. On May 7, 2009, I inquired about the government's policy aimed to promote competent medical interpreting through the official website of the Ministry for Health, Welfare and Family Affairs. The remarks quoted here are an official's written reply to my inquiry. She is responsible for medical tourism affairs in the Division of Health Industry Policy.

[...] 정부는 외국인환자 유치 활성화를 지원하기 위해 관련 전문인력양성 사업의 일환으로 외국인환자 유치 및 응대에 필요한 의료통역전문가 양성 사업 추진을 검토 중에 있습니다. **의료통역사는 의료용어, 의료약어, 시술내용에 대한 이해 및 일상언어표현에 대한 전문가. 현재 양성 중인 국제진료 코디네이터는 해외환자의 진료 및 입원을 전반적으로 안내하고 병원 내 생활을 도와주는 역할로 언어적 수준은 일상 회화 능력으로 충분하여 의료통역사와는 구분됨.** 향후 무자격 의료통역 중재자의 난립을 방지하고, 통역의 질적 수준 제고를 위한 의료통역사 자격증 제도 도입과 관련하여 의료통역사 양성 해외사례, 국내 의료통역 현황조사 등의 기초연구를 바탕으로 자격인증시험, 자격증 발급 등에 대해서 중장기 검토할 예정임 [...]

[...] At the government we aim to foster professionals who can assist healthcare providers in drawing international patients. To that end, we are now considering how to nurture healthcare interpreters necessary to attract and communicate with international patients. *The healthcare interpreter is a person who has a good command of a language [in which the foreign patient speaks] and an expert who is keenly aware of medical terminology (including abbreviations) and procedures. The international medical coordinator serves as a guide for international patients when they are admitted to hospital and treated there. The two are quite distinct in that the latter is only required and expected to speak a basic level of foreign language. To prevent the use of unqualified language mediators in medical settings and to increase the quality of interpreting, we consider introducing a medical interpreter certification system. We will pursue work on certification development over the mid- and long-haul. To do so, we will conduct research on training programs available in foreign countries and assess the current situation of healthcare interpreting in Korea. [...]* (My translation; all emphases are mine)

The official's statement above illustrates two important points. First, the government plans to formulate mid- and long-term policies aimed to train professional interpreters in an effort to lure international patients into the domestic healthcare market. This means that healthcare interpreter services in

Korea are now being debated from the standpoint of the economic significance of medical tourism. Second, healthcare policymakers differentiate professional healthcare interpreters from medical tour coordinators or language mediators and feel the need for 'trained' or 'certified' healthcare interpreters. It is worth noting that a medical interpreter is described above as a 'communication expert knowledgeable about medical lingo' or a 'professional interpreter with health literacy,' while a medical tour coordinator is perceived as something of a 'helper' or 'guide' who only has basic communication skills.

The recent move by the government to support the medical tourism sector seems to culminate in the revision of relevant laws. Recently government agencies including the health ministry have involved actively in revising and implementing the *Enforcement Rule of the Medical Service Act* in order to help healthcare providers to attract foreigners in need of medical care. The revised rule, effective on May 1, 2009, permits registered hospitals and clinics to seek out medical travellers directly through marketing activities.¹⁰⁾ According to a report released by the health ministry (MIHWAF 2009, June 19), the number of foreign patients visiting six hospitals affiliated with the CKMP jumped 41.3 percent year-on-year to 1,061 in May (the month when the revised rule came into force). It was found that both healthcare providers and health travel agents attempt to take advantage of the new legal conditions. As of June 15, 2009, 277 medical facilities and 26 intermediaries registered with the health ministry to cash in on the boom in medical travel (MIHWAF *ibid.*). This seems thanks partly to a series of presentations given in April by government officials to provide useful information on best practices in medical travel, the revised Medical Service Act and the prevention of medical disputes.

10) Prior to the revision, healthcare providers were prohibited from directly attracting international patients. Article 25 of the Medical Service Act provides that "No person shall introduce, conciliate, or induce patients to medical institutions or medical persons, or provoke such act for profit." <http://unpan1.un.org/intradoc/groups/public/documents/APCITY/UNPAN009439.pdf>

In line with these changes, government-financed institutions have supported the medical tourism sector in various ways. The CKMP disclosed guidelines for healthcare providers, health travel agents and international patients on May 19, 2009 to facilitate the process of medical travel and to reduce the possibility of medical disputes occurring. Although legally non-binding, these guidelines recommend that hospitals should provide medical interpreter services and international patients should check whether hospitals in which they are to receive medical treatment provide quality interpreter services during their entire medical visit. Meanwhile the KHIDI established an office responsible for the registration of hospitals and health travel agents on April 27 and opened the Medical Call Center on May 1 in order to provide various services for foreign patients. Additionally, it submitted in December 2008 to the health minister a 160-page report on how to prevent and tackle medical disputes with foreign patients. In terms of healthcare interpreters, this report suggests that they should be nurtured to satisfy the needs of international patients and to prevent the occurrence of malpractice and administrative problems.

