



Hacettepe University Graduate School of Social Sciences

Department of Translation and Interpreting

English Translation and Interpreting Programme

**VIDEO REMOTE INTERPRETING (VRI): A NEW DIMENSION FOR TURKISH
HEALTHCARE SYSTEM**

Sıla Saadet TOKER

Ph.D. Dissertation

Ankara, 2025

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ACCEPTANCE AND APPROVAL

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ETİK BEYAN

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[imza]

[SILA SAADET TOKER]

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ABSTRACT

TOKER, Sila Saadet. *Video Remote Interpreting (VRI): A New Dimension for Turkish Healthcare System*, Ph.D. Thesis, Ankara, 2025.

Recent technological advancements lead people to find technology-mediated solutions to respond to the increasing needs for public services, including healthcare. Therefore, video remote interpreting emerges as an evolving mode which has gradually gained prominence throughout the world, allowing people with linguistic and cultural differences to make use of such services available from remote locations, which is deemed to fulfil the principle of equity in access to healthcare. To this end, this research seeks to provide an overview regarding the video remote interpreting (VRI) mode and its current practices in the exemplary countries where this system has successfully been integrated through reviewing available regulations and legislative frameworks, as this system is yet to be available in Türkiye. Additionally, this research aims to investigate the expectations of interpreters, physicians, and foreign patients from the potential future implementation of video remote interpreting services in the Turkish healthcare system. To this end, the data for this research was first generated through a document analysis. In this vein, administrative documents such as legislation and other related documents of the countries performing good practices of video remote interpreting services having been provided in their healthcare system have been studied. Secondly, semi-structured in-depth interviews were conducted with the participation of three interlocutor groups: interpreters, physicians, and foreign patients as potential users so as to investigate their expectations from video remote interpreting services, which may hopefully provide relevant information just in case such services may be planned to be integrated into the Turkish healthcare system in the future. Additionally, the research diaries kept by the researcher also facilitated a deeper insight into the situation. Consequently, this research is expected to contribute to the possible integration of video remote interpreting services within the Turkish healthcare system.

Keywords

Video remote interpreting, remote interpreting, healthcare services, health, Information and Communications Technology (ICT).

ÖZET

TOKER, Sıla Saadet. *Video Yoluyla Uzaktan Çeviri: Türk Sağlık Sistemi için Yeni Bir Boyut*, Doktora Tezi, Ankara, 2025.

Son zamanlarda ortaya çıkan teknolojik gelişmeler, insanları sağlık hizmetlerinin de dahil olduğu kamu hizmetlerine yönelik artan ihtiyaçlara cevap vermesi için teknoloji aracılı çözümler bulmaya yönlendirmektedir. Bu doğrultuda, video yoluyla çeviri hizmetleri dünya çapında giderek adını duyuran ve gelişmekte olan bir tür olarak ortaya çıkmaktadır. Ayrıca, sağlık hizmetlerine erişimde eşitlik ilkesini yerine getirmek gayesiyle bu tür hizmetlerin, dilsel ve kültürel farklılıkları bulunan nüfusa yönelik uzaktan sağlanmasına da olanak sağlamaktadır. Bu kapsamda, bu araştırma, ilk olarak video yoluyla çeviri hizmetlerini genel bir bakış açısı ile açıklamayı, daha sonra ise bu çeviri türünün Türkiye’de uygulanmadığı göz önüne alınarak bu hizmeti sağlık sistemlerinde başarılı bir şekilde sunan örnek ülkelerin uygulamalarını, mevcut düzenleme ve yasal çerçevelerini gözden geçirerek ortaya koymayı amaçlamaktadır. Ek olarak, bu çalışma Türk sağlık sisteminde video yoluyla çeviri hizmetinin gelecekte uygulanması halinde tercümanlar, doktorlar ve yabancı hastaların beklentilerini ve düşüncelerini araştırmayı amaçlamaktadır. Bu doğrultuda, araştırmanın ilk veri seti doküman analizi yoluyla elde edilmiştir ve bu çeviri türünü kendi sağlık sistemlerinde iyi örneklerle uygulayan ülkelerin yasal ve diğer ilgili dokümanları ortaya konmuştur. İkinci veri setini elde etmek için gelecekte Türk sağlık sistemine entegre edilmesi ihtimalinde video yoluyla çeviri hizmetlerine yönelik beklentilerini ve düşüncelerini öğrenmek amacıyla tercümanlar, doktorlar ve yabancı hastalardan oluşan üç farklı potansiyel kullanıcı grubuyla yarı yapılandırılmış derinlemesine görüşmeler gerçekleştirilmiştir. Son olarak, araştırmacı tarafından veri toplama aşamasında tutulan araştırmacı günlükleri ise durumun daha derinden gözlemlenmesine katkıda bulunmuştur. Sonuç olarak, bu araştırma video yoluyla çeviri hizmetlerinin Türk sağlık sistemine olası entegrasyonuna katkı sunmayı amaçlamaktadır.

Anahtar Sözcükler

Video yoluyla uzaktan çeviri, uzaktan çeviri , sağlık hizmetleri , sağlık, bilgi ve iletişim teknolojileri.

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ABBREVIATIONS

ACA :Affordable Care Act

ADA :Americans with Disabilities Act

AIIC :International Association of Conference Interpreters

ALC :Association of Language Companies

ANT :Actor-Network Theory

ATA :American Translators Association

AUSIT :Australian Institute of Interpreters and Translators

AVIDICUS:Assessment of Video-Mediated Interpreting in the Criminal Justice System Projects

BSL :British Sign Language

CALD :Culturally and Linguistically Diverse

CCHI :Certification Commission for Healthcare Interpreters

CHIA :California Healthcare Interpreting Association

CLAS :Culturally and Linguistically Appropriate Services

DDA :Disability Discrimination Act

DHH :Deaf or hard of hearing

DI :Distance Interpreting

EP :European Parliament

EU :European Union

ICT :Information and Communications Technology

ISDN :Integrated Services Digital Network

ISO :International Organization for Standardization

ITTS :Implementing Transnational Telemedicine Solutions

ITU :International Telecommunication Union

LEP :Limited English Proficiency

LOTE :Language Other than English

MISS :Medical Interview Satisfaction Scale

NAATI:National Accreditation Authority for Translators and Interpreters

NCIHC:National Council on Interpreting in Health Care

NDIS :National Disability Insurance Scheme

NHS :National Health Service

NHSGGC: National Health Service Greater Glasgow and Clyde

PAHO:The Pan American Health Organization

PEI :Patient Enablement Instrument

PHSA :Provincial Health Services Authority

PWD :Persons with Disabilities

RC :Research Committee

RI :Remote Interpreting

TA :Thematic Analysis

TFDI :Taskforce on Distance Interpreting

THC :Technical and Health Committee

TI :Telephone Interpreting

TIS :Translation and Interpreting Service National

VCI :Videoconference Interpreting

VITS :Victorian Interpreting and Translating Service

VRI :Video Remote Interpreting

WHA :World Health Assembly

WHO :World Health Organization

FIGURES

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INTRODUCTION

The digitalization era leads people to find technology-mediated solutions to respond to the increasing needs for public services for all people in particular vulnerable populations with linguistic and cultural differences. This tendency results in a shift from in-person to remote service provision, including public service settings. As an open and constantly evolving area, remote interpreting incorporates new technological advancements and responds to the changing needs to overcome disparities in access to public services. Remote interpreting (RI) generally refers to the type of interpreting services provided in situations where an interpreter is not physically present in the service setting, yet can communicate from different locations. The utilization of this type of interpreting significantly evolved thanks to the technological advances in recent years; moreover, its adoption has accelerated after COVID-19 hit the whole world. This technology-aided type of interpreting is generally provided either over the phone or via a video system and can be used as an alternative to face-to-face interpreting when it is not feasible due to cost or time constraints. As a recently growing practice, remote interpreting services are used in various settings such as healthcare, legal, education, and business. Especially in the field of healthcare, where linguistic and cultural differences have become a distinctive and vital challenge in service provision (WHO, 2010, p.8-9), remote interpreting enables an efficient and low-cost opportunity for instant deployment of professional interpreters (Havelka, 2020, p.1). The language barriers can be addressed through remote interpreting services in healthcare settings since it provides services for patients who can't speak the language of the healthcare providers, especially in areas where an on-site interpreter is not available. As one of the modalities of remote interpreting, video remote interpreting (VRI) has emerged as a particularly promising option due to its ability to incorporate visual and auditory cues and it provides more information for efficient communication such as facial expressions and voice effects.

The use of video remote interpreting in healthcare settings and thereby the ongoing research are gradually increasing worldwide; however, its practice is yet to be available in the Turkish healthcare system. In this respect, a survey which was administered to healthcare interpreters in Türkiye after COVID-19 by Şan and Duru (2020) demonstrated that there was a demand stated by the interpreters for the endorsement of technological tools – in other words telephone and video

conferencing - in service provision, which would allow them to serve remotely. This study highlights that integrating the internet and video remote interpreting systems driven by advancing technologies into this country's healthcare system would lead to different achievements, also noting that the framework of professional competencies might need to be revisited, considering the requirements of these new tools. Thus, the non-availability of video remote interpreting services in the Turkish healthcare system brings about the need for relevant research to present the current national context with respect to the potential implementation of such a service that might be integrated into the system in the future.

Thus, the purpose of this research is first to find how video remote interpreting for different languages is provided in the top four exemplary countries where this type of interpreting is efficiently provided. Second, this study aims to investigate the expectations of interpreters, physicians, and foreign patients from the potential future implementation of video remote interpreting services in the Turkish healthcare system.

To this end, the data for this research will first be generated through a document analysis. In this vein, administrative documents such as legislation and other related documents of the countries performing good practices of video remote interpreting services having been provided in their healthcare system were reviewed and studied. Secondly, semi-structured in-depth interview questions have been directed to the physicians, foreign patients, and interpreters so as to investigate their expectations from video remote interpreting services, which may hopefully provide relevant information just in case such services may be planned to be integrated into the Turkish healthcare system in the future. Additionally, the research diaries to be kept by the researcher are also intended to facilitate a deeper insight into the situation, considering that "qualitative methods take the researcher's communication with the field and its members as an explicit part of knowledge instead of deeming it an intervening variable, unlike quantitative research" (Flick, 2009, p.16). The collected data has been analysed to inquire about current insights of the above-mentioned three group interlocutors on video remote interpreting services and their expectations from the potential implementation of such services in Türkiye in terms of their perceived ease of use, perceived usefulness, perceived affordances and intention to use. As a result, the suggestions to be drawn at the end of the research are expected to contribute to the possible establishment and

development of video-mediated remote interpreting services within the scope of the Turkish healthcare system. In this vein, the content of the thesis is given chapter by chapter below.

Chapter 1 of this study provides a general introduction and brief information on what this thesis aims to investigate. Related information will be presented in a more detailed way in the subsequent parts, namely problem situation, aim of the study, importance of the study, research questions, assumptions, limitations, and definitions of some important terms.

Chapter 2 is devoted to the literature review, which presents the current situation of remote interpreting and its sub-modality, video remote interpreting, on both the national and international levels. It also explains the relevant studies on video remote interpreting services. Lastly, it provides a general overview of video remote interpreting in healthcare services and how it is currently practised in the top four exemplary countries.

Chapter 3 sheds light on the theoretical framework of the study, focusing on Actor-Network Theory (ANT). First, it provides a general overview of ANT, outlining its key principles. Then, it explores the relevance and applicability of ANT within the field of Translation and Interpreting Studies, highlighting how this theory frames the methodology of this thesis.

Chapter 4 presents the methodology used in the study. The design of the study, participants, procedure, data collection instruments, and information on data analysis methods are provided.

Chapter 5 demonstrates the findings and discussion of the results of the data collected from the field, analysed through thematic analysis as a qualitative data analysis method.

Chapter 6 presents the conclusion of the study. Based on these conclusions, suggestions for further research are provided.

