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初探北台灣醫療體系中的口譯需求：醫師觀點

Exploring the Demand for Professional Interpreting Services in Northern Taiwan's Hospitals: Physicians' Perspectives

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國立臺灣大學碩士學位論文
口試委員會審定書

初探北台灣醫療體系中的口譯需求：醫師觀點
Exploring the Demand for Professional Interpreting Services in Northern Taiwan's Hospitals: Physicians' Perspectives

本論文係李立心君（學號 R03147008）在國立臺灣大學翻譯碩士學位學程完成之碩士學位論文，於民國 107 年 5 月 30 日承下列考試委員審查通過及口試及格，特此證明

口試委員：

（指導教授）

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摘要

受到國際化浪潮影響，台灣移民人口增加，近年也掀起了觀光醫療的風潮，兩項因素皆會推升醫療體系中跨語言溝通的頻率。國外研究顯示，如果沒有適切的體制讓跨文化溝通更加順暢，醫療體系中的語言隔閡可能會造成醫師誤判病情，也會降低病人就醫的滿意度。有鑑於此，台灣政府與民間組織皆已起身而行，試圖透過建立口譯體制消弭醫院中的語言隔閡問題，但國內仍缺乏相關研究探討醫院跨語言溝通現況、對口譯服務的需求與預期。若未全面了解現況與需求，不管是政府或民間恐怕都難以建立真正符合醫療體系需求的口譯體制。本研究的目標即是要彌補此缺口，透過深度訪談 21 位在台灣北部地區醫學中心服務的醫師，了解院內跨語言溝通情形與口譯需求。研究結果顯示，台灣醫師鮮少進行跨語言溝通，如遇到無法以中文溝通的病患或陪同病患就醫者（如：家屬、看護），醫師會以英文溝通、採取比手畫腳等溝通策略、或請求非專業口譯員協助。雖然部分醫師認為若能設立專業口譯服務體制，將會帶來益處，但多數醫師認為現況可接受、不需要另設體制。整體而言，台灣醫院對專業口譯服務的需求低於預期，政府與民間組織若想進一步推動，應將此結果納入考量。

關鍵字：口譯、社區口譯、醫療口譯

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Abstract

Globalization has greatly impacted Taiwan's medical system with the increase in immigrants and medical tourists contributing to the rise in cross-language communication in hospitals. Without the establishment of proper measures to facilitate cross-language communication, language barriers can lead to inaccurate diagnosis and unsatisfactory medical experiences for both patients and physicians as shown by previous research. Being aware of the potential problems, Taiwan's government and private organizations have taken measures to overcome the barriers. However, little research has been conducted to explore the current situation of cross-language communication, demand for professional interpreting services, and expectations of professional interpreting services in Taiwan's hospitals. Without understanding these issues, it is difficult to create an interpreting system that suits the needs of Taiwan's medical system. With this in mind, this research aims to explore the current situation in Taiwan's hospitals and physicians' demand for professional interpreting services by conducting in-depth interviews with 21 physicians working at medical centers in Northern Taiwan. The results show that physicians do not engage in cross-language communication very often. When they do, they communicate with patients or patients' proxies in English or with the help of ad hoc interpreters. Physicians also apply various strategies, including gesturing and drawing. While some physicians regard professional interpreting service systems as nice to have,

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most physicians find the current situation acceptable and do not consider professional interpreting services in hospitals necessary. Overall, judging from the participants' responses, the demand for professional interpreting services may be lower than expected in Taiwan's hospitals.

Key words: interpreter, community interpreting, medical interpreting

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Chapter 1 Introduction

1.1 Background of the Study

Globalization has greatly influenced Taiwan's medical system by bringing more Limited Chinese Proficiency (LCP) patients to Taiwan's hospitals. LCP is defined by the author, by replacing English with Chinese in the definition of Limited English Proficiency used by Divi, Koss, Schmaltz, and Loeb (2007), as having limited ability or inability to speak, read, write or understand the Chinese language at a level that permits the person to interact effectively with health care providers or social service agencies.

LCP patients in Taiwan come from two major sources. First is immigrants that hold an Alien Resident Certificate (ARC) issued by the government. Over the past decade, the number of ARC holders has increased from 439,476 to 717,736 (National Immigration Agency, 2018). It is estimated that ARC holders visited hospitals 6 million times in 2017[1]. The second major source of LCP patients is "Medical Tourism". Lunt et al. (2011) defined medical tourism as a phenomenon that "occurs when consumers elect to travel across international borders with the intention of receiving some form of medical treatment."

[1] While there is no accurate and updated data on migrants' utilization of medical services, estimation can be made based on historical data. According to a report published by the Bureau of National Health Insurance, each foreign insurer received medical services 8.896 times in 2010. Since all ARC holders are required to enroll in the National Health Insurance Program, by multiplying the average to the number of ARC holders in 2017, which was 717,736, it can be inferred that 6 million visits to hospitals were made by foreign residents.

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Fourteen million patients are estimated to be crossing borders for medical services every year (Patients Beyond Borders, 2017). With its affordable, high-quality health care, Taiwan has seen an increase in international patients on the back of the trend of medical tourism. The number of medical tourists grew significantly from 2012 to 2015 before plummeting in 2016 and 2017. It is worth noting that the main factor of the plunge was the significant decrease in the number of medical tourists from China. During the same period of time, the number of medical tourists from places other than China grew steadily and nearly tripled (National Tourism Bureau, 2017). In other words, the sharp decline in the number of medical tourists in 2016 and 2017 does not undermine the argument in this study that globalization has brought in more LCP people to Taiwan. The drastic increase in people from non-Chinese speaking countries can lead to an increase in the frequency of physicians' communication with LCP medical tourists. Figure 1 shows the increase in potential LCP patients from 2012 to 2017.

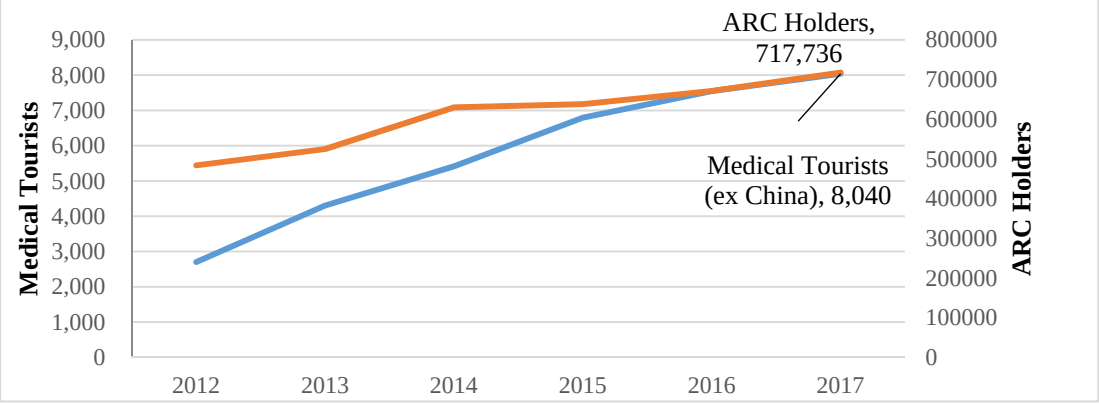

Figure 1. The growth of ARC holders and medical tourists from non-Chinese speaking regions

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Increase in the number of LCP patients may create language barriers that may lead to serious problems in health care systems. Both LCP patients and physicians in Taiwan regard language as a major factor that reduces LCP patients' medical accessibility and quality of care (Tsai, Chen & Gong, 2001; Yang & Wang, 2003; Shen, 2006; Chen & Chu 2009; Chen 2013). Similar issues have been observed in other countries, with research showing that language barriers leading to inaccuracy in diagnosis and unsatisfactory medical experiences for both patients and physicians (Alpert, Kesselman, Marcos, & Urcuyo, 1973; Bagchi et al., 2011; Sarver & Baker, 2000).

Although direct communication is the optimal choice for patients, there are usually not enough bilingual physicians in a hospital to provide bilingual service for everyone who needs it (Karliner, Jacobs, Chen, & Mutha, 2007). More importantly, without defining the sufficient level of language proficiency in providing medical care, asking a physician to communicate in his second language may cause more problems (Baker, 1996; Diamond, Schenker, Curry, Bradley, & Fernandez, 2009; Diamond, Tuot, & Karliner, 2012).

In a language discordant situation[2], bilingual medical staff, family members, friends, and other untrained bilinguals are often asked to serve as ad hoc interpreters. However,

[2] "Language discordant situation" is defined in this study as a situation in which providers and patients do not share the same language in accordance with Hsieh (2018).

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empirical studies have shown that in comparison with professional interpreters, ad hoc interpreters tend to make more errors, which can lead to adverse medical events (Ebden, Bhatt, Carey, & Harrison, 1988; Elderkin-Thompson, Silver, & Waitzkin, 2001; Flores et al., 2003). All the potential risks may prevent patients with limited language proficiency from receiving fair care in hospitals, and thus create a discriminating medical system.

Being aware of the language barriers and hoping to ensure equal access to health care, many developed countries require institutions to provide language assistance to every individual in need (Brisset, Leanza, & Laforest, 2013; Flores, 2000). A key type of language assistance in the medical context is the provision of professional interpreting services at hospitals. In the United States, for example, medical institutions receiving funds from the federal government are required to ensure that “interpreters are readily available during all hours of its operation” (Flores, 2000). Taiwan’s government and society are also aware of above-mentioned potential problems and have taken measures to overcome language barriers. For example, medical interpreters hired by the government can be found at local medical centers. The International Medical Translators and Interpreters Association (IMTIA), a non-profit organization, was founded by Fu Jen Catholic University with a view to training more medical interpreters. However, the current situation, demand for and expectations of professional interpreting services in Taiwan remain under-explored.

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1.2 Purpose of the Research

Without understanding the current situation and expectations of interpreting services, it is impossible to create an interpreting system that suits the needs of Taiwan's medical system. With this in mind, this research aims to acquire an overview of the demand for and expectations of professional medical interpreting services in Taiwan from physicians' perspectives. By conducting in-depth interviews with 21 physicians currently practicing medicine in Taiwan's medical centers, the study aims to answer the following research questions:

1. What is the current situation of cross-language communication in Taiwan's hospitals?
2. Do physicians need the help of professional interpreters to communicate with LCP patients or the patients' proxies (i.e. family members, care givers)?
3. What are physicians' expectations of medical interpreting services?

Variations of demand among physicians can be significant due to differences in years of experience, position, department, and personality. Hence, the goal of this exploratory research is not to generalize physicians' demand for professional interpreting services but to acquire a brief overview on current need in order to lay a foundation for further research on the issue.

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1.3 Structure of the Study

The present study contains five chapters. Chapter 1 gives an overview on the research background and introduces the subjects of interest. Chapter 2 reviews studies conducted in Taiwan and abroad related to the existence and impacts of language barriers in hospitals, current solutions and challenges in overcoming the language barriers, the underutilization of professional interpreting services, and the current situation in Taiwan. Chapter 3 describes the methodology applied to conduct the research, including the design of interviews and methods of data analysis. Chapter 4 presents and discusses the results of the study. Chapter 5 states the significance and limitations of the study, and provides suggestions for future research in the field.

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Chapter 2 Literature Review

Globalization has impacted healthcare systems worldwide. While little research on cross-language health care has been done in Taiwan, a number of quantitative and qualitative research has been conducted oversea. In this chapter, the researcher begins by reviewing research conducted abroad to explore the existence and impacts of language barriers, current solutions and challenges, the underutilization of professional interpreting services, and then gives a review on research conducted in Taiwan that helps provide an overview on the country's current situation. The chapter is wrapped up with a summary of the literature review.

2.1 Existence and impacts of language barriers in hospitals

Research has long indicated the existence of language barriers in hospitals and its negative impacts on accessibility to health care. Positive correlation between utilization of health care usage and English ability was identified by Hu and Covell (1986). Another two broad-based surveys conducted in the United States also revealed that low English proficiency of parents can lead to less health care received by their Hispanic children (Kirkman-Liff & Mondragón, 1991; Weinick & Krauss, 2000).

Even when patients do gain access to the medical system, the quality of care is far from being guaranteed. Patients may encounter discriminating medical staff and

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physicians may find it hard to provide optimal care even if they are willing to (Berghout, van Exel, Leensvaart, & Cramm, 2015; Hunter-Adams & Rother, 2017). The efficiency and effectiveness of care can also be impaired. Baker (1996) pointed out that when an interpreter is not present where language barrier exists, patients may not be able to fully understand the diagnosis and treatment. Language barriers can also lead to a lower rate of preventive care (Woloshin, Schwartz, Katz, & Welch, 1997), a lower follow-up rate (Sarver & Baker, 2000), a lower information recall rate (Seijo, Gomez, & Freidenberg, 1991), a higher probability of being hospitalized (E. D. Lee, Rosenberg, Sixsmith, Pang, & Abularrage, 1998), and a longer check-up time (Hampers, Cha, Gutglass, Binns, & Krug, 1999). Differences in the "rates" arising from differences in language proficiency reflect disparity in health care when language barriers exist.

Divi et al. (2007) further explored possible adverse impacts brought by language barriers. By screening through more than 1,000 adverse event[3] incident reports collected from six hospitals in the United States in 2005, the research highlighted that adverse events cause more harm to limited English proficiency (LEP) patients than to English speaking patients, and that 52.4% of adverse events related to LEP patients arose due to communication errors. Another study on the correlation between language proficiency

[3] An adverse event is defined in the study as any "unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient".

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and patient safety risk conducted recently in the Netherlands led to similar conclusions. In the mixed method study, van Rosse, de Bruijne, Suurmond, Essink-Bot, and Wagner (2016) identified the increase in safety risk, including omission of safety checks and inability to communicate in acute situations, through patient questionnaires, medical document analysis, and interviews with patients as well as care providers. The problems can be more significant in mental health treatments where psychiatrists rely solely on consultations with patients to make diagnoses and prescriptions. In a language discordant situation where psychiatrists cannot communicate with the patients smoothly, inaccurate diagnosis may be delivered (Alpert et al., 1973; Sabin, 1975). In other words, even in developed countries with advance medical systems as the United States and the Netherlands, health care may still pose risks to patients who are not proficient in the countries' major languages.

2.2 Current solutions and challenges

Due to the problems arising from language barriers, provision of language assistance is required by law in some countries to mitigate the disparity in the health care system. The United States published a Guidance Memorandum that requires health service providers to provide language assistance to limited English proficiency persons (Flores, 2000; Office of Management and Budget, 2002). The British government also established regulations to ensure patients' right to communicate in their own languages (Brisset et al.,

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2013). In accordance with the governments' requirements, Medical institutions in the United States have implemented several solutions. A clear compilation of the solutions was done by Downing and Roat (2002) and restructured into Table 1 by the author of this study.

Table 1

Models for the provision of language access in health care settings

Bilingual Provider Models
• The provider shares the patient's language. • The provider does not share the patient's language but is able to provide services in that language.
Bilingual Patient Model
• The patient is bilingual and can communicate with the provider in their language.
Interpreter Models
• Ad-hoc models: bilingual clinical staff model, bilingual non-clinical staff model, community service agency staff model, family and friends model • Dedicated interpreter models: staff interpreter model, contract interpreter model, agency model, volunteer model

Note. Table 1 is adapted from Downing, B., & Roat, C. (2002). Models for the provision of language access in health care settings. California: National Council on Interpreting in Health Care and Hablamos Juntos.

While patients and physicians are usually satisfied with language concordance situations where both sides speak the same language and direct communication can be established, there are not enough bilingual physicians or patients, and it takes a long time

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for one to acquire proficient language skills (Pérez-Stable, Napoles-Springer, & Miramontes, 1997; Schenker et al., 2010). Kline, Acosta, Austin, and Johnson (1980) further pointed out that while physicians may "feel good" communicating in the patients' language, some patients actually prefer communicating through an interpreter. In addition, there is no clear standards for language proficiency in a medical context, making it difficult to judge whether a care provider is qualified for providing medical services in another language (Diamond et al., 2012). Without clearly defining the status of being "bilingual", when a physician overestimates his language abilities, suboptimal services might be provided and information discrepancies between physicians and patients may thus arise (Baker, 1996; Diamond et al., 2009). Such "false language concordance" between physicians and patients may cause more harm than a language discordant condition where interpreters are required to bridge the gap between the two sides.

When a physician is unable to communicate effectively with a patient, an interpreter may be called for. However, the interpreter may be an ad hoc interpreter who is an untrained bilingual happening to be available at the time. These people are often patients' family and friends, nurses, medical staff, or other bilinguals through whom the patient or the physician gains assistance (Karliner et al., 2007). While ad hoc interpreters may be easier to find, research has found that ad hoc interpreters tend to make more errors than professional interpreters due to adding their own thoughts, omitting important

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information, and misinterpreting technical terms (Ebden et al., 1988; Flores et al., 2003; Karliner et al., 2007; Marcos, 1979; Nápoles, Santoyo-Olsson, Karliner, Gregorich, & Pérez-Stable, 2015). In a quantitative study conducted in two large emergency departments in the United States, Flores, Abreu, Barone, Bachur, and Lin (2012) indicated that the error rate of ad hoc interpreters is two times the professional interpreter's error rate, and the errors made by ad hoc interpreters are significantly more likely to cause clinical consequences, such as misinterpretation of dosing instructions. Problems with using ad hoc interpreters are also identified in Sweden. Through interviews with Kurdish refugees, Fatahi, Nordholm, Mattsson, and Hellström (2010) revealed a case where a doctor ordered electrocardiography for a Kurdish man seeking help for wanting to vomit because the interpreter who was the patient's friend did not know the word for "vomiting" in Swedish.

Although many believe that using bilingual medical staff can reduce interpreting errors, evidence from empirical studies contradict that assumption. Elderkin-Thompson et al. (2001) observed 21 encounters where nurses were asked to serve as interpreters. They found that since the nurses were fully aware of the physicians' hypotheses of potential diagnoses, they occasionally twisted the patients' words to fulfill the hypotheses. Furthermore, because interpreting is not a nurse's duty, the nurse may also find the work burdensome and thus reluctant to provide assistance (Drennan, 1996). The use of ad hoc

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interpreters also violates confidentiality. Family members serving as interpreters may find it awkward to discuss sensitive issues, such as sex matters, with the patient even as an interpreter (Hunter-Adams & Rother, 2017; Marcos, 1979).

To prevent potential risks, New South Wales State in Australia ruled that “Use of non-professional interpreters such as family or friends is not just a breach of the Standard Procedures, but also a breach of the duty of care owed to the patient, and could result in legal action” (New South Wales Government, 2017). The American Medical Association (2007) also advises physicians to view using ad hoc interpreters as a “last resort”. A guide to the use of different types of medical interpreting services proposed by American Medical Association is excerpted above as Table 2.

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Table 2

Comparison of types of medical interpreting

Type of Interpreter	Average Availability	Professionalism (known ethics of interpretation)	Comfort to patient	Interpreting quality	Circumstances where interpreter type is appropriate
Trained on-site Interpreter	Varied	High	Moderate-high	High	All
Trained telephonic interpreter	High	Moderate-high	Moderate	High	All
Bilingual healthcare practitioner	Varied	Moderate-high	High	Moderate-high	All
Trained bilingual staff	Low-moderate	Moderate-high	Moderate	Moderate-high	Moderate-high risk circumstances (depends on level of training)
Untrained bilingual staff	Varied	Low	Low-moderate	Low	Low-risk circumstances **
Bilingual family member or friend	Moderate-high	Low	Varied	Low	Low-risk circumstances **

Adapted from: Hsieh E. Understanding medical interpreters: re-conceptualizing bilingual health communication. Health Commun. 2006; 20: 177-186

*Examples of possible use circumstances:

- Low: Nonmedical communication such as scheduling follow-up or making appointments for referrals; some low-risk medical encounters, such as medication refills, annual influenza vaccination, otitis media recheck.
- Moderate: Routine follow-up for chronic disease, patient triage
- High: Consent discussions, diagnostic evaluations for new problems, end-of-life discussions.