In sum, Korea has recently undergone a sea change in the socio-legal dynamics of medical tourism and interpreting. The situational changes were driven partly by the government which regards the business of medical travel as a new source of economic benefits and healthcare interpreting as a 'means to business ends.' That explains why it allocated additional budget for the training of professional medical interpreters, preparing to establish a system whereby certified interpreter services are used in medical settings. In particular, the recent revision of a healthcare-related law has laid the institutional foundation on which healthcare providers and health travel agents can involve more aggressively in the business of medical travel.

3.2 Training and Education

To the best of my knowledge, there is no institution of higher education in

Korea which offers a formal degree program on medical interpreting. The training programs now available are focused largely on medical travel. The training institutions fall into three categories: (a) university-affiliated institutions, (b) private-sector institutes and (c) government-financed institutions. There are varying degrees of difference in the curriculum among these organizations, depending on the goal of training/education and the target group.

3.2.1 University-Affiliated Institutions

At present, universities and colleges in Korea do not provide degree programs on healthcare interpreting which carry academic credits. However, some university-affiliated institutions offer similar programs to those interested in pursuing a career as a medical interpreter, medical coordinator, or medical tour coordinator.¹¹⁾ Among them are the School of Continuing Education (SCE) at Sookmyung Women's University and the SCE at Ehwa Womans University. Sookmyung SCE offers a medical interpreting course and a course in medical tour coordinating,¹²⁾ while Ehwa SCE offers courses in medical coordinating and medical tour coordinating.

In the case of Sookmyung SCE, the objective of the medical interpreting course is to "foster the 'professionals with medical knowledge,' who can provide interpreting services for patients who speak English."¹³⁾ This course

11) The medical tour coordinator is an expert who provides a variety of 'medical tour services' for those who seek medical care. There is a fine distinction between medical tour coordinator and medical coordinator. The medical tour coordinator is a combination of the medical coordinator and the tour coordinator (KMTI, n.d.).

12) Sookmyung SCE's healthcare interpreting course has been temporarily stopped at the time of this writing to further develop the course contents. (Personal communication with the official in charge, June 23, 2009)

13) Sookmyung's interpreting courses are offered in two languages, English and Japanese. In this paper, however, only the English course is discussed because the curricula of both courses are not different. In Korea, English is one of the most in-demand foreign languages for medical interpreter services.

lasts for 68 hours (4 hours per day; 17 Saturdays) and application requirements are the "ability to communicate in English." The class size is 20 and the selection of students is made "on a first-come-first-served basis." The three instructors have academic backgrounds in public health or nursing science. Table 1 below illustrates part of Sookmyung SCE's syllabus for medical interpreting.

Table 1: Advanced Course in Healthcare Interpreting
The School of Continuing Education at Sookmyung

Week	Contents
1	An overview of course
2	An overview of medical tourism US healthcare system
3	The Medical Service Act and health insurance The current situation of healthcare providers
4	Procedure for handling medical affairs Affairs related to medical fees
5	Basic English used in hospitals
6	English in medical settings: admission and discharge
7	Expressing medicalese in plain English Admission and discharge
8	Anatomical and pathological terminology
9	Examination at hospital departments Medical professionals and hospital employees
10	Terminology related to disability and rehabilitation Dietary management for patients
11	Medical documents
12	Terminology related to dermatology and plastic surgery
13	Terminology related to dental care and oriental medicine
14	Medical tourism marketing Terminology related to health check-ups
15	Concierge's tasks related to examination
16	Role play
17	Final test ¹⁴⁾

14) Competency testing is done at the end of this course. It seems, however, that a

In the class schedule above, at least three points merit attention. First of all, although this course is named "Advanced Course in Healthcare Interpreting," interpreting practice is precious few. Instead it is centered on honing English communication skills and medical vocabulary specific to each hospital department. Secondly, the students are required to acquire 'system-level' knowledge at the onset of the course. It may be reasonable to assume that those aware of the healthcare system and related statutory policies will better understand interpreter-mediated situations than otherwise. Thirdly, matters concerning medical tourism and hospital administration are covered, too. The presence of medical tourism-related contents in this course may be relevant, considering that Sookmyung's website declares "We expect those who [successfully] complete this course to become medical tour coordinators or freelancers [freelance coordinators], or to be able to work at medical tour marketing agencies." After all it may be argued that this course is intended to nurture medical coordinators or medical tour coordinators rather than medical interpreters.