CHAPTER 1

This chapter provides a foundational framework for the study by outlining the problem situation, research aim and significance, research questions, and key conceptual definition. It also clarifies the study's assumptions and limitations, offering a comprehensive overview of the scope and direction of the research.

1.1 PROBLEM SITUATION

Developing technology, especially after the pandemic, is constantly observed to lead humankind to digital solutions while responding to their needs in recent years. In this regard, community services provided in different settings began to shift from in-person to remote in the era of digitalization. With its vital importance for human life, especially health services are highly affected by this shift, which was first taken as a temporary measure, but is becoming permanent day by day. Since health professionals and policymakers are recently searching for innovative service delivery models to ensure uninterrupted access to essential health services, especially for vulnerable groups, some countries have introduced remote interpreting practices at varying stages of implementation and development.

This practice also aims to help vulnerable population groups as target user, including linguistically and culturally diverse migrants and refugee populations to get access to healthcare services in an equitable manner; thus, avoiding the exacerbation of health inequalities.

Remote interpreting has been used in medical settings for those people with linguistic and cultural differences to meet their needs in seeking healthcare services. While this service traditionally was offered as telephone interpreting which relies on telephone connection between the interlocutors without no participant view, remote interpreting (RI) with an interpreter's virtual presence, named as video remote interpreting (VRI) recently gained prominence and emerged as a growing practice in the light of new digital solutions in health settings. This mode of interpreting in healthcare settings is available to provide solutions for doctor-patient interaction in hospitals and other healthcare settings (Braun, 2011, p.37).

In the past decade—particularly over the last four years with the impact of the COVID-19 pandemic—the use of remote interpreting, especially via video conferencing, has gained increasing attention in healthcare settings. While academic interest has predominantly emerged within medical studies focusing on disease management and the delivery of high-quality healthcare services, the interpreting dimension remains relatively underexplored. This study, therefore, addresses this gap by taking into account the interpreting dimension and contributing to the respective field in the utilization of technology-aided services in healthcare provision.

To better understand how such services could be integrated into the Turkish healthcare system, this research was designed to identify international good practices and to observe the needs and expectations within the local context through direct engagement with the potential users of such a system. Considering that video remote interpreting services are not described in the Turkish healthcare system and no available implementation exists, a document analysis, as the first data source of this research has been carried out to outline the good practices in the countries where remote interpreting services in their healthcare system are available. Afterwards, a user expectation survey was administered to physicians, foreign patients, and interpreters as potential users to investigate their expectations from video remote interpreting services that might be integrated into the Turkish healthcare system in the future. In addition to conducting the interviews with the above-mentioned three groups of interlocutors, the research diaries were also recorded for deeper insight into the situation. The collected data was analyzed to inquire about those three groups of interlocutors' current opinions on the concept of video remote interpreting services and their expectations from the potential implementation of the video remote interpreting services in Türkiye in terms of their perceived ease of use, perceived usefulness, perceived affordances, intention to use. The four key themes—perceived ease of use, perceived usefulness, perceived affordances, and intention to use—were initially inspired by the framework of Lazard et al. (2021) and served as the foundation for formulating the research questions; further details on their adaptation can be found under the 'Data Collection Tool' section.

As a result, the suggestions to be drawn at the end of the research are expected to contribute to the possible establishment and development of video-mediated remote interpreting services within the scope of the Turkish healthcare system.

1.2 AIM OF THE STUDY

This study, owing to its interdisciplinary nature, aims to review how remote interpreting for different languages in healthcare services is provided in the countries where this type of interpreting is efficiently provided.

The study also aims to inquire into the expectations of physicians, interpreters, and foreign patients from the potential implementation of remote interpreting services in Türkiye in the future, where no such practice is available yet for a linguistically and culturally diverse population in its healthcare system.

All related data would form a basis for some suggestions to be made at the end of the thesis to be proposed for the possible integration of VRI system into the healthcare system in Türkiye.

1.3 IMPORTANCE OF THE STUDY

Türkiye does not currently have any available video remote interpreting services in its capacity. Considering that excellent and efficient remote interpreting services are available in foreign countries in their healthcare systems, this study were carried out to develop an understanding of how the most appropriate systems have been established in the concerned countries and also the vision that will pave the way to a possible decision to establish a VRI system.

Considering that a video remote interpreting service is not described in the Turkish healthcare system and that no available implementation exists, this research will provide a platform for the potential users (physicians, interpreters, and foreign patients) to offer feedback and opinions about the possible integration of such services into the Turkish healthcare system. It reveals the current opinions on the concept of video remote interpreting services and their expectations from the potential implementation of video remote interpreting services in Türkiye regarding their perceived ease of use, perceived usefulness, perceived affordances, and intention to use.

Ultimately, the findings of this research are expected to play a pivotal role in the possible establishment and development of video-mediated remote interpreting services, potentially improving the healthcare services provided in Türkiye.

1.4. RESEARCH QUESTIONS

The research questions of this research are presented below:

1. How do the exemplary countries perform video remote interpreting services in their healthcare system in light of their available administrative documents?
 - a- Legislation and regulations
 - b- Practice
2. What are the expectations of interpreters, physicians, and foreign patients from the potential implementation of the video remote interpreting services in the Turkish healthcare system in terms of the following factors:
 - a- perceived ease of use
 - b- perceived usefulness
 - c- perceived affordances
 - d- intention to use
3. What sort of a systematic structure can be the best possible example to provide a VRI service in the Turkish healthcare context?

1.5. DEFINITIONS

The definitions presented below were used to designate the framework of concepts adhered to in the study for the purposes of this research, to avoid confusion.

- (1) Ease of use (Kullanım kolaylığı): The degree to which a new video remote interpreting tool/system which resulted in adopting a process into the existing healthcare system can be utilized effortlessly and intuitively without requiring extensive effort.
- (2) Usefulness (Yararlılık): The extent to which a new video remote interpreting tool/system effectively enables users to achieve their goals or fulfill specific needs.
- (3) Perceived affordances (Uygunluk): The qualities or features of a new video remote interpreting tool/system that suggest or enable specific actions, as interpreted by users based on their prior experience and expectations.

- (4) Intention to use (Kullanma isteği): The possible user's deliberate willingness to adopt and engage with a new video remote interpreting tool/system as a new technology in the future while providing or receiving health care services.

1.6. ASSUMPTION

- The respondents are assumed to respond to the questions raised during the interviews sincerely.

1.7. LIMITATIONS

- The conclusion drawn from this research is limited first to the data gathered from publicly accessible institutional information extracted from the respective legislation and regulation and secondly to the results of the user expectation survey administered to physicians, interpreters and foreign patients along with the research diaries recorded by the researcher.
- Findings are based on data collected from physicians and interpreters working in a single private hospital, as well as patients who received services there. The responses may have been shaped by the specific service conditions and working environment of the hospital, which could limit the generalizability of the results to other healthcare settings.
- Target users: This research sample only includes people with limited language proficiency. The services provided for the deaf and hard of hearing or people with speech impairments are not included within the scope of this research data collection process.

CHAPTER 2

LITERATURE REVIEW

This chapter focuses on the literature review of the study. Basic information on remote interpreting is presented along with its modalities which are telephone interpreting and video remote interpreting in the first part. This section also addresses the practices and research on video remote interpreting at both international and national levels along with its relevant studies in the related literature. The second part provides a general overview of video remote interpreting services and sheds light on the video remote interpreting services provided in the healthcare systems of the top four exemplary countries, along with their respective administrative and legislative documents.

2.1. REMOTE INTERPRETING

Technological developments and societal changes lead people to find alternative solutions to overcome the language barriers experienced in communication. To keep pace with those developments, distance interpreting emerged and was defined as information and communication technology (ICT) enabled interpreting of a distant speaker at a certain event by the International Association of Conference Interpreters (AIIC, n.d).

Remote Interpreting is used to ``gain access to an interpreter in another site in virtual settings at which the primary participants themselves are distributed across different sites`` (Braun, 2015, p.364). The practice of remote interpreting can be carried out in different forms, such as simultaneous, consecutive, and dialogue interpreting, as well as in the form of spoken or sign language interpreting.

Paneth (1957, as cited in Braun, 2015) noted the first reference to remote interpreting in 1957 and described the practice “as a neat and obvious use of interpreters”. Despite the fact that remote interpreting practice was considered controversial at first mainly due to the reduced sensory input available to interpreters working in this modality (AIIC, n.d), its practice gradually increased, especially after the restrictions imposed after COVID-19 which is an ongoing global pandemic which keeps this ICT-enabled interpreting type as an attractive option for service delivery and a growth area in the market.

The varied use of ICT-based solutions under the general category of distance interpreting has led to the emergence of different interpreting modalities in response to evolving market demands in recent years. Previously, distance interpreting was considered an umbrella term encompassing various technology-mediated interpreting types, including remote interpreting. For instance, ISO Standard 20108 (2017) defined distance interpreting as “interpreting of a speaker in a different location from that of the interpreter, enabled by information and communications technology,” positioning remote interpreting as a subcategory. However, with the publication of the updated ISO 2024 standard, this distinction has been revised, and remote interpreting is now considered synonymous with distance interpreting, reflecting the increasing convergence of terminology in professional practice. In the revised version (2024), it is defined as “interpreting of a speaker or signer in a different location from that of the interpreter enabled by information and communications technology,” thereby explicitly including sign language users in the definition. This terminological shift signals a broader recognition of remote interpreting as a fundamental component of modern language access services, inclusive of both spoken and signed language modalities.

Previously, the terminology used in the field of distance interpreting exhibited considerable variation, largely due to the existence of numerous categories and modalities within the domain. This lack of uniformity often led to inconsistencies in both academic and professional discourse. For example, Krasnopeyeva (2021) analyzed the taxonomy and terminology associated with distance interpreting and its sub-modalities, revealing that in both her working language (Russian) and in English, the terminology was highly diverse and lacked conceptual stability (p. 143). This finding reflects the broader challenges the field faced in achieving terminological clarity prior to more recent standardization efforts.

As this form of interpreting has evolved alongside technological advancements, it has often been referred to as technology-mediated interpreting. In parallel with the development of the field, the categorization and terminology used to describe such practices have also undergone significant changes over time. This ongoing evolution has resulted in the use of varied terms across academic and professional literature, reflecting efforts to capture the expanding scope and complexity of the practice. A range of examples drawn from existing publications can illustrate how this

terminological diversity has emerged and shifted throughout the years. As a remarkable scholar, Sabine Braun has studied remote interpreting for nearly two decades. Her work has significantly contributed to the development of this area as she has conducted many studies and published relevant articles, research papers, and a book that sheds light on this field, mainly focusing on remote interpreting in criminal proceedings. Braun and Taylor (2011), in their article where they present an overview of practices and research on this type of interpreting in legal proceedings, utilize two different terms with a distinction of the interpreters being positioned in different locations as “Videoconference Interpreting (VCI)” and “Remote Interpreting” (RI) were explained; moreover, they introduced the term “video-mediated interpreting” as an umbrella term to cover all those varying forms of interpreting. According to their definition, - the first term – videoconference interpreting refers to the form of interpreting in which the interaction takes place at two video-linked locations with the interpreter being situated at either end of this video link, while the latter – remote interpreting, refers to the form of interpreting in which the interaction takes place at a single location, like a courtroom; however, the interpreter provides interpretation via video link from a remote location such as another courthouse (ibid, p.34).

In line with this distinction, videoconference interpreting involves the use of a video link to facilitate communication between geographically separated parties, whereas remote interpreting refers specifically to the use of technology for “the sole purpose of linking a legal interpreter to the proceedings” (ibid., p. 41).