**Experts in medical communication consider this an option of last resort.

Note. Table 2 is excerpted from the Office guide to communicating with limited English proficient patients. American Medical Association.

Physicians and patients also tend to be more satisfied with professional interpreting services (Bagchi et al., 2011; Farooq, Fear, & Oyebode, 1997; Karliner, Pérez-Stable, & Gildengorin, 2004; Kuo & Fagan, 1999). A survey showed that more than 90% of physicians and patients are satisfied with professional interpreting services, which is

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significantly higher than other forms of interpretation (Kuo & Fagan, 1999).

Countering most people's belief that professional interpreting services are not cost efficient, the cost of solving problems resulting from no interpreters or the use of ad hoc interpreters may be even higher. In the United States, it is estimated that medical errors cost the country 17 to 29 billion US dollars each year (Office of Management and Budget, 2002). While it is not determined how much of the money was spent on addressing the errors arising from language barriers, the number and significance of errors made when language barriers are not appropriately dealt with are higher as demonstrated in research reviewed above. It is therefore reasonable to infer that language barriers can lead to higher cost of error remediation. Furthermore, when communication does not go smoothly, physicians may need to conduct more extensive examinations to acquire critical information, and patients' conditions may become more complicated due to incompliance to instructions, both adding to the cost of care provision (Hampers & McNulty, 2002; Jacobs, Shepard, Suaya, & Stone, 2004).

Overall, using professional interpreting services to overcome language barriers is relatively effective, safe, and possibly more cost-efficient than other language assistance models.

2.3 Underutilization of professional interpreting services

Even with previous research revealing the problems arising from language barriers

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and the use of ad hoc interpreters, professional interpreting services are often underutilized, even in countries where professional interpreting services are widely available, such as Australia, the United Kingdom and the United States (Dowbor et al., 2015). A national survey conducted in the United States found that over 80% of resident physicians used ad hoc interpreters despite potential risks (K. C. Lee et al., 2006).

Underutilization of professional interpreting services may reflect the fact that while patients and physicians are both satisfied with professional interpreting services, they often find ad hoc interpreters acceptable as well (Brisset et al., 2013; Flores, 2005; Hornberger, Itakura, & Wilson, 1997; Kuo & Fagan, 1999; Leman, 1997). Instead of using a professional interpreter, some patients find it easier to trust their family and friends as interpreters (Edwards, Temple, & Alexander, 2005). Physicians also consider ad hoc interpreters good enough to facilitate communications. While Kuo and Fagan (1999) identified that both patients and physicians are most satisfied with professional interpreting services, the authors, who are both physicians, wrapped up the study by suggesting the use of friends and family as interpreters for cost control. The conclusion shows that some physicians may undermine the professionalism of interpreters (Hale, 2007). Diamond et al. (2009) further described physicians' behavior of underutilization of professional interpreters as a "getting by" phenomenon, in which physicians choose other strategies over finding a professional interpreter for convenience or for personal

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reasons, such as the willingness to practice their second languages, despite the fact that they know the care provided is suboptimal.

The underutilization of professional interpreting services may lead to higher costs of operating a professional interpreting system (Jacobs et al., 2004). While research shows that physicians tend to become more willing to cooperate with a professional interpreter after being educated on the risks of underutilizing the interpreting system, raising awareness takes time (Jacobs, Diamond, & Stevak, 2010). To prevent a waste of resources, it may be more prudent to take all stakeholders' perceptions into consideration when designing a language service system instead of building a costly system that people underuse because their needs are not fully met.

2.4 Current situation in Taiwan

As stated in Chapter 1, LCP patients in Taiwan come from two major sources, which are foreign residents and medical tourists. With the increase in LCP patients, problems with language barriers has drawn attention from researchers in Taiwan. Previous research has shown that language proficiency is a major barrier for foreign residents in health care (H.-Y. Chen, 2013; M.-L. Chen & Chiou, 2009; Tsai et al., 2001). Tsai et al. (2001) found that more than 60% of foreign workers from the Philippines and Thailand do not seek medical treatment right away, among whom 40% stated language as the reason for postponement. To view the issue from a different angle, H.-Y. Chen (2013) illustrated

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interactions between physicians with Southeast Asian patients through in-depth interviews with 11 Taiwanese physicians. The physicians interviewed identified language as a major challenge in their interactions with patients. Overcoming the language barrier is also important for attracting medical tourists. Lin (2011) demonstrated that language is a major factor that affects international patients' decisions on receiving medical services oversea.

While the researcher of this study could not acquire data of patients' backgrounds from hospitals due to privacy protection policies, the government's data gives a general picture of the backgrounds of medical tourists. The data shows that 74% of the 30,764 medical tourists that visited Taiwan in 2017 came from China (excluding Hong Kong and Macau in this study because Mandarin is not the standard language spoken by local people). Although the data is sorted based on the patients' citizenships and should not be viewed as an accurate categorization of languages spoken by medical tourists, it can be inferred that at least 70% of the tourists are not LCP patients and may not have any significant impacts on Taiwan's medical system in terms of cross-language communication. Still, it should be noted that the number of people from countries aside from China has been growing over the years and if the trend continues, more LCP patients may come to Taiwan as medical tourists in years to come.

With a view to promoting medical tourism, the government established the

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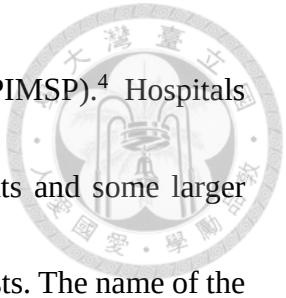

"Promotion for Internationalization of Medical Services Program" (PIMSP).[4] Hospitals that are members of the program aim to attract international patients and some larger hospitals have set up a department dedicated to serving medical tourists. The name of the department varies. For the anonymity of the participants of this study and for simplicity, such departments are all referred to as the Department of International Medical Services regardless of the actual names used at the hospitals. Most hospitals provide language services. However, only one hospital specifically stated on the official website that interpreting services are provided at extra charge on the patient. The most common form of language services is actually escort services where a hospital would assign a bilingual staff member to accompany the patient throughout the process of receiving medical services. The staff member may serve as an interpreter if needed but is not a professional interpreter nor is interpretation his primary responsibility.

Aside from hospitals, Taiwan's government and non-profit organizations are also taking measures to overcome language barriers in medical contexts. Taiwan's government has recruited on-site interpreters to serve at local medical centers. There are also two national hotlines that provide various services to foreigners, including interpreting

[4] The official title of the program initiated by the Executive Yuan is "醫療服務國際化旗艦計畫". As of June 2018, English official name of the program has not been found by the researcher. Therefore, the term, "Promotion for Internationalization of Medical Services Program"(PIMSP), used in the study is translated by the author, and is subjected to change should the government announce an official English title for the program.

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services. However, due to resource constraints, these services are restricted to basic interactions and the interpreting services are not provided by professional interpreters (Fan, 2011). In the private sector, a non-profit organization called the International Medical Translators and Interpreters Association (IMTIA) was founded by Fu Jen Catholic University in 2015 with a view to train medical interpreters in the high-end market. According to IMTIA's official website, one of the organization's missions is "to organize international medical translator and interpreter certification examinations". While such examinations have not been held, the statement per se shows IMTIA's ambition to facilitate the professionalization of medical interpreting systems in Taiwan. In addition, IMITIA has organized a 48-hour training program for Chinese-English and Chinese-Japanese language service providers who assist LCP patients to receive health check-ups. The training program includes lectures on basic knowledge of health check-up, interpreting courses, and actual practice in hospitals. The design of the program is similar to that of the training programs for interpreters in California. There are 24 training programs for medical interpreters in California and the curricula also include interpreting techniques, medical knowledge, and actual practice (Fan, 2011). While IMITIA is still a young association and the effect of talent cultivation may take years to surface, it is fair to say that the ultimate goal of the IMITIA is to create a sound medical interpreting system.

While previous research in Taiwan has revealed the existence of language barriers

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in hospitals and the public and private sector are working on providing solutions to the problems arising from language barriers, a comprehensive view on the current situation of cross-language communication with LCP patients from all sources has not been constructed. The demand for medical interpreting in Taiwan also remains unclear.

2.5 Summary

Research conducted in Taiwan and other countries has demonstrated the challenges posed by language barriers in health care. Without overcoming the barriers, disparities in health care cannot be eliminated and promotion of medical tourism can be difficult. Studies conducted in Taiwan mainly focused on Southeast Asian immigrants and addressed the issue from patients' perspectives. This study aims to shed light on the issue of language barriers and the need for language assistance in Taiwan's hospitals on a broader scope by incorporating all types of cross-language communication between physicians and LCP patients regardless of the patients' backgrounds. In addition, understanding that Taiwan's government is putting efforts into establishing professional medical interpreting services, this study also explores the demand for and expectations of professional interpreting services in hospitals from the physicians' points of view so as to provide practical suggestions to the government on designing a system that suits actual needs.

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Chapter 3 Research Methodology

The researcher conducted twenty-one in-depth one-on-one interviews with physicians working at medical centers in Northern Taiwan in this qualitative study. Each interview took around 0.5-1 hour. Venues were selected by the physicians. While most were conducted at the hospitals that the participants work at, some were conducted at coffee shops in Taipei for the participants' convenience. All the interviews were transcribed and coded by the researcher.

3.1 Sampling

Purposive sampling and snowball sampling are applied in this study in accordance with Chen (2013)'s sampling method. Twenty-one physicians participated in the study. All participants are government certified physicians currently working at one of the nine hospitals classified as medical centers[5] in Northern Taiwan that are members of the "Promotion for Internationalization of Medical Services Program"(PIMSP). The nine hospitals include Tri-Service General Hospital, Taipei Municipal Wanfang Hospital, MacKay Memorial Hospital, Shin Kong Wu Ho-Su Memorial Hospital, National Taiwan University Hospital, Cathay General Hospital, Taipei Veterans General Hospital, Far Eastern Memorial Hospital, and Chang Gung Medical Foundation. The PIMSP program

[5] Hospitals in Taiwan are categorized by the government into 4 levels, which are Medical Centers, Regional Hospitals, Local Hospitals, and Clinics. While scale is not the sole categorizing metric, the scale of the 4 categories are generally in descending order.

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is organized by Taiwan's central government and members in the program are those willing to participate in promoting medical tourism. Therefore, it can be inferred that physicians working in these hospitals have a higher likelihood of treating LCP patients. The research focuses on the 9 medical centers because they are large in scale and tend to attract more patients.

Among the twenty-one participants, seven are residents who are only in charge of inpatients, and fourteen are staff physicians who are responsible for outpatients' diagnosis and treatment (Table 3). The participants are scattered in the nine hospitals mentioned above (Table 4) and work in various departments (Table 5). Considering the exploratory nature of this study, it is the researcher's intent to invite participants from diverse backgrounds in order to acquire a broader understanding of physicians' demand in different hospitals and departments.

Table 3

Participants' positions

Position	Number of participants
Resident—1st & 2nd year	5
Resident—3rd & 4th year	2
Staff physician—less than 5 years	9
Staff physician—5 years and above	5

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Table 4

Participants' hospitals

Hospital	Number of participants
Chang Gung	2
MacKay	2
Wanfang	2
Cathay	1
Taipei Veterans	3
NTU	3
Shin Kong	1
Far Eastern	6
Tri-Service	1

Table 5

Participants' departments

Department	Number of participants
Oral Surgery	1
Plastic Surgery	1
Neurology	2
Dermatology	2
Otolaryngology	1
Pediatrics	1
Radiation Oncology	3
Psychiatry	1
Urologic Surgery	1
Cardiology	1
Endocrinology	4
Chest	1
General Medicine	1
Ophthalmology	1

3.2 Interviews

In-depth, semi-structured interviews were conducted. The interview structure contains 8 main open-ended questions along with some follow-up questions designed by

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the researcher beforehand. The first version of the interview outline was designed by the researcher based on Diamond et al. (2009)'s interview outline and revised in collaboration with a Taiwanese physician with more than five years of working experience in Taiwan's hospitals to ensure that the questions suit the current situation in Taiwan (Appendix 1). The physician served as an advisor to the research and is not listed as one of the participants.

Four pilot interviews were conducted in October 2017 to further ensure the validity of the interview outline. The outline was revised based on the pilot studies. For the remaining seventeen interviews conducted between November to December in 2017, the second version of the interview outline was applied (Appendix 2). Since the revisions were minor, the results of the pilot interviews were analyzed along with other interviews instead of being separated.

All participants received an invitation letter written in Chinese from the researcher with an introduction to the purpose of the study and a list of the interview questions. An interview was scheduled once the participant accepted the invitation through email. The length of the interviews ranged from 0.5 to 1 hour. The interviews were conducted in Chinese. At the beginning of the interview, the researcher would give a brief introduction to the research, ask the participant to sign the Consent Form for their participation in the study, and then move on to the questions listed on the outline. The researcher adhered to

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the sequence of the outline in general to avoid skipping questions. However, when a participant touched upon other issues listed in the outline, the sequence may be changed to maintain the flow of the interview. When a participant brought up a new issue, the researcher may ask follow-up questions to get an elaboration. The researcher also paraphrased or elaborated on the outline to clarify the questions for participants. Before ending the interview, the researcher would confirm certain background information with the participant, including years of experience, practicing department, and oversea experiences. Lastly, the researcher would ask the participant to look through the outline again, and reconfirm that all the questions have been answered and that the participant has no more thoughts to add.

All the interviews were recorded with the consent of the participant. For the participants' privacy, the researcher would stop recording when a participant picked up the phone or talked about personal issues unrelated to the research matter. The participants were reminded at the beginning that they have the right to stop the recording at any time during the interview, ask the researcher to delete the recording, or ask the researcher to leave out certain comments even after being recorded. Among the twenty-one participants, only 1 participant asked the researcher to take two comments off the record for personal reasons.

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3.3 Data Analysis

The method for data analysis for the study is designed by the author and based on Chen (2013) and Edwards et al. (2005). Transcriptions were made within a month after the interviews had been conducted. After thoroughly reading through the transcriptions, the researcher first categorized the content into 3 main categories, which are background information, current situation in the hospitals, and physicians' expectations of professional interpreting services. More detailed recurring themes were then identified and coded by the researcher. All the codes were induced from the interviews instead of being set by the author in advance. A complete chart of the codes can be found in Appendix 3.

After coding the data, quotes were excerpted and translated into English. The translation was done by the researcher and reviewed by one professional translator and a bilingual physician, who is not a participant of the study to ensure the accuracy and objectiveness of the translation.

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Chapter 4 Results

In this chapter, results of the twenty-one interviews conducted will be presented in four sections. The first section gives an overview of cross-language communication in Taiwan's hospitals. In the second section, all categories of cross-language communication between a physician and a Low Chinese Proficiency (LCP) person (patient or patient's proxy) as indicated in Figure 2 below will be analyzed individually. The third section states the demand for and expectations of professional interpreting services from the physicians' perspectives. The last section provides in-depth analysis of the results.

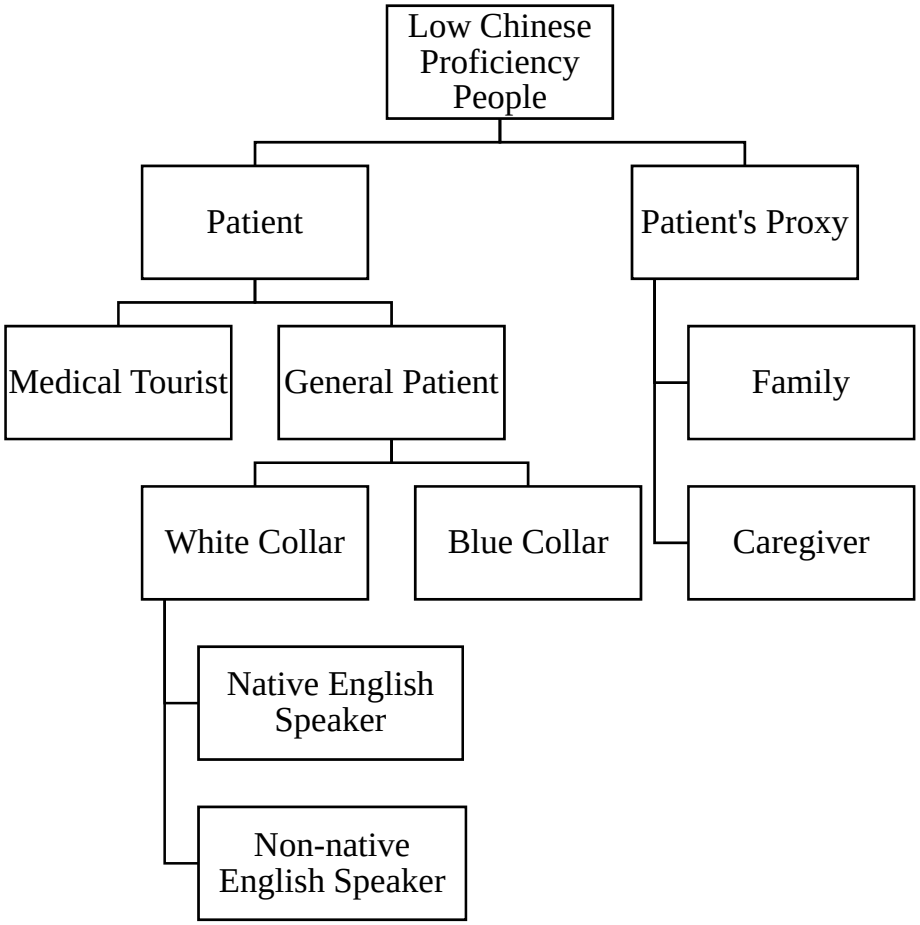

Figure 2. Categories of LCP people that physicians may encounter

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To ensure anonymity, participants are addressed and quoted by their assigned numbers, for example Participant 2 or #2. The department and current position of a participant would be shown in a parenthesis following the assigned number when the physician is quoted. The symbols used to demonstrate a participant's position are R (resident) and V (staff physician) followed by the years they have served in the position. For example, a 1st-year resident would be addressed as R1 and a 5th-year staff physician would be addressed as V5. Where a senior physician has served as a staff physician for more than ten or tewnty years, the position of the person would be referred to as V10+ or V20+. The symbols are chosen because they are commonly used in Taiwan's medical system. When a quote is cited, the original quote, which is in Chinese, would be stated in a parenthesis underneath the translated quote.

4.1 Frequency of cross-language communication and backgrounds of patients

While physicians with more than 10 years of experience observed an increase in LCP patients, all the physicians stated that the frequency of cross-language communication in general remains low. Most physicians treat fewer than 8 LCP patients per week. Some physicians even treat less than 1 LCP patient each month.

#1(oral surgery, V10+): There are certainly more [LCP patients] than before, but the number has not increased by much. At most it's 1 to 2 [LCP patients] per month.

（相較以前當然變多，可是變多的幅度不是很大。一個月頂多 1、2 個。）

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#2(plastic surgery, V10+): There is indeed an increase in foreign patients. My hospital is receiving more and more [foreign patients] thanks to our promotion [of medical tourism].

（外國病人確實比較多。我們醫院越來越多，因為我們醫院有在推嘛！）

#16(radiation oncology, V5): The number is probably fewer than 10 in a year.

（一年可能不會超過 10 個。）

In other words, LCP patients may actually account for only a small portion of all the patients at this time and may not bring significant effects to the medical system.

There are two methods of registration for patients. LCP patients may register through the Department of International Medical Services at each hospital or go through the general registration process for outpatients. While the Department of International Medical Services is dedicated to serving medical tourists, many international patients traveling to Taiwan for medical purposes do not register through the Department of International Medical Services due to high registration fees. A senior physician, Participant 10, who is well-known in Guam, Indonesia, and Palau, bluntly commented that many of his Indonesian patients come as general outpatients because the registration fee for medical tourists is exorbitant.