In the case of Ehwa SCE, fostering medical coordinators and medical tour coordinators is one of the most important curricular goals. The medical coordinator course, offered every Saturday for 20 weeks, targets "people with high-school diplomas who have worked in medical institutions for two years or more" or "people with the academic background of two-year college diplomas or better." The class size is 40 to 50 and the instructors include those who majored in health education. Similarly, the medical tour coordinator course is a Saturday course, which runs 10 weeks. The instructors include hospital administrators, tour agents, health researchers, and medical doctors. Although the class size is not specified, the target learners are defined in detail, as shown in such phrases as "working medical tour coordinators," "interpreters,"

high grade on the final test does not necessarily guarantee a Certificate of Successful Completion. According to the website, those with the attendance rate of more than 80% will receive the Certificate.

"hospital managers and administrators," and "medical staff."

It is pertinent to point out that the two courses offered by Ehwa SCE are directed almost entirely at 'coordinating activities in medical settings.' The medical coordinator course covers topics such as hospital services, methods to serve patients, medical marketing, hospital manager's core competence, hospital process re-engineering, and so on, while the medical tour coordinator course addresses issues such as medical environment, trends in medical tourism, leadership and communication abilities, medical management, field trips to hospitals, concierge services, medical marketing, and legal requirements on medical tourism. In Ehwa SCE's case, topics concerning language are simply omitted or covered in insufficient depth.

3.2.2 Private-Sector Institutes

It seems that no private-sector institutes offer a special course in healthcare interpreting. However, some of them argue that their training programs on medical tour coordinating are helpful to those seeking to work as interpreters in medical settings. Among them is the Korea Medical Tourism Institute (KMTI), which offers a four-month training program.¹⁵⁾ For the first three months (60 hours; every Sunday), the enrollees learn about laws on healthcare tourism, the process of medical tour, medical tourism marketing, health insurance for non-Korean speakers, communication strategies, medical tourism CRM, etc. Then they can apply for a one-month workshop including a field trip to a hospital, or for a remedial language course (available in English, Chinese or Japanese). Both the workshop and the language course charge the applicants separate fees. KMTI's course is much the same as that of Ehwa SCE, save that it provides a workshop program and a separate language course. In general, training programs offered by SCEs and private-sector institutes seem to be barely distinguishable.

15) I do not have any conflicts of interest to declare.

3.2.3 Government-Financed Organizations

Since October 2007, the Korea Tourism Organization (KTO), a government-financed institution established to promote the nation's tourism industry, had provided a medical tour coordinator course targeting health workers from CKMP-affiliated hospitals. The current six-week program offered by the KTO was created in June 2008 in cooperation with the Healthcare System Gangnam Center of the Seoul National University Hospital. The enrollees take a seven-hour lecture-oriented class on Saturday and participate in on-site training on a weekday. The curriculum of the course is akin to those provided by the aforementioned training organizations. Those whose attendance rate is over 80 percent receive a 'certificate of completion.'

In addition, the KTO provides a 17-hour course in medical travel free of charge for Korean nationals speaking Russian, Arabic or Mongolian—three foreign languages relatively obscure in Korea. Those who want to take part are required to submit a tour guide license, a copy of diploma in respective languages (or a certificate of studentship), or documentary evidence on interpreting experiences. A striking feature of this crash course is that the participants are given opportunities to learn 'culture bumps' or cultural diversity which should be considered in cross-linguistic medical encounters.

Furthermore, the KTO provides an online educational program which focuses on medicalesse and basic English expressions used in hospitals (For more information, visit the website, <http://meditour.credu.com>). This language program, consisting of 20 mini-lectures featuring the simulated situations of hospital departments, is said to target interpreters and hospital workers. The launch of the program is meaningful in that before its inception, there was not an online or offline program that focuses wholly on medical language. However, it also has its limitations: it is available only in English (as of this writing) and dependent mainly on rote-learning approach.