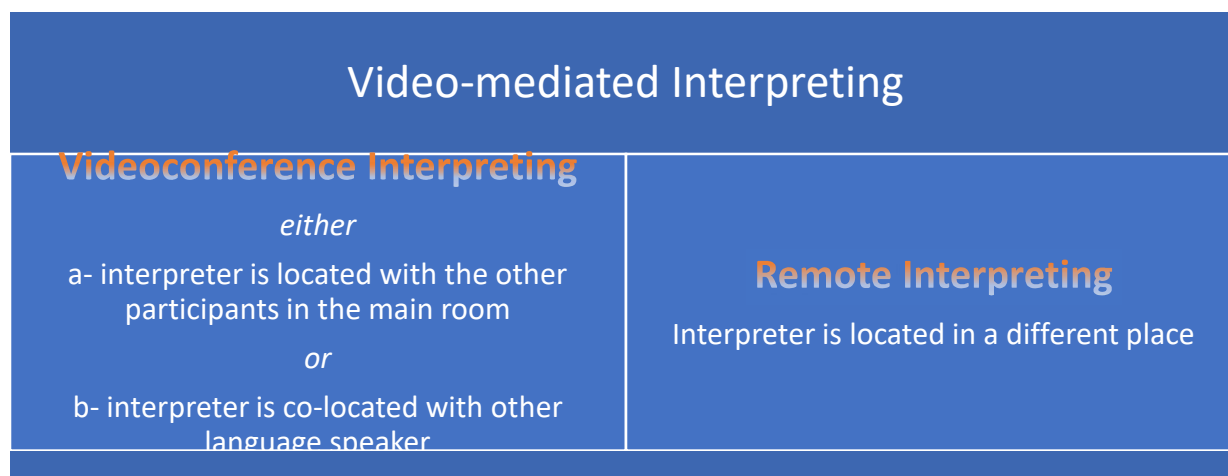


Figure 1: Braun and Taylor's initial terminology use in their study titled "Video-mediated interpreting: an overview of current practice and research: Videoconference and remote interpreting in criminal proceedings" published in 2012

In 2015, Braun explains key terms and concepts, specifically related to remote interpreting in her related article. In her work, she defines remote interpreting as below (2015, p.364):

"...remote interpreting (RI), refers to the use of communication technologies to gain access to an interpreter in another room, building, town, city or country. In this setting, a telephone line or videoconference link is used to connect the interpreter to the primary participants, who are together at one site.

Braun classifies remote interpreting into two primary modalities: telephone-based and videoconference-based interpreting. In both cases, the main objective is to connect the interpreter with the primary interlocutors, who are typically co-located at a single site (ibid). In this work, Braun also acknowledges the ongoing ambiguity in the terminology used within the field. To address this, she proposes the use of two cover terms: telephone-based interpreting, referring to remote interpreting conducted via telephone or interpreter-mediated phone calls; and videoconference-based interpreting, referring to remote interpreting delivered through videoconferencing platforms or interpreter-mediated video interactions. The figure below presents alternative terminology that is often used interchangeably with these two overarching categories.

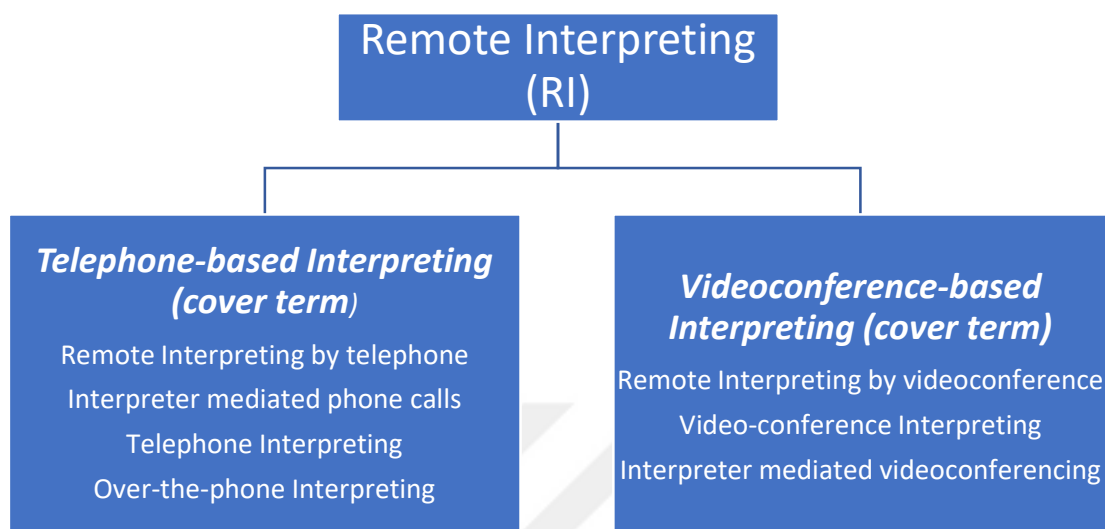


Figure 2 : Braun's classification for remote interpreting and different terminology use in her study published in 2015

Braun further distinguishes teleconference interpreting as a separate modality from remote interpreting, defining it as a three-way (multi-point) communication setup in which each participant—including the interpreter—connects from a different location via telephone or videoconference link. What sets teleconference interpreting apart from remote interpreting is the spatial distribution of the participants. Unlike remote interpreting, where the primary interlocutors are typically co-located and only the interpreter is remote, in teleconference interpreting all parties are geographically dispersed. As Braun emphasizes, the two modalities are not interchangeable due to this key structural difference (see the below figure).

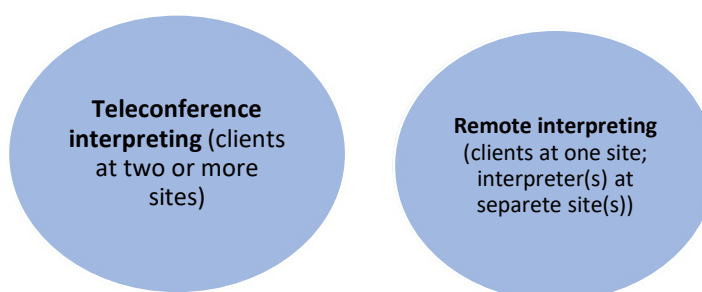


Figure 3: Participant distribution of location for teleconference interpreting and remote interpreting

Further elaborating on terminology use, Braun (2019, p. 272), in her contribution to the Handbook of Translation and Technology, presents an updated framework illustrating the various terms applied to different technological configurations and participant location settings in interpreting. She notes that while the modalities of technology-mediated interpreting—also referred to as distance interpreting—are not yet standardized, the term distance interpreting continues to function as an umbrella concept encompassing all such modalities. In her classification, Braun organizes these modalities based on the communication technology employed (e.g., telephone, videoconference) as well as the physical distribution of participants and interpreters (ibid). This approach aligns with her earlier work and reinforces the idea that spatial configuration remains a primary factor in the categorization of technology-mediated interpreting practices (see below figure).

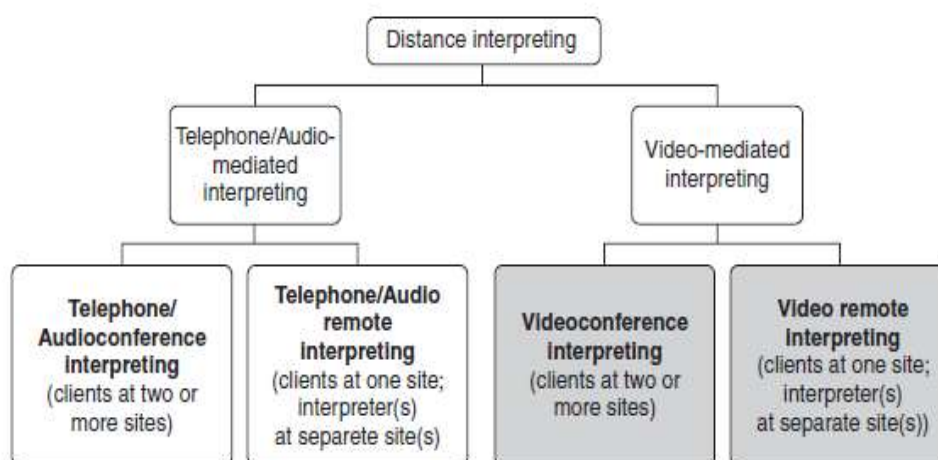


Figure 4: Braun’s finalized (improved) categorization on the modalities of distance /technology mediated interpreting published in 2019

Building on her theoretical contributions to the field, Braun has also played a pivotal role in applied research and implementation. She notably served as a lead researcher in the Assessment of Video-Mediated Interpreting in the Criminal Justice System (AVIDICUS) projects, which were completed in three phases in 2008-2016 and tremendously contributed to video-mediated interpreting services provided in the legal settings and a more detailed and the most up-to-date classification (see below figure) is presented in Project’s official website (AVIDICUS, n.d).

Classification – by medium of communication

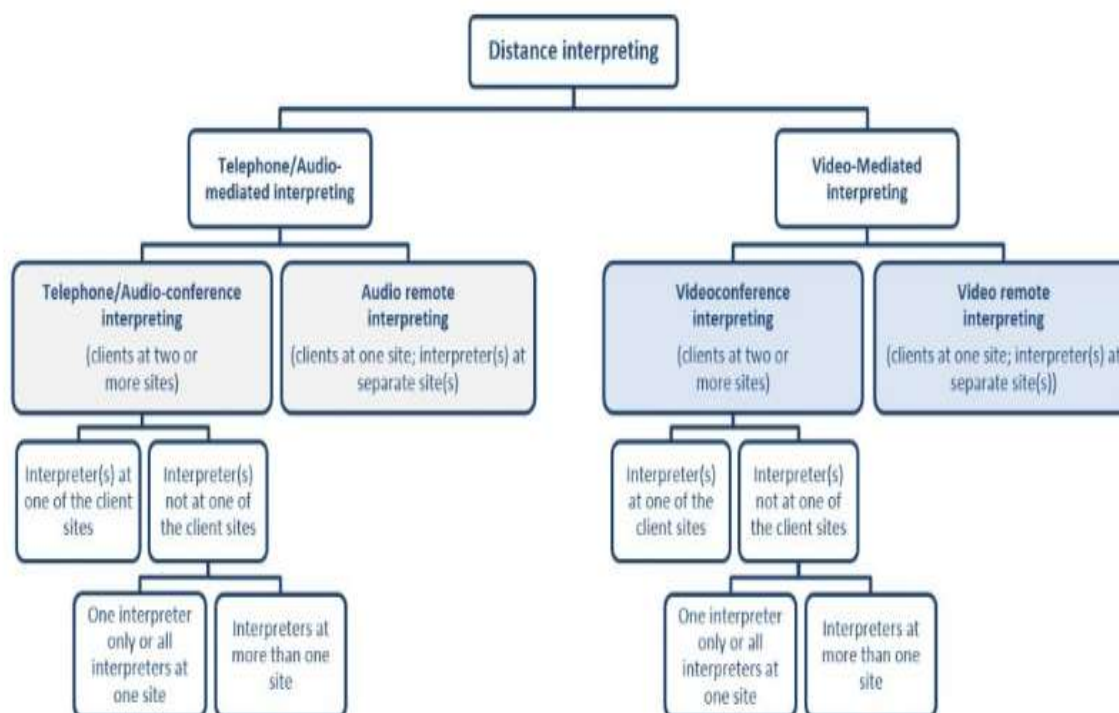


Figure 5: The up-to-date classification presented in the official website of AVIDICUS projects (currently available in 2025)

In addition to the typologies discussed above, the International Association of Conference Interpreters (AIIC) presents a classification of interpreting modalities that was formally adopted at the AIIC Assembly in 2015. The figure below has been extracted from AIIC's official website and illustrates this classification. The typology is structured according to two main criteria: whether the participants are in direct or indirect visual contact, and the physical location of the interpreter or interpreting team.