#10(cardiology, V20+): [Registering through] the Department of International Medical Services is very expensive. The rate is around 40% more than general registration. The

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Department of International Medical Services basically provides services in English and they charge extra for everything and everything is much more expensive. [Therefore, most foreign patients coming to Taiwan for medical services] register directly through the general counter and not through the Department of International Medical Services to pay the standard price for foreign outpatients.[6]

（國際醫療部很貴，他的價錢會加 40%還是多少，國際醫療部基本上是講英文，要幫他 extra charge，每個東西都特別貴。他就自己直接掛號就不需要國際醫療部，就照我們平常自費的價格。）

In this study, because there is no precise data showing the number of international patients registering through the general route and the phenomena of such hidden medical tourists is not the focus of the study, only patients that register through the Department of International Medical Services are viewed as medical tourists.

Medical tourists account for a very small portion of LCP patients. One reason may be that most medical tourists request senior physicians. Participants in this study, however, are relatively young with less than 10 years of experience. Two young physicians commented that medical tourists tend to request for their instructors.

[6] In Taiwan, every legal resident, including ARC holders must enroll in the National Health Insurance System. Once insured, all the medical services covered by the insurance become low. However, tourists or other foreigners without legal residential status, have to pay the self-payment prices. The rate, however, is still lower than that charged by the Department of International Medical Services.

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#5(otolaryngology, V2): The Department of International Medical Services also refers patients to us, however, those patients are usually VIPs with prestigious background or patients who have connections in the hospital. […] They seldom come to junior doctors like me.

（我們醫院國際醫療部也會轉介，但是那種一般都是身分比較特殊的，或者是說認識醫院什麼人的。[…]一般比較 junior 不會讓我看。）

#9(urologic surgery, V2):I seldom treat [medical tourists]. Maybe only 1 or 2 in a year. But my teachers who are more well-known often receive requests from medical tourists.

（我比較少，大概一年會遇到 1、2 個，但是我的老師，比較有名的老師他們就常遇到。）

However, the frequency of treating medical tourists can be low even for senior physicians. Participant 2 is a senior physician with more than 15 years of experience and is also a member of the Department of International Medical Services at his hospital. His hospital is dedicated to attracting medical tourists and he is well-known in the world for his expertise in plastic surgery. He stated that he treats dozens of LCP patients each year, among which only around three to five are medical tourists. Another senior physician, Participant 10, is an authority in his field with over thirty years of experience. He has been the chief of his department and has been attracting patients from abroad. While he

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does treat many international patients, he estimated that among every 10 international patients, only 1 registers through the Department of International Medical Services.

Compared to medical tourists, the increase in international patients registering through the general route and its impact on the medical system is more significant. The background of LCP patients registering through the general route can be divided into two major categories, which are white-collar patients and blue-collar patients.

“White-collar patients” refers to patients of higher socio-economic status. They may be white-collar employees at multinational corporations, business travelers or tourists from developed countries. “Blue-collar patients” refers to patients of lower socio-economic status. In Taiwan, this group of blue-collar patients mainly come from Southeast Asia. They may come to Taiwan as a low-skill worker or a spouse to a Taiwanese man.

The frequency of receiving white-collar patients and blue-collar patients mainly depends on the location of the hospital. Several physicians mentioned the impact of location on patients’ backgrounds.

#3(neurology, R1): I did meet many foreign patients when I did my PGY [post-graduate year] rotation in the ER. Because there are many Japanese in the Linsen N. Road area [which is where my hospital is].

（這樣講起來，那 PGY 急診遇到不少， 因為林森北路很多日本人。）

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#6(pediatrics, R4): In Yilan[7], most of the LCP patients are foreign spouses. […] I think there are some embassies around here [where my hospital is] and there are also many Japanese people and Koreans.

（宜蘭那邊幾乎都是外配。[…]這附近好像有一些外國使館，而且日本人、韓國人也蠻多。）

#10(cardiology, V20+): The demography of patients at [my hospital] is unique. First of all, most of our foreign patients are from the Taipei American School. […]They all have high socio-economic status. Their language ability is relatively better and we can communicate in English just fine. Another group of patients is foreign caregivers. They often come in only once and their employers won't bring them here again.

（[我們]醫院的病人群比較特別。第一件事，我這邊的外國人最多是美國學校，[…]這些外國人通通都是比較 High socio-economic，所以他的語文能力也都相對比較強，用英文溝通大概不會有任何問題。另一個就是外傭，外傭是另外一個族群，有時候他們通通都是，常常看一次，雇主就不見得帶他來了。）

#19(dermatology, V1): I would say there are two types of foreign patients, those who speak English, and those who speak Southeast Asian languages, such as Indonesian or Vietnamese. The latter are mainly blue-collar workers. Those who speak English are

[7] Yilan is a county in Eastern Taiwan, which is an-hour drive away from Taipei city. It is known for the agricultural and tourism industry.

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from European countries or the United States. Most are here for work, some are professors or students at [a university nearby]. This is because of [my hospital's] location. So I think [the ratio of the two types of patients] is about fifty-fifty. We receive a lot of students. At the same time, because this area is an aging community, we also receive lots of Indonesian or Vietnamese foreign caregivers.

（我都把他分兩邊啦！一個就是講英文的，一個就是講東南亞的，要嘛就是印尼的，要嘛就是越南的，這邊大概都是來這邊做勞工階層的為主，然後外國人的，講英文的大概就是有歐洲的或是美國的，大部分都是來工作，或是老師或是[附近大學]的學生，就是[我們]醫院的關係，所以我覺得一半一半，因為我們這邊學生，[附近大學]來的也很多，我們這邊也算是老化社區所以印傭那些族群或是越南看護其實也蠻多的。）

Judging from the participants' observations, hospitals in certain areas, such as New Taipei City, may be receiving more blue-collar patients while hospitals in Taipei City receive more white-collar patients.

Both white-collar and blue-collar patients are diverse in terms of their home countries. White collar patients from the United States, Japan, and Korea are mentioned most frequently by physicians. Blue-collar patients are mostly from the Philippines, Vietnam, Thailand, and Indonesia. The result is consistent with the data compiled by the National Immigration Agency, which lists citizens from the above-mentioned countries

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as major ARC holders in Taiwan (Table 6). In addition, around 90% of the ARC holders from Indonesia, Vietnam, the Philippines, and Thailand are classified as foreign workers（外籍勞工）as shown in Table 7. Foreign workers include in-home caregivers, housemaids, fishermen, labor in the construction industry, and construction workers, who are all classified as low-skilled workers and are often from low socio-economic backgrounds.

Table 6

Top 10 home countries of ARC holders in Taiwan

Ranking	Home Country	Number of ARC Holders
1	Indonesia	257,881
2	Vietnam	228,264
3	The Philippines	164,092
4	Thailand	82,977
5	Malaysia	24,581
6	Japan	18,182
7	United States	12,791
8	Korea	5,481
9	India	3,968
10	Canada	2,985

Table 7

Percentage of foreign workers among the top ranking home countries of ARC holders

Home Country	Number of Foreign Workers	Percentage
Indonesia	245,778	95%
Vietnam	199,533	87%
The Philippines	157,525	96%
Thailand	74,394	90%

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4.2 Current situations of cross-language communication

When physicians encounter LCP patients, the most common solution is directly communicating with the patient in English as described by Participant 5 and 15.

#5(otolaryngology, V2): I always ask the [foreign patients] directly whether they speak English.

（我都直接問他們會不會講英文。）

#15(chest, V3): When we first meet a non-Chinese speaking patient, we would first try communicating in English. For example, Filipino patients can more or less speak some English, and patients from Western countries can usually speak English.

（第一時間我們還是會用非中文體系，我們就是以英文常是溝通看看。畢竟像是有些來自菲律賓籍，多少英文還是有辦法溝通，一些其他歐美體系，英語都沒有太大問題。）

The solution has been plausible because English education is compulsory in Taiwan and physicians in Taiwan are trained using English textbooks. Some physicians confidently stated that they have no problem communicating with patients in English at all.

#2(plastic surgery, V10+): [Whether or not a physician would communicate differently in English] has to do with [the physician's] language abilities. For me, [speaking English or Chinese] makes no difference.

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（[醫生用英文講會不會有所不同]跟語言能力有關係，我個人是都一樣。）

#7(radiation oncology, V1): If a patient speaks English, we don't encounter any barriers because physicians at my hospital have above-average English skills. So I haven't encountered any challenges in terms of communication.

（會講英文對我們來說就完全沒有障礙，因為我們這邊的醫生來講，英文能力我覺得大家都水準以上，溝通這部分我是沒有遇到什麼障礙。）

#18(ophthalmology, R1): Basically, as long as a patient speaks Chinese or English, I can communicate with him without any problem. […] Actually, the textbooks we use, the papers we read are all written in English. We are used to those department-specific nouns and technical words. We are used to using the English terms. In fact, there are times when I don't know how to say an English word in Chinese when I talk to a Taiwanese patient.

（基本上只要會講中文或英文的話，我們就會覺得好像我跟他溝通都還 ok，沒有太大的障礙。[…]其實像我們現在，我們平常在念的什麼教科書啊！我們在看那些 paper 什麼都是英文啊！我們很習慣我們[這個科別]的名詞那些術語，很多我們都習慣用英文講，反而有時候是在跟台灣人講的時候不知道這個英文怎麼翻成中文。）

However, it is worth noting that the physicians quoted above all have spent years abroad at English speaking countries. One of them is even a board certified physician in

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the United States. On the contrary, most physicians interviewed have not spent years abroad and many admitted that while they are able to communicate with patients in English, the content and the style of communication in English may differ from that practiced in Chinese. In other words, many physicians trained in Taiwan still feel there is some limitations in speaking in their second language.

#4(dermatology, R1): You need to demonstrate for foreign patients. [...] I might skip some details because I don't know how to say it in English. The part I omit would not be very important though. For example, I may tell the patient to "use a cotton swab to roll gently on the wound and don't rub on it" in Chinese. But when I talk to a foreign patient, I would simply say "clean the wound with cotton swabs." I would leave out the "rolling" part. While it is not that important, I do think it represents a gap in patient communication.

（外國病人比較需要示範給他看。有些很細的步驟我可不會跟他解釋，因為我不知道怎麼用英文解釋，我只好跳過去。但那可能不是一個真的很重要的步驟。譬如說，「拿棉棒在傷口上面用滾的，不要用搓的。」我可能在講中文的時候會講，可是我在跟外國病人的時候，我只是會說，「clean the wound with cotton swabs。」我不會說要用滾動的，雖然這沒有很重要，但我覺得還是有落差。）

#9(urologic surgery, V2): There are things I want to ask but I cannot use very precise words in English.

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（有一些你想要問的東西，你用英文還是我是覺得沒辦法那麼 specific。）

#13(endocrinology, V2): After all, my English ability is not that good. There are things that are difficult. After all it's not my mother tongue, I cannot be as thorough in English as I am in Chinese. Say, I can deliver 100% of my messages in Chinese, but if I speak English, I might only deliver 70% to 80%of what I intend to say.

（畢竟我的英文程度也不敢說多好，有時候有一些東西妳也很難，畢竟不是我的母語，沒辦法講英文講得跟講中文那麼得詳細，如果我講中文可以講 10 分的話，我覺得我講英文可能只能講 7、8 分。）

From the quotes above, it is clear that certain messages may be omitted due to physicians' limited language ability when they are forced to communicate with patients in English.

In addition, even when a physician is confident in his English ability, he may still be forced to reduce the amount of information delivered in English when English is not the patient's mother tongue either.

#5(otolaryngology, V2): Sometimes I would find that the patient's English is not very good. Even if you give him a lot of information, he may not understand the message. He may find it even more frustrating. […] I would evaluate the situation. If his English is okay, and he raises questions, I would answer them. But if he is not good at English

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or I don't see any serious problems, I may not proactively give more information. So I think there's a difference.

（有一些她如果已經發現她其實英文不是很好，你感覺跟她講很多，她也不知道你在講什麼，好像會造成她一些困擾。[…]我有時候就會看，如果她英文 ok，她有問到我就會跟她講，但是如果她英文不是很好，或是我覺得我看完沒有什麼問題，可能就不會主動想到要跟她講更多，我覺得還是會有一些差別。）

Even though the above quoted physicians noticed the limitations of communicating in English, they did not express uneasiness about the situation or unwillingness to speak English. On the contrary, some physicians are very reluctant to provide medical services in English

#3(neurology, R1): Some physicians find speaking English tiresome. If they have a choice, they wouldn't speak English.

（有醫生覺得講英文蠻辛苦的，可以的話真不想講。）

#9(urologic surgery, V2): We try our best to help. But when we want to deliver some specific messages, we hope to use our mother tongue, which is Chinese. When we elaborate on some concepts or things that need to be treated, we don't want to use English or other languages that we are not familiar with. That goes for all doctors. We all know that the medical environment in Taiwan is not very good and conflicts [between patients and physicians] can happen. What if someone records the

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conversation? They may record a part where you make a mistake. You didn't intend to, but when you use an unfamiliar language, there's always something not accurate enough. This is what we are concerned about. We don't want to be in a situation where we know the answer, where we wouldn't have made any mistakes in Chinese, but make a mistake in another language. The consequential problems can be hard to deal with.

（我們能夠幫的盡量幫，但是有一些在比較精準，希望使用我們母語，就是中文或是國語在講，在闡述一些觀念或是應該治療的東西的時候，我覺得用英文講，或是其他一些我們不熟悉的語文講，醫生都不希望這樣子。因為目前大家都知道醫療環境不是那麼好，有可能有一些糾紛，那別人如果錄音呢？錄到你講錯的地方，你不是有意講錯的，但是你用你不熟悉的語言總是會有一些沒有那麼精準的部分，這是我們 care 的點，我們不希望說，明明我們就知道，明明我們就不會講錯、用中文就不會講錯，但是你用其他的語言你講錯了，之後衍伸的問題就很難處理。）

All in all, using English to communicate with LCP patients seem to work out "okay" on the surface, but possible downsides should not be neglected.

When a LCP patient does not understand English, physicians would use other communication strategies. Common strategies include gesturing, drawing, writing, or using an ad hoc interpreter. Since the strategies used are slightly different depending on

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the patients' backgrounds, the strategies used to communicate with different groups of patients will be elaborated separately in the following sub-sections.

Whether the physician chooses to communicate in English or use other strategies, the time spent on treating a LCP patient is consistently longer than treating a Taiwanese patient. Almost all the physicians stressed this point.

#4(dermatology, R1): It takes more time to treat a foreign patient.

（看外國病人會花比較多時間。）

#9(urologic surgery, V2): You only have 3 to 3.5 hours and you need to distribute it among so many people [80 patients]. 3 hours is 180 minutes. No more than 200 minutes to treat 80 patients. How much time can you spend on each patient? Probably around 2 to 3 minutes. [In the case of treating] a foreign patient, […] first of all, you speak slower. And [maybe] he doesn't understand what you are talking about. [The consultation] can take 5 to 6 minutes. In addition, if he wants to be treated in the US way, he would expect you to talk to him for 20 minutes. […] Some physicians do find it troublesome. I also think it's troublesome.

（你只有三個小時到三個半小時，要分給這麼多人[80 人]，三個小時就是 180 分鐘，頂多到 200 分鐘分給 80 個人，你一個可以多少？大概就是 2-3 分鐘。一個外國人，你第一個講話就會變比較慢，他也聽不懂你在幹嘛，可能變成五、

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六分鐘，如果他又很希望美國式的看診，一個醫生跟你看要 20 分鐘。[…]有些醫生的確覺得很麻煩，我也覺得很麻煩。）

Time stress along with the stress of not communicating in their mother tongue place great burden on physicians in Taiwan. The current situation, however, does not provide physicians with other choices but to find their own solutions to overcome language barriers and deal with such stress.

In the following three sub-sections, the researcher will review the current situation of cross-language communication in treating medical tourists, cross-language communication in treating general patients, and cross-language communication with patients' proxies respectively.

4.2.1 Cross-language communication in treating medical tourists

Medical tourists are viewed as VIPs at all the hospitals studied. While each hospital has a different policy, special services are always provided. However, only two hospitals stated on their website that translation services are provided, and only one promised to assist patients in seeking interpreters if needed (Please refer to Table 8 on Page 81). According to the physicians interviewed, only two had experience treating medical tourists with the assistance of a professional interpreter.

#7(radiation oncology, V1): Our hospital is in the area with embassies. Pacific islands that have diplomatic relationship with Taiwan will be provided with an interpreter by

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the Ministry of Foreign Affairs. I once treated, I think an Ambassador's wife? I'm not quite sure since it was several years ago. That was the only time an interpreter was involved.

（我們這邊因為是使館區，有一些台灣的太平洋島國邦交國，會配一個外交部給他一個口譯。[…]我遇到有口譯服務的大概只有那一位。）

#10(cardiology, V20+): Patients from Palau would definitely come with an interpreter. […] A professional one.

（帛琉一定有個翻譯的人在旁邊。[...]專業的人）

It is worth noting that in both cases above, the interpreters were hired by the patients' side, not the hospital. Furthermore, in the case of Participant 10, the interpreter interpreted from Palauan into English. In other words, despite the presence of a professional interpreter, the process of consultation was conducted in English, which is the physician's second language.

Even though professional interpreting services are not provided for medical tourists in most hospitals, physicians are generally not concerned about language barriers in medical tourism. One reason may be that within the small number of medical tourists, very few are LCP patients. As stated in Chapter 1, international patients from China account for 70% of medical tourists. Participant 7's statement supported the data.

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#7(radiation oncology, V1): When we talk about medical tourism, most patients are from China. So language is not an issue at all.

（所謂國際醫療最多的是中國大陸的，這個東西完全沒有語言的問題。）

Furthermore, even if a patient comes from countries other than China, he may still be fluent in Chinese.

#21(endocrinology, V2): Most [medical tourists] are oversea Chinese, so translation is not a big problem.

（[國際醫療]華僑居多，所以基本上翻譯不太會是問題。）

Secondly, physicians do not view language barrier as a serious issue because the patients are often well-prepared.

#2(plastic surgery, V10+): They would ask before they come, so they already know the details of the surgery [that they are undertaking].

（他們來通常就是打聽好才過來，所以就是知道手術細節。）

#5(otolaryngology, V2): They would make consultations beforehand. Staff from the Department of International Medical Services would make arrangements for them. So the patients probably know they are undertaking a surgery.

（他們會先問好，國際醫療部的人會安排，所以他們也大概知道自己要手術。）

Participant 2 further added that in practice, his hospital works with local hospitals overseas and encourage local doctors in those countries to transfer patients to Taiwan. In

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this case, patients come to Taiwan only because medical skills or infrastructure are not advanced enough in their home countries. The patients are fully prepared because they are already briefed by their local doctors. Possibly because of this reason, Participant 2 confessed that he even once communicated with a Mongolian patient that did not speak Chinese nor English using Google Translate before the surgery. The surgery was carried out successfully and the process went smoothly without causing medical disputes.

Overall, medical tourists are from high socio-economic backgrounds and are more prepared when they go to the doctors. They know what they want and are capable of overcoming language barriers with their own resources.

4.2.2 Cross-language communication in treating general patients

Treating general patients is another story and can create serious language barriers that deter the physicians from providing optimal medical services. LCP general patients can be divided into two categories according to their backgrounds: white-collar patients and blue-collar patients. As stated in 4.1.1, white-collar patients come from developed countries and blue-collar patients are mostly from Southeast Asia.

White-collar patients are from higher socio-economic backgrounds, well-educated, and tend to raise more questions. Blue-collar patients, on the other hand, are from lower socio-economic backgrounds, have little bargaining power, and tend to follow the

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physicians' instructions without questioning. Such differences in behavior can influence the process of communication.

#16(radiation oncology, V5): It is hard to explain their condition to them [Southeast Asian migrant workers]. On the other hand, he is also afraid of talking with you about his disease. This situation makes many physicians anxious.

（你很難跟他溝通那麼多病情，他也不敢跟你溝通那麼多病情，變成大部分醫生心裡都有很多擔憂。）

#19(dermatology, V1): When we take history, patients from Southeast Asia are straightforward. You don't need to explain much to them. But patients from European countries or patient who can speak English tend to be more inquisitive.

（如果有需要問診的話，或者是他們有的時候，像如果是東南亞這一群的話，其實都蠻乾脆的，你不大需要跟他解釋。但是歐美來的或是會講英文的這群人，其實他們比較會問。）

As described by Participant 16 and 19, blue-collar patients tend to ask fewer questions. Such behavior makes it hard for physicians to determine whether their messages have been successfully delivered.