While the three programs offered by the KTO are targeted mainly, but not exclusively, at those interested or involved in medical tourism, the Advanced

Training Program on Healthcare Interpreting (ATPHI), which has been offered by the government since mid-July 2009, aims at fostering professional healthcare interpreters. The 200-hour program targets various groups including health workers proficient in foreign languages, working medical interpreters and graduates of interpreting schools. The language groups accommodated by the course are English, Chinese, Japanese, Russian and Arabic. It is said that candidates are screened for oral proficiency and participants are assessed through a post-course competency test. The tests administered during the course are a major determinant of whether participants will receive a certificate of successful completion. Interestingly, those who complete this course are obliged to volunteer as medical interpreters for 100 hours in the public sector.¹⁶⁾ It is worth noting that the ATPHI has been prepared and run by three entities: (a) the health ministry responsible for managing and supervising the training project; (b) the Korea Human Resource Development Institute for Health and Welfare (KHRDI), a subordinate of the health ministry in charge of course administration; and (c) an ad-hoc consultative committee consisting of professional interpreters, academics and medical professionals.

The ATPHI consists of five major sessions as illustrated in Table 2 below. What sets it apart from the other programs discussed so far is that it puts emphasis on both system- and communication-related knowledge and on-site training. Here "on-site training" refers to the field work and the mandatory interpreter services to be performed after the course, and the "system- and communication-related knowledge" means a background knowledge of healthcare services and medical interpreting that is all helpful to professional practice. Given that the latter part of this course consists of a medical terminology session and a field trip session (and volunteer interpreter services), one might argue that the course is centered increasingly on practice and is a

16) The public sector includes free clinics for foreigners and the International Medical Call Center.

hybrid of an ordinary medical tour coordinator program, a medical terminology program (like Sookmyung SCE's), and a workshop program (like KMTI's).

Table 2: The Curriculum of the ATPHI (MIHWAF & KHRDI 2009, May)

Session	Class content	Method
Introduction to medical interpreting (30 hours)	<ul style="list-style-type: none"> - Changes in the medical environment - The direction that the government is taking with regard to policies aimed to attract international patients - The present and future of healthcare interpreter services 	Lecture and group study
The process of medical interpreting & communication (60 hours)	<ul style="list-style-type: none"> - Tasks to be undertaken step by step in relation to medical interpreting - The culture of Korean healthcare and the healthcare process of hospitals - The characteristics of communicative event in medical settings - Patient's healthcare needs and the methods of consulting specific patients (history-taking; patient consulting services; admission and discharge processes, etc.) 	
Healthcare laws & international health insurance (30 hours)	<ul style="list-style-type: none"> - Basic knowledge of international and domestic healthcare laws and regulations - Actions to prevent and tackle medical disputes with international patients - Theoretical and practical issues on international health insurance 	
Medical term (30 hours)	<ul style="list-style-type: none"> - Medical terms used in major departments - Terms used in reference to diseases and symptoms 	
Field work & case study analysis (50 hours)	<ul style="list-style-type: none"> - Field trips to major hospitals affiliated with the CKMP (exam, surgery or autopsy rooms) - Procedures for working with patients and providers 	Practice

The ATPHI is differentiated in three respects from the previous training programs. First, it has a pretest, a midterm and a posttest to assess language competency and the participant's knowledge of the healthcare sector. All the

applicants for the ATPHI are screened for language competency (and interpreting competency), which may explain why interpreting skills and technique are not covered in detail in this course. It should be remembered that participants in the traditional programs are often selected on a first-come-first-served basis and hardly need to prove their language competency before, during, or after the course. In addition, the previous courses do not require the students to take a final exam which may determine whether they will have successfully complete the course. When it comes to the traditional programs, there appears no distinction between a 'certificate of attendance' and a 'certificate of successful completion.' Second, the ATPHI is focused more on the practice side, as mentioned in passing. Even though it may be hard to compare the ATPHI with US healthcare interpreter training programs which assign a great portion of hours of instruction to interpreting practice proper, the ATPHI gives greater consideration to professional practice than other comparable programs in Korea. The fact that the target groups of the ATPHI include "graduates of interpreting schools" shows that language and interpreting competency is a major prerequisite for entry into the course. It should be reminded that 'bilingualism' or 'interpreting competency' are demanded in the entry process regardless of the target group to which an applicant belongs. Third, a follow-up to the implementation of the training program is expected in various ways. Although much still remains to be seen given that the ATPHI has just been launched, the government plans to provide continuing education for those who complete the course and to continuously track graduates by forming a "network of healthcare interpreters." In addition, it will consider introducing a certification system based on an evaluation of the ATPHI.