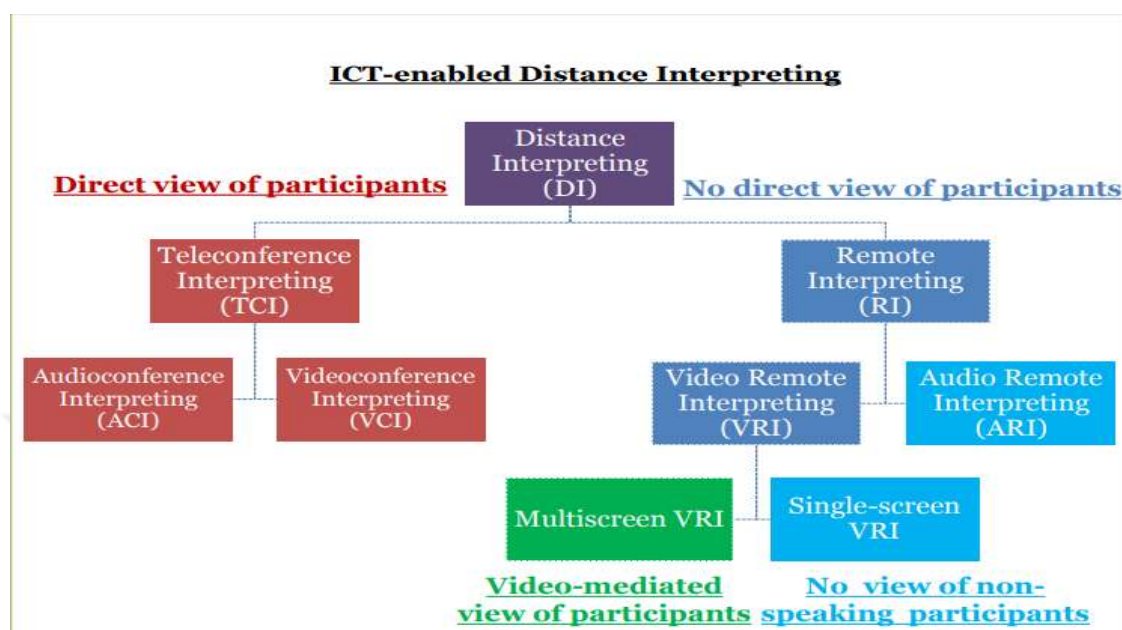


Figure 6: The classification presented by AIIC in the official website, accepted AIIC 2015 Assembly during the Debate on Remote Interpreting

In addition to the historical development of terminology—which simultaneously offers insight into the evolution of the remote interpreting field—English definitions and their corresponding English–Turkish translations are provided in Appendix 8: Glossary to further clarify the terminology discussed throughout this chapter. Additionally, this study adopts the classification proposed by the International Association of Conference Interpreters (AIIC), a leading professional body in the field, which presents an up-to-date typology aligned with current market trends and service demands. Accordingly, all headings and subheadings in this chapter have been structured based on this classification.

To better understand the origins and institutional authority behind the adopted classification, it is essential to briefly introduce the role and structure of the International Association of Conference Interpreters (AIIC).

The International Association of Conference Interpreters (AIIC) was founded in 1953 as a global association of conference interpreters to ensure service quality, professional ethics, and working conditions protecting the interpreter's health and well-being. The Association comprises numerous

committees and working groups focusing on various topics, from technical and health issues to research and training, all of which are administered by volunteer members. According to AIIC, Remote Interpreting, which is classified under ICT-enabled interpreting services, can be distinguished from other modalities by the lack of direct visual contact between the interlocutors involved in the interpreting process.

AIIC had committed itself to the developments in this field and raised its concerns about remote interpreting solutions to protect the particular interests of the interpreters, like working conditions and well-being at a certain level, and promote high standards of quality before the pandemic, which hit the whole world at the end of 2019 and made humankind locked to their homes. To this end, AIIC published "AIIC Position on Distance Interpreting (DI)" in 2018 to emphasize that Information and Communications Technology (ICT) leads to the emergence of new interpreting modalities and its intertwining with conference interpreting might have negative implications on the multilingual communicative process as a whole (AIIC, 2018a, p.1). This position paper also refers to the importance of all ISO standards relating to conference interpreting, interpreting equipment, and sound and image input to interpreters, indicating the requirement of all Distance Interpreting modalities to meet not only the applicable requirements of those standards but also the Association's technical specifications (ibid, p.2). This paper is of great value in presenting the Association's rigorous stance towards Distance interpreting modalities since it also refers to AIIC Task Force on Distance Interpreting (n.d.), which conducted AIIC's first Distance Interpreting Survey in January 2018.

This first AIIC survey on the use of 4 types of DI, namely Videoconference, Audioconference, Video Remote, and Audio Remote Interpreting, aimed to map the landscape and have a better understanding of the types and frequency of distance interpreting modalities used by members. Report on Survey concludes above-listed four distance interpreting modalities under scrutiny are somewhat different not only from a technical point of view but also their frequency of use and their implementation channels are not same; therefore, these differences need to be acknowledged, and the discussion should take place on working conditions governing different distance Interpreting modalities (AIIC, 2018b, p.43). At the end of the report, the survey calls for additional systematic research into the cognitive ergonomics of distance interpreting modalities to establish

minimum standards and best practices, keeping in mind the increase in the frequency of use across all modalities inquired under Distance Interpreting in this survey.

Upon changing realities, the association has released a new position paper dated 15 April 2020 referring to DI from home, which had to be welcomed by the whole world due to contamination risk for holding in-person meetings due to COVID-19. In this position paper, AIIC presented recommendations specific to the COVID-19 scenario regarding new working conditions, remuneration, and the use of remote simultaneous interpreting equipment.

The difference in AIIC's stance towards distance interpreting modalities can be clearly observed in two different position papers released by AIIC, respectively, in 2018 and 2020. While the first states that "AIIC has always supported face-to-face interpreting scenarios (technology, mode, and working conditions) that underpin interpretation quality and interpreter well-being" (AIIC, 2018a, p.1), the latter indicates "modalities of work with interpreters located together should always be preferred over work from home" (AIIC, 2020a, p.2) as a result of association's acknowledgment of evolving conditions, especially after COVID-19 which leaves no other alternative scenario.

Acknowledging the seismic shift to technology-mediated interpreting modalities, AIIC has set up the Taskforce on Distance Interpreting (TFDI) as a focal point for the association on all matters about the communication solutions provided by distance, with its consultative and coordinating functions. TFDI leads AIIC's response to the new paradigm in collaboration with other AIIC groups, while its primary responsibilities include gathering evidence-based information for the practice of various distance interpreting forms, articulating the association's position, and providing guidance and guidelines for its members in their efforts in various DI modalities for keeping pace with the developments in the field (AIIC, n.d).

The Taskforce presents itself as a consultative, coordinating, research, awareness-raising, and outreach body of the association. In its consultative capacity, the TFDI equips its members and groups with related advice and assistance and feeds AIIC's Executive Committee on policy decisions concerning technical, physiological, psychological, and practical aspects of distance interpreting modalities (ibid).

As to its coordination role, the TFDI is made up of representatives of different groups, which include all interpreters (freelance, consultant, staff), its working group on the International Organization for Standardization, the Training and Professional Development Committee, the Sign Language Network, the Advisory Board, its Executive Committee, the Research Committee (RC) and the Technical and Health Committee (THC). TFDI aims to coordinate DI activities with those groups, mainly hand in hand with the last two indicated groups (ibid).

In its research capacity, the TFDI has carried out innovative research in the field of DI, which was an association-wide online survey on the frequency of use of different distance interpreting modalities in early 2018. The results of the survey are explained in the related chapter of this research, in which all relevant studies are presented in the field of video remote interpreting. The force also expresses that further research is also needed into its impacts in real-life situations, mainly with a focus on the service quality, health, and well-being of interpreters (ibid).

Lastly, the TFDI is responsible for raising awareness and advocating for its members at DI-interpreting-related workshops, conferences, and other international activities. It is of the essence for the TFDI to engage with members on DI issues to provide them with the necessary toolkit just before they accept the offers or negotiate with employer organizations. It adheres to AIIC's core values of teamwork, interpretation service quality, interpreter well-being, and a consolidated commitment to promoting multilingualism (ibid).

Despite the fact that AIIC acknowledges, through its research component, further guidelines and recommendations are to be developed after carrying out further research on the field, the AIIC Taskforce on Distance Interpreting published "AIIC Guidelines for Distance Interpreting" in 2019. It updated it in March 2020 to reflect the new impacts of COVID-19 on the field. The guideline clearly states its primary purpose: to define "minimum standards and best practice recommendations applicable to working conditions for video remote conference interpreting in simultaneous mode" (AIIC, 2020b, p.2). Therefore, it should be noted that this guideline does not provide any information for any technology-mediated interpreting modality if there is no transmission of images of speakers and/or audience to the interpreter, such as telephone calls or audio conferences. AIIC aims to take a position to accompany the development of Distance

Interpreting on the world markets by providing input in shaping up-to-date requirements and recommendations in the provision of conference interpreting services in remote settings through these guidelines (ibid, p.1). The guidelines give detailed coverage of the topics related to working conditions and minimum standards such as location, presence of technician, interpreter access to software along with the relevant documents, confidentiality, data protection, briefing, the requirement of a language disclaimer added to the web streamed and/or archived recording, intercommunication, screens and microphone management and technical requirements, image quality and latency.

Distance interpreting modalities can be used for different underlying motivations, with their advantages and disadvantages. On the upside, first and foremost, it helps to provide low-cost remote interpreting services since all parties are not required to be physically in attendance, which puts budgetary constraints out of the way, such as accommodation and transportation expenses for the interpreter. It also speeds up the process due to the fact that professional interpreters' instant deployment is possible, and more to the point whenever they are needed urgently (Havelka, 2020; Devaux, 2017). Devaux (2017, p. ix), in her dissertation on technology-mediated interpreting in criminal court hearings, highlights that these remote solutions also enhance the security of interpreter-mediated communication. On the downside, the use of remote interpreting raises questions about interpreting quality, communication dynamics, training, and skills required for remote interpreters compared to onsite/face-to-face interpreting. Additionally, deterioration of working conditions along with remuneration is among the debatable issues. As a form of interpreting practiced in the encounters where public services are provided, remote interpreting also leaves a question mark on minds regarding equal access to public services such as healthcare and justice (Russo et al., 2020, p.235).

Interpreters mediate communication in various settings which also requires remote interpreting modalities. Remote interpreters are also in great demand across public services, which results in them mainly providing community interpreting services, in other words. Typical settings they provide services are healthcare (medical consultation, hospitals, medical centers, any setting where a health consultation is needed), legal (law-enforcement agencies, police stations, detention centers, courts, hotspots for refugees), social and education (social service centers, schools, online

training sessions) and other settings (operations connected to emergency hotlines, administrative and public sector offices, tourism and entertainment, insurance companies, banks) (Russo, 2018, p.50). That all-inclusive range for work settings makes remote interpreting an overarching interpreting modality used across all fields, such as dialogue, conference, media, and especially health and legal. Moreover, it should be acknowledged that there is a growing demand for remote interpreting in legal, healthcare, business, and educational settings, and both methods are used to deliver spoken and sign-language interpreting alike (Braun, 2015, p.2).

As explained in detail in the above paragraphs, focusing on classification and terminology used, Remote Interpreting (RI), as an ICT-enabled interpreting of a distant speaker, has two types of interpreting - audio (telephone) and video remote interpreting. While their similarity is the remote location of the interpreter, the difference between them is the availability of a video-mediated view of the speaker for the interpreter in the latter one, while the interpreter does not have a view of the speaker or any other participants (AIIC, n.d).

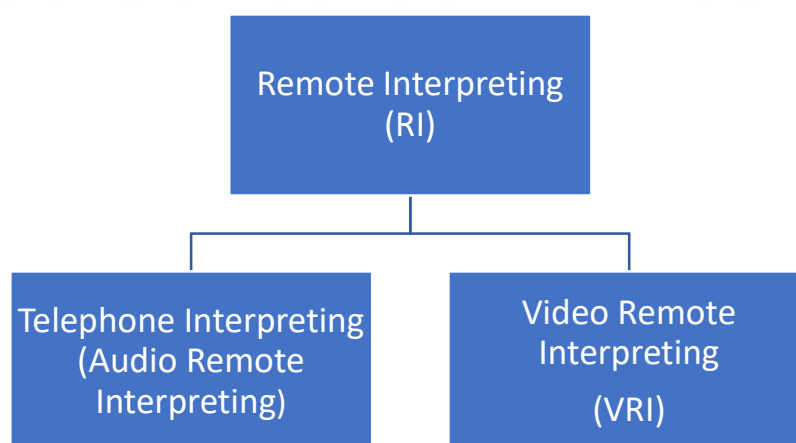


Figure 7: Types of Remote Interpreting (RI)

Based on this classification, the following sections will provide a more detailed examination of each mode of remote interpreting, exploring their specific characteristics, use cases, and implications within healthcare settings, beginning with an analysis of telephone interpreting.