White-collar patients can be further divided into two groups based on their mother tongues. As described earlier, because English education is compulsory in Taiwan and physicians are trained in English in medical school, most physicians find treating native

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English-speaking patients relatively easy. First of all, these patients usually do not have trouble understanding the physicians' messages. Some physicians mentioned that the patients would proactively double check with them.

#1(oral surgery, V10+): They [English-speaking patients] would double confirm with me.

（他們[病人]自己會重複確認。）

#17(general medicine, V4): Unless we need to explain some medical terms, communicating with native English speakers is easier. At least they understand most of what you say. Even if you do not speak standard English, they can take a good guess at the meaning.

（除非有一些醫療術語我們必須要去解釋，不然跟母語是英文的人溝通是要比較簡單一點，至少你講的英文他大概都聽得懂，就算你講得不標準，他大概猜一猜也知道那個意思。）

Secondly, these native-English speaking patients are from developed countries and tend to be well-educated. This fact can make physicians more at ease.

#5(otolaryngology, V2): Patients from English-speaking countries often have some basic understanding about [their own condition]. They are not like Taiwanese patients, who know nothing at all. These patients are familiar with their bodies and some basic

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medical terms. Those terms are not technical terms for them. […] Basically, you don't have to worry about them not understanding what is going on.

（如果你面對是英語系國家的病人，他們其實都有一些認識，他們不會像台灣的病人什麼都不知道，他們對自己的身體還有一些基本的名詞對他們來說，那些不是專業名詞。[…]基本上你不用擔心他不懂發生什麼事情。）

#6(pediatrics, R4): For [patients from] English-speaking countries, some less technical terms can be used conveniently. I just say the word and they would understand what I'm talking about.

（有時候英語系的國家在這部分，有些不是那麼艱深的專業用語，其實我覺得還蠻方便，就直接講他們其實就懂了。）

On the flip side, the combination of good language skills and high socio-economic background may lead to endless questions that occasionally annoy physicians under tight schedules.

#19(dermatology, V1): Sometimes I feel like they think they are in the United States. But the fact is that I need to treat 50 patients, not 15. […] So with more experience, I would highlight the main points for them and not let them [ask questions endlessly].

（有時候會覺得他好像把這裡當成美國，但是其實我們有 50 個病人要看，不是 15 個病人。[…]看久了以後會幫他抓重點，也不能讓他就是[無止盡地問下去]。）

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In addition, nearly half of the participants expressed the challenge they face in using plain English when communicating with native English-speaking patients.

#4(dermatology, R1): When we were trained in medical school, we did use English textbooks. However, the terms we learned are academic English terms. I think some concepts are hard to explain to patients in simple terms. Explaining in plain English is the biggest challenge I face.

（我們在醫學教育的過程，雖然都是用英文教科書。可是專有名詞都是學術英文，要用白、很平民的用語跟他們[病人]解釋一些東西的時候，我覺得其實是有困難的。要用比較淺顯易懂的 plain English 跟他們解釋，我覺得這是我最大的障礙。）

#9(urologic surgery, V2): It is difficult and challenging for us to bring up technical terms and raise questions colloquially.

（你的專有名詞或是你希望問的問題，要很口語地問他問出，這個對我們來講還是有一些挑戰跟困難度。）

#19(dermatology, V1): It's not hard to deliver professional knowledge because we were trained in English at medical schools. However, I need to think twice for colloquial terms. For example, when I teach a patient how to change dressing, and I encounter some difficult words that he doesn't understand, I would need to find a more colloquial way of explanation. Sometimes I need to use Google to search medical English or

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colloquial terms. So these unprofessional stuff, so-called plain language, requires me some time to think. Unless you were born or have spent a long time oversea, or have received special training, otherwise I think you'd still be stuck using plain language.

（要表達專業上面的知識應該還好，因為我們在醫學院本身就是用英文，但是有一些比較口語的可能就要想一下。比方說衛教他換藥的部分。有一些我們講如果比較深的字，他可能會聽不懂，可能要換一個口語的方式，有的時候就是要 Google 看醫用英文，或是看比較常見口語的方式。等於是專業的東西，要用他們說叫 plain language 去解釋的話，可能要想。除非你是天生就是在國外，或是有在那邊很長的，或是有特別受過訓練的，要不然我覺得口語化這一塊好像還是會覺得卡卡的。）

Regardless of certain challenges, no physicians expressed genuine concerns about treating English-speaking patients in English. Non-native English speakers, in contrast, can cause more problems. Japanese and Korean patients are the most common groups of white-collar LCP patients in Taiwan due to geographical proximity. During the interviews, many physicians shared their experiences in treating Japanese and Korean patients. Most have encountered some troubles when communicating with Japanese patients at one time or another.

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#13(endocrinology, V2): Treating Japanese or Korean patients is difficult. The Korean patients I've met are okay. I could communicate with them in simple English. However, Japanese patients cause more problems. Some cannot communicate with me at all.

（日韓是如果真的來是蠻困擾的，我個人遇過的韓國通常還可以，英文簡單溝通大概還可以，但是日本的就蠻困擾的，有一些完全沒有辦法。）

#18(ophthalmology, R1): Communication [with non-native English speakers] is harder because their English may not be that good. For example, Japanese patients are common. [...] I do not speak Japanese and some Japanese are bad at English pronunciation and are not that good at English.

（溝通上會比較困難，因為他英文可能也不太好。比方說日本來的，這種有時候就很常見，日本人的話，因為我也不會日語，日本人有時候英文發音真的不太好，他們英文也沒有到很好。）

Noticing that treating non-native English speakers can be challenging, physicians have come up with different strategies to communicate with this group of patients. They would try to find an ad hoc interpreter, use Google translate, use gesturing or use pictures.

#6: [Sometimes] we have to communicate with Japanese and Korean patients in English but some of them are not good at English. Then we have to see if someone nearby happens to know a bit of Japanese and English, or we may need to communicate via written text.

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（日韓有一些真的他們變成用英文溝通，但是有的英文也很不熟，偶爾會需要在那邊看有沒有剛好旁邊有一個比較會一點日文也會一點英文這種，就可能或者筆談。）

#7(radiation oncology, V1):: Some doctors speak fluent Japanese. Many radiologists or nurses at our hospital are also fluent in Japanese. So we always manage to find someone to help. There doesn't seem to be a need for interpreting service.

（有一些大夫日文講得很好，我們的放射師跟護理師很多也都日文講得很好，所以我們總是找得到有人協助他們，所以似乎也沒有需要口譯服務。）

#12(neurology, R2): I once met a Korean who doesn't speak English at all. He doesn't understand English either. […] But some of the nurses know a little [Korean]. They used Google [Translate] to translate some words and showed the words to him. It was kind of like vocabulary cards. We used vocabulary cards to translate.

（我上次遇到那個韓國人他是完全不會講英文。他也聽不懂。[...]但護理人員有些人會一些用 Google 弄一些字，翻譯出來的字給他看，有點像字卡，字卡來翻譯。）

#18(ophthalmology, R1): [When treating non-native English speakers,] you have to speak in English very slowly, explain patiently, and sometimes you need to draw pictures. […] We would prepare an anatomical picture of the human eye. When a patient doesn't understand me, I would point to the pictures and say, "Here. Problem. Here. You have

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some problems here." or something like that. Anyway, so we use gestures and communicate this way. Just try to make him understand.

（[遇到非英文母語的病患時]，你講英文就要變講比較慢，要耐心解釋，甚至有時候你要畫圖。[…] 我們都會自備一個眼睛的解剖圖、構造圖，用講的病人聽不懂就開始指，這邊啊！Problem！Here！You have some problems here！之類的，反正就是透過比手畫腳，類似這種溝通，你想辦法讓他了解。）

Some physicians would use written text to communicate with Japanese patients because some Chinese characters are borrowed by Japanese, also known as *kanji*（漢字）. However, this strategy can lead to confusion at times. Participant 9 shared his experience in treating a Japanese patient that lead to misunderstandings. The patient is married to a Taiwanese woman, but did not come to the doctor with his wife when participant 9 tried to explain to him that he had "bladder carcinoma in situ". In Chinese, "carcinoma in situ"（原位癌） can be directly back-translated to "original cancer". In fact, carcinoma in situ happens at an early stage when found in other organs. However, carcinoma in situ is a serious problem that requires extensive care when the tumor grows in the bladder. Because Participant 7 wrote the word "carcinoma in situ" in Chinese, it was the only word the patient could use to do research.

#9(urologic surgery, V2): He believed [his condition] is in its early stage. When we told him he will require extensive treatment, he questioned us because he looked up

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"carcinoma in situ" and it means early stage. He didn't understand why we told him it's dangerous. […] Eventually, we had to write down the information and told him to ask his wife to immediately translate our message for him.

（他就覺得是早期，然後你跟他講你要很 extensive 的 treatment 的時候，他就會覺得很奇怪，他就會說，他查的原位癌是早期，他會 question 你，你會覺得很奇怪，因為你本來就跟他講是一個很危險的。[…] 後來就是請他太太一定要，我們就用白紙黑字寫下來然後跟他講、跟他太太講，請她馬上翻譯給她先生聽。）

Another case of misunderstanding took place when a pediatrician failed to deliver the message accurately to a Korean father. Participant 6 talked about one time when he treated a child who suffered from serious fever. Fever was actually one of the symptoms of the child's illness, so the fever did not need to be treated. However, because the Korean father didn't understand the explanation made by the physician, he raged when the child's fever didn't come down. The physician commented that language was an issue and that case left a deep impression on him.

#6: I think it was mostly my fault. […] I didn't explain clear enough in English and his English was not that good either.

（比較多都是我自己。[…]英文我也沒講那清楚，然後他英文也不是那麼 ok。）

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To avoid these misunderstandings, the use of ad hoc interpreters is common when physicians communicate with white-collar, non-English speaking patients. Because the use of ad hoc interpreters is a major issue that requires deep analysis, this strategy will be discussed in a separate section later.

Overall, physicians have concerns treating white-collar patients that do not understand Chinese or English. However, not all participants mentioned such experience and they have mostly managed to communicate with the patient even without the help of an interpreter.

Physicians' communication with blue-collar LCP patients is a different story. All the participants talked about the language barriers they have encountered when treating blue-collar LCP patients. Many expressed their frustration.

> #13(endocrinology, V2): It's harder to communicate with immigrants, foreign workers. Those who come as a laborer and are of lower socio-economic background, this group of patients can have more communication problems. Two things. First of all, those labors may not have the sufficient level of knowledge to communicate with us. Second, language becomes a barrier. So far, it is impossible to overcome language barriers. If he doesn't understand Chinese nor English at all, it's very troublesome in the medical context.

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（比較不能溝通的大概就是移民，移工啦！來這邊做工，稍微社經地位稍微比較偏低的這一個群組，在這些群組上面我覺得溝通就比較有問題，因為是兩種，第一當然他們本身移工的知識可能沒有到達一個可以跟我們好溝通，另一個就是語言上的障礙。語言上的障礙基本上目前來講是沒有辦法克服，如果他完全聽不懂中文，然後又不會英文，大概就是一個在醫療上面就會很麻煩。）

#15(chest, V3): If we meet a patient from a non-English speaking country, especially from Southeast Asia, say Indonesia or the Philippines, patients who aren't that good at English, we would encounter a barrier.

（如果牽涉到像剛才講的那一種非母語體系，又偏向是東南亞國家，印尼或是一些菲律賓體系裡面，有一些不太擅長英語的，我們其實就會遇到障礙了。）

When a blue-collar LCP patient comes in by himself, physicians often use gestures to communicate with him.

#13(endocrinology, V2): Patients from Southeast Asia often have thyroid problems. [...] This is something I can identify from their appearance. With some gesturing, he would know my answers. It's like communicating with [deaf people].

（東南亞大概就是目前甲狀腺比較有問題[…]那種大概就是外觀上我就可以看得出來，他是為什麼來的。稍微加一些手語，比一比，他大概就知道是還是不是，類似一個比較[聽障式]的溝通。）

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#17(general medicine, V4): I would use simple [words] and gestures to communicate with the patient when there is no one that can help.

（盡量用簡單然後肢體語言去跟他講，如果完全沒有人可以幫忙。）

#20(endocrinology, R4):: When the agent is absent, I would try gesturing. I had worked in the emergency room for a while. At the ER, I once saw a foreign worker that simply pointed at his stomach. […] [Even though we cannot communicate with them,] we would still do some check-ups and try to save his life first. If we cannot communicate at all, I would use gestures or Google translate.

（如果是仲介都不在的話，可能就是比手畫腳。之前我也有去急診待過一陣子，也有那種移工一來就指著肚子這樣子[…]可是我們基本上還是會先以救命為主，還是會幫他做檢查啦！真的完全沒有可能就是給他比呀！或是 Google translate 之類的。）

Aside from gesturing, another common method of overcoming the language barrier when treating blue-collar patients is using an ad hoc interpreter. Most patients are accompanied by their friends or agents. Some physicians even encourage the patients to find an ad hoc interpreter to help. The use of ad hoc interpreters will be discussed in a latter section.

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4.2.3 Cross-language communication with patients' proxies

Aside from communication with patients, language barriers can be present when physicians communicate with patients' proxies, such as caregivers and family members. This existence of language barriers was not expected by the researcher. Instead, it was identified during the first few interviews where half of the physicians brought up the challenge they face when communicating with patients' foreign caregivers.

This problem occurs most often when treating inpatients. The most common case is that a patient has been bed-ridden for a long time and is accompanied by a foreign caregiver instead of a family member. While foreign caregivers who have been in Taiwan for a longer period of time can usually speak at least a little Chinese, physicians find it hard to acquire information from or give instructions to foreign caregivers who are new to Taiwan.

> #4(dermatology, R1): Sometimes the old man/woman is bed-ridden and cannot express anything, so you need to ask the caregiver. When you encounter a caregiver who does not speak Chinese or English at all, you would need to gesture or use single words to communicate. […] I think it's a big problem. We communicate with caregivers very often, especially for inpatients since the patients' family may not be at the ward all the time. Instead, they would go home and leave the caregiver to accompany the patients. You [as a physician] go to check on the patient every day, but the senile patient cannot

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express himself at all or may be suffering from dementia. So you ask the caregiver, but you often cannot get the information that you need.

（有時候阿公阿嬤是臥床都不會表達，你就是要問那個照顧他的人。就變成有時候真的會遇到他們的中文跟英文完全不行，就會變成比手畫腳，或是單字。[…]我覺得這是很大的問題，看護有時候很常，尤其是住院病人，家屬可能不會一直在旁邊，回家留下看護在旁邊。你每天會去看病人，阿公真的是完全沒辦法表達，或是失智或什麼，就要問旁邊的看護，常常都問不到你要的東西。）

#5(otolaryngology, V2): Some inpatients are cared for by foreign caregivers. The caregiver may have recently arrived in Taiwan and only speaks English. If she knows English, it is okay, we can still communicate. But it may be hard to communicate with those from Vietnam, the Philippines, or Indonesia in the beginning. And we need to wait for the patient's family members. […]Head and neck cancer patients are in the hospital longer. They would be accompanied by a foreign caregiver. When we communicate with the caregiver, such as telling him to fetch something, asking him to inform us [physicians] when his employer [the patient's family members] come, or instructing him to feed and care for the patients, these things can be difficult to teach if his is not proficient in Chinese.

（有時候病人住院是一些外勞在顧的，有些外勞可能剛來沒多久，只會英文，會英文還好，還可以溝通，其他什麼越南、菲律賓或印尼，一開始就會比較難

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一些，要等到家屬來。[…] 頭頸癌會住院比較久的就是外傭，有時候跟他們溝通，比如說要拿什麼東西，或是老闆來要跟大家講，或是要怎麼給他餵、怎麼顧什麼的，他中文不好就很難教。）

The problem of not being able acquire critical information from caregivers can be even direr in the case of mental illnesses. Participant 8, who is a psychiatrist, shared an experience of treating a patient with mental illness.

#8(psychiatry, R1): The patient suffered from alcohol withdrawal syndrome. Heavy drinking probably messed up his mind. He hit people every day. He hit the caregiver every night but forgot about it in the morning. I wanted to know what happened at night but the nurse wasn't there at night. So only the caregiver knew what happened in the ward. I wanted to know if his behavior at night showed the signs of delirium. But all I could ask was "Did he hit you?" She would say, "Hit me." All she could say was "He hit me." In Chinese. She would say, "He hit me". But aside from that, when I asked her, "Did he know the time and date? Or whether it was day or night?" The caregiver didn't understand my question. I need to confirm if the patient still had a sense of time and date, or know the people near him, whether he has reality or not. Because delirious patients may lose their sense of reality during the night. […] I wanted to make sure if he hit people because he was conscious and simply wanted to hit someone or because he was delirious. But when I asked the patient, the patient would say "Yesterday? I fell

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asleep. I forgot. Did I hit someone? Maybe yes. In the end, we can only assume that he is delirious, though we cannot be certain.

（病人是酒精戒斷症候群，他可能已經喝到腦子不正常了，每天就是打，每天晚上會打看護，但是白天完全忘記這回事，我想知道他晚上發生什麼事，但是晚上不會有護理師在旁邊看，所以他們那間房只有看護知道他們發生什麼事，那我想要知道他晚上是不是符合叫做「譫妄」的情形，所以我只能頂多問到就是他有沒有打你？他說，打我。他只會講「他打我」，中文，他會講他打我。但是其他的我問他，「他知不知道現在幾月幾號？晚上、白天？」這個看護就聽不懂。因為我要確定病人在晚上，他是不是知道人事時地物是什麼，有沒有現實感。因為「譫妄」的人，他在晚上這個東西會消失。[…]我要確定他打人是真的他理性上，他純粹想打人，還是那時候他已經處於譫妄的情形。但是我問病人，病人說「我昨天發生…我就睡著啦！我忘記了，我有打嗎？可能有吧！但是我忘記了。」所以說，好吧！我們就猜他可能有，但是我們也完全沒有辦法確定這件事。）

In the story that Participant 8 shared, the patient was eventually transferred to a rehabilitation center after a month because the National Health Insurance only covers the expense of acute psychiatric wards for one month. Participant 8, however, did not think his illness was cured and believed that he could have adjusted the dosage of drugs or the treatment methods if he had been able to retrieve accurate information from the

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caregiver.

Overall, the stories shared by physicians show that it is hard for medical staff to gather detailed information on the conditions of inpatients when facing language discordant caregivers.

In cases where physicians cannot communicate with the foreign caregivers, they would sometimes turn to the patients' family members.

#9(urologic surgery, V2): If [I cannot communicate with the caregiver], I would call the patient's family and ask them to find someone to accompany the patient.

（如果是這樣[跟看護無法溝通]我都會直接打電話跟家人講說，請他們要有人在旁邊。）

#14(endocrinology, V5): Sometimes when the caregiver is not capable of doing the job, I would urge the family to keep a close eye on the caregiver. I would also give the caregiver some homework. For example, when I want the caregiver to monitor the patient's blood sugar, I would hand her a booklet, draw some pictures to show her how to test blood sugar, and ask her to return the booklet to me next time.

（我有時候如果看護沒辦法，我就盯家屬去盯看護，但是我會給他一個功課，像我們量血糖，我會給他本子，我會畫下來說，你要怎麼驗，他下次來就是要給我這個東西。）

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However, a physician raised a point that the inability to communicate with an LCP caregiver can be dangerous in the case of an emergency.

#21(endocrinology, V2): Sometimes there are no family members around and you can only ask [the foreign caregiver]. But she cannot provide some information because she doesn't understand your questions. Some caregivers cannot communicate in English either. This situation would be very hard to deal with. Oftentimes, we have no other choice but to call the family members to acquire the information you need. Usually we can communicate with family members. However, it can be dangerous at times. In some urgent cases, we cannot find any family members during daytime. They may be at work.（有些就因為剛好家屬都不在，你要問他[外籍看護]，有一些 information 他根本沒辦法提供，因為他狀況就可能他聽不懂你講什麼，有一些英文也不行，這種就真的很困難。這種大部分最後就只好打電話問家屬，一些你想知道的訊息，基本上家屬還可以跟你溝通啦！但是真的危險有時候真的，有時候比較緊急狀況，可能白天找不到家人，他可能在上班。）

Another common way of communicating with LCP caregivers is using ad hoc interpreters who are also foreign caregivers. Due to the significance of the topic, the strategy will be discussed in the next section.