4. Discussion and Suggestions

4.1 Socio-Economic and Legal Aspects

In Korea, great attention has recently been paid to healthcare interpreter services partly due to a variety of measures taken by the government to expand the medical tourism sector. They include

- (a) removing regulatory barriers to healthcare providers and health travel agents which seek to attract international patients;
- (b) financing and devising a medical interpreter training program; and
- (c) making promotional and administrative efforts to help healthcare providers and health travel agents to adapt easily to the new business environment.

It seems that like in such countries as the US, government intervention in Korea is fundamental to raising the awareness of interpreter services in medical settings. However, the case of Korea is somewhat unique in three respects as shown in Table 3 below.

Table 3: Government Intervention in the Area of Healthcare Interpreting

	US (California)	Korea
Goal	• To get rid of healthcare disparities	• To promote medical tourism
Target	• LEP patients (immigrants and expats)	• Foreign patients living abroad (inbound medical travellers)
Features	<ul style="list-style-type: none"> • Enacting sector-specific regulations and/or laws to impose legal obligations on healthcare providers to provide CLAS (culturally and linguistically appropriate healthcare services) • Encouraging non-governmental actors to provide medical interpreter training 	<ul style="list-style-type: none"> • Revising the healthcare law to encourage the healthcare sector to involve more actively in medical tourism (hopefully in medical interpreter services) • Playing an active role in providing medical interpreter training

As mentioned before, much of discussion about healthcare interpreter services in Korea takes place in the context of medical tourism. However, access to quality medical services seemed to be often foreclosed to long-term Korean expatriates and migrant workers, who were supposed to be the target population of medical interpreter services. It is unfortunate that translation/interpreting services for them were not the topic of ample discussion in Korean society. According to the Ministry of Labor (2009, July 24), foreign workers started on July 27, 2009 to receive the results of their health check-ups in their native languages (English, Chinese, Thai, Vietnamese, Mongolian, Indonesian, Russian, Pakistani, Bangladeshi or Sri Lankan), despite the fact that 16 years have passed since the Industrial Trainee System was introduced.¹⁷⁾ It was also reported by the ministry that interpreter services over the phone or through the internet will be provided for migrant workers who want to know details on their medical exams. Although those translation/interpreting services, albeit belatedly, were designed to enhance the quality of healthcare services for expats living in the nation, it does not seem a coincidence that policy makers suddenly moved to provide such language services. One might argue that the target groups of interest to healthcare officials in relation to LAS have been expanded only recently to include foreigners residing in the nation, and that the recent developments in the area of medical tourism contributed to promoting discussion about 'overall' healthcare interpreter services in Korea.

Another issue to be considered as regards medical interpreter services is that medical tourism and related interpreter services may be the issues of interest entirely to large hospitals. Community clinics and small private practices, which receive few foreign patients if any, may not be interested in the business of medical tourism. There is a possibility therefore that they will

17) The Industrial Trainee System was introduced in 1994 to teach foreign apprentices advanced technologies and to ease the shortage of manual labor at the so-called 3-D workplace—difficult, dangerous and dirty.

continue paying scant heed to LAS issues, leading to the perpetuation of healthcare disparities between large hospitals and small private practices. As small clinics at the community level are not the major targets of medical travel policies, they cannot still get incentives and resources to introduce competent interpreter services. Given that not all foreign residents can afford to receive medical treatment in large hospitals, the current government policies aimed to promote medical travel will unlikely address interpreting-related issues at the source. It appears essential therefore that a (central) register of available medical interpreters by language should be established to meet local demand. As even at present the demand for healthcare interpreters is great among oriental medicine clinics and plastic surgery clinics in Gangnam-gu, Seoul, some private-sector educational institutes provide those clinics with a roster of available healthcare interpreters and coordinators at the request of the ward government.¹⁸⁾ As the number of people emigrating to Korea has risen steadily, policies on healthcare interpreter services should not be directed only at medical tourism and large hospitals.

After all, it seems that without the force of a legal instrument, overall issues related to healthcare interpreter services will remain unaddressed. One of the effective ways not only to promote medical tourism but to create an environment which places *all* non-Korean patients on an equal footing with Korean-speaking counterparts is to introduce a special bill on LAS in medical settings, in a similar way that the US federal government enacted the *Court Interpreters Act* in the late 1970s. In light of the commitment the government now has, it does not appear humanly impossible for Korea to introduce such a legislative proposal. An Act on Language Assistance Services in Medical Settings or a Medical Interpreters Act would govern the obligations and responsibilities of healthcare providers for the employment of interpreters, the

18) Personal communication with Lee Hyun-Chang, head of *MiraeSearch*, a private institute involved in healthcare-related education and consulting (June 22, 2009)

roles of medical interpreters, the rights of foreign patients, and the functions and obligations of competent authorities, to name but four. Such an act may be further specified to cover issues such as interpreter training, interpreting fees, the recruitment and use of interpreters, and hopefully systems of certification and accreditation. Whatever form such legal requirements take, what really does count is to require that healthcare providers take 'concrete' measures to offer quality LAS to limited- and non-Korean speakers in medical settings.

To lay the groundwork for the enactment of a special act and to institutionalize a medical interpreter system, it is advisable that a three-stage study should be done with the support of the government. First and foremost, a nationwide survey should be conducted to assess the situation of existing interpreter services. Just as every task involving problem-solving always requires a critical analysis of the present situation, success in this domain would also be achieved with a thorough analysis of available services. It should be remembered that very little is known about the profile of medical interpreters in Korea (e.g. the numbers, concurrent positions and demographic characteristics of medical interpreters). Next, both research into medical interpreter services in selected countries and relevant literature review should be conducted to learn about factors that may affect the parameters and dynamics of healthcare interpreting and to reduce the possibility of facing problems much like those documented in other countries. In this part, researchers may look into the case of the US in relation to access law, training programs, a history of problems, and so forth. Finally, practical and effective solutions to the present challenges should be come up with based on the previous studies. Given that the conditions of the healthcare sector are varying depending on time and country, it is imperative that any solution for Korea should be compatible with its socio-legal conditions as well as the needs of the industry. In particular, the healthcare environment which has been undergoing rapid changes should be analyzed to ensure that a solution is in line with the plank of the nation's future healthcare policies.

4.2 Training and Education

In Korea, those wanting to enter the 'profession' of healthcare interpreters are educated and trained through limited routes. They may go through one of the programs offered by government-run institutions, private-sector institutes, or continuing schools affiliated with universities. It is problematic that most of the training programs are designed for prospective medical coordinators or medical tour coordinators. As there are few opportunities to learn healthcare interpreting per se, those seeking to work as a medical interpreter participate in a medical tour coordinator program or simply give up any training opportunity. It is shown that some healthcare interpreter training programs underline medical terminology or healthcare system without giving due consideration to the 'practice' portions of healthcare interpreting. It is most disturbing that there is an acute lack of training programs under which the subtleties of healthcare interpreting are taught and discussed.

One of the common features of the training courses mentioned so far (except the ATPHI) is that language screening is not required for entry into the courses. It is commonly assumed that without resources to teach medical interpreting and communication, only those with proficiency in a foreign language should be allowed to participate in a given interpreting program. It is because even medical tour coordinators must have a basic command of a foreign language to facilitate communication between healthcare providers and foreign patients. Some of the medical tour coordinator programs stress the importance of interpreting and/or communication skills without incorporating sufficient portions of language teaching into the curriculum. All this is not irrelevant to the fact that the vast majority of instructors are not experts on communication or interpreting but those who specialize in medical travel or public health. It seems that these shortcomings have been overcome to some extent by the government-proposed ATPHI. As mentioned earlier, ATPHI

developers who include interpreting experts evaluate the language competency of applicants, obviating the need for comprehensive interpreting teaching during the course.

By all accounts, the ATPHI is perceived as a medical interpreter training program which takes into account the strengths and weaknesses of traditional medical tour coordinator programs. On the one hand, the ATPHI is not dissimilar to a medical tour coordinator program in that it accentuates matters such as healthcare systems, international health insurance, healthcare climate, and field trips to hospitals. Its underlying assumption is that 'healthcare knowledge' is fundamental to medical interpreting. In addition, it opens on weekends just like the other training programs probably because running a weekend course is a practicable way to invite competent bilinguals and working interpreters who are somewhere else in gainful employment. On the other hand, the ATPHI is out of the ordinary in that issues such as the process of medical interpreting, the characteristics of (interpreted) communicative event, and healthcare culture are addressed in the program, and in that it accommodates more language groups than the other programs.

The significance of the ATPHI may be identified elsewhere. In light of the fact that the ATPHI is a government-proposed program, it may be held up as a model for medical interpreter training programs. Given that even in the US, there is no standardized or required curricula across all healthcare interpreter programs (Dower 2003), it is predicted that the ATPHI will be conducive to developing a follow-up program and a brand-new medical interpreter training program in the future.

For all the signs of progress cited above, there are countless numbers of things to be contemplated in relation to training and education. What is the most desirable format, if any, of a medical interpreter training program? What are key curricular components? Under what criteria should the students (or trainers) be selected? What are core competencies for medical interpreters? Is it appropriate/necessary to teach modes of interpreting, interpreting techniques and

the basic concepts of interpreting? How will the students be able to address the roles of a medical interpreter (as a conduit, clarifier, advocate, culture broker, etc.)? Contents about the professional conduct of medical interpreters (e.g. a code of ethics) should be assimilated into the curriculum? Are role plays and practicum necessary at the final stages of the course? Are (standardized) learning materials needed to ensure the training program is effective? Is it necessary to train the trainers? The list of relevant questions may be far beyond our expectations.

While there are numerous details to be hammered out to create a specific medical interpreter training program, I shall suggest that before devising a training program, the following three points should be considered. First, the curriculum should be determined considering the hours of instruction, the number and profile of target populations, and other related factors. In particular, to enhance the effectiveness of the program, a list of core curricular subjects should be made regardless of the type of the training program. It may be helpful in this regard to look closely at the US which has a broad spectrum of training programs. In respect of the core subjects of US medical interpreter training programs, Roat's general description of the shared contents of relatively short courses (5) may be informative and instructive:

- role and ethics,
- basic interpreting techniques (use of the first person, positioning, pre-sessions, modes, consecutive interpreting and sight translation),
- controlling the flow of the session,
- health care practice medical terminology,
- professional development, and
- impact of culture.

While Roat points out that it is difficult to effectively analyze the detailed contents of longer courses, some US programs deal with a broader set of

matters such as introduction to healthcare interpreting, healthcare climate, healthcare systems, competency testing, and practicum (16-75). It may be argued that US training programs place great emphasis on 'professional practice' and the 'interpreter' as a professional, unlike in Korea where the programs are basically orientational in nature and barely provide skill-building. As such, an investigation should be also conducted of why such a difference occurs and whether the shared contents listed above need to be integrated into a medical interpreter program. In particular, serious consideration should be given to whether (and the extent to which) the contents related directly to the skill development of medical interpreting should be included in a future training program. That is because some of the ATPHI participants are simply bilinguals or bilingual health workers who may have little or no experience of interpreting in the field. It is generally assumed that there is a world of difference between 'interpreting' and 'speaking a foreign language fluently.'

Second, a medical interpreter training program should have a variety of rigorous requirements for students in order to enhance the quality of interpreter services and to ensure program viability and effectiveness. It should be reminded that in most cases, thus far, whoever signs up for a training course has been welcomed, and that a certificate of attendance was deemed synonymous with a certificate of successful completion. This is hardly surprising, given that a considerable surge of interest in medical interpreting has not been witnessed until recently and there is still no competency testing or certification exam for medical interpreters. As seen before, however, the constellation of factors affecting healthcare interpreter services in Korea has just been changed. Government officials assert that the caliber of medical interpreting should be high enough to sustain the boom in medical tourism, and healthcare providers have begun demanding trained and well-prepared interpreters. For medical interpreter services to be successful, training programs should be offered in such a way that the select participants are exposed to the complexity of interpreter-mediated interactions through rigorous tasks.

Third, training approaches to healthcare interpreting should be taken extensively in order to increase access to training opportunities. Currently training opportunities for specialization in this field are very limited to the extent that only the government offers a substantive program. To meet the growing demand for competent healthcare interpreters, other sectors of society should work to provide a wide selection of training programs. Considering the current circumstances of Korea, three actors may be involved in implementing a medical interpreter training program.

The first actor is institutions of higher education, especially the graduate schools of interpreting in which select trainee interpreters are trained. If, however, it seems difficult to offer healthcare interpreting degrees at the four-year college level or the two-year postgraduate level, vacation programs or intensive courses may be provided separately so that only those interested invest additional time in learning healthcare interpreting. To encourage participation, it is advisable that these programs should carry academic credits and incentives.

The second actor is none other than healthcare providers. As it is widely assumed and reported that bilingual hospital employees double as medical interpreters, they may be 'potential' interpreters not to be ignored at all. Training programs offered by hospitals (e.g. in-service workshops) are advantageous because bilingual employees are easily accessible and well aware of healthcare teams and medical knowledge, and because hospitals offer 'need-based' programs suitable to their circumstances. In some cases, bilinguals with enough understanding of healthcare may work better than inadequately trained interpreters or full-time interpreters who often get confused by medical jargon. It should be remembered though that self-proclaimed 'bilingual' employees frequently commit translation errors, thereby doing a disservice to doctor-patient communication (NCIHC 6).

The third actor is (for-profit) private institutes. Private institutes, considered most accessible to the public, have the flexibility to offer programs with

sufficient breadth and time formats. However, to increase the involvement of the private sector, a license or certification system for medical interpreters should be introduced at the initiative of the government. If only certified or qualified medical interpreters were allowed to work in medical settings and official recognition of this 'profession' were achieved (along with higher pay scales), then training programs offered by private institutes would emerge in great numbers.

There is no denying that formulating a high-quality training program requires an abundance of resources, time and energy, especially when debates about such training have yet to develop to maturity. The task of Korea to create an appropriate training program now appears all the more difficult on the grounds that socio-economic circumstances surrounding healthcare interpreter services are unique, that the urgency of the need for healthcare interpreter services is greater than ever before, and that a foundation for healthcare interpreter training is not established yet. It follows that a comprehensive study of healthcare interpreter training programs should be conducted with Korea's uniqueness considered in great detail, and that open debates about various facets of healthcare interpreter services should be promoted in society.

5. Conclusion

This paper attempts to deal with socio-legal and training issues concerning medical interpreting in Korea mainly from the perspective of medical tourism. It points to not merely the revision of the Medical Service Act and the subsequent changes witnessed by the medical tourism industry, but also the roles that public-sector organizations have recently played in promoting the business of medical tourism/interpreting. It is reasonable to assume that the recent rise of medical travellers to Korea and the concomitant demand for

healthcare interpreters will reshape the nation's healthcare tourism industry and the dynamics of medical interpreter services.

This paper also describes a few training programs currently available to those seeking to work as medical interpreters. The fact of the matter, however, is that most of the programs are designed for future medical (tour) coordinators, only addressing healthcare interpreting in a perfunctory and minimal way. Against this backdrop, a government-proposed course in 'professional' healthcare interpreting kicked off recently, opening the doors to specialized training in medical interpreting. By all accounts, it is a training course that is meant to solve many practical problems with the traditional training programs.

The latter part of this paper is intended to add a little dash of colors to the picture painted earlier, pointing to what is required to develop the nation's healthcare interpreter services in the long term. Of course my suggestions and analyses are far from all-embracing ones. Rather they are a drop in the ocean. Different stakeholders including healthcare policymakers, curriculum developers and interpreting trainers/researchers have the sheer number of related issues to tackle.

As the present paper is based mainly on a descriptive account of the present situation of healthcare interpreting in Korea, its conclusions are descriptive and suggestive rather than definitive. It follows that future research should be done in an empirical and experimental manner to get a more accurate and detailed picture of healthcare interpreter services.

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[Abstract]

The Socio-Legal and Training Landscape of Healthcare Interpreting in Korea: From the Viewpoint of Medical Tourism

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The recent rise of medical tourists coming to Korea has brought a concomitant demand for, and interest in, healthcare interpreter services in the country. The sudden boom in medical tourism has been driven partly by the government, which recently removed regulatory barriers to healthcare providers attracting international patients and provided administrative support for healthcare providers, medical tourists and medical travel agents.

In addition, the government recently supported the development of a medical interpreter training program called the ATPHI, thereby changing the training landscape of this field. The 200-hour training program differs widely from the traditional programs, most of which target those seeking to become 'medical tour coordinators' and focus largely on textbook knowledge.

Despite the recent signs of progress, however, a number of issues on healthcare interpreting remain unaddressed. This study suggests that one of the most effective ways to deal with those issues is to introduce a special bill on healthcare interpreting, which may cover a range of topics including the recruitment of medical interpreters and the rights of international patients.

In relation to healthcare interpreter training programs, this study suggests that curriculum should be organized in a way that better reflects related factors, that rigorous entry and/or completion requirements should be adopted, and that training opportunities should be increased in number and scope.

▶ Key Words: medical tourism, healthcare interpreting, a bill on healthcare interpreting, healthcare interpreter training programs

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