2.1.1. Telephone Interpreting (TI)

As a basic definition, telephone interpreting is the modality of remote interpreting whereby the interpreters are connected to some or all participants by an audio link/telephone (Russo et al., 2020, p.235). Telephone interpreting was first introduced in 1973 as free of charge by the Immigration Department in Australia to respond to the increasing need for communication in other languages due to waves of immigrants coming to the country (Kelly, 2008, p.5). In the USA, telephone interpreting was first initiated in 1981 by a young police officer in collaboration with his colleague from the Defense Language Institute to establish an organization -Language Line Services- to overcome language barriers, only as a charity organization. However, it quickly expanded beyond police clients into other markets, like health care, and was transformed into a for-profit organization. (ibid, p.5). For decades, telephone interpreting brought people with different language backgrounds the ability to communicate with each other; therefore, the services reached an even larger group. However, phone call costs were high in some countries, and long-distance calls were expensive, which resulted in relatively slow growth and innovation in TI until the mid-1990s, when people shifted to using mobile telephony rather than landlines. As a result of this big revolution, this led to a price decrease particular in fixed-line telephony, with the effect of greater capacity of new technologies, as well. This shift has liberated telephone interpreting from its obligatorily local and expensive use, and it lifted the confines of local networks and opened a new door for the practice of TI (Ozolins, 2011, p.34).

Looking at the relevant research on telephone interpreting, Fernández and Russo (2020) draw a multidisciplinary theoretical and methodological framework for the study of telephone interpreting in their article published in 2020. The authors discuss the relevance of telephone interpreting components with, respectively, Ethnography of Communication, Conversation Analysis, Prosody, and Phonetics, with the aim of their contribution to a more comprehensive approach to the study and training of telephone interpreting.

The Handbook of Remote Interpreting allocates a chapter focused on telephone interpreting and presents descriptive articles on telephone interpreting and its comparison with traditional methods. The first study published by Rodriguez (2018) explains the essential components of telephone

interpreting and the differences between telephone and face-to-face interaction, the classification of telephone interactions, the cultural aspects of phone calls, and the impacts of information and communication technologies on telephone interaction. The second study explains the figurations for participants' location in telephone interpreting, sound quality, equipment, and system design, and communication management. It guides readers about the steps to be taken pre-/during/post telephone interpreting sessions. In the last study presented under this TI-specific interpreting section, Amato (2018) introduces the challenges and solutions through some paradigmatic examples.

A comparative study conducted by Wang and Fang (2019) aims to compare the accuracy of interpreting performance in telephone and on-site interpreting through 3 simulated tasks; one is on-site while the others are telephone interpreting. According to the results, interpreters' performance was found to be accurate in all three tasks, and the study identified the potential reasons behind the accurate and inaccurate interpretations.

Another study (Wang, 2018) investigates the interpreter's perspective on the suitability, remuneration, and quality of telephone interpreting and reports the findings from a survey conducted with 465 telephone interpreters. The study does not reveal optimistic results for the use of telephone interpreting. The interpreters reported serious problems, such as its use in inappropriate situations, and dissatisfaction resulting from the low remuneration for telephone interpreting; therefore, many interpreters declared a higher interest in providing on-site interpreting services, not telephone interpreting. In addition, the interpreters contributed to the study with their opinions regarding how the quality of telephone interpreting can be enhanced and highlighted that those interpreters, service receivers, and interpreter employers must work together to improve the service.

With a solid foundation of academic research in place, it is essential to consider the results and perspectives if any policy development is at stake. However, recent technological advancements led to a tremendous transformation in the modality of remote interpreting, and the power of video communication also revolutionized the field. Integration of video technology into remote

interpreting opened a new era and provided real-time interpretation services from a distance; however, sustaining the essence of face-to-face interaction.

2.1.2. Video Remote Interpreting (VRI)

The International Telecommunication Union (ITU) defines video remote interpreting (VRI) in a technical paper published in 2020 as follows (ITU, 2020, p. 3):

“A system or service that provides a remote sign language interpretation between a sign language user and a hearing person using a telecommunication means”

ISO Standard 20108 defines VRI as “(a type of) interpreting delivered from a different location than that of the speaker and the audience, enabled by information and communications technology (ICT), with sound and image from speakers being transmitted to interpreters”.

It has unique main characteristics that differ from other modalities of distance interpreting. First of all, the interpreter has no in-person view of the speaker and the audience; in the same vein, the location of the interpreter is different from the other interlocutors engaged in interpreter-mediated communication. Furthermore, such visual input as the view of the speaker, audience, and visual material available for the audience is shown to interpreters on one or several screens (ISO, 2017). This provides an advantage to see the facial expressions, which is one of the fundamental elements of effective communication, contrary to telephone interpreting.

According to the AIIC definitions and diagram released on its website, if the interpreter has only a video-mediated view of the speaker but not the view of other participants, this type is called single-screen video remote interpreting, while it is called multiscreen video remote interpreting if s/he has not only the view of the speaker but also some or all of the other speakers.

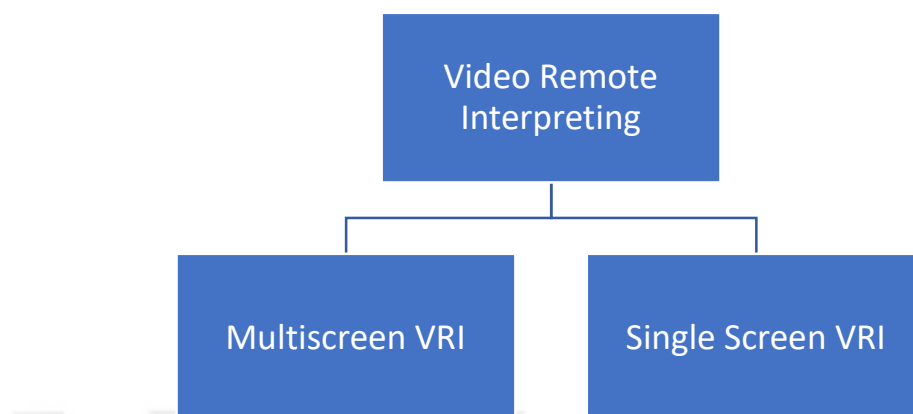


Figure 8: Types of Video Remote Interpreting (VRI)

Video remote interpreting has gained prominence since it offers many advantages over traditional on-site interpreting methods to overcome its limitations. It provides substantial flexibility and overcomes the limitations of service provision as a qualified interpreter can be accessed from various locations, reduces costs such as travel and logistics, and enhance accessibility through a range of devices such as tablets, computer, or even phone.

2.1.2.1. Video Remote Interpreting (VRI) in the World

Keeping pace with technological advancements, the number of VRI practices increases to address language barriers and facilitate effective communication between interlocutors in those settings worldwide.

The earliest documented experiment on video remote interpreting was carried out by UNESCO in 1976 to test the use of the Symphonie satellite. The experiment linked the UNESCO headquarters in Paris with a conference hub in Nairobi, with the interpreters in Paris. Similar experiments were also carried out by the United Nations in the 1970s-1980s (University of Surrey, n.d).

As ISDN-based (Integrated Services Digital Network) video conferencing was first in place in the 1990s, a video telephony experiment by the European Telecommunications Standards Institute was carried out in 1993, and the International Telecommunications Union organized a collaborative study with École de Traduction et Interprétation in 1999 to assess human factors such as psychological aspects. The latter study found that the interpreters' performance in video remote interpreting was reduced faster than their on-site performance. Moreover, the European Parliament

(EP) conducted a similar study in 2004, and its results presented no significant differences between video remote interpreting practice and on-site performance (ibid. and Şengel, 2022, p.175).

Remote interpreting was introduced in the 1980s; however, this has gradually been replaced by video remote interpreting since it ensures that interpreters have more visually supportive inputs, such as the screen of other interlocutors and any additional materials. Video remote interpreting (VRI) has begun to be widely practiced in various public service settings, including healthcare, legal, and business, along with meetings held by international organizations.

Looking at the practices in the legal settings, the first well-known example of VRI in legal settings was a central video interpreting hub introduced by the 9th Judicial Circuit Court of Florida in 2007 (the University of Surrey, n.d). The location of the interpreters working in the hub is configured to allow a combination of consecutive and simultaneous interpreting. The Florida courts (n.d.) define themselves as a leader in applying this technology and state that the courts were able to bridge the geographical divide between people in need of access to services and qualified interpreters. Similarly, the Metropolitan Police Service in London introduced the practice of video remote interpreting in 2011. It established centralized hubs linked to London police stations and consisted of interpreters working in consecutive mode (the University of Surrey, n.d).

More importantly, the Article 7.6 under the European “Directive on the right to interpretation and translation in criminal proceedings (2010/64/EU)” released in 2010 explicitly states that:

“Where appropriate, communication technology such as videoconferencing, telephone or the Internet may be used, unless the physical presence of the interpreter is required in order to safeguard the fairness of the proceedings.”

The first academic studies on VRI in the legal settings were conducted under the scope of AVIDICUS (Assessment of Video-Mediated Interpreting in the Criminal Justice System) Projects, 2008-2016, with the financial support provided from the European Commission’s Directorate-General for Justice (see Relevant Studies section for detailed information). Those projects formed the basis for adopting the related legislation on video remote interpreting practice in legal settings.

Remote Interpreting Guide for Courts and Court Staff was released in 2014 by the National Center for State Courts in the USA, and it presents basic information on definitions, how it works, minimum technology requirements such as video screen, video camera, endpoint bandwidth, computer, software, quality of service, etc. Moreover, the California Federation of Interpreters released the “Video Remote Interpreting Position Statement” in 2013 on the grounds of the notification of the United States Department of Justice to all state courts about their obligation to provide meaningful access to all court users regardless of their language abilities. Considering California state courts provide service to the largest number of people with limited English proficiency nationwide, it is reasonable to conclude that VRI, when used appropriately, can expand language access in the courts despite the Federation’s concerns.

Video remote interpreting practices play an essential role in ensuring equal access to justice when a person accused or suspected of a crime is engaged in criminal proceedings in which a foreign language is spoken and needs to get informed about their rights. By the same token, its practice in healthcare settings is of vital importance to deliver quality care and address the health inequalities resulting from linguistic and cultural diversities.

Masland et al. (2010) state that poor communication resulting from limited language proficiency might cause lower patient use of preventive care, misdiagnosis, increased testing, low medication adherence, and increased hospital and emergency room admissions. They present relevant data in their publication to document the use of telephone and video interpretation solutions to improve healthcare communication with persons with limited English proficiency.

It is unfortunate that there is no EU directive or legislative reference in EU resources regarding access to remote language services provided in healthcare settings, as it is available for those provided in legal settings. In the USA, even though (video) remote interpreting had been practiced even before, the sudden rise of technology-mediated interpreting solutions with COVID-19 was inevitable, especially in healthcare settings. To this end, numerous civil society organizations put an intensive effort in place and began to present several resources for language access during COVID-19. National Council on Interpreting in Health Care (NCIHC, n.d.) explicitly indicates its effort to ensure healthcare interpreters’ safety during the pandemic and presents a list on its official

website. The best practice guidelines provided step-by-step guidance on connecting qualified interpreters during healthcare access through a remote channel. All those resources and guidelines have built a solid foundation for video remote interpreting practices. For example, “Providing Interpreting Services During COVID-19” was collectively prepared by the National Council on Interpreting in Health Care (NCIHC), Association of Language Companies (ALC), American Translators Association (ATA), Certification Commission for Healthcare Interpreters (CCHI), California Healthcare Interpreting Association (CHIA), CoPTIC America (an advocacy organization), and Interpret America. Moreover, some countries have their country-specific legislative documents for video remote interpreting practice, and the details can be found in the relevant section on exemplary countries.

Even though it is not widely practiced, video remote interpreting is also used in business and education settings purposes, such as training staff and capacity building. It eliminates language barriers, resulting in practical learning skills.

In summary, there is an increase in the use of video remote interpreting in various settings where people need access to public services worldwide. As further research is conducted on the practice of video remote interpreting, the continued improvement will help to shape more country-specific guidelines and result in the adoption of respective legislations.

2.1.2.2. Video Remote Interpreting (VRI) in Türkiye

Despite the growing significance of healthcare interpreting services in Türkiye, driven by the increasing number of international patients seeking treatments such as organ transplantation, infertility procedures, or wellness-related care (Toker, 2019, p. 23), video remote interpreting has not yet been integrated into the national healthcare system. Research on the use of VRI in the Turkish healthcare context also remains scarce, limiting the available knowledge on its potential implementation and impact. In light of this gap, the following section reviews the limited academic studies that have addressed related themes within the Turkish context.

Okuyan and Şahin (2019) conducted a survey-based study on remote interpreting technologies. This study aims to reveal the perspectives and expectations of interpreting market representatives

on remote interpreting practice through the administration of a questionnaire to 34 companies, members of the Turkish Association of Translation Companies. According to the survey results, the representatives stated that their lowest level workload belongs to remote interpreting, with the respective percentages of 18% for simultaneous interpreting and 10% for consecutive interpreting. However, the representatives highlighted that it is a promising modality in light of the technological developments, and they would be better prepared for the required setup to respond to this need. To this end, integrating remote interpreting modalities into the training curriculum was seen as a must, considering its high potential to be improved and exponentially increase practices.

Referring to the above study, Şahin (2022) published a script to explain her experiences with remote interpreting as a freelance interpreter. She recommends that Skype provides more advantages than Zoom since the user is not limited to 40 minutes. She adds that the lack of physical presence of the interpreter may cause the concurrence of speeches, blinking the fact that an interpreter is putting a cognitive effort behind. As another advantage, she states that note-taking during an online meeting requires less effort since the speakers constantly repeat themselves due to the lack of affirmative facial expressions such as nodding. The author also highlights the requirement to download up-to-date versions of relevant applications such as Zoom and Skype Lite, indicating that the availability of a high-speed internet connection is a must. In conclusion, she recommends the integration of lectures on remote interpreting into the current curriculum, as it has been done for the 2021-2022 academic year at the Sakarya University Department of Translation and Interpreting.

Şan and Duru (2020) focus on how healthcare & community interpreting services are provided under COVID-19 conditions by administering a questionnaire to the interpreters to get their perspectives as healthcare interpreters working during the pandemic. Although this study does not directly investigate the remote interpreting practice, the results imply that the integration of remote interpreting services can help to enhance our health system and there is an obvious demand stated by the healthcare interpreters themselves during the interviews. The authors recommend that the integration of technological tools into the interpreting process in the 'new structure' should be

reflected in the professional standards in line with requirements for those new tools, so that quality remote interpretation services can be ensured.

Şengel (2022) investigates the usability of the Zoom platform from the perspective of professional conference interpreters and focuses on the ergonomics of remote simultaneous interpreting practices. The USE (Usefulness, Satisfaction and Ease of Use) questionnaire developed by Lund was administered to 16 conference interpreters, although 75 were contacted. It aims to examine the usability of the platform by conference interpreters. Results found that the usability of the Zoom platform is of high scores, and interpreters welcome the improvement of the platform, which shows interpreters have the desire to improve the available remote simultaneous interpreting ergonomics.

In conclusion, the practice of video remote interpreting in Türkiye preserves its significant potential to strengthen accessibility to public services, especially healthcare services and facilitate communication in different sectors between service providers and culturally and linguistically diverse people.

Given that Türkiye occupies a unique geographic position and a large area situated as a bridge between Asia and Europe continents, the video remote interpreting solutions offer several advantages, such as the elimination of the constraints of distance (especially between rural and urban), enabling the equal public services regardless of the location, even for underserved areas where on-site interpretation opportunities may not be available, addressing the logistical challenges and reducing the travel duration and expenses. Responding to different emergencies (refugee flow after the Syrian War, earthquake in the Southeast region), Türkiye can benefit from the flexibility of this practice so that immediate access to qualified interpreters can be provided in urgent situations or in case of unexpected language needs through quick on-demand remote language support. Integration of video remote interpreting practice in Türkiye would foster inclusivity and empower individuals with limited language proficiency who need public services. However, the necessity of availability of respective software and applications along with a robust internet infrastructure must be borne in mind. The training of interpreters on technology-mediated interpretation practices can further optimize the quality of the services.

2.1.2.3. Relevant Studies on Video Remote Interpreting

Despite the scarcity of research in this field in Türkiye, there are not only quite a number of studies but also a few doctoral dissertations published on the international platform. In addition to the research, several projects implemented by international and supra-national organizations shed light on the current practice of remote interpreting. The field has started to gain prominence in recent years, keeping in step with the development of technology worldwide. Even though the practice was controversial among interpreters, the last several years have seen an increase in this practice, especially after COVID-19, which left no other solution other than remote communication between people; therefore, the relevant research field caught the attention of scholars who began to carry out many field studies. This section will provide a generic insight into research and initiatives conducted in the related field.

Several projects have been implemented in the last two decades, mainly focusing on training remote interpreters. Interpreting in Virtual Reality (IVY) Project, as an EU-funded Lifelong Learning Programme, was carried out in 2011-2013. The IVY project utilized the features of three-dimensional technology to ensure an adaptive 3D virtual environment that provides “the acquisition and application of skills” required in interpreter-mediated encounters. The rationale behind the implementation of this project is the consideration for the difficulty of achieving an ever-broadening range of interpreting scenarios in light of the increasing level of multilingualism in Europe with traditional teaching methods; therefore, it aims to adapt interpreters to the 3D virtual environment so that they can be adaptive to the virtual environment and exploit the potential of the virtual reality products. The project's deliverables include but are not limited to the review of best practices, 3D environment, and interpreting scenarios for interpreters, pedagogical evaluation report, and guidelines (IVY, n.d).

Another European project, Evaluating the Education of Interpreters and their Clients through Virtual Learning Activities, aims to evaluate the virtual learning environments not only for the interpreters' training but also to educate the professionals/clients who can work with the interpreters in their daily lives. The rationale behind this project is that information and communication technologies can offer an opportunity to simulate real-life practice; therefore,

learners can gain a similar experience of situatedness and authenticity. Likewise, its use in interpreter training also ensures the same opportunities for interpreting students and the people who may work with them. In addition, using such technologies during the training will support students in acquiring digital competence (EVIVA, n.d). Interpreting students, users of interpreting services (clients), trainers of interpreters, and virtual learning tool developers were the target groups of this project. The document outputs of this project include, but are not limited to, a report on evaluation methods, videoconferencing environments, a report accompanying role play material, evaluation studies, and a best practice guide (ibid).

Both above-explained EU-funded projects were conducted under EU Lifelong Learning Programme in coordination with the University of Surrey, and they pave the way for future research in the field of remote interpreting since they have many content-rich deliverables/reports and provide a fair amount of food for thought for scholars in the field.

Assessment of Video-Mediated Interpreting in the Criminal Justice System (AVIDICUS) Projects package, with its quite comprehensive nature in video-mediated interpreting, has been carried out from 2008 to 2016 in coordination with the University of Surrey as three subsequent projects. All three successive projects focus on video-mediated interpreting practices, specifically in legal settings.

The AVIDICUS 1 project was carried out in 2008-2011, and its primary aim was to investigate whether the quality of video-mediated interpreting (VMI) is good enough for criminal proceedings so that a significant step towards improving judicial cooperation across Europe would be taken. The specific objectives of the project were to identify the baseline situation where video-mediated interpreting would be most helpful with its different configurations from a criminal proceedings point of view, to assess the reliability of video-mediated interpreting from an interpreting point of view by conducting a series of comparative case studies (face-to-face interpreting vs. VMI) in order to formulate a set of recommendations for EU criminal justice services regarding the use of video-mediated interpreting in criminal proceedings, and to develop training modules on those new forms of interpreting to equip interpreter students, practicing legal interpreters and legal practitioners with the knowledge extracted based on the findings of those surveys. Implementation

of AVIDICUS 1 was successfully completed, and awe-inspiring outcomes are of outstanding contribution to the field, which is a set of recommendations for video-mediated interpreting practice in criminal proceedings such as benefits, risks, guidelines for best practice documents along with a set of training modules to equip legal practitioners, practicing interpreters and interpreting students with the relevant knowledge. On the other hand, it reveals that “further research was required to investigate how the combination of technological mediation through videoconference technology and linguistic-cultural mediation through an interpreter affects the specific goals of legal communication and to elicit adaptive strategies to mitigate such effects” (AVIDICUS, n.d.). Last but not least, the outcomes of this project served Criminal Justice Systems across Europe to develop common regulations on video-mediated interpreting practice in criminal proceedings. AVIDICUS 1 was a cooperative project involving partners in several European countries implemented in coordination with the University of Surrey (the UK) and partnership with Lessius Hogeschool Antwerp (Belgium), Local Police Antwerp (Belgium), Ministry of Justice (the Netherlands) and Legal Aid Board (the Netherlands), TEPIS Polish Society of Sworn and Specialised Translators (Poland) and one internal evaluator (AVIDICUS 1, n.d)

AVIDICUS 2 was implemented in 2011-2013, and its objectives are listed below in line with the findings of its previous phase (AVIDICUS 2, n.d.):

- To equip the national authorities, legal practitioners, interpreters and European citizens with the gained knowledge about the use of video-mediated interpreting (VMI) for criminal proceedings
- To develop current insights further into remote forms of interpreting and reveal the best practice through research into the behavioural and communicative aspects of video-mediated interpreting services provided in criminal proceedings.
- To advance training opportunities for video-mediated interpreting not only for interpreters but also for legal practitioners.

In the scope of this second phase, the outcomes include but are not confined to a series of European workshops were held to train nearly 300 legal practitioners and interpreters on video-mediated interpreting, a set of recommendations and guidelines were revised regarding the use of VMI, its

benefits and challenges in criminal proceedings, three mini guidelines (for legal practitioners, interpreters, and European citizens) were published about the video-mediated interpreting practice in criminal proceedings and they were designed to be integrated in the European e-Justice portal. AVIDICUS 2 was a cooperative project involving partners in several European countries implemented in coordination with the University of Surrey (the UK) and in partnership with Lessius Hogeschool Antwerp (Belgium), Institut Télécom (France), Ministry of Justice (the Netherlands) and Legal Aid Board (the Netherlands) and one internal evaluator.

While the findings of the AVIDICUS 1 and AVIDICUS 2 projects assessed the viability and quality of video-mediated interpreting practices carried out in criminal proceedings, AVIDICUS 3 (n.d), implemented as the last phase in 2014-2016, turned its focus on the design and implementation of bilingual video-mediated communication solutions. The primary aim of this project was to carry out a comprehensive assessment of the videoconference system as a communication tool in legal institutions across Europe to understand its suitability for bilingual communication. The project also aims to reveal the individual and institutional needs for training regarding bilingual videoconferencing and provide this training set using videoconferencing methods if needed.

Under the scope of the research conducted in AVIDICUS 3, a “combination of over 100 stakeholder interviews, fieldwork in videoconferencing facilities and observations and qualitative analysis of over 300 videoconferencing-based proceedings” was used to examine the existing bilingual videoconferencing practices in different legal institutions located in 12 European countries. The project points out that legal and institutional stakeholders might underestimate the complexities of communication provided through the interpreter and bilingual videoconferencing and that a more comprehensive understanding of the specific requirements of that combination must be acquired in legal settings. AVIDICUS 3 was also a cooperative project involving partners in several European countries implemented in coordination with the University of Surrey (the UK) and in partnership with the Ministry of Security and Justice of the Netherlands, KU Leuven University, and Institut Mines Télécom, University of Trieste and one internal evaluator.

In conclusion, these three projects contributed quite a lot to the video remote interpreting field but were limited to legal settings. Several reports, one book, many articles, and chapters, along with one comprehensive book, were published as the outcomes of the subsequent projects. The methodology, survey tools, and reports of each project shed a bright light on further studies to be carried out in the video-mediated interpreting practiced in other settings.

SHIFT in Orality (Shaping Interpreters of the Future and Today) is another project focused on interpreter-mediated actions in 2016-2018, and it is an Erasmus+ project funded by the European Commission. The project is coordinated by the University of Bologna in Forlì. In contrast, the project partners are the Universities of Surrey, Granada, and Pablo de Ovide, as well as Dualia and Veasyt. The primary aim of this project is to present a solution for training in remote interpreting to be provided in Higher Education and Lifelong Learning in cooperation with a European network of universities offering interpreting programs. It aims to systematize the development of training resources to extend them to cover other settings in which RI is needed. Four different reports as outputs of the projects were presented. Firstly, "Characteristic features of remote discourse" provides a theoretical framework and generic definitions. Secondly, "Remote Technologized Interpreting (Telephone-Based and Video-Based Remote Interpreting)" describes a framework and a definition for remote, technologized, dialogic interpreter-mediated interaction. Thirdly, the report titled "Remote Interpreting Services: Future Or Present?" explains the results of a market survey in Italy, Spain, and The United Kingdom, and lastly, the "Handbook of Remote Interpreting" offers practical suggestions and tips for teaching and practicing remote interpreting (Shift in Orality, n.d; Spinolo, 2018).

All those projects explained have a guiding spirit, and their outputs will play an important role in the design of the methodological tool for the aim of this research. Sabine Braun, as a remarkable scholar in the field of distance interpreting with her numerous publications, has led several of those multinational research projects regarding video-mediated interpreting. (O'Hagan, 2019, p.xiii). Braun (2015, p.2) mainly focuses on socio-technological practices of interpreting and states that the gradual development of (video) remote interpreting sparked debates on the issue of efficiency for service provision; therefore, interpreting scholars began to raise questions of feasibility and working conditions and conducted respective studies.

As a first example, Pöchhacker (2014) conducted a study through a field test implementation in Austria to inquire the viability, acceptability, and usability of the remote interpreting arrangement, putting the mode-based comparison, consecutive versus simultaneous, at the center of the trial. In the scope implementation of this field test, he analyses video recordings of interviews with three families with inadequate German language proficiency in the simultaneous and consecutive mode of interpreting as a selected part of the whole data set of the pilot project. He assessed the issues sought from all three perspectives—patients, providers (doctors), and interpreters to elicit feedback on satisfaction from all perspectives through debriefing interviews after the remote examination. The study highlights how social forces such as public and professional attitudes, are essential for successful project implementation. The study results reveal that essential off-the-shelf videoconferencing tools proved fully viable in the high-performance, and acceptance of videoconferencing-based and remote simultaneous interpreting was relatively high. The interpreters stated that working in remote video mode was practical without any extra need for special adjustments. Despite some setbacks experienced for testing on simultaneous remote interpreting, it is possible to say that video remote interpreting in simultaneous mode can be considered as functional as video remote interpreting in consecutive mode. It should be noted that Pöchhacker's study became a great source of inspiration for the study design part of this research since it describes a trial design in video remote interpreting services to investigate its viability, acceptability, and usability and also sheds light on various issues from social policy at administration level to communication technology used for interaction in a healthcare setting.

Another study by Jones et al. (2003) similarly explores the feasibility and acceptability of the remote interpretation services during general practice consultations in healthcare. The study was conducted in a health setting in London with a sizeable Turkish-speaking population served by only one physician. The same interpreter is used for all consultations through three interpreting methods: a physically present interpreter and two remote interpreters accessed by videoconferencing and telephone. This study employed three different types of questionnaires: The Patient Enablement Instrument (PEI), a 21-question version of the Medical Interview Satisfaction Scale (MISS-21) questionnaire, and a questionnaire prepared by the researcher with four questions designed to explore the patient's perceptions of the quality of communication and

degree of discomfort with the interpreting process and sense of wellbeing after the consultation. The study results show that both remote methods are feasible and acceptable, even though patients who seemed unwilling to express a preference seem glad to have an interpreter.

Korak (2010, as cited in Pöchhacker, 2014) also carried out a study to investigate the feasibility of remote medical interpreting via Skype through interviews with patients, interpreters, and doctors in a hospital located in Graz. He found out that 14 patients were satisfied despite the opposite opinions of the majority of the patients. While 17 doctors stated their satisfaction with the services provided via Zoom, seven interpreters stated their opinions in favor of remote interpreting despite such quality issues with image and sound.

Researchers also conducted several comparison studies between different remote and on-site interpreting modalities to assess their advantages and disadvantages.

Azarmina and Wallace (2005) conducted a systematic review that included any published or unpublished research article with telephone or video conference interpretation as an intervention. In the scope of this review, nine articles were identified for review, but only one addresses a randomized controlled trial. In contrast, the others compare remote interpretation with other methods of interpretation. They also evaluate different themes, including time, satisfaction, quality of service, and costs. Generally, the review concludes that patients and doctors were as satisfied with remote interpreting as with face-to-face interpreting, but that interpreters preferred the latter.

Locatis et al. (2010) conducted a study to compare remote medical interpretation provided by telephone and videoconference to the services provided in person. Patients, providers, and interpreters each independently completed scales evaluating the quality of clinical encounters. Results reveal that patients welcome all methods at the same level, but providers and interpreters rated higher for the encounters with in-person interpretation. There seems to be no significant difference between the rates of the providers and interpreters for remote methods. Providers and interpreters have a distinctly higher preference for video over the phone.

These comparative insights into interpretation modalities highlight the growing relevance of remote solutions in clinical settings, paving the way for a more focused discussion on video remote interpreting in healthcare.

2.2. VIDEO REMOTE INTERPRETING (VRI) IN HEALTHCARE SERVICES

To better understand the implications of VRI in healthcare encounters, it is essential to begin with a general overview of its role and impact in facilitating communication between healthcare providers and patients.

2.2.1. General Overview

Effective communication between health professionals and patients is vital in healthcare service provision for the interlocutors since physicians need to receive accurate medical histories, and patients need to understand the physician's instructions well. Moreover, if those patients are people with different languages and cultural backgrounds, this communication gains much more importance since preventative services can be delayed, health inequities can exacerbate, and chronic conditions and acute symptoms can deteriorate when the language barrier is not addressed. Inappropriate use of medication, more extended hospital stays, and poor patient satisfaction can be other implications resulting from the lack of consideration (Interpreter Intelligence, n.d.). The consideration for linguistic differences is also essential when health care is provided as remote services through information and communication technology tools.

Video remote interpreting practice could diminish or even eliminate the use of family members and relatives for conveying health messages to the patient. Considering the family members and relatives are not certified interpreters and trained in the medical field, they can easily be emotionally involved in the interaction, may skip an important phrase while expressing the message into the target language. In this regard, easy and quick access to a qualified interpreter through virtual services is important, as they can deliver a message in a clear and precise manner.

Haralambous et al. (2019, p.2) highlight that using an accredited interpreter has been shown to improve diagnosis, patient satisfaction, outcome, and communication between the health

practitioner and individuals with limited language proficiency in the host community considering the issue regarding the quality of care and access barriers for underserved groups such as non-indigenous minorities or migrants who already experience health disparities may arise. (Truong et al., 2022, p.970-971).

International Telecommunication Union (ITU) (2020), a specialized agency of the United Nations on information and communication technologies, released a guideline on web-based remote sign-language interpretation or video remote interpretation systems. This guideline explains the general requirements of a VRI system and its functional components. Even though it is more focused on scenarios where sign language interpreters may attend to provide service for persons with disabilities (PWD), it also sheds light on other remote services such as online treatment and distance education. With its specific chapter on VRI and telemedicine services, this document presents practical information, such as the general requirements of VRI services operation and terminals.

The guideline presents that VRI services in healthcare are generally provided differently when both the service provider (physician) and receiver (patient) are in the same location, but the healthcare interpreter connects from a different location to the service room (ibid, p.5).

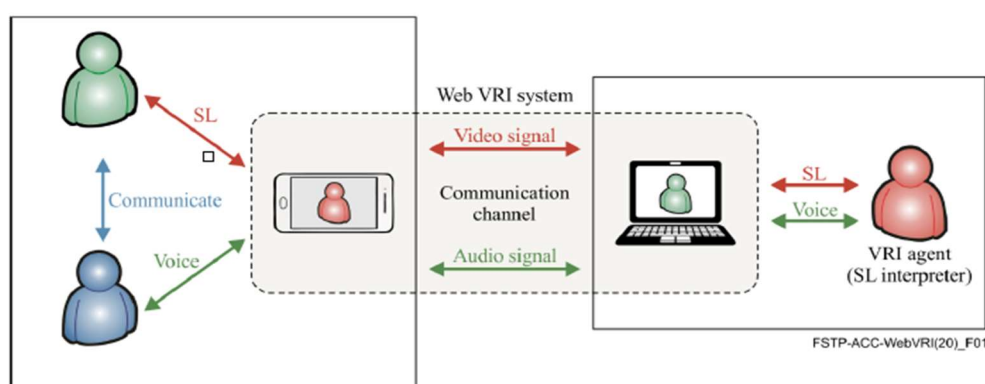


Figure 9: General case of a web VRI system in a case where both healthcare professionals and patients are in the same location and connecting online to a virtual interpreter

This practice of video remote interpreting uses technological advantages to bring virtual interpreters who can be seen from a computer screen, mobilized through wheels, and can connect

to the room where the patient and physician are interacting. The computer screen with wheels is generally located next to the patient's bedside so that the patient can see the virtual interpreter.



Figure 10: An example from a virtual interpreting session during the healthcare service provision

The interpreter virtually connecting to the patient room rather than having physical presence eliminates the wasted time which the interpreters spend on their way to reach the patient room from one setting to another, or even within the same building where the healthcare is provided. Virtual interpreters enable the patients to get needed healthcare services immediately in their languages.

The VRI service also includes the case where the service provider (physician) and receiver (patient) both participate in an online conversation, such as an online medical consultation, and the virtual interpreter attends online, similarly.

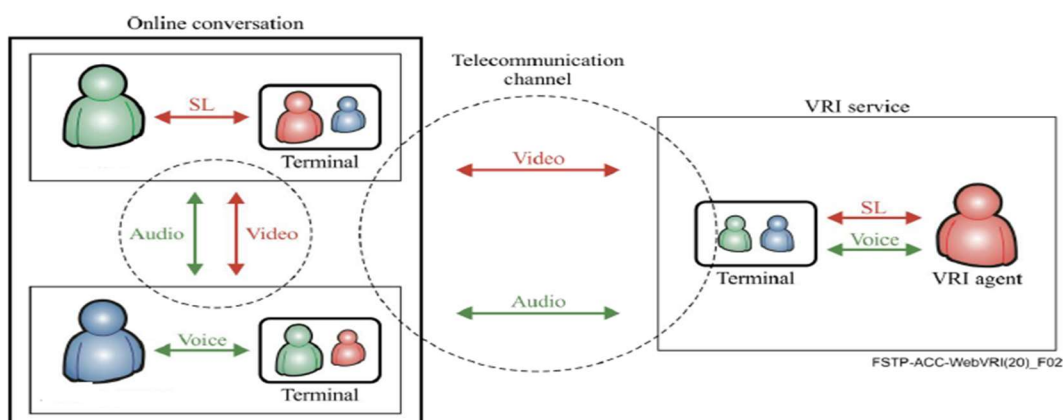


Figure 11: All interlocutors are in different locations (e.g. telemedicine, tele-education)

Touching upon the healthcare practice where all interlocutors connect each other from different locations, it would be enlightening to elaborate the broad concept of digital health which is composed of various categories, such as mobile health (mHealth), health information technology (IT), wearable devices, telehealth and telemedicine, and personalized medicine (FDA, n.d). All categories gained prominence after COVID-19 hit the whole world and the number of practices climbed up in those days, and several studies were carried out on those increased practices made as no other solutions were left due to restrictions and contamination risk, especially in health settings.

As a component of telehealth, *telemedicine* is defined as “the delivery of health-care services where distance is a critical factor, by all health-care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment, and prevention of disease and injuries all in the interests of advancing the health of individuals and their communities” (WHO, 2022, p.2).

While telehealth can be used as an umbrella term that covers healthcare service delivery by various health professionals through information communication technology tools, the term “telemedicine” mainly refers to healthcare services provided only by physicians.

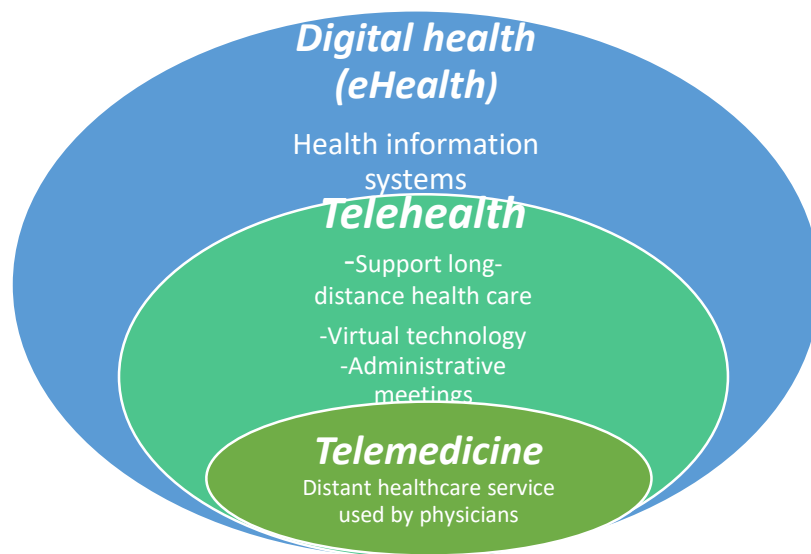


Figure 12: Simplified representation of types of health services provided through information communications technology (ICT)

Even though the use of telemedicine has been on the rise after COVID-19 hit the whole world, the telemedicine practice was introduced even before to ensure rural and remote communities get access to healthcare services, given that this practice reduces unnecessary hospital visits and travel expenses sustainably. “Implementing Transnational Telemedicine Solutions (ITTS) Project” funded by The Northern Periphery Programme was carried out in 2011-2013 and led by the Centre for Rural Health in Inverness, Scotland. The countries Greenland, Iceland, Faroe Islands, Ireland, Northern Ireland, Scotland, Norway, Sweden, and Finland were included in the scope of the project. Even though all those countries are distinctive, they have shared components with their dispersed populations living in remote areas and their harsh weather conditions prevent people from traveling to healthcare settings. The project aimed to increase countries’ familiarity with capabilities for improving healthcare delivery and professional satisfaction. The ITTS team also aims to encourage engaged healthcare providers to explore possible technological solutions in the context where they serve (Casey et al., 2013, p.52).

Looking at the historical background of the development and strengthening of e-health and digital solutions in healthcare, resolutions released play a vital role in urging countries to take action and direct their efforts towards creating a consistent vision. In 2005 the World Health Assembly (WHA), as the decision-making body of the World Health Organization and was attended by delegations from all WHO Member States, published its resolution WHA58.28 on eHealth to its Member States for their consideration to prepare a long-term strategic plan for developing and implementing eHealth services in line with their priorities and resources. To this end, more than 120 Member States have developed their strategies and policies. In 2013, the World Health Assembly adopted another resolution, WHA66.24, regarding eHealth standardization and interoperability, to urge Member States to consider developing their policies and legislative mechanisms linked to an overall national eHealth strategy. (WHO, 2021a, p.4). Upon releasing those resolutions, WHA recognized the need to strengthen the digital health implementation and adopted Resolution WHA71.7 on digital health to request from WHO Director-General to develop a global strategy in May 2018. This strategy was developed upon a consultative process and launched in March 2019. “The global strategy on digital health 2020–2025” was endorsed by the Seventy-third World Health Assembly in 2020 through decision WHA73.28 (ibid, p.4). The

World Health Organization, a UN specialized agency on health, published numerous guidelines and documents which elaborate on how telemedicine practices should be applied in the last two decades. The Pan American Health Organization (PAHO), WHO Regional Office for Americas has published a report on “Defining evaluation indicators for telemedicine as a tool for reducing health inequities,” presenting the perceptions from the participants in a discussion forum.

Integration of video remote interpreting services into the countries’ healthcare systems doubtlessly provides a substantial contribution to equal access to healthcare services for the people speaking different languages in the host countries. The guideline published by the International Telecommunication Union in 2020 notes that further details of the interaction between the VRI system and telemedicine can be obtained only through future studies (p.13).

The preceding discussion on telemedicine has highlighted its growing relevance in modern healthcare delivery, particularly in expanding access to services across geographically and socially marginalized populations. Within this broader framework, video remote interpreting emerges as a critical component that enhances communication in telemedical interactions, ensuring linguistic accessibility and patient comprehension regardless of location. The integration of VRI into telemedicine not only addresses language barriers but also reinforces the principle of equitable healthcare, especially for individuals with limited proficiency in the dominant language or those who are deaf or hard of hearing.

To further contextualize the use and implications of VRI in healthcare settings, recent academic studies will be presented in order to provide empirical insights into its application, challenges, and perceived benefits.

To begin with, Kushalnagar et al. (2019) conducted a cross-sectional study to examine Deaf patients’ experiences with Video Remote Interpreting (VRI) technology in healthcare settings in the United States. Drawing on data from 555 Deaf adults surveyed through the Health Information National Trends Survey in American Sign Language (2016–2018), the study revealed that only 41% of respondents were satisfied with the quality of VRI services. Lower education levels and male gender were associated with higher satisfaction ratings. Notably, interpreter interference—

defined as actions that hindered patients' willingness to disclose health information—was found to significantly increase dissatisfaction, with affected individuals being three times more likely to report negative perceptions of VRI quality. The study highlights the need for high-quality video resolution to support sign language communication and emphasizes the importance of interpreters being proficient in both expressive and receptive skills, along with basic medical and rehabilitative knowledge. These findings underscore the technological and human factors that influence Deaf patients' trust and satisfaction with VRI in healthcare contexts.

Following this, Yabe (2019) explored the preferences of healthcare providers and Deaf or hard-of-hearing (DHH) patients regarding the use of Video Remote Interpreting (VRI) versus in-person interpreting in both critical and non-critical care contexts. Employing a mixed methods design, the study combined an online survey with qualitative interviews to gather data from 103 participants, including healthcare providers experienced with limited English proficiency (LEP) and DHH patients, as well as DHH individuals themselves. The findings revealed no statistically significant difference in preference for interpreting modality in critical care settings; however, for non-critical care, a statistically significant preference for in-person interpreting was observed ($p = .035$). Qualitative results further supported this, with both groups expressing a clear preference for in-person interpreting during critical care due to its perceived advantages in communication effectiveness, accuracy, and overall care quality. The study also highlighted persistent challenges with VRI, including connectivity issues and limited adaptability during interactions. Accordingly, the author recommends targeted improvements in VRI equipment, interpreter training, and institutional support to enhance communication outcomes in healthcare environments.

In the context of healthcare systems adapting to crisis conditions, Bachelier (2022) published a thesis examining the implementation and usability of Video Remote Interpreting (VRI) in Australian healthcare settings during the COVID-19 pandemic. The research was motivated by the urgent need to maintain equitable access to interpreting services when face-to-face interpreting was no longer feasible. Utilizing a mixed-methods approach that included surveys and interviews with various stakeholders, the study triangulated data to assess the effectiveness of VRI and its potential to replace or complement existing modalities such as onsite and telephone interpreting. The findings revealed a marked shift in preference from telephone to video remote interpreting as

the primary remote option during the pandemic. However, both healthcare professionals and patients continued to favor onsite interpreting when available. The study concludes that while VRI has gained significant traction, particularly during crisis response, the future of healthcare interpreting in Australia is likely to adopt a hybrid model, combining remote and in-person services based on context, accessibility, and user preference.

This study is particularly relevant to the present research, as it offers valuable insights into the institutional adaptation to VRI in healthcare settings, potential user perceptions, and the practical challenges of integrating remote modalities—elements that closely align with the aims of this thesis in exploring the feasibility of VRI implementation in Türkiye.

Building on the findings of her thesis, Bachelier and Orlando (2024) published a peer-reviewed article examining the use of Video Remote Interpreting (VRI) in Australian healthcare settings during the COVID-19 pandemic. Situating the analysis within the broader historical context of healthcare interpreting in Australia, the study draws on data collected through a mixed-methods approach—including surveys and interviews with stakeholders such as healthcare providers and patients—to assess the usability and perceived effectiveness of VRI. The findings indicate a noticeable shift from telephone interpreting to VRI as the preferred remote modality, particularly during the pandemic when face-to-face interpreting was largely unavailable. However, the study also confirms that onsite interpreting remains the most preferred modality among participants when circumstances allow. This research provides empirical evidence of both the adaptability and limitations of VRI in times of crisis, reinforcing the importance of institutional readiness and user-centered implementation strategies in remote healthcare communication.

Adding to the growing body of literature, Rivas Velarde, et al. (2022) conducted a scoping review to examine the current state of evidence regarding the use of Video Remote Interpreting (VRI) in healthcare settings for Deaf and hard-of-hearing sign language users. The review included 15 eligible studies—ranging from literature reviews and surveys to qualitative and mixed-methods research—drawn from a systematic search of seven medical databases. The authors highlight that while VRI is increasingly recognized for its flexibility and cost-efficiency compared to in-person interpretation, especially in high-income countries, critical gaps persist in the literature concerning

interpreter training, communication quality, and implementation in low- and middle-income contexts. The review suggests that VRI has the potential to reduce communication barriers and improve healthcare interactions for DHH patients; however, its effectiveness depends on adequate infrastructure, including high-quality video devices, stable internet connections, and interpreters trained in medical settings. The findings underscore both the promise and limitations of VRI in advancing equitable healthcare access for Deaf communities.

Additionally, examining the use of VRI in a highly sensitive clinical context, Trumm, et al. (2023) explored the experiences of deaf patients and interpreters using video remote interpreting in a medium secure psychiatric setting during the COVID-19 lockdown. Adopting a qualitative research design, the authors conducted structured interviews with twelve Deaf patients and three interpreters, analyzing the data through thematic analysis. Seven major themes emerged from the study: resource availability, ease of use, technical issues, misunderstandings, setting-specific limitations, personal preferences, and human factors. Across all interviews, participants expressed dissatisfaction with the current state of VRI technology in this context, with particular concern about misunderstandings and the potential for serious safety and medico-legal consequences. While the findings indicate that the existing technological setup is not adequately suited for secure psychiatric environments, the authors suggest that user feedback could inform improvements in VRI design and application. The study highlights the importance of tailoring VRI systems to the specific needs of high-risk healthcare settings to ensure effective and safe communication.

While the general overview has outlined the foundational role of video remote interpreting in enhancing communication and ensuring equitable access to healthcare services, this section has also incorporated recent empirical studies that offer critical insights into the practical implementation, challenges, and user experiences associated with VRI in various healthcare contexts. Building on this foundation, the following section turns to country-specific experiences to further examine the legislative frameworks, institutional arrangements, and technological strategies that support the integration of VRI into national healthcare systems. These exemplary cases provide valuable lessