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A Qualitative Synthesis of Patients' Experiences of Healthcare Interpreting*

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1. Introduction

Due to the continuous rise in migration flows mostly originating from developing to more developed countries, modern societies have become more culturally diverse suffice to say that few countries are monolingual or monocultural. As a result, community interpreting, which grew with the emergence of the welfare migrant state (Hale 2007: 27), has been in constant high demand. While different labels are used depending on the specific focus and context, i.e. "public service interpreting" (Valero Garcés 2003 in Hale 2007), "dialogue interpreting" (Mason 2001 in Hale 2007), and "liaison interpreting" (Gentile et al. 1996), community interpreting is most broadly used to refer to types of interpreting other than conference interpreting which caters to the linguistic needs of minorities living in the host society in order to provide equal access to social and public services. Despite the fact that it is the "poor sister" (Kelly 2014 in Taibi and Ozolins 2016: 17) of conference interpreting, community interpreting has more at stake as a higher level of accuracy is required due to greater consequences of inaccuracy (Hale 2007: 32).

This is evident in healthcare interpreting whose goal is to provide the best care possible to patients by ensuring successful communication between the doctor and patient. Language barriers can have a negative impact on the health of patients who do not speak the mainstream language including "inappropriate diagnosis, poorer adherence to treatment and follow-up, more medication complications, longer hospitalizations and decreased patient satisfaction" (Brisset et al. 2013: 131). Conversely, bridging this gap can increase patient satisfaction, adherence to medication and follow-up, and patient-reported health (Karliner et al. 2007: 728).

Studies address the impact that interpreting has on the quality of healthcare (Karliner et al. 2007; Bauer and Alegria 2010; Flores 2005) and conclude that using professional interpreters improves the quality of care relative to using untrained ad hoc interpreters which is still the norm in many countries.

A review of existing studies on medical interpreting, many of which are qualitative investigations, find that they mostly deal with the experience of the interpreter and physician and little light is shed on the patients' point of view (Brisset et al. 2013: 135). Also, the findings of many of these qualitative studies diverge due to the different contexts of the individual studies.

Against this backdrop, this study attempts to synthesize the findings of existing qualitative studies on the patient experience in order to piece together a bigger picture and elucidate a thicker description of healthcare interpreting.

The research questions are as follows:

What is the patient experience of using interpreters－both professional and

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ad hoc – in medical consultations?

How does the patient experience differ depending on the type of interpreter?

2. Method

2.1 Overview

This study adopts a meta-ethnographic approach for qualitative knowledge synthesis. Pioneered by Noblit and Hare (1988) in the field of education, meta-ethnography is a methodological approach which collects, compares, and synthesizes the key findings of selected qualitative studies with the primary goal of drawing cross-case conclusions through systematic comparison (Saldaña 2015: 204). Through an interpretive and inductive process, meta-ethnography reduces the accounts while preserving the sense of the original accounts and ultimately makes "a whole into something more than the parts alone imply" (Noblit and Hare 1988: 28). The key is that the goal of such meta-synthesis is not to produce an oversimplification of the original findings but to retain the differences and complexities, ultimately "achieving more, not less" (Saldaña 2015: 205).

Central to the meta-ethnographic methodology is the process of "translation" which takes place during the analysis phase. It involves comparing and contrasting the key metaphors in the individual studies to determine how they relate to each other and reach interpretations which later become the material which meta-ethnographers use to synthesize individual case studies (Doyle 2003: 330).

The seven-phase approach proposed by Noblit and Hare were followed. The main steps were as follows: (1) determining the topic of interest and

searching the literature (phases 1 & 2), (2) repeated readings to identify key concepts and determine the relationship between studies (phases 3 & 4), (3) translating the studies into one another (phase 5), and (4) synthesis (phase 6).

2.2 Data Collection

A purposive sampling of related articles was conducted to collect data. The systematic reviews by Brisset et al. (2013) and Rocque and Leanza (2015) were used as a starting point as these studies provided a comprehensive reference of qualitative studies on healthcare interpreters from the perspectives of interpreters (both professional and ad hoc), practitioners, patients and administrative staff. This was supplemented by an online search to include studies that were published after 2013 and thus not included in the reviews. This was done on Google Scholar with the terms "medical interpreter", "medical interpreting", "healthcare interpreter" and "healthcare interpreting". The choice of limiting the query to English was intentional and has to do with the nature of meta-ethnography. The researcher was mindful of the fact that written accounts and interpretations serve as the basic ingredients of a meta-ethnography. While Noblit and Hare (1988) do not maintain that the original language of a case study must be used, the researcher agrees with the view of Doyle (2003) who underscores the importance of preserving the particulars of the individual studies by consciously focusing on salient language and adhering to the words of the original authors because "in qualitative research, interpretation flows from the material presented." (Doyle 2003: 332) If multilingual data were involved, ensuring that nothing was lost in translation would be a challenge. In order to maintain the particularities of the original studies, queries were limited to English.

Of the retrieved articles, an initial screening was conducted by excluding articles which (1) were not qualitative in nature or which used mixed-methods, (2) focused solely on the perspectives of family members, (3) could not be accessed by the researcher, and (4) were written by the same authors using identical data sets.