When caregivers do not speak English or Chinese, physicians can turn to family members as a last resort. But in another scenario where the main communicating

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counterpart is the family member and the person is not proficient in Chinese nor English, the physician would have no one to turn to. When language barriers bar physicians from communicating with family members, serious problems can arise in an emergency. Participant 15, who is a surgeon vividly shared a commonplace scenario.

> #15(chest, V3): For instance, we often encounter emergency situations in the ICU (intensive care unit). The patient may suddenly show cardiac and pulmonary arrest. When this happens we know that the patient is in dire condition and has a high chance of dying despite resuscitation effort, and communication with the patients' family will be very important. In fact, this situation is rather common: a foreign worker gets injured at work and ends up in the ICU, shortly the patient's loved ones fly all the way here. They are unfamiliar with the environment and do not understand our words. Then the aforementioned scenario takes place, the patient has a cardiac arrest and requires emergency resuscitation. Normally when this happens, as a pulmonary specialist, if we know that the patient has little chance of survival, we will suggest the family members to choose palliative care. In this case, however, we will need immediate translation to communicate with the patient's family members in a clear and timely manner. Because English is not our native language, miscommunication can still occur which will definitely result in further complications.

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（比方說在加護病房裡，其實常常會遇到比較緊急的狀況，病人可能突然就沒有了呼吸心跳，心跳會停下來，事實上我們預期這個病患可能狀況就沒有很理想，他應該死亡率非常高，即便急救下去可能也是枉然，這時候就很需要跟他的家屬。因為事實上這種情形常常發生，外籍勞工在台灣工作發生意外，送往加護病房之後，接下來親友可能就千里迢迢從國外趕過來，但是人生地不熟、語言也聽不懂，突然又發生這樣緊急，剛剛講的這樣的情境，突然失去性命、沒有心跳開始急救，遇到這樣的情形，我們胸腔科的醫師來說，這種病患如果預期不太能夠回得來，我們其實應該是勸家屬走向安寧緩和的路，這條路，這樣的狀況之下在語言上就很需要即時，因為病況是即時，突然發生，我們就很需要即時跟家屬先溝通清楚。因為在非自己母語的，即便用英語溝通可能溝通上還是有一些出入障礙，絕對會有一些問題。）

In the scenario described by Participant 15, language barrier not only wastes the precious time of saving lives and saying goodbye, it also places great mental stress on both the physician and the patient's family.

The existence of language barriers in communicating with patients' proxies can be concluded with Participant 18's statement.

#18(ophthalmology, R1): Aside from the patient, the patient's friend, relatives, or family can be our main subject of communication. Because the patient per se cannot

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communicate with us, it can be difficult when that major communicator is not proficient in English.

（除了病患以外，有時候就是他的朋友、他的親戚，他的家屬，有時候反而這個是主要溝通的對象，因為病患無法溝通，這個主要溝通的對象只要英文不太通就會有點困難。）

Whereas communication between physicians and patients is crucial, the importance of communication between physicians and patients' proxies should not be neglected when discussing the impacts of language barriers on the provision of medical services.

4.2.4 The use of ad hoc interpreters

It has been demonstrated in Chapter 2 that past research repeatedly showed the negative impacts of the use of ad hoc interpreters. However, according to the participants of this study, the use of ad hoc interpreters remains prevalent in Taiwan's hospitals regardless of the patient's background. While some physicians have concerns cooperating with ad hoc interpreters, they have no other choices but to rely on the unprofessional services as stated by Participant 5 and 13.

#5(otolaryngology, V2): I may tell her to bring a friend who is more proficient in Chinese to translate for her. Or ask her if there is anyone else she knows that can help. Or ask her if her employer would come with her. This is all I can do because there is no one else who speak the Southeast Asian language.

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（我就可能會直接跟他說，你就帶一個中文比較好的朋友來，跟你講。或者是說有沒有其他認識的可以講，或是說他們如果老闆會願意陪他們來。就只能這樣，因為也沒有其他會這種東南亞語言。）

#13(endocrinology, V2): At [my hospital], we cannot find any interpreter to help facilitate communication. So we need to rely on [the patient's] friend that speaks a little Chinese or English, or even his employer or agent. That's pretty much how it is.

（以目前[我的醫院]來講，我們也找不到可以幫我們溝通的口譯人員，接下來大概要嘛就是找[病患]自己的朋友，會一點國語或是會一點英文的，甚至是找他的僱主或是仲介公司，大概是這樣子啦！）

In addition, many physicians believe the service provided by ad hoc interpreters is sufficient and that they do not need a professional interpreter as long as they can find an ad hoc interpreter. In other words, the existence of ad hoc interpreters may be a factor that undermines the demand for professional interpreters. Due to the significance and relevance of this issue, the use of ad hoc interpreters is singled out and discussed in this section as a major strategy applied by physicians to overcome language barriers.

There are three kinds of ad hoc interpreters mentioned by the participants. The first is friends and family. The second is agents or employers of foreign workers. The last is other foreign workers. Participants usually have confidence in friends and family. However, physicians' perceptions on cooperating with agents or employers of foreign

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workers varied. In the following paragraphs, the use of the three kinds of ad hoc interpreters will be reviewed respectively.

Physicians are used to relying on the patient's friends and family to interpret for them.

#10(cardiology, V20+): I have more problems with Indonesian patients. Usually Indonesian patients are overseas Chinese. What usually happens is that a Chinese Indonesian is satisfied with our services. Since there is no National Health Insurance in Indonesia, he brings a relative/family member, who is also an overseas Chinese, or his friend to us next time. However, the people he brings do not understand Chinese. So when we communicate with the new patient, he would speak Indonesian. We would have someone translate and help us ask the patient questions. Because he [the new patient] is introduced by a former patient, the person who brought him to us in the first place would serve as the interpreter.

（比較有狀況其實是印尼，印尼人。印尼會過來通常也是華僑，但是常常狀況是這樣，一個印尼的華僑來我們這邊看病看得不錯，因為印尼沒有全民健保，所以下次他就把他的家人帶來，那也是華僑，或是朋友帶來。但是帶來之後他就不會華文了，所以他們跟我們講的時候，他就講印尼話、我們再翻譯，我們再問過他，他因為是有人介紹，就是那個大力介紹的人負責翻譯。）

In some cases, the patient would serve as an interpreter for his friends and family.

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For example, Participant 6, who is a pediatrician, mentioned that when he treated a bilingual child with English-speaking parents, he would sometimes communicate with the kid in Chinese and let the child communicate with the parents for him. While the physician also explained crucial points to the parents in English, the child still played an important role in lowering the language barrier. Another case of a patient being the interpreter took place in the psychiatric department.

#8(psychiatry, R1): The patient was proficient in both Japanese and Chinese but his mother only spoke Japanese. We wanted to ask the mother some questions so the patient served as an interpreter. The mother talked to the patient and the patient translated for us.

（病人是日語跟國語都可以，但是病人的媽媽是講日語，我們有些事情要問病人的媽媽，所以他可以這樣子翻過來，他跟病人講，病人再跟我們講。）

Physicians may be concerned about the friend or the family member's language ability.

#5(otolaryngology, V2): I once met a foreign worker who came in with someone who I thought was her agent but was actually her friend. Her friend had been married to a Taiwanese for many years and speak fluent Chinese, so she served as an interpreter. So you can say some more complicated concepts and the friend would explain to the patient. However, sometimes you don't know if there's any incongruity [between your

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message and her words] because you don't know their language and the person is not a professional interpreter. She is simply from the same country as the patient, speaks good Chinese, and able to understand Chinese. She also speaks the patient's language. However, she is just a friend and not a professional interpreter.

（我有看過有外勞我以為她帶來的是仲介，結果她說那不是仲介是她朋友，可是她嫁來台灣很多年了，所以她國語講得非常得好，所以她就幫忙做翻譯。變成你可以講稍微複雜一點的，她會跟她解釋，可是其實有時候你也不知道到底中間有差多少，因為你不會那個語言，那個人不是專業的翻譯員，她只是同鄉，中文很好、聽得懂，也會講她們的家鄉話，變成你，就是她朋友，不是一個專業的人員啊！）

However, Participant 5 was the only physician who directly expressed the concern about patients' friends' inability to interpret accurately.

Overall, physicians seem to trust friends and family as ad hoc interpreters even in cases where these ad hoc interpreters may be biased. Take the above-mentioned case in psychiatry described by Participant 8, the physician believed that the patient would deliver all necessary messages even though he mentioned that patients with mental illness often do not think they need to be hospitalized and the patient was actually reluctant to serve as an interpreter.

On the contrary, many physicians do not trust agents or employers as ad hoc

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interpreters even though reliance on them is commonplace and often the only choice left to the physicians.

Physicians do not trust the agents or employers mainly because of their positions as supervisors of patients and may thus affect the patients' behaviors.

#3(neurology, R1): I think it is more troublesome when the employer is present. He may be the employer or the agent. He would inquire you on the labor's condition. You would explain to him in Chinese and he would explain to the patient. However, we do not understand what the employer says [to the patient]. We do not know what message the worker receives. Does he know how to care for his wounds or that he needs rehabilitation? Does he know he has labor insurance? You would fear that the patient's rights are controlled by [the interpreting employer]. […] We can only rely on the employer or the agent, but he may have his own concerns. Maybe his factory cannot afford to let this worker get a day off. Maybe he doesn't want the patient to participate in rehabilitation or even receive follow-up checkups. Or maybe the employer does not want to pay for treatment, so on and so forth. All the scenarios are possible.

（我覺得雇主來了才是問題。也許可能是雇主、可能是仲介，他們可能會跟你問這個勞工的病情，你就用中文跟他講，雇主會解釋，是問題是雇主解釋什麼我們聽不懂。我們不曉得勞工接受到的訊息到底是什麼。後續怎麼照顧傷口，他應該要做復健，他到底知不知道？還有這些他有時候有勞保之類的，你其實

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有點擔心他的權益是不是被那個人控制了。[…]我們只能靠雇主跟仲介，但是他可能有他自己考量，可能我工廠裡缺這個人手很不方便，幹嘛什麼，可能不希望他做復健、不希望他做回診，甚至是雇主不願意出那個錢讓他接受治療等等，這類狀況都有可能。）

#13(endocrinology, V2): I think that when I find an agent or an employer to make a medical decision for the patient, the patient does not express his thoughts to us directly. His decision is passed on to us by the employer. The lack of neutrality makes us concerned. […] I have met authoritative employers. When an employer comes in with the worker and they are on good terms, it's okay. However, the companionship of an employer may lead a patient to conceal his illnesses.

（我們會覺得說，今天我找了一個仲介公司或是找一個雇主來，幫他做醫療決策，可是病人沒有直接向我們表達，那他的醫療決策是從雇主口中轉述給我們的，失去了一個中立的立場，有時候我們會比較擔心。[…] 我有看過雇主是那種權威式的，這時候有時候就是雇主陪同，雇主跟病人的關係如果好的話其實是還蠻不錯的，如果雇主陪同有時候反而會有時候病人有一些隱瞞的病情會沒有講出來。）

#15(chest, V3): It is common to see agents serve as interpreters for both inpatients and outpatients. We can tell from their tone that sometimes they are very impatient. When the agent is impatient, communication would not go smoothly. [The patient] may be

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afraid and may thus simplify his symptoms and not describe in details. So when we do history taking, all we get is a simple "yes, and no" answer, straight answers. At times, we may therefore overlook some details.

（仲介在溝通轉譯上，坦白說這個在病房也好、門診也好，這種多少都會遇到，其實從他們溝通的語氣上就聽得出來，有時候仲介就很不耐煩，不耐煩的狀況之下，溝通本身可能就會有點不順，[病患]有點害怕，可能就把一些症狀簡而化之，沒有辦法描述得很 detail，相對來說問診上我們聽到的結果就是非常簡單，有、沒有，一翻兩瞪眼的答案，但有時候其實就忽略掉也許一些比較小的一些細節。）

Conflicts of interest between the patient and his/her employer or agent reasonably raise many physicians' concerns. Some physicians, however, do not hold such negative attitudes towards agents and employers that serve as interpreters. They think it is good to have someone to help and trust that the agents and employers would not want to harm the patients. A participant also mentioned that it is important to make sure the agent/employer is supportive of a patient's decision.

#11(radiation oncology, V3): We would try our best to strike a balance. Of course we need to put the patient at the center. We do know that everyone's perspective is different because of personal interests. But if the patient is a foreign worker, he would need to communicate and negotiate with the agent [on future treatments]. In a sense, we are

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assisting them to communicate with each other. We need to find a [treatment plan] that the agent can accept. This way we're really doing good for the patient.

（我們會盡量想辦法讓中間找到一個大家平衡點，當然還是以病人為中心，但是某種程度至少，因為某種程度雖然大家利益出發點不一樣，但是其實有些事情也是病人本身他如果是移工的話，也會遇到他跟仲介之間要去後續做一些溝通跟協調的問題，所以某種程度，我們有點像在輔助這個過程，去幫忙他們。我們也要找到一個仲介可以接受，才可以做下去的方法，這樣才真的是對病人比較好。）

#14(endocrinology, V5): I think it's good to have the agent present. It's certainly a good thing. Because he can help me deliver my messages so that I don't need to be worried that language becomes a barrier in letting the patient's right of understanding his illness.

（我覺得仲介在是好事，當然是好事。因為我覺得他可以幫助我去把這個東西傳遞，我也比較不擔心，比較不用說因為語言的溝通影響到這個病人了解這個病的一個權益。）

#20(endocrinology, R4):: We cannot be 100% sure what the agent's interpretation is. However, we believe [they] won't want to harm others. So we trust their translation.

（仲介跟他翻成什麼，我們其實沒有百分之百的掌握啦！但是，相信大家都不會希望對對方不好啦！所以就還是信任他們的翻譯。）

#21(endocrinology, V2): I think most employers would let the patient make major

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decisions themselves.

（我覺得重大決定，大部分雇主還是比較會給他本人決定。）

Regardless of their confidence in agent/employers' neutrality, some physicians have come up with strategies to ensure the accuracy and completeness of the interpreters' interpretation. For example, while Participant 14 stated that it is nice to have agents as interpreters, she has taken measures to ensure that the agent/employer does not omit important messages.

#14(endocrinology, V5): I would not say everything at once. I would say a few things and ask the agent to [translate] and see if the patient understands.

（我不會全部一次講完，我會先講一些，然後說，你現在告訴他。然後看他懂不懂。）

Another physician uses a similar strategy as Participant 14.

#21(endocrinology, V2): We would tell the interpreter to be mindful of certain points. Usually, we would say one sentence and ask him to translate the sentence. By doing so, I think the possibility of making mistakes is lower.

（我們都會跟翻譯的人講清楚哪些要注意，一般做法都是我們講一句、他講一句，這樣應該錯的機率是比較少。）

In other words, whereas physicians have concerns with regard to the agent/employer's stance as an ad hoc interpreter, they have no other choices but to rely

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on the agent/employer. All they can do is to apply different strategies to ensure the accuracy of interpretation.

The last kind of ad hoc interpreters commonly used in hospitals is other foreign workers. This scenario often takes place when physicians cannot communicate with inpatients' foreign caregivers. Several physicians mentioned turning to other foreign caregivers for help at wards.

#12(neurology, R2): When we encounter [foreign caregivers] with little experience, we would find someone from their country that serves at the same ward to interpret for us.

（有時候遇到那些比較資淺的[外籍看護]，同病房有另外一個跟他同家鄉的拉過來當翻譯。）

#17(general medicine, V4): Most foreign caregivers are from Indonesia. I think they receive some training before they come to Taiwan. Some are not that good. But basically, we would use body language, so we would say "pat him" and actually pat [the patient] to demonstrate. We would use simple English with gestures to let the caregiver understand her job. If that doesn't work, there are many other foreign caregivers in the hospital, and we can just ask them to help translate.

（為現在看護大概都是印尼的，大概來之前好像也都會受一些 training，有一些當然不太好啦！啊一樣啊！就肢體語言，就說拍一拍，拍給他看，講一點點簡單的英文配上動作讓他了解他要做什麼事情。真的不行，反正這麼多床都有

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外傭，找別床的比較會講的外傭來幫忙講。）

#20(endocrinology, R4):: Caregivers are also good interpreters. Many caregivers are from Vietnam and Indonesia. […] Some of them are not proficient in Chinese, but the caregiver serving the patient in the next bed may be an Indonesian that came to Taiwan earlier. She may have stayed in Taiwan for a long time and married to a Taiwanese husband. In that case, her Chinese is very proficient. So we can ask the caregiver of another patient to serve as an interpreter.

（看護其實也是一個很好的翻譯員。因為很多看護他其實，之前有一些越南來的、印尼來的，[…]但他中文不太好，但是隔壁床的看護他就是那種可能比較早一點來的印尼人，已經可能在台灣，外籍新娘，在台灣很久了、中文就很好，有時候我們翻譯也甚至可以靠隔壁床的看護之類的。）

Several physicians stated that caregivers with more experience would know some Chinese and that is why they can rely on these senior caregivers as interpreters. In addition, the caregivers are often more than willing to help. Participant 3 described that when she needed to acquire some information through foreign caregivers, the caregiver working for the patient next by would actively help her to communicate with the caregiver.

#3(neurology, R1): The caregiver caring for the patient in the next bed would come to help and discuss with each other. It is like a support group. It's quite interesting.

（隔壁床也會幫忙聽，就會開始這個那個，或有一個自救會，蠻有趣的。）

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Participant 20 also thinks that most foreign caregivers are passionate about helping to facilitate the communication.

#20(endocrinology, R4):: Usually they would help their compatriots. Some are very eager to help. They would help you deliver the message [to another caregiver] without being asked.

（通常他們會幫助自己家鄉的人，所以他們有一些蠻熱心的，還會幫你主動告知。）

From the tone of physicians, it is apparent that they appreciate and are satisfied with the help of senior caregivers when they encounter language barriers.

Without a professional interpreting system, physicians have become reliant on ad hoc interpreters in Taiwan's hospitals. More importantly, many physicians seemed satisfied with the help of ad hoc interpreters albeit understanding that these interpreters are not professional and cannot provide optimal services.

4.2.5 Hospitals' measures to overcome language barriers

On the institutional level, hospitals have also made some efforts of overcome language barriers. Most of the 9 hospitals included in the study state on the official websites that language services are provided for medical tourists (Table 8).

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Table 8

Language services provided for medical tourists

Hospital	Language services provided for Medical Tourists
Chang Gung	Not specified Website: http://www.chang-ung.com/en/about.aspx?id=71&bid=7
MacKay	Translation-language translation Website: http://www.mmh-imsc.org/en/services-1/
Wanfang	Translation services Website: http://healthcare-p.tmu.edu.tw/OLD/tw/WFH/International.htm *Note: The list of services cannot be found on the English website.
Cathay	Provide Chinese, English and Japanese customer service Website: https://www.cgh.org.tw/en/health_care_services/international_01_tw.html
Taipei Veterans	Other-language-speaking patients will be helped by volunteers or translators Website: https://imsc.vghtpe.gov.tw/archive/page/services
NTU	Bilingual inquiries Website: https://www.ntuh.gov.tw/en/IMSC/services/default.aspx
Shin Kong	We have coordinators who can speak English, Japanese, Cantonese, French, Palauan, and Chinese. We can translate all the documentations, such as letters of consent, discharge instructions, and other medical documents for treatment into the appropriate language for the patient's convenience. Special arrangements may be available for other languages. Website: https://www.taiwan-healthcare.org/medical/niche-medical-Service?mtsProductsSysid=MtsProducts20161208184218469074367
Far Eastern	Provide Chinese and English Guidance Website: http://depart.femh.org.tw/ips/eng/about2.html
Tri-Service	Interpreter (additional charges required) Website: http://wwwu.tsgh.ndmctsgh.edu.tw/wenslee/ims/imsengs/index.asp

However, the information is not clear. When translation services or bilingual services are provided, most do not specify the languages of services. The phenomena may reflect the hospitals' negligence of such services.

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In fact, all the physicians interviewed stated that they have not cooperated with translators or interpreters provided by the Department of International Medical Services. Some hospitals would hire bilingual members as patient's escort to accompany the patient throughout the process of receiving medical services. The staff may at times serve as ad hoc interpreters. However, interpretation is not their prime task and they are not professional interpreters.

#5(otolaryngology, V2): I don't think [the escort from the Department of International Medical Services] is an interpreter. Even if they do interpret, they are not professional interpreters.

（我覺得[國際醫療部成員]不是翻譯。他們就算用翻譯也不是專業的翻譯。）

#19(dermatology, V1): For students or foreigners [registering through the Department of International Medical Services], the European or American patients would have someone who speaks English escorting them. If the nurse is not proficient in English, the staff would help to interpret. If the physician speaks good English, they can communicate with the patient directly.

（[國際醫療]學生或是外國人的話，歐美的很多是他們會帶上來，他們帶上來就有一個會講英文的人。如果今天譬如說護理師比較不會，他就會幫他翻譯，醫生如果說英文比較好的，我們就可以直接溝通。）

The hospital that Participant 14 and Participant 15 work for has come up with ways

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to assist general patients.

#14(endocrinology, V5): Our hospital does have an interpreting system. The hospital conducted a survey on the languages physicians know and asked physicians whether they would be willing to serve as an interpreter if a patient needs one.

（我們醫院其實有安排翻譯。我們醫院會統計醫師知道、認識的，知道什麼語言，跟我們統計如果有這個病患你願不願意當翻譯。）

#15(chest, V3): There's a service center at my hospital where social workers provide translation services in languages such as Vietnamese. However, they can only provide written text translation [and not interpreting].

（我們院內有一些社工服務處，也有提供一些像越語翻譯的部分也可以提供，但是能提供大概僅止於紙本上而已。）

As shown by the quotes, hospitals may have noticed the potential problems and have taken measures to overcome the language barriers. However, the hospital's strategy as an organization is in fact not far from physicians' personal strategies, which include using ad hoc interpreters and finding bilingual staff members to communicate with LCP patients directly. The variation of language pairs are also insufficient to meet the needs. Participant 14 further pointed out that while the hospitals asked physicians to serve as interpreters, there are no physicians that know Vietnamese or Thai in the hospital. The two languages, however, are often used by Participant 14's patients.

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4.3 Demand for and expectations of interpreting services

Physicians participating in the study mainly stated that they are satisfied with the status quo and regarded the establishment of a professional interpreting service system as unnecessary. One major factor contributing to the low demand for professional interpreting services is that physicians think the frequency of seeing LCP patients is still low.

#14(endocrinology, V5): I don't think we need [a professional interpreting service system]. It is not cost-efficient. I mean medical cost. In addition, there aren't many [LCP patients]. […] In the past years, I may be able to count the number of [LCP] patients I've treated with my ten fingers. I have seen thousands of patients in the past couple of years and only 10 are [LCP patients].

（我覺得不需要[設立口譯體系]，因為這樣子不合成本，醫療成本。而且這種病患沒有到很多[…]這幾年可能病人十個手指頭可以數出來，這幾年我可能看了幾千個病人，那我才占可能十個。）

#18(ophthalmology, R1): I think the main reason [that we don't need a professional interpreting service system now is that] there are not many [LCP patients]. If Taiwan really becomes globalized and the government successfully promotes international medical services and people speaking different languages come to Taiwan, we [physicians] would feel the frequency of meeting these patients increase and thus feel

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the need [for interpreting services].

（我覺得主要是因為這種病人還不夠多啦！你如果將來台灣真的很國際化，政府真的推國際醫療，真的一堆那種奇怪國家語言的人都來台灣的話，當我們感受到這個病人頻率上我們就會覺得有需要了啊！）

Another factor contributing to the low demand is the lack of trust in interpreters. Several physicians expressed their concerns about the interpreters' ability to interpret medical concepts and would prefer to communicate with the patient directly as long as the patient can speak English. In other words, while physicians do have concerns about communicating in their second language, they feel even more uncomfortable giving control to a third party.

#3(neurology, R1): [If the patient speaks English,] I would prefer communicating myself [and not through an interpreter]. […] In some cases, the patient may not want others to know about his history of illnesses.

（[病人會講英文的話]我會比較傾向還是自己問。[…]有一些 case 病史是病人不希望別人知道。）

#10(cardiology, V20+): If [the patient] speaks English, I prefer communicating with him directly. Because sometimes when you communicate through an interpreter, you cannot control the quality of the interpretation.

（如果他的英文溝通，我會希望直接跟他溝通。因為有的時候是這樣，你透過

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一個翻譯，你沒辦法控制那個翻譯的品質。）

In addition, the idea of “getting by” raised by Diamond et al. (2009) can be observed in Taiwan’s hospitals, too. While most physicians agree that they would prefer working with an interpreter to deliver accurate messages when the patient needs to make major decisions, they find accurate interpretation unnecessary in minor cases.

#14(endocrinology, V5): As long as I can communicate with a patient, I don’t need an interpreter. For now, I do feel worried but if a patient seems to have grasped the key point, I think it’s okay. In some cases where he doesn’t understand me at all, I might need an interpreter. I’m concerned that he might not understand the details but as long as he understands the main points, such as the name of the illness and the drugs, I think it’s fine. […] I think having [the laborer’s] agent [to serve as an interpreter] is enough.（如果可以溝通我就不需要翻譯，暫時我是擔心，但是之後病人好像還是可以抓到重點，我就覺得還好。有一些真的沒有辦法我就覺得需要，連可能他會聽不懂我跟他講，我就覺得需要。因為我所擔心的是比較細節的地方，但是重點一些病名、藥物，他是聽得懂，那我就覺得還好。[…]我覺得仲介的角色對我來說就已經夠了。）

#17(general medicine, V4): Let’s be frank, for minor maladies, what you do doesn’t really matter to the patient at all. On the other hand, sometimes we are involved in making an important decision. Let’s say, maybe the patient comes to the clinic and was

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found to have some kind of tumor. You explain to him that this requires tissue biopsy, and further treatment may be needed if the tumor is found to be malignant. In situations like this, you may find yourself in trouble if you do not communicate very clearly. This is when I would wish there is a way to relay my meaning fully. But not for the trivial stuff.

（我覺得如果簡單的病，講得白一點，就算妳沒有幫他做什麼也不會怎麼樣的，那種其實也還好。但是我覺得一些重要的 decision making，譬如說，假設他這次來，突然發現一個也許腫瘤什麼東西的，妳跟他講要做切片，後面要怎麼，後面如果是惡性的要怎麼治療什麼的，這種如果沒有講清楚的話會有點麻煩。通常是在這個時候，會比較希望說有一個妳可以 fully 把妳的意思傳達的管道，小事情就不用了。）

However, more than one physician admitted that the idea of "triviality" may vary because of the patient's background.

#7(radiation oncology, V1):: I do think we always need better communication, however, a patient's socio-economic background determines how he is treated. This is undeniable. For example, you mentioned a case of a bed-ridden patient and his foreign caregiver that cannot communicate effectively [with us]. And you said that we [physicians] think it's okay to use gesturing. However, if the patient were Terry Gou [a Taiwanese tycoon], he wouldn't be treated that way. So I think the issue is related to socio economic status

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in a sense.

（我覺得當然你要做到更好的溝通永遠是需要的，但是有時候真的是病人本身的 socio economic 會決定他被對待的方式，我覺得這個都難以否認。比方說你說病人臥床，外傭不太會講，比手畫腳當然你說我們覺得 ok，但是實際上假設這個人是郭台銘好了，他就不會被這樣對待。這些事情我覺得都還是背後有 socio economic 的程度在裡面。）

#17(general medicine, V4): For general patients, I think "the simpler the better". You grasp 70 to 80% of what I say. I give you 70-80% of the information and you get 70 to 80% of that information. That should be enough. However, for medical tourists that demand more of medical services, you cannot just give him 70 to 80% of the information. You have to be more definite, explain his illness clearly and interpret his data and test results for him. This is when you might need a professional to assist you to make things clearer. I think patients have different needs. Those who pay for international medical services and those foreign workers are of different levels. […] They expect to get what they've paid for. […] So in the case of international medical services where patients are looking for better quality of care, an interpreter certainly can help facilitate communication between physicians and patients.

（一般的病人我覺得就是「簡單就好啦！」你有聽懂七、八分，我跟你講七、八分你有聽懂七、八分就差不多了。可是如果做這種國際醫療，是那種要求比

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較高的，他可能沒辦法你只跟他講七、八分，可能就要更 definite 的講，把他的病都講清楚，解釋他的 data，解釋他的做出來的一些結果，這些也許就會需要專業人員在一旁協助會更清楚，因為畢竟是我覺得需求有點不同，你說那種花錢來做國際醫療的跟這些移工來那個，我覺得層級還是有點不太一樣。[…]人家給你什麼 pay，你要給人家什麼樣的服務啊！[…]這種國際醫療比較希望品質再拉高一點的，有一個口譯員的話，對醫病兩個之間的溝通的確會有一些幫助。）

As demonstrated by the aforementioned quotes, physicians do agree that professional interpreters can help deliver their messages more accurately, but believe that working with ad hoc interpreters is sufficient in most cases, especially when a patient is not a VIP.

It is also revealed that demand for professional interpreting services also depends on the interpreter's language pairs and the physician's department. Many physicians regard Chinese-English interpreters as unnecessary because they also have fair command of English.

#7(radiation oncology, V1):: For physicians, the demand for English interpreters is low. If we can expand the market to other countries, such as other Western countries or European countries, the demand for interpreters may be higher.

（醫師端如果完全是講英文的，我覺得需求能比較低一點點。當然如果我們有

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辦法去開拓一些其他國家的市場，比方說西方市場或者是歐洲的市場，這部分的需求會比較高一點。）

#17(general medicine, V4): The demand [for interpreters] is higher for non-native English speakers. Most physicians in Taiwan have good command of English because we've been using English textbooks since an early age. And we often participate in overseas conferences, going around the world to network at International Medical associations.

（非英文母語比較需要啦！英文其實台灣的醫師普遍英文都不錯，因為我們從小都是念英文教科書的，我們像參加一些醫學會常常開會都在國外，都要去世界各地，世界的醫學會交流。）

#20(endocrinology, R4): At my hospital, physicians all have fair command of English, so we don't need English interpreters. We need interpreters for those patients that do not speak English, such as foreign workers from Indonesia and Vietnam.

（以我們醫院來講的話，如果是英語系那些我們其實醫生的基本英文能力都可以，英語這部分是不太需要，比較會需要的是一些不太會英文的一些外籍移工，包括印尼、越南。）

The results indicate that the demand for Chinese-English interpreters is particularly low in hospitals and that providing interpreters with other language pairs may be more urgent.

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Characteristics of different departments also play a crucial role in affecting physicians' perceived demand for interpreters. In general, surgeons tend to put more focus on explaining the surgical processes because surgeries are usually more urgent and complicated. On the other hand, physicians that focus on internal diseases are more concerned about instructions on drugs administration.

For example, a physician in the Department of Oral Surgery mentioned that he would be more careful and double check with an LCP patient if he is going to conduct a surgery. Other surgeons also talked about how they find it challenging to explain surgeries, especially those related to major decisions.

> #5(otolaryngology, V2): When we need to perform emergency tracheostomy or intubation, or need to send the patient to the operation room for fluid drainage, we must make decisions immediately. We cannot wait for you to go home and ask, or wait for a few hours to find someone [to interpret for you]. This is a more troublesome case.（如果緊急要做氣切、要插管，或是要去開刀房做引流那些的話，這種都是當下就要決定，不是讓你回去問，或是等一下、等幾個小時、找誰來[翻譯]，這種情形就會比較麻煩。）
>
> #9(urologic surgery, V2): It is hard to explain the patient's disease condition, as well as the surgery we performed. Because as surgeons our job does not end with the resection of the lesion, we also need to follow up afterwards. We need to follow the protocol And

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it is hard to explain to LCP patients.

（解釋手術，病情解釋困難。因為我們外科系不是只有當下把它處理掉，有很多日後要追蹤，都是一整個 protocol 要按著走，那個其實你要對不會講中文的人[講解]是有些困難。）

Physicians that deal with internal diseases are often more concerned about medication since the diseases mostly require long-term medication.

#14(endocrinology, V5): For patients [with diabetes], I'm worried about whether they understand how to take their medication. I'm concerned that he might not understand how to take the drugs, so I would ask him again to make sure that he understands how to take the drugs. It takes me more time to treat these outpatients.

（我會擔心他[糖尿病病患]口服藥他吃的方面，了不了解怎麼吃，會擔心有聽沒懂，一般我還是會再問病人，你了解怎麼吃？會再三確認，這種病患門診時就會花比較多。）

#16(radiation oncology, V5): [I am concerned about] the treatment process, side effects of the treatment, long term side effects and long term follow up. […] I fear I do not explain clearly enough.

（[擔憂的環節]治療進行的部分，還有一些治療過程中的副作用，或是一些長期的副作用，長期追蹤的部分。[…]會擔心講得不夠清楚。）

#21(endocrinology, V2): Some drugs can cause lethal side effects. We would specifically

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emphasize on that because I'm afraid that the patient does not understand or misinterpret. […] What we worry the most in diabetic patients is the issue of hypoglycemia. We have to make it clear to the patient how dangerous hypoglycemia is, and how to treat it. Especially because it is often related to the side effect of the drugs as well as the patient's diet. Some drugs for thyroid illnesses can also cause serious allergies.

（有些藥物真的副作用產生他會致命，那一塊我們會特別去強調，怕他聽不懂或是理解有問題。[…]我們最常怕的就是血糖病人就是低血糖這一塊，那個要跟他講清楚，低血糖的處理，他的嚴重性那些，因為那個大部分還是藥物副作用跟他的飲食那些，再來是甲狀腺一些藥，有些過敏會很嚴重。）

No physicians, however, are more concerned about language barriers than psychiatrists. Participants 8, a psychiatrist, explained how he cannot provide medical service when he cannot communicate with the patient.

#8(psychiatry, R1): I think psychiatrists [really need interpreters]. Because we cannot say okay, let me test your blood. If the number is high, you have this disease. Psychiatrists rely solely on history taking to identify symptoms and make a diagnosis. So if you cannot do that, you can't even know if he is suffering from a certain disease or whether he needs to receive a specific treatment.

（我覺得精神科[特別需要口譯]。因為精神科沒有辦法說，好，我幫你抽血、

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你這個數值很高，所以你就是這個病。精神科都是用問診的去確定症狀，才能下診斷，所以如果你不能確定，他甚至連他是不是這個病、要不要接受這個治療都有問題。）

A physician in a different department also stated that she cannot imagine how psychiatrists can overcome language barriers.

#17(general medicine, V4): [Psychiatrists] probably cannot do anything [when they encounter language barriers]. They even need to keep the medical record in Chinese [whereas other departments use English]. They must rely on talking.

（[精神科醫師]應該沒辦法吧！他們連病歷都要寫中文的，他就是要靠講話啊！）

These self-perceived demands for professional interpreting services are reflected on physicians' estimation of the value of interpreting services. When the researcher asked the physicians to quantify the value of professional interpreting services in monetary terms, many stated that it depends on the interpreter's language pair, the significance of the message, and the department that the physician works at.

A surgeon that speaks fluent English believes that English interpreters are not needed but is willing to pay 5000 NT dollars per hour for an interpreter that speaks languages little known in Taiwan, such as Mongolian. An otolaryngologist thinks that an interpreter should be paid 300 to 500 NT dollars per hour if he serves a general outpatient, but when

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the interpreter is there to help interpret information related to a surgery, the rate should be 1000 to 1500 NT dollars per hour. The psychiatrist that stressed the importance of communication in making diagnosis for mental illnesses stated that an interpreter should be paid 3000 to 5000 NT dollars per hour if the interpreter speaks a language that he does not speak.

The numbers should not be taken as an indication of medical interpreters' estimated pay at hospitals because physicians would not be the ones paying for professional interpreting services and that the question was not designed to identify absolute numbers but to gauge the value of interpretation perceived by physicians. That being said, the numbers can still reflect the fact that physicians value professional interpreting services in cases where the interpreters speak rare languages that they do not speak, and when the interpreters can alleviate their concerns.

While the demand for interpreters is low, the expectations of professional interpreters appear high. With regard to a medical interpreting system, physicians are looking for professional interpreters that are well-trained in medical terms, maintain a neutral stance, and can deal with cultural differences along with language differences.

Some physicians are concerned that interpreters are not familiar with medical terms and would expect professional interpreters to receive some training in medical knowledge before providing services.

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#2(plastic surgery, V10+): [The interpreter] must understands the language of different departments.

（[口譯員]要非常懂得各科的語言。）

#11(radiation oncology, V3): If an interpreter has received medical training, I think their service would be useful and I would be willing to use the service.

（我覺得如果是這樣的狀況[口譯員受過醫療訓練]應該是有幫助，也會願意使用。）

#16(radiation oncology, V5): I am worried about [the interpretation] of medical terms. I am already worried that I cannot explain the terms well when communicating with foreigners. […] Technical terms or information related to medical services may not be [explained] clearly, and with an interpreter…If the interpreter understand medical practices or medicine in general, we would be comfortable since he can make things clearer for us. […] If we can make sure that, say the interpreters receive simple training or know [more about medicine], it would be nice in terms of facilitating communication.

（會擔心說有一些醫療術語的部分，因為本來在跟外籍人士溝通就會擔心這個部分講得不是很好[…]專有名詞或是比較偏醫療行為的部分會講得不夠清楚，如果中間再經由一個翻譯的部分，如果這個翻譯很了解醫療行為或是醫療這部份我們當然會很放心，因為他幫我們講得更清楚。[…]如果中間可以確保，譬如說翻譯的人員他們也能夠有一些簡單的訓練，或是比較了解，溝通上面會

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是很好的銜接。）

#17(general medicine, V4): A medical interpreter has to work on [understanding] medical terms.

（當醫院的口譯員就會變成他在一些醫學名詞上面可能也是得要下功夫。）

#18(ophthalmology, R1): [Interpreters] may need to be trained so that they know some common medical terms.

（[口譯員]可能要稍微訓練一下，對於一些常用的醫學的詞要有一些認識。）

Judging from the quotes, physicians would be more willing to collaborate with an interpreter if the person is medically-trained.

Maintaining a neutral stance is also an important characteristics that physicians look for in professional interpreters.

#12(neurology, R2): I think if the interpreter is not a person of interest [to the patient], then the situation may be simpler and an interpreter can [be helpful].

（我覺得口譯員如果是一個跟他沒有關係的人，那可能可以，比較單純。）

#13(endocrinology, V2): Usually we would hope to have an interpreter who holds a neutral stance and is not a person of interest to anyone, not the physician, not the employer. He works for the interest of the patient. Treating illnesses should always be done for the patient's benefit. We hope that there can be a neutral interpreter to deliver messages for us.

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（通常我們會希望有一個口譯是他是中立的立場，他沒有牽扯到任何一方的利益，沒有醫生的利益，也沒有雇主的利益，都是站在病人的立場，其實疾病本來就是要站在病人的立場，我們會希望有一個中立的口譯員在那邊幫我們做一個傳達的部分。）

Physicians' expectations of interpreters being medically trained and maintaining neutral stance resonate with their concerns about the use of ad hoc interpreters. While physicians are mostly satisfied with the assistance of ad hoc interpreters, they hope the interpretation to be even more accurate and without distortions.

Some physicians further mentioned that they would expect the interpreters to actively explain culture differences for them aside from simply translating the words.

#1(oral surgery, V10+): Aside from language differences, cultural differences should not be neglected either. […] I think interpreters can deal with cultural differences. They may be more familiar with [the patient's] language and culture. If they are willing to help, the communication can go a lot smoother.

（不要忽略語言之外還有文化差異。[…]我覺得如果文化上差異可以用再口譯，因為口譯可能對[病人的]這個語言、這個文化可能研究比較多，如果願意幫忙的話，我覺得溝通會順太多了。）

#4(dermatology, R1): I would want [the interpreter] to explain more about cultural differences. After all, I may not know the patient's culture. It is better to know more

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about it.

（我會希望他解釋多一點，文化方面的詮釋，畢竟可能不了解對方、病患的文化，如果多了解一點會是好的。）

Participant 12 stated that she would like the interpreter to explain cultural difference to her and told a story about how she was not sure if she had offended a Japanese male patient by repeating a question about bedwetting in front of his wife. The wife interpreted the question into Japanese but the patient went silent.

#12(neurology, R2): I cannot correctly sense the patient's emotion. His way of thinking may be different from me [because of cultural differences].

（我覺得抓不到對方的情緒，他的想法大概會不一樣。）

It is worth noting that the problem of cultural differences was not an issue that the researcher intended to explore. Instead, the first participant actively brought up that he hopes an interpreter can solve the problem for him. The statement was then supported by other participants when the researcher inquired them on whether they would like an interpreter to explain cultural differences to them aside from solely interpreting between different languages.

In conclusion, the expectations of interpreters generally lie in the understanding of medical terms, maintaining neutrality, and the ability to explain cultural differences.

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4.4 Discussion

The participants' responses are consistent with H.-Y. Chen (2013)'s findings in which physicians notice the existence of language barriers but often hold a passive attitude towards overcoming such barriers. Such attitude is very similar to Diamond et al. (2009)'s description of the physicians' "getting by" mindset. Diamond conducted the research after noticing that residential physicians tend to underuse professional interpreting services, and eventually found out through interviews that many physicians found other communication methods good enough and decided not to use professional interpreting services for their convenience or other personal reasons. Jacobs et al. (2010) pointed out that physicians need to be trained as well. According to the study, physicians' willingness to leverage professional interpreting service system increased after receiving training courses on the use of professional interpreting services.

The background of the current research is different. Taiwan's hospitals have yet to establish a professional interpreting service system, so physicians were not comparing different choices they already have, but comparing the options they have today with an "imaginative" professional interpreting system. Therefore, it cannot be assumed that the mindset of "getting by" would persist if a system is in place. However, people's values do not change overnight. And this study does show that physicians are not fully aware of the risks of not using professional interpreting services. Therefore, if Taiwan is to

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establish such a system someday, training programs may be required to ensure that physicians know the value of the system and have the ability to utilize the system efficiently.

Digging deeper into the idea of “getting by”, it is revealed in the interviews that many physicians find the current situation acceptable because the frequency of seeing LCP patients is simply too low. Since they do not need to deal with LCP patients often, they do not find taking more time to communicate with the patients extremely troublesome. A participant, who once let a patient go without knowing his real condition due to language issues, even admitted that before being interviewed by the researcher, he had never thought about seeking other ways to solve the problems arising from language barriers. He was not alone. It was apparent that none of the participants really thought about the issues of language barriers before. It took all the participants some time to think of a case to share with the researcher during the interview.

However, there are two issues worth considering. First of all, this may be a chicken and egg situation. No one can tell whether it is because there are few LCP patients so the demand for interpreters is low, or it is because there are no good professional interpreting services so LCP patients do not come to the doctors. Consistent with the findings of Tsai et al. (2001), many participants mentioned that patients that do not speak English or Chinese do not go to the hospital. In other words, there may be a number of LCP patients

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out there who are deterred from turning to Taiwan's medical system due to the existence of language barriers. This may also be the reason why even with the sharp increase in immigrants and medical tourists over the years, physicians do not seem to notice such an increase. Once a system is built, more LCP patients may show up and the demand for professional interpreting services may increase.

Secondly, socio economic issues must not be overlooked. While one case of a physician treating a LCP medical tourist with Google Translate was brought up in the interview, the case happened years ago. Over the years, hospitals have come up with other ways to assist medical tourists to overcome language and cultural barriers by either providing an escort staff or by cooperating with local physicians. The patients per se are also resourceful and can find their own solutions to overcoming language barriers, including hiring professional interpreters. The situation is very different for low socio-economic patients, particularly blue-collar workers that come from Southeast Asia. Physicians either have to communicate with them through rudimentary measures or find an ad hoc interpreter. The ad hoc interpreter is more often than not the agent or the employer of the worker, which can lead to a conflict of interest. Without a professional interpreting service system, physicians are left with no choice but to accept the fact that they have to let go of details. "If the person were Terry Gou, he would not have been treated that way" was a quote from a physician. He was depicting a scenario where the

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Taiwanese tycoon, Terry Gou, was bed-ridden and a physician cannot communicate smoothly with his foreign caregiver. If the person was the billionaire, no one would think that using only gesturing is acceptable. The same idea applies to all scenarios in hospitals where language barriers exist. Mr. Gou would probably not be forced to communicate in his second language let alone gesturing. It all boils down to socio economic issues when certain people simply do not have the voice to say “we are not okay with getting by”. And while the frequency of encountering LCP patients may be low as gauged by the physicians, for the LCP patients that encounter language barriers, it means a 100% possibility of running the risk of being misdiagnosed due to language difference.

The problem, however, can be very hard to solve due to a lack of resources. H.-Y. Chen (2013) stated that some hospitals once set up special outpatient clinics for immigrants from Southeast Asia but later shut down the clinics due to low rate of utilization and lack of budget. It is nearly impossible to find interpreters for all languages immediately around the clock. Taiwan’s medical system is already facing a crisis because the number of patients exceeds the systems’ capacity. Almost all the participants complained about how they need to take care of more than 50 patients in 3 hours and cannot spend 20 minutes on each patient like physicians in the United States do. The two facts combined make physicians believe that it is not plausible to establish a professional interpreting service system like the ones in the United States. First of all, they do not

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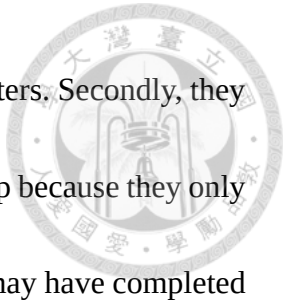

believe the hospitals have enough money to hire professional interpreters. Secondly, they do not think they would have enough time to ask an interpreter for help because they only have less than 5 minutes for each patient. A physician thinks that he may have completed the communication process as the interpreter is rushing to the spot.

Taking the current situations into consideration, the participants provided practical suggestions on establishing a language service system that may suit Taiwan's needs. The suggestions can be divided into three categories: translation of texts, centralized services, and use of technologies.

Physicians noted that hiring interpreters can be expensive and it may be easier to start from translating written texts, including patient education pamphlets and consent forms. At this time, hospitals in Taiwan have been working on translating information for patients. However, as revealed by H.-Y. Chen (2013), because the government has not established specific standards on the level of language services that hospitals should provide for LCP patients, the quality of translation varies greatly. Some hospitals asked bilinguals rather than professional translators to translate the documents only for hospital accreditations. Some participants in the current study also mentioned that the scope of translation at her hospital remains small. In most cases, only English translation is provided and many documents are only written in Chinese. Physicians suggested that patient education pamphlets and consent forms should be translated into various

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languages to make it easier for physicians to explain different procedures in details. According to the ranking of top 10 home countries of ARC holders in Taiwan, written medical documents should at least be translated into Indonesian, Vietnamese, Thai, Malaysian, Japanese, Korean, and English (Please refer to Table 6 on page 36 for the ranking list).

Translation of text is also important in attracting more medical tourists since language concordance affect medical tourists' picks of destinations (Lin, 2011). Yeh (2013) compared the medical tourism industry in Taiwan, Thailand, and Korea. Thailand and Korea are both renowned destinations of medical tourists in Asia. Korea was even awarded as the "Health and medical tourism: Destination of the year" by the International Medical Travel Journal (IMTJ) in 2018. It was clearly shown in Yeh's study that Thai and Korean medical institutions have both put much effort into overcoming language barriers for medical tourists. For example, the Bumrungrad Hospital in Thailand provides language services in twenty-four languages. The Samsung Medical center provides interpreting services in English, Arabic, Russian, Mongolian, Chinese and Japanese. The official website of the two hospitals are written in at least 3 foreign languages. On the contrary, among the nine hospitals chosen as the target of the study, five hospitals only present their websites in Chinese and English. Another three hospitals have further translated the website into Japanese. Only Chang Gung Medical Foundation managed to

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provide websites in seven languages, including Japanese, Vietnamese, Arabic, Indonesian, Russian, English, and Chinese. While an official website only provides a small part of written information about a hospital, it does reflect the hospital's ambition to attract international patients. If Taiwan is to broaden the base of medical tourists, translation of websites may be the first step towards better marketing outcomes.

The second suggestion made by the physicians is to pool resources together so that the expense of building a professional interpreting service system can be reduced. Participant 12 stated that the timing of encountering LCP patient is unpredictable, so the cost of hiring a full-time interpreter may be extremely high for each hospital. Therefore, it may be better for the government to set up regional interpreter centers and notify the hospitals on where to find the interpreters. Participant 18, who did not think professional interpreting services is needed due to the low frequency of meeting LCP patients at this time, believes it would be more cost efficient to establish a call center dedicated to medical interpreting to scale up the demand and lower the overall cost. Another physician also agreed that founding a call center should be plausible.

The suggestion of using telephone interpreting is in fact very practical from the aspect of the provision of interpreting services. First of all, telephone interpreting is already commonplace overseas. L. J. Lee, Batal, Maselli, and Kutner (2002) found that patients are satisfied with the telephone interpreting services provided by AT&T. The

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satisfactory rate is even higher than using an ad hoc interpreter. Dowbor et al. (2015) further pointed out that the implementation of telephone interpreting system tend to reduce the use of ad hoc interpreters, and other nonprofessional strategies. In Australia, even video interpreting services are provided. In other words, experiences in hospitals abroad have proven the use of call centers satisfactory and effective. Secondly, Taiwan has already built up similar systems. The Ministry of Labor and the National Immigration Agency have both set up call centers to provide language services, which include interpreting services, for foreigners in Taiwan. However, the systems were not established for medical services only, and the "interpreters" that serve at the centers are not professional interpreters. In addition, the representative from the National Immigration Agency bluntly expressed the lack of budget and the challenges of providing professional interpreting services in the conference focusing on translation and interpretation policies held by the National Academy for Educational Research in 2013. Medical interpreting is relatively technical and require a higher level of privacy protection. If the government is to set up a call center for medical services, medicine-specific issues should be taken into consideration. For example, the interpreters need to be medically trained and understand the ethics of confidentiality. Still, now that the government has the experience of operating call centers, a new system dedicated to medical interpreting services can probably be established with better results.

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The last suggestion proposed by the participants is to leverage new technologies. Two physicians believed the problems can be solved with the advance in artificial intelligence and translation systems. While the physicians did not go into details as to the specific systems that they are looking for, their reasons for preferring machines over human beings are worth noting. One physician suggested the use of machines because machines would record the communication processes and that the record can be reviewed to make sure the information has been interpreted correctly afterwards. Another physician wanted to use translation software because the cost would be lower and the systems would be accessible any time. The two comments resonate with the physicians expectations of professional interpreters. They would like the interpreters to interpret accurately and arrive on the spot instantly.

All in all, based on experiences in other countries and physicians' observations, Taiwan could start from using low-cost measures, such as text translation, telephone interpreting, and machine translation instead of providing 24-hour on-site professional interpreting services.

Since physicians expect medical interpreters to be well-trained, the design of training programs should be taken into account. To meet up with physicians' expectations of interpreters being medically literate, neutral, and culturally sensitive, related courses should be included in the training curricula. While establishing training programs can be

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expensive, the government or private organizations may start with specific languages and cater to the demands of departments that encounter more LCP patients to save budget. For example, Indonesia is the number-one home country for ARC holders, so training of Indonesian interpreters should be a priority. In terms of training interpreters to provide services for medical tourists, each hospital can start from the department they want to promote the most. Shin Kong Wu Ho-Su Memorial Hospital, for example, has established its fame in cardiac surgery, and could thus start with training interpreters in the Cardiac Department.

Aside from interpreting for LCP patients that speak foreign languages, language barriers caused by local dialects, including Taiwanese, was brought up by more than one participants coincidentally. In Taiwan, Chinese is the official language and many young people do not understand Taiwanese at all. Some elderly people, however, believe Taiwanese is the “true language” of Taiwan and will become irritated when talking to someone who does not speak Taiwanese at all. Some participants do not understand Taiwanese or speak Taiwanese fluently. They would find it hard at times to communicate with local patients who only speak Taiwanese, and some have been scolded by the patient for not being able to speak the language. Participant 13 pointed out that not only patients are globalized today, Taiwan has more and more physicians who are not Taiwanese. Physicians who are originally from Macao, Myanmar or other countries may not be able

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to communicate with local patients in these local dialects. Such language barriers within Taiwan thus should not be overlooked in this globalized world.

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Chapter 5 Conclusion

5.1 Summary of Results

The 21 in-depth interviews with physicians working at medical centers in Northern Taiwan show that the use of professional interpreters is practically non-existent. In the only two cases of cooperating with professional interpreters mentioned by the participants, the interpreters were not hired by the hospitals. And in those two cases, both patients were medical tourists that registered through the Department of International Medical Services. In addition, in one of those cases the interpreter was there to interpret from English into the patient's mother tongue. In other words, the physician was still speaking English, which is his second language, even with the presence of an interpreter. On the other hand, using ad hoc interpreters and directly communicating with patients have become the major strategies applied by physicians when communicating with LCP patients.

The strategies physicians use can be summarized into Figure 3 and Figure 4. In Figure 3, Strategy C refers to direct communication, including communicating in English, gesturing, and drawing. Strategy B is the use of ad hoc interpreters, and Strategy A is the use of professional interpreters. The frequency of the application of a strategy is higher towards the base of the pyramid. Figure 4 demonstrates the strategies used by physicians in different situations.

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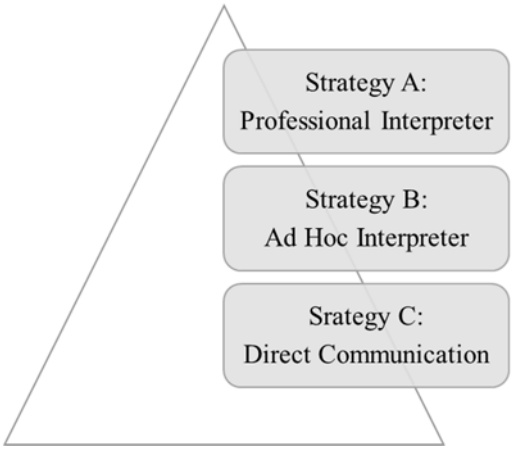

Figure 3. Strategies used by physicians

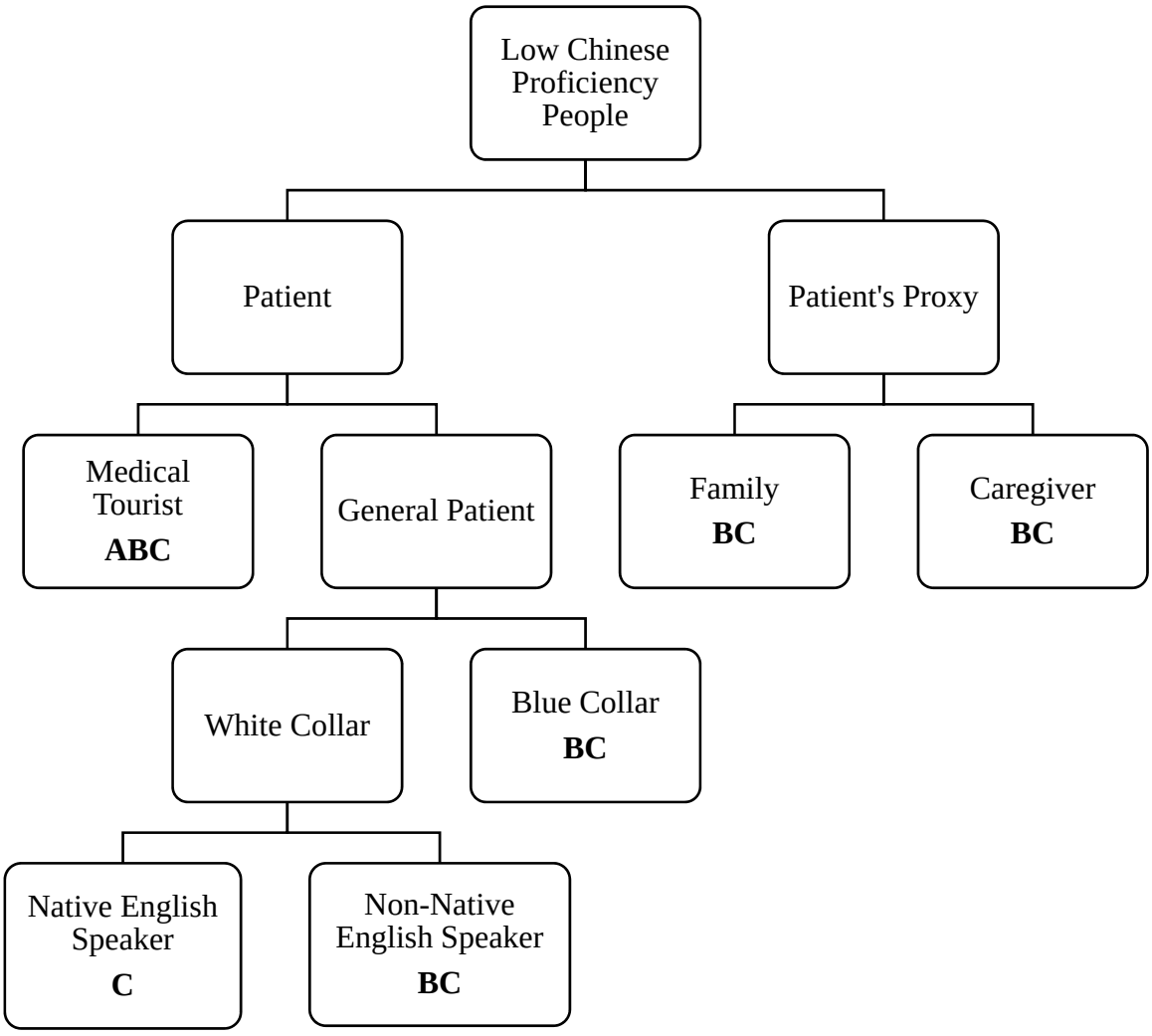

Figure 4. Strategies applied in different cases

**Note. Symbol A/B/C in bold refers to strategy A, B, and C as indicated in Figure 3.*

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Cases of misunderstanding have arisen, and yet those cases have not lead to dire consequences that the physicians know of. Therefore, while the physicians did confess having concerns about not working with a professional interpreter, they have found the current situation acceptable.

5.2 Relevance to current situation in Taiwan

Research on cross-language communication and medical interpreting conducted in Taiwan mainly addresses the issue from the angle of immigrants' adaptation to Taiwan's society. For example, Tsai et al. (2001) and M.-L. Chen and Chiou (2009) focused on factors deterring foreign workers from seeking medical treatment, and both identified language as a major factor. Yang and Wang (2003) and Shen (2006) explained how language barriers can negatively affect the quality of health care received by foreign spouses.

Fan (2011) and H.-Y. Chen (2013) are the two research most closely related to the current study. Fan (2011) shed light on the medical interpreting system in Taiwan. Through interviewing medical interpreters at local medical centers, the research revealed the interpreters' views on current training programs and the interpreting system. However, Fan (2011) did not explore the demand for interpreters from the users' perspectives. On the other hand, H.-Y. Chen (2013) zoomed in on the current situation of cross-cultural communication and slightly touched upon physicians' demand for interpreting services.

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The research, however, was still addressing the issue from a social perspective and did not dig into different scenarios of cross-language communication or the possible structures of a medical interpreting system. This research aims to fill the gaps of the two previous research by exploring physicians' views on cross-language communication in hospitals as well as their demand for professional interpreting services from the angle of an interpreter.

In addition, as mentioned in Chapter 1, the trend of medical tourism should not be neglected. Whereas the number of medical tourists is low currently and may not bring significant impacts to the medical system, language barriers can limit Taiwan's ability to attract more international patients. As shown by Lin (2011), language concordance is an important factor that international patients take into consideration when deciding on their destinations of receiving medical treatments. With other Asian countries, such as Korea and Thailand, aggressively building up their medical tourism industry by offering strong language services, Taiwan should not ignore the importance of language services should the government want to promote the medical tourism industry and compete with other countries.

All in all, this study adds on to previous studies conducted in Taiwan by providing an overview on cross-language communication in hospitals and the demand for medical interpreting services. The study incorporates all scenarios of cross-language

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communication in Taiwan's hospitals, including physicians' interactions with LCP local patients, LCP international patients, and even LCP patients' proxies. Furthermore, whereas the research participants are physicians, the researcher is an interpreter and thus can combine the point of views of users and providers of interpreting services.

5.3 Limitations and recommendations for future research

There are a number of limitations to the study. First of all, it is a qualitative research with limited participants. While the researcher has tried to reach out to participants from different backgrounds, it is impossible to find participants that reflect the demography of Taiwan's physicians. The participants' views may not be generalized as views of all physicians in Taiwan. However, the results of the study can be used as a base to create questionnaires for future quantitative studies.

Secondly, the researcher only selected participants from 9 medical centers in Northern Taiwan. The original purpose was to find participants with higher probability of treating LCP patients. However, this sampling approach also limited the sample size. Hospitals in Taiwan suffer from uneven distribution of resources. By choosing the 9 medical centers in Northern Taiwan, the researcher focused on the hospitals with abundant resources, whereas small-scale hospitals may not have the resources to promote medical tourism and may not attract as many LCP patients. In addition, the demography in Northern Taiwan is very different from other regions in Taiwan. Because the capital

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city, Taipei, is located in Northern Taiwan, the region is the major gathering place for white-collar LCP patients. The demography of patients in Southern or Eastern Taiwan can be very different. In fact, several physicians mentioned in interviews that the scenarios were very different when they served at hospitals in other cities. Future research can therefore focus on hospitals of smaller scale or hospitals in other areas to acquire a broader picture of the demand for professional interpreting services in hospitals around Taiwan.

Thirdly, the researcher explored the demand for professional interpreting services solely from physicians' perspectives. The results can be very different if the participants of the interviews are other people in the system, including nurses and patients. Research conducted overseas has shown that patients may find their experience of seeing a doctor without an interpreter unsatisfactory even when a physician find the situation satisfactory (Kline et al., 1980). Similar trends may be observed in Taiwan, too. In addition, nurses, technical staff, and administrative staff's perspectives are also worth exploring. In Taiwan, getting into medical school requires high marks in all subjects in admission exams, including English. The teaching material used in medical school is also written in English. Therefore, command of English among doctors is generally above average. Language requirements for nurses, technical staff, and administrative staff, on the other hand, are comparatively lower. Therefore, whereas most physicians found it acceptable to

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communicate with patients in English, other staff members may not find communicating in English an acceptable and feasible alternative.

Fourthly, as Diamond et al. (2012) argued, physicians' second language proficiency should be evaluated and policies on the use of second language skills in clinical care should be established. In this research, most physicians claimed that they are able to communicate with patients in English, but no one knows their actual level of English competence or how proficient in English the physicians need to be in order to conduct medical consultation in English. Future studies may explore this issue by shedding light on the gap between physicians' self-proclaimed English skills and the actual outcome of their communication with patients in English. In addition, Taiwan's situation is different from that of the United States', where Diamond's study was conducted. In the US, at least one speaker is communicating in his mother tongue. The most common scenario is an American physician speaking Spanish or a Spanish patient speaking English. On the other hand, Taiwanese physicians are often communicating with non-English speaking patients in English, which means the two sides are in fact communicating in a language foreign to both. While this is a common communication method used in the world of English-as-a-lingua-franca (ELF), whether such method is suitable for a place that requires a high level of accuracy is questionable. Therefore, future research can also focus on comparing the situation where the physician treats an English-speaking patient in English and where the

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physician treats a non-English speaking patient in English. By doing so, the research would show whether the situation of cross language communication in Taiwan is indeed more dangerous than the situations oversea explored by other researchers.

Lastly, the researcher failed to acquire consent from hospitals or the government for official data and therefore solely relied on information published online and the interviews of physicians. Future research may reach out to hospitals or the government to get more comprehensive and authoritative data in order to provide more constructive suggestions on policies.

The present study is merely a preliminary step towards understanding the demand for professional interpreting services in Taiwan's hospitals. Future studies can continue to explore the demand from different perspectives and at a larger scale so as to paint a comprehensive picture of the situations of cross-language communication and demand for interpreting services in Taiwan's hospitals. It is hoped that the government and the private sector would utilize the results of this study and future related studies to create a language services system that suits Taiwan's need and thus ensure a medical system where language is no longer a barrier to optimal medical services.

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Appendix 1 Interview Outline (Version 1)

1. 請問您多常替不會講中文的患者進行診療？（一週幾次）

   How often do you treat Low Chinese Proficiency (LCP) patients?

2. 請問您如何與這些病患溝通？是否曾經使用醫院的口譯服務或尋求旁人協助？（如果沒有，跳第 4 題）

   How do you communicate with those patients? Have you ever use the hospitals' professional interpreting services or ask someone around you to help interpret? (If not, jump to question 4.)

3. 如果曾經使用口譯服務，請談談與口譯員合作的經驗（正式或非正式口譯員皆算）。

   Please tell me about you experience of working with an interpreter (either professional or unprofessional interpreters).

   a. 為什麼當時決定與口譯員合作？

      Why did you choose to work with an interpreter?

   b. 您認為口譯員是否讓診療過程更順利？

      Do you think the interpreter helped facilitate the medical process?

   c. 您認為口譯服務品質如何？

      What do you think about the quality of the interpretation?

   d. 過程中有沒有出現意外狀況？

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Did any unexpected events take place?

4. 沒有使用口譯服務的原因是什麼？是因為沒有申請管道，還是認為沒有需要？

Why didn’t you apply for professional interpreting services? Was it because you didn’t know how to apply for it or that you didn’t think interpreting was needed?

5. 請談談以英文和外國病患溝通的經驗。

Please tell me about your experience of communicating with LCP patients in English.

(1) 以英文問診和以中文問診最大的差別是什麼？

What’s the major difference between communicating with patients in English and in Chinese?

(2) 以英文和患者對話時，遇到那些挑戰？

Did you face any challenges when you talked to patients in English?

(3) 以英文與患者對話時，您會刻意調整溝通方式嗎？（例如：多講解一點、重複確認對方是否了解您傳達的意思）

Did you adjust your communication approaches when talking to a patient in English? (For example, elaborate more on your messages, double check if your message has been fully delivered, etc.)

(4) 患者的母語是不是英文，溝通時是否有差異？

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Is talking to a non-native English-speaking patient different from talking to a native-English speaking patient?

(5) 您認為如果當時有口譯員在場，會不會影響您對患者傳遞的內容？

If there were an interpreter, do you think the messages you delivered would have been different?

6. 您是否在與外國患者溝通時遇到困難，因此造成診療上的錯誤或差一點出錯？

Can you think of a time when communication issues with LCP patients has led to errors or near misses? Please elaborate.

7. 您認為哪些改變會讓您更願意且更輕鬆地使用口譯服務？（例如：院內翻譯體制改變、針對醫師與口譯員合作進行教育訓練、院方加強宣導申請口譯服務的管道等。）

What would make it easier for you to use interpreter? (For example, changes in the interpreting system, increased staff awareness/education, training on using of interpreters, awareness of their availability, etc.)

8. 您認為如果要提高與非中文母語的外國患者溝通的品質，醫院還可以做些什麼？

What else can the hospital do to increase the quality of communication for LCP patients?

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9. 針對國際醫療的口譯服務，您還有什麼要補充說明的事項嗎？

   Is there anything else you think we should know about interpreting services in medical tourism?

*Note: The English translation is for demonstration only and was not included in the interview outline sent to the participants.

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Appendix 2 Interview Outline (Version 2)

1. 請問您多常替不會講中文的患者進行診療？

   How often do you treat Low Chinese Proficiency (LCP) patients?

   (1) 國際醫療部轉介、自行就醫的病患，哪一種比較多？主要是哪一些語種？

   Do the LCP patients mainly come as medical tourists or outpatients? What are the major mother tongues of the LCP patients?

2. 請問您如何與這些病患溝通？是否曾經使用醫院的口譯服務或尋求旁人協助？

   How do you communicate with LCP patients? Have you ever use the hospitals' professional interpreting services or ask someone around you to help interpret?

   (1) 國際醫療部的人員是否曾協助病患找翻譯？

   Has the staff at the Department of International Medical Services assisted the patient to find an interpreter?

   (2) 移工就醫時，是否有雇主陪同？

   Are foreign workers accompanied by their employers?

   i. 雇主翻譯是否讓診療過程更順利？

   When employers serve as interpreters, do they help facilitate the process of care provision?

   ii. 過程中有沒有出現意外狀況？

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Have you encountered any unexpected events when treating foreign workers?

3. 請談談以英文和外國病患溝通的經驗。

Please tell me about the experience of communicating with LCP patients in English.

(1) 以英文問診和以中文問診最大的差別是什麼？

What's the major difference between communicating with patients in English and in Chinese?

(2) 以英文和患者對話時，遇到那些挑戰？

Do you face any challenges when you talked to patients in English?

(3) 以英文與患者對話時，您會刻意調整溝通方式嗎？（例如：多講解一點、重複確認對方是否了解您傳達的意思）

Do you adjust your communication approaches when talking to a patient in English? (For example, elaborate more on your messages, double check if your message has been fully delivered, etc.)

(4) 患者的母語是不是英文，溝通時是否有差異？

Is talking to a non-native English-speaking patient different from talking to a native-English speaking patient?

(5) 以您的科別來看，哪一個環節或診療流程特別需要反覆溝通？

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In the case of your department, do you find any parts of the health care processes that require repetitive communication?

(6) 您是否在與外國患者溝通時遇到困難，因此造成診療上的錯誤或差一點出錯？

Can you think of a time that communication trouble with LCP patients has led to errors or near misses? Please elaborate.

4. 整體而言，與病患溝通時，您是否希望有口譯員在旁輔助？

Overall, do you hope that an interpreter can assist you to communicate with LCP patients?

(1) 病患為英文母語者的情況

When the patient is a native English speaker, do you think it's better with an interpreter?

(2) 病患為非英文母語者的情況

When the patient is not a native English speaker, do you think it's better with an interpreter?

5. 除了病患，您有沒有在與其他人溝通時，因為語言不同而遇到困難？是否希望有口譯員在場？

Aside from the patients, have you encountered any language barrier when communicating with others in the hospital? In those cases, do you wish an

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interpreter was present?

6. 若能找到口譯員協助溝通，您願意提供多少報酬？

   If an interpreter is available, how much money are you willing to pay?

7. 您認為如果要提高與非中文母語的外國患者的就醫品質，醫院還可以做些什麼？

   What else can the hospital do to increase the quality of care for LCP patients?

8. 針對這個主題，您還有什麼要補充說明的事項嗎？

   Do you have anything to add on this subject of interests?

   *Note: The English translation is for demonstration only and was not included in the interview outline sent to the participants.

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Appendix 3 Coding Chart

Code	Meaning	Example
AHN	Ad hoc interpreters-negative	I think it is more troublesome when the employer is present. （我覺得雇主來了才是問題。）
AHP	Ad hoc interpreters-positive	I think it is good to have the agent present. （我覺得仲介在是好事。）
AHS	Ad hoc interpreters-strategy	I would not say everything at once. I would say a few things and ask the agent to [translate]. 我不會全部一次講完，我會先講一些，然後說，你現在告訴他。
AHU	Ad hoc interpreters-use	The [patient] would serve as an interpreter. （變成[病人]翻譯。）
B	Background	There are not many patients from Thailand. More from Indonesia or Vietnam. （泰國也蠻少的，印尼、越南比較多。）
BL	Background-location	In Yilan, most of the LCP patients are foreign spouses. （宜蘭那邊幾乎都是外配。）
CED	Differences in Chinese/English communication	I might skip through some details. （有些很細的步驟我可不會跟他解釋。）
DD	Demand for interpreters-department	I think psychiatrists [really need interpreters]. （我覺得精神科[特別需要]。）
DL	Demand for interpreters-language	Taiwan should at least provide interpreting services in English, Japanese, and some Southeast Asian languages. （台灣應該至少要有英文、日文，跟幾個東南亞語系。）
DN	Demand for interpreters-negative	I don't think we need [a professional interpreting service system]. It is not cost-efficient. （我覺得不需要[設立口譯體系]，因為這樣子不合成本。）
DP	Demand for interpreters-positive	I think it would be better if [an interpreter were present].

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		（我覺得[如果有人可以翻譯]會比較好。）
DQ	Demand-quantify	5000 an hour. （一個小時 5000 塊吧！）
DTR	Demand for interpreters-trust	When you communicate through an interpreter, you cannot control the quality of the interpretation. （透過一個翻譯，你沒辦法控制那個翻譯的品質。）
EC	Expectations of interpreters-cultural interpretation	I would like him to explain more cultural differences to me. （我會希望他解釋多一點，文化方面的詮釋。）
EI	Expectations of interpreters-in-time arrival	LCP outpatients may walk in unexpectedly. In such cases, will [the system] be able to provide interpreting services? （遇到外籍的一些病患門診就是很突發，這樣的狀況底下有沒有辦法提供這樣的足夠的能力，口譯。）
EN	Expectations of interpreters-neutrality	We would hope the interpreter to be neutral. （通常我們會希望有一個口譯是他是中立的立場。）
ESGP	English speaking general patients	For [patients from] English-speaking countries, some less technical terms can be used conveniently. I just say the word and they understand what I’m talking about. 有時候英語系的國家在這部分，有些不是那麼艱深的專業用語，其實我覺得還蠻方便，就直接講他們其實就懂了。
ESGPC	English speaking general patients-challenge	It is difficult and challenging for us to bring up technical terms and raise questions colloquially. （專有名詞或是你希望問的問題，要很口語地問他問出，這個對我們來講還是有一些挑戰跟困難度。）
ESN	English speaking-negative	Some physicians find speaking English tiresome. If they have a choice, they wouldn’t speak English. （有醫生覺得講英文蠻辛苦的，可以的話真不想講。）
ESP	English speaking-positive	If a patient speaks English, we don’t encounter any barriers.

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		（會講英文對我們來說就完全沒有障礙。）
ET	Expectations of interpreters-training	[Interpreters] may need to be trained so that they now some common medical terms. （[口譯員]可能要稍微訓練一下，對於一些常用的醫學的詞要有一些認識。）
F	frequency	I may encounter fewer than 10 [LCP patients] a year. （一年可能不會超過 10 個。）
FD	Future demand for interpreting services	In the future, Taiwan's Southbound Policy may bring in more patients from Southeast Asian countries, such as Malaysia and Indonesia. The demand for interpreters [of Southeast Asian languages] may increase. （未來馬來西亞、印尼，因為我們南向政策應該會有更多東南亞的人會來，這一部分可能相對也會變多。）
GS	General situation	When we first meet a non-Chinese speaking patient, we would first try communicating in English. （第一時間我們還是會用非中文體系，我們就是以英文常是溝通看看。）
GST	General strategy	I would show the [information] on my computer to the patients and let them do research on their own. （在電腦上面點給他們看這個到底是什麼，再讓他們自己去查或是翻。）
HS	Hospital system	Our hospital conducted a survey on what languages each doctor knows and ask the doctors whether they would be willing to serve as an interpreter when need be. （我們醫院會統計醫師知道、認識的，知道什麼語言，跟我們統計如果有這個病患你願不願意當翻譯。）
LB	Language barriers	At times, we do face language barriers. （有時候真的會有語言的障礙。）
MT	Medical Tourist-general comment	They would ask before they come, so they already know the details of the surgery [that they are undertaking].

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		（他們來通常就是打聽好才過來，所以就是知道手術細節。）
NESB	Non-English speaking general patients-blue collar	It is hard to inquire [blue collar LCP patients] on their illnesses. They are also afraid of telling you much about their conditions. （你很難跟他溝通那麼多病情，他也不敢跟你溝通那麼多病情。）
NESBC	Non-English speaking general patients-blue collar-challenge	It is harder to communicate with foreign workers. （比較不能溝通的大概就是移民，移工啦！）
NESBS	Non-English speaking general patients-blue collar-strategy	If they cannot communicate in English, I would use single words or draw pictures to communicate. （如果英文很不 ok，就用單詞、用畫圖。）
NESGP	Non-English speaking general patients	Some Southeast Asian patients are of low socio-economic backgrounds. He may not speak Chinese nor English. （有一些東南亞社經地位比較低，他可能第一個他不太會講國語，他也不太會講英文。）
NESGPC	Non-English speaking general patients-challenge	Japanese and Korean patients can cause lots of troubles. （日韓是如果真的來是蠻困擾的。）
NESGPS	Non-English speaking general patients-strategy	I would gesture or draw pictures. （比手畫腳加上畫圖。）
PI	Professional Interpreter	Patients from Palau would definitely come with an interpreter. […] A professional one. （帛琉一定有個翻譯的人在旁邊。[...]專業的人。）
PS	Possible solutions-general	At the registration desk, the administration staff can help him find a physician that speaks his language. For example, I have a colleague who got her degree at Cambridge University. She has great command of English. It would be nice if [an English-speaking patient] is sent to her in the first place.

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		（他們在掛號的時候，如果他怎麼樣的語言就針對那個醫師，因為我們有一些醫師，像我們科有一個學姊她是英國劍橋的，她英文就很好，如果在前一線他來就直接是掛給她就好了啊！）
PSP	Possible solutions-pooling resources together	Maybe we can set up a call center. When I encounter a problem, I can call in to find an interpreter. This is a more plausible solution in Taiwan. （如果可以有一個類似服務專線，只要設定一個 center 在那邊，今天我遇到這個問題我可以撥打進去，那邊有一個固定在幫我們翻譯，在台灣可能這樣應該是比較有可能。）
PST	Possible solutions-technology	It would be nice if we can use hardware facilities to [overcome language barriers]. （我覺得硬體的設施如果可以幫忙也不錯。）
PSTR	Possible solutions-translation	Aside from interpretation, maybe we can translate Chinese documents into Vietnamese or Indonesian. （除了語言溝通之外，可能的話、可以的話把一些文字這些中文版的也許能夠翻譯持越南文，或是印尼文。）
PV	Prolonged visit	It takes more time to treat a LCP patient. （看外國病人會花比較多時間。）
PXC	Patient's proxy-caregiver	Sometimes a patient is bed-ridden and cannot express himself. Then you need to inquire the caregiver for information. （有時候阿公阿嬤是臥床都不會表達，你就是要問那個照顧他的人。）
PXF	Patient's proxy-family	The patient cannot talk. He probably speaks Chinese but his family members only speak English. （他是沒辦法好好講話的病患，他應該是會中文，但是他的家屬都是要講英文的。）
RC	Real Cases	The story about a Mongolian patient that received a surgery after communicating with the doctor through Google Translate. 蒙古來的，用 Google Translate　*This is not a direct quote but a summary of the case.

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SE	Socio-economic issues	I do think we always need better communication, however, a patient's socio-economic background determines how he is treated. This I undeniable. （你要做到更好的溝通永遠是需要的，但是有時候真的是病人本身的 socio economic 會決定他被對待的方式，我覺得這個都難以否認。）
TR	Triviality	For most patients, I think we can just keep it simple. （一般的病人我覺得就是「簡單就好啦！」）
TWD	Taiwan's Dialect	If you leave Taipei and go to Middle Taiwan or Southern Taiwan, patients would think it's your problem that you do not speak [Taiwanese]. （你如果離開台北到中南部，他會覺得你很有問題，你怎麼可以不會講[台語]。）

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