Ultimately, a total of ten peer-reviewed articles on the patient experience of medical interpreting were selected for analysis.

〈Table 1〉 Summary of articles

no.	Author (year)	Country	Method	Participants	Type of Interpreter[1]	Key Findings
1	Ngo-Metzger et al. (2003)	US	focus group	n=122 (Chinese, n=66; Vietnamese, n=56)	P, A	- Patients recognize the importance of interpreting quality - Preference for professionals over family members (due to shifting power dynamics and lack of training), gender-concordant interpreters, and word-for-word translation.
2	Edwards et al. (2005)	UK	semi-structured interview	n=50 (Chinese, n=10; Kurdish, n=10, Bangladeshi, n=10; Indian, n=10; Polish, n=10)	P, A	- Patient preferences for ad hoc interpreters from their informal networks (due to importance attached to trust and personal qualities)
3	Robb et al. (2006)	UK	interviews, focus group	n=83 (service users, n=18; professional interpreters, family interpreters, GPs, nurses, receptionists, practice managers, n=65)	P, A	- Trust emerged as an important theme in patient narratives. - Three different types of trust (voluntary trust, coercive trust, and hegemonic trust) were identified and were found to have key implications on the communication.
4	O'Donnell et al. (2007)	UK	focus group, interviews (one-to-one, group)	n=52 (African region, n=10; Eastern Mediterranean region, n=18, European region, n=16; South-East Asia region, n=8)	P	- Most asylum seekers generally satisfied with the quality of interpreting in primary care - Tension between interpreters' neutral translation and interpreters acting as advocates
5	Hadziabdic et al. (2009)	Sweden	semi-structured interview (phenomeno-graphic approach)	n=17 (Yugoslavia)	P, A	Three descriptive categories identified: (1) prerequisites for good interpretation situations, (2) the interpretation situation (aspects of satisfaction or dissatisfaction), (3) measures to facilitate and improve the interpreter situation
6	MacFarlance et al. (2009)	Ireland	action research (participatory research)	n=26 (Serb-Croat, n=7; Russian, n=19)	A	- Reported tension between having trusted friend/family member as interpreter and the burden of managing the situation - Clear preference for trained, professional interpreters - Using ad hoc interpreters led to misunderstanding and misdiagnosis causing frustration and anxiety
7	Barron et al. (2010)	UK	focus group	n=24 (Pakistani, n=11; Bangladeshi, n=6; Chinese, n=7)	P, A	- Patients unaware of healthcare professionals' role in service provision - Concerns over the appropriateness of using children as interpreters and the potential breach of confidentiality with friends - Women inventing illnesses rather than discuss sensitive issues with family - Attributes of interpreters
8	Costa et al. (2014)	UK	semi-structured interview	n=7 (Pakistani, n=3; Polish, n=2; Portuguese, n=1)	P, A	Three patterns of response to interpreters identified: (1) negative impacts on therapy, (2) the interpreter as conduit for therapy, (3) the therapist and interpreter as a shared enterprise
9	Hadziabdic et al. (2014)	Sweden	focus group interview	n=13 (Arabic)	P, A	- Using interpreters seen as both possibility and problem - Good language skills, medical terminology, translation ability, neutrality, objectivity, homogeneity viewed as important interpreter qualities
10	Zendedel et al.	Nether-	semi-	n=21	P, A	- Greater trust in ad hoc

	(2018)	lands	structured interview	(Turkish)		interpreters due to fidelity reasons. - Patients not intimidated by the trusted interpreter acting as primary interlocutor and were empowered by their presence

2.3 Data analysis

The meta-ethnographic analysis was conducted according to the phases proposed by Noblit & Hare (1988) starting with thorough and repeated reading of the selected articles. Initial readings were aimed at gaining an overall familiarity with the studies and their original contexts. Summaries were made in grid form as shown in Table 1. Once a basic understanding was established, studies were read again for key concepts or metaphors which were coded via open coding on the Atlas.ti program. In vitro coding was used for salient themes that emerged as second-level constructs in order to preserve the voices of the authors and remain as faithful as possible to the individual studies. After the first cycle of coding, individual codes were later grouped to determine common descriptive themes. The relevant codes and concepts were organized in a table to determine the relationship between the individual studies and draw comparisons.

Through repeated readings of the studies and juxtaposition of the concepts or metaphors, the researcher was able to determine both partial overlaps and contradictions of some of the key concepts. Ultimately, a line of argument synthesis was conducted to create a comprehensive understanding of the patient experience alongside reciprocal and refutational translations which were employed to interpret the overlapping and contradictory aspects of certain key concepts.

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1) P: Professional interpreter, A: Ad hoc interpreter

3. Results

This section reports on the results of the meta-ethnographic synthesis. The analysis led to 22 descriptive themes from which the following nine synthetic themes were drawn: “overcoming the hurdles to access”, “the preferred interpreting situation (aspects of satisfaction/dissatisfaction)”, “interpreter preferences (pros and cons)”, “important interpreter qualities”, “perceived interpreter roles”, “patient actions and reactions”, “trust”, “familiarity”, and “power and control”. Upon these synthetic themes, the following key themes were identified: “accessing services”, “quality of services”, “interpreter-related aspects”, “patient actions and reactions”, and “the communication dynamic”. For sake of brevity, this section will be devoted to a discussion on key findings that pertain to the research question of this research, namely the patient experience of services and related preferences. Details of the analysis can be found in the appendix.

3.1 Accessing Services

The first key theme of the synthesis relates to the patient experience of identifying interpreters and accessing services. Patients experienced both external and internal barriers to accessing professional services. External barriers could be found in the lack of in-house interpreters to provide consistent services (Edwards et al. 2005; Hadziabdic et al. 2014) and limited language support in the booking stage (Edwards et al. 2005; O’Donnell et al. 2007). Internal barriers include patients’ lack of awareness of interpreting services (Barron et al. 2010; Edwards et al. 2005) and social stigma of seeking help within certain communities holding patients back from accessing support (Barron et al. 2010). The variety of structural barriers in accessing professional interpreters often resulted in the involuntary use of ad hoc interpreters in situations where professional interpreters were not available (i.e. for unexpected visits (Hadziabdic et al. 2009, 2014), when the doctor failed to book an interpreter (Hadziabdic et al. 2014), etc.). Otherwise professional interpreting services were hard-earned through negotiations with the healthcare professional (MacFarlance et al. 2009) who served as "gate-keeper", often judging on behalf of the patient whether interpreting services were needed or not. Patients in this situation voiced their wish for healthcare professionals to play a more active role in service provision by providing more information (Barron et al. 2010; Hadziabdic et al. 2009), actively booking interpreters for their patients (Hadziabdic et al. 2014) and providing consistency by booking the same interpreters who reflect the patients' needs (Hadziabdic et al. 2009, 2014).

3.2 The Interpreting Situation: Quality of Services

Patients addressed various aspects of the interpreter-mediated encounter with particular focus on their preferred arrangements and aspects of satisfaction and/or dissatisfaction.

A key prerequisite for a good interpreting situation is arranging an appropriate interpreter. Aside from the professional qualities, personal traits and attitude of the interpreter, patients mentioned the importance of being matched with interpreters that shared the same dialect (Hadziabdic et al. 2009, 2014; O'Donnell et al. 2007) and gender as themselves (Barron et al. 2010; Hadziabdic et al. 2009, 2014; Ngo-Metzger et al. 2003; Zendedel et al. 2018): different dialects could result in inadequate treatment, and different genders were found problematic in medical consultations that dealt with sensitive issues. In the same vein, they also thought that having flexibility in choosing the interpreter provided for a good interpreting situation (Hadziabdic et al. 2009, 2014). Once they were matched with a suitable interpreter, patients wanted to spend adequate time with the interpreter during the session (Ngo-Metzger et al. 2003) and possibly meet with them over numerous encounters in order to build trust (Edwards et al. 2005; Hadziabdic et al. 2009; Robb et al. 2006). Through

such trusted interpreters, patients were able to express themselves freely in their mother tongue (Hadziabdic et al. 2014) which is of particular importance in psychological consultations.

Arranging of services was a major source of dissatisfaction not only when service users were matched inappropriately with interpreters of the wrong language/dialect but also when services were not consistent or referral documents inadequate leading to failure in service provision (Hadziabdic et al. 2014).

3.3 The Interpreter: Interpreter-related Aspects

3.3.1 Important Interpreter Qualities

Patient perceptions of important interpreter qualities could be categorized into aspects of professionalism and personal traits.

Professional aspects include interpreting-related skills and qualifications such as language proficiency (Edwards et al. 2005; Hadziabdic et al. 2014), professional training and knowledge (Barron et al. 2010; Edwards et al. 2005; Hadziabdic et al. 2009, 2014), and code of confidentiality (Barron et al. 2010; Edwards et al. 2005; Hadziabdic et al. 2014). Patients also thought that it was important for interpreters to work independently i.e. to be paid for privately (Barron et al. 2010; Robb et al. 2006).

Personal traits include the attitude and character of the interpreter－expressions of openness, respect, empathy, and proactively offering advice for the patient (Edwards et al. 2005; Hadziabdic et al. 2009; Ngo-Metzger et al. 2003; Robb et al. 2006). Notable is the importance service users attach to cultural appropriateness. Due to the sensitive nature of the medical encounter, patients (particularly women) found it important for the interpreter to be of the same gender (Barron et al. 2010; Hadziabdic et al. 2009, 2014; Ngo-Metzger et al. 2003; Zendedel et al. 2018). Patients also believed it was important for interpreters to come from the same country, use their dialect, and have the same cultural background which includes political and religious views (Barron et al. 2010; Hadziabdic et al. 2014). This was expressed by services users from conflict regions in Africa and the Middle East where animosity exists between people of different political and religious affiliations.

3.3.2 Preferred Types, Pros and Cons: Professionals vs. Ad hoc

The analysis highlighted how patient circumstances and needs led to different preferences. Opinions were divided between those who preferred professionals due to professional aspects including professional knowledge, accurate interpreting, neutrality and confidentiality (Hadziabdic et al. 2009, 2014; Ngo-Metzger et al. 2003; O'Donnell et al. 2007) and ad hoc interpreters due to availability and trust (Edwards et al. 2005; Robb et al. 2006; Zendedel et al. 2018), confirming the findings of Brisset et al. (2013) that not all patients share a preference for professional interpreting but levels of satisfaction correlated with the emotional proximity the patient feels toward the interpreter. This study found that interpreter preferences depended highly on the nature of the illness and consultation. Service users preferred family and friends to serve as interpreters for uncomplicated medical issues due to trust and familiarity (Edwards et al. 2005; Robb et al. 2006; Zendedel et al. 2018) but drew the line when the stakes were high in which case patients appreciated the interpreter's neutrality and higher possibility of adequate treatment (Hadziabdic et al. 2014).

As can be expected the respective pros and cons of the interpreter types were correlated: the ad hoc interpreter fell short in areas that the professional was appreciated for, and vice versa. Professional interpreters were appreciated for their professional training and knowledge (Edwards et al. 2005; Hadziabdic et al. 2009, 2014; Robb et al. 2006), language proficiency (Edwards et al. 2005; Hadziabdic et al. 2014), professional and neutral attitude (Hadziabdic et al. 2009), code of confidentiality (Edwards et al. 2005; Hadziabdic et al. 2014; Zendedel et al. 2018) and the good relationship they maintained with the

clients (Barron et al. 2010; Edwards et al. 2005; Hadziabdic et al. 2009, 2014). The lack of such professional aspects was noted as a major disadvantage of using family and friends as interpreters which include lack of training, professional knowledge (medical terminology, medical service, procedures) and limited language skills, the culmination of which could lead to miscommunication and ultimately inadequate treatment (Barron et al. 2010; Costa et al. 2014; Hadziabdic et al. 2014; MacFarlance et al. 2009; Ngo-Metzger et al. 2003). Interestingly, too much professionalism could also be a problem as there was the rare complaint of professionals "staying in role" (Costa et al. 2014) and maintaining a neutral attitude rather than being an advocate. Also, not all professionals were considered professional enough as noted in the criticism that professionals lack the necessary training to deal with health issues and medical terminology (O'Donnell et al. 2007). This reflects the reality of community interpreting which mostly caters to the linguistic needs of minority languages for which professional T&I training often does not exist.

The main advantage of having family and friends interpret was the familiarity they brought into the consultation. The long-standing trust built between the patient and the ad hoc interpreter as well as the practical support provided by the family member or personal acquaintance allowed feelings of empowerment and confidence (Hadziabdic et al. 2009; Robb et al. 2006; Zendedel et al. 2018). Conversely, trust-related issues were cited most often as disadvantages of professional interpreters. These include concerns over accuracy (Hadziabdic et al. 2009, 2014; Ngo-Metzger et al. 2003), confidentiality (Hadziabdic et al. 2009, 2014; O'Donnell et al. 2007) and neutral or indifferent attitude (Costa et al. 2014; Edwards et al. 2005; Hadziabdic et al. 2009). Trust-related complaints stem from lack of familiarity－distance between the patient and interpreter. Patients voiced concerns over accuracy and confidentiality particularly when the interpreter did not share their dialect, religion or country of origin (Hadziabdic et al. 2009).

Notable opinions regarding ad hoc interpreters were the concerns service users had over confidentiality and stigma. This is when relationships get in the way, when patients feel there are "strings attached" to their familial and/or social ties. Privacy concerns can be expected as untrained, informal interpreters are not bound by a code of confidentiality as professionals are. Concerns are aggravated, ironically, by the close proximity with the ad hoc interpreter－trust-related concerns arose even with those whom the patient claimed they could trust. Even within the close circle of immediate family and intimate friends, patients found it challenging to share intimate health issues and expose their vulnerabilities: patients (mostly women) were reluctant to expose their bodies or discuss sensitive matters in front of family members even children (Barron et al. 2010; Hadziabdic et al. 2009, 2014; MacFarlance et al. 2009; Zendedel et al. 2018) and wives fabricated non-existing medical conditions in the presence of their husbands (Barron et al. 2010). When the range of intimacy is expanded to include the larger ethnic community, concerns of social stigma arose as patients feared that their or their children's private information would be shared with the community (Barron et al. 2010; Edwards et al. 2005; MacFarlance et al. 2009). Such concerns were often culturally-driven due to cultural perceptions of sensitive matters and particular diseases.

3.3.3 Interpreter Roles

A wide spectrum of interpreter roles were identified including the most common role of communication aid (Hadziabdic et al. 2009, 2014; MacFarlance et al. 2009), practical guide or caregiver (Hadziabdic et al. 2009; Zendedel et al. 2018), advocate (Barron et al. 2010; Zendedel et al. 2018), and member of the healthcare staff (Hadziabdic et al. 2009). The analysis also revealed new interpreter roles－notably that of the interpreter as barrier (Costa et al. 2014; Hadziabdic et al. 2009, 2014) and as strategic means to an end (Robb et al. 2006).

Patients who perceived the interpreter as a barrier complained that the interpreter interrupted their direct communication with the doctor (Costa et al. 2014; Hadziabdic et al. 2014) reducing intimacy which can be problematic particularly in psychiatric consultations. The sense of dependency on the interpreter caused discomfort for some patients as can be seen from their accounts of how using the interpreter "feels like a walking stick" (Hadziabdic et al. 2009: 456). Some other service users viewed the interpreter as a means to an end, merely a necessary step they had to go through in order to receive their prescription or medical treatment (Robb et al. 2006). To them, the interpreter's role was solely strategic. This reflects previous findings which show that patients with clear expectations of specific outcomes such as referrals or prescriptions engage in more strategic speech focused on manipulating the outcome (Greenhalgh et al. 2006: 1170).

3.4 The Patient: Actions and Reactions

An important theme was the role the patient plays in the interpreter-mediated medical consultations through a range of actions and reactions: 1) coping strategies used by patients in case of failed communication, 2) feelings of shame and embarrassment, and 3) reaction to stigma and taboo.

In cases when communication with the doctor failed－either due to the absence of an interpreter or substandard interpreting quality－patients resorted to an array of strategies to remedy the situation which could be positioned across a spectrum from active to passive. Active strategies included cancelling the consultation altogether, requesting the interpreter to repeat themselves, or asking the doctor to find a new interpreter for them (Hadziabdic et al. 2009). Passive strategies included just "muddling through" (Hadziabdic et al. 2009: 442) i.e. attempting to make the best of what they could, sometimes "patching together" information they heard with the family member or friend accompanying them (MacFarlance et al. 2009: 213), turning to their personal network of informal interpreters including family, seeking a bilingual doctor, or inaction (Robb et al. 2006). An extreme strategy was when the patient made up a fake illness (Barron et al. 2010). While the patient is taking strong action to avoid the problem head-on in this case, the researcher believes that this should be considered a passive strategy as the patient is refusing to address the problem directly.

As mentioned, patients reported feelings of shame and embarrassment sharing sensitive information or undergoing physical exams in the presence of interpreters of the opposite sex even when the interpreter was a family member (Hadziabdic et al. 2009, 2014; Zendedel et al. 2018). The shame associated with sensitive health issues had religious and cultural roots as noted by patients of Asian ethnicity. In this light, phone interpreting, despite its many disadvantages, provided some protection and sense of security as it enabled patients to receive interpreting services with anonymity (Hadziabdic et al. 2009, 2014).

Interestingly, stigma was not only attached to sensitive issues of health but also to initial access as some ethnic communities reportedly found it taboo to seek help from interpreters (Barron et al. 2010). Taboo was also found in general concepts of health with certain diseases such as skin lesions stigmatized by certain communities (MacFarlance et al. 2009). As a result, patients who were reluctant to seek medical help risked their health by postponing treatment showing how culturally-driven concepts of health are.

3.5 The Communication Dynamic: Trust, Familiarity, Power and Control

Within this communication dynamic involving the patient, interpreter, and doctor, the intertwining concepts of trust, familiarity, power and control emerged to be central.

The asymmetrical balance of power in bilingual medical consultations puts patients in a vulnerable position as they often have no choice but to concede

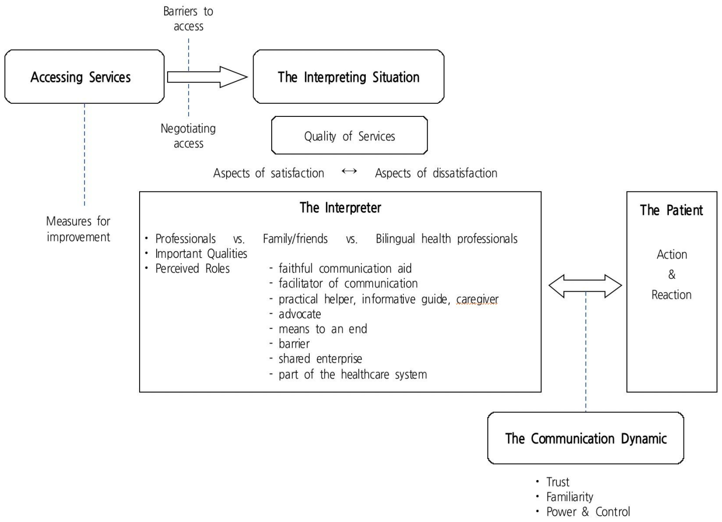
their control over the communicative situation to the interpreter. In such cases of coercive trust, patients were fearful that the interpreter may abuse their linguistic power during the consultation (Robb et al. 2006) and expressed the desire to book professional interpreters of their choice (Hadziabdic et al. 2014) in an effort to control the identity of the interpreter.

Conversely, patients felt empowered and less threatened in the presence of a trusted interpreter, particularly family over whom they had control and who advocated for them in decisive situations (Zendedel et al. 2018). In such cases of voluntary trust, service users trusted the accuracy of the informal interpreters even though their performance could not be verified (Zendedel et al. 2018) and expected them to assume the role of advocate. Ironically, dependence on family can also result in feelings of helplessness and discomfort (Zendedel et al. 2018). This was noted particularly when children served as interpreters－patients felt that the interpreting situation disrupted the traditional balance of power between parent and child (Ngo-Metzger et al. 2003).

As such, building trust with the interpreter is an important issue for patients in bilingual medical consultations. It was found that trust was enhanced when the interpreter displayed professionalism (interpreting skills, linguistic proficiency, professional training and knowledge, code of confidentiality) (Barron et al. 2010; Edwards et al. 2005; Hadziabdic et al. 2014; Robb et al. 2006), good character (attitude of openness, empathy, respect) (Hadziabdic et al. 2009; Robb et al. 2006) as well as cultural appropriateness and homogeneity namely sharing the same background as the patient i.e. gender, dialect, country of origin, and political/religious background (Barron et al. 2010; Robb et al. 2006). Such familiarity was not only built on the commonalities of dialect, ethnicity, and country of origin but also resulted from a continuity of positive encounters over time (Edwards et al. 2005; Hadziabdic et al. 2009; Robb et al. 2006) hence the importance of booking the same interpreter when possible. In contrast, patients expressed doubt over the objectivity of interpreters who came from “enemy” territory and distrusted those with whom they had few encounters (Robb et al. 2006). Such mistrust was more evident when the patient is dealing with sensitive health issues (Robb et al. 2006).

The line-of-argument that emerged as a result of the synthesis is depicted in the diagram below.

Diagram. The Patient Experience of Healthcare Interpreting



4. Discussion & Conclusion

4.1 Discussion

As a meta-ethnography of qualitative studies on healthcare interpreting, the aim of this study was to reveal the experience of patients as users of professional and non-professional interpreting service. The line-of-argument

synthesis showed the different facets of the patient experience from accessing services, aspects of the interpreting situation, patient actions and reactions, to the communication dynamic between the patient and interpreter.

The significance of this study is twofold: first, by narrowing the scope to the experience of patients as service users, the synthesis could reveal the subtleties of patient perspectives that were otherwise overlooked in existing systematic reviews; and second, as a meta-synthesis of qualitative research, it provides a fuller and deeper view of the patient experience.

The synthesis brought to light the unique nature of the multilingual medical encounter and the vulnerable position the patient is in. The study showed that patient preferences in the type of interpreter was a reaction to such vulnerabilities and was highly contextual and fluid. More importantly, it revealed the role that the patient plays in the medical consultation by highlighting the various actions they take to remedy failed communication and the affective reactions that they have to the shifting dynamics of the communication.

4.2 Limitations and Future Research Orientations

This study is not without its limitations. First, the sample studies were all international studies conducted outside of Korea and written in English. While English is the lingua franca of academia, searching for English-only articles naturally excluded other languages and possibly limited the scope of investigation. Second, a meta-ethnography conducted by a single researcher will have its limits. Noblit and Hare did not provide guidelines regarding this issue but it is customary for a research team to engage in a meta-synthesis to cross-check data to allow for a deeper and varied interpretation of the research question and add validity to the findings.

Such limitations shall be addressed in future research, first and foremost by conducting a qualitative meta-synthesis on the Korean situation. At the time of research, the researcher failed to identify a qualitative article written in the Korean context that pertained to the research question[2]. Once a body of qualitative research grows domestically, meta-syntheses such as this study can be conducted to shed light on domestic practices and draw implications for Korean researchers and practitioners.

4.3 Implications for Practice and Education

Although the results of this study may not be directly applicable to the Korean context, they provide us with an understanding of the particularities of the patient experience which can guide us in developing training programs, making policy decisions, and conducting future research.

First, there needs to be an examination of the structural barriers to access including the role of the healthcare provider in booking and patient awareness of services. Efforts should also be made to ensure that patients are given a choice of interpreter to facilitate trust.

Second, the patient perspective of interpreter qualities must be incorporated in medical interpreter training. Future programs should not only focus on enhancing professionalism in trainees but also other trust-enhancing factors, particularly factors that can erode trust i.e. attitude and cultural appropriateness.

Third, more research needs to be conducted domestically on the patient experience of medical interpreting particularly on the role they play in the communication process.

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[2] In a recent review of medical interpreting literature in Korea, Kim (2018) was able to identify only 28 articles on medical interpreting: a cursory review of the articles shows that none of the studies were case studies on patient perspectives. Similarly, a review of interpreting studies conducted by Won (2018) found 19 case studies published between 1997~2017 of which only eight were case studies on various aspects of medical interpreting. None of them investigated the service user perspective.

4.4 Conclusion

Key findings of this study corroborate existing literature on medical interpreting. Namely, the oscillating roles of the interpreter within the relational dynamic and issues of trust-control-power were revealed in the meta-ethnography by Brisset et al. (2013). What differentiates this study is the primary focus on the patient which revealed in particular (1) the various strategies adopted by the patient in order to address communication issues and their reactions of shame and embarrassment regarding taboo issues, and (2) the communication dynamic of trust-familiarity-power/control and the subtle balance among these forces. Contrary to the views of T&I scholars who emphasize the ethical imperative to provide professional interpreters in medical settings (Leanza 2007: 12), patients would sometimes prefer to have a friendly face in the doctor's office with them. These themes are worthy of further scholarly inquiry and could be explored in future research.

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Appendix

〈Table〉 Key themes of 1st order research

Key theme	Synthetic theme	Descriptive themes	Individual codes
Accessing services	Overcoming the hurdles to access	Barriers to accessing services	- Awareness of professional services (varying degrees of knowledge; request for service information; stigma of seeking help) - Difficulty of accessing professionals (language barriers; lack of in-house interpreters; limited access for non-scheduled visits; inconsistency of service provision)
		Negotiating access	- Accessing informal interpreters (negotiating the use of informal interpreter with GPs; easy availability of family/friends especially for unexpected visits, no-shows, doctors' failure to book interpreters) - Healthcare professionals' role in booking interpreters (doctors unwilling to book professional interpreters; mixed reaction towards ad hoc interpreter)
		Measures for better access	- Wish for healthcare professionals to play active role in booking interpreters - Need for healthcare professionals to provide consistency by booking the same interpreter and respecting patient preferences in booking (i.e. interpreter with same language/dialect/country of origin/gender as patient) - Need to hire in-house professionals to interpret - Need for health professionals to provide more information about where to book professional interpreters - Need for better training for interpreters (language skills & terminology, professional attitude)
Quality of services	The interpreting situation: preferred arrangements & aspects of satisfaction/dissatisfaction	Prerequisites for a good interpreting situation	- Arranging appropriate interpreter (same dialect/gender; flexibility in choice of interpreter) - Adequate time spent with interpreter; numerous encounters to get to know & trust the interpreter - Interpreter qualities (professional qualities; appearance; personal traits & attitude) - Environmental factors (secluded room, face-to-face encounter)

			- The importance of being able to speak freely in your mother tongue (particularly during psychological consultations)
		Aspects of satisfaction	- Professionalism - Interpreter behavior and attitude - Interpreter’s role (advisor; conduit; spokesperson; helper/informative guide; communication aid; shared enterprise; empowerer)
		Aspects of dissatisfaction	- Arranging of services (interpreting provided via telephone; lack of documentation in referral records; mismatch of language/dialect; lack of continuity)
Interpreter-related aspects	The interpreter: preferred types, pros and cons	Preferences: type of interpreter, mode of interpreting	- Professional interpreter over ad hoc interpreter (family, friends) due to neutrality and enhanced possibility of adequate treatment especially for important health issues and psychological consultations - Informal interpreters preferred in uncomplicated situations due to fidelity (trust that the interpreter will side with the patient in critical situations) - Face-to-face interpreting preferred over telephone which is disliked due to body language, technical issues, and inability to control the identity of the interpreter - Telephone mode desirable method in uncomplicated situations due to accessibility & anonymity in sensitive consultations
		Professional interpreters: pros and cons	(Pros) - Professional training - Language proficiency - Professional knowledge (service procedures & medical terminology) - Code of confidentiality - Professional/neutral attitude (respect, empathy, kindness, calm & secure impression) - Physical appearance - Professional attire - Good relationship with interpreter (Cons) - Wrong language/dialect - Lack of proficiency (linguistic & translation-skills) - Lack of training to deal with health issues & medical terminology - Concerns over accuracy (especially with interpreters of different religion/country of origin) - Concerns over confidentiality/privacy (qualms over sharing sensitive topics; no assurance of confidentiality) - Lack of continuity needed to build trust - Attitude problems (superior attitude, being neutral or “staying in role” rather than being an advocate, unprofessional attitude)
		Ad hoc interpreters (family & friends): pros and cons	(Pros) - Easily available - Trust built on mutual understanding & obligations - Familiarity with patient’s concerns/complaints - Provides support & practical help - Feeling of empowerment & confidence (Cons) - Not available at all times - Lack of training (medical terminology) - Limited language skills (lack of language skills leading to wrong diagnosis, prescription, treatment) - Lack of professional knowledge (service procedures & medical terminology) - Misunderstandings leading to wrong treatment - Concerns over confidentiality/privacy (personal information being shared within the small ethnic community) - Concerns about stigma (embarrassment about sharing sensitive topics; shame about showing body in front of family of opposite sex; “special diseases” causing more privacy concerns; inventing illnesses rather than share embarrassing topics) - Inappropriateness of using children to interpret (unnecessary burden; limits to topics that can be discussed with family; concerns of children missing school) - Limited disclosure of information causing health ramnifications
		Ad hoc interpreters (bilingual healthcare professionals): pros and cons	(Pros) - Healthcare training - Good interpreting skills - Practical assistance - Effective help without delay - Financial benefits (interpreting for “free”)

			(Cons) - Lack of training - Interpreting is outside of their official duties - No duty of confidentiality - Superior attitude
	The interpreter: important qualities	Important interpreter qualities: professionalism	- language proficiency - professional training & professional knowledge (accuracy; knowledge of medical terminology) - culturally appropriate - code of confidentiality - independent (privately paid) interpreter
		Important interpreter qualities: personal traits	- Character & attitude (openness, respect, empathy, proactive stance (offering advice)) - Culturally appropriate (interpreter of the same gender (for sensitive matters), with the same dialect, from the same local community/country of origin, share political/religious background)
	The interpreter: perceived roles	Interpreter roles & tasks	- Interpreter as faithful communication aid (enables the patient to express concerns, feelings, pain in mother tongue; provides patient with full information, even cancer diagnosis; wholehearted commitment to facilitate communication in therapy) - Interpreter as practical helper, informative guide, caregiver (reading signposts/letters; making appointments, taking patients to the GP, collecting/tracking prescriptions, functioning as patients' memory) - Interpreter as advocate - Interpreter as a means to an end (Provider of technical support via linguistic interpreting; interpreter used instrumentally to achieve strategic goal) - Interpreter as barrier (interrupting direct communication with doctor; reduces intimacy with healthcare staff; "feels like a walking stick";) - Interpreter as shared enterprise with doctor ("collaborative triangle") - Interpreter as part of the healthcare staff
The patient: actions and reactions	The patient: actions and reactions	Actions: coping strategies used by patients in case of failed communication	- Asking interpreter to repeat - Ask for new interpreter - Cancel the consultation - Muddling through ("patching together") - Going to bilingual doctor - Using the voluntary sector (including family) - Inaction (just coping with unsatisfactory interpreter) - Make up fake illness
		Reactions: feelings of shame/ embarrassment, stigma & taboo	- Feelings of shame and embarrassment sharing sensitive issues with interpreter (family members & professional interpreters of the opposite sex) - Embarrassment mentioned as a drawback of using ad hoc interpreters - Shame of sharing sensitive health issues rooted in religious/cultural reasons - Anonymity over the phone provides protection the patient from shame when discussing sensitive issues - Shame/Stigma attributed to seeking help from an interpreter in the patients' local communities - Stigma of certain diseases within the local community making patients reluctant to seek medical help
The communication dynamic: the relationship among trust, familiarity, power & control	Trust	Trust: characteristics of trust	- Trust may be traded off for good English competency or vice versa. - Trust is a dynamic element of relationships that is assessed and re-assessed over time. - Trust in the accuracy/honesty of informal interpreters even though unverifiable - Competence was not mentioned as a trust enhancing/decreasing factor - Cases of coercive trust where patients report feelings or resignation to the situation (having no choice but to trust the interpreter)
		Trust: factors and barriers	- Familiarity with interpreter ("my interpreter"; based on commonalities in language/dialect, ethnicity, country of origin) - Interpreter's perceived personal qualities (gentle, caring, empathetic, respectful, non-judgmental attitude) - Interpreter's professional qualities (professional training, linguistic skills, knowledge of the system, medical terminology, accuracy, code of confidentiality, commitment) - Interpreter's physical qualities (body language, appearance, professional attire) - Neutrality (independent & privately paid) - Continuity of positive encounters over time

			- Mistrust rooted in ethnic/political tensions, causing doubt over objectivity (interpreter's country of origin; "them enemies") - Interpreter's perceived personal qualities (perception of coldness & hostility) - such qualities leading to perceptions of low competence - Lack of continuity - Nature of the health problem (private/intimate issues; sexual health problems; mental health problems, domestic violence, child rearing)
		Trust: ad hoc interpreters (family) and trust	- Preference for informal interpreters over professionals for reasons of trust (trust that they would "be on my side") - Doubts about children being honest about passing on bad news - Preference for children over husbands (mistrusting husbands as interpreters)
		Trust: expectation of trust	- Interpreter will take my side in power struggle (voluntary trust) - Fear of the interpreter abusing linguistic power (coercive trust)
	Familiarity	Familiarity	- Familiarity seen as a factor of trust - Importance placed on homogeneity; interpreters with the same dialect, country of origin, religious/political affiliation, gender - "My interpreter" - Preference for family & friends as interpreters due to familiarity
	Power & control	Loss of control in the interpreting situation	- Helplessness in the choice & booking of professional interpreter leads to passive action in case of quality issues - Fear of professional interpreter abusing linguistic power - The inability to control the identity of the interpreter causes feelings of insecurity when interpreting is conducted over the telephone - Patients submitting to interpreter in control
		Power dynamic and trust in interpreters	- Feelings of empowerment in the presence of trusted interpreter - Patients prefer family member as interpreter due to trust & the factor of control (especially when children are interpreting) - Feelings of helplessness/powerlessness (due to feeling of dependence on family) - (Family) Interpreters perceived as being in control of the medical interaction (side-talk activities seen as a natural consequence of patients' low language proficiency) - The power dynamic shifting when children act as interpreters for parents, creating discomfort for the patient

[Abstract]

A Qualitative Synthesis of Patients' Experiences of Healthcare Interpreting

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This article reports the results of a qualitative meta-synthesis of existing literature on user perspectives on community interpreting with focus on the patient experience of healthcare interpreting. A meta-ethnographic synthesis of ten peer-reviewed articles revealed key themes of accessing services, quality of services, interpreter-related aspects of service, actions and reactions of patients, and the communication dynamic. The analysis identified external and internal barriers to accessing professional interpreting services, the preferred arrangements and aspects of satisfaction/dissatisfaction, the pros and cons of using professional vs. non-professional interpreters, patient perceptions of important interpreter qualities and roles, coping strategies used by patients in the interpreter-mediated encounter, as well as issues of trust, familiarity, power and control which play a role in the communication dynamic.

▸ Key Words: medical interpreting, healthcare interpreting, community interpreting, user experience, qualitative synthesis, meta-ethnography
▸ 주제어: 의료통역, 의료보건통역, 커뮤니티통역, 사용자 경험, 질적 종합연구, 메타문화기술지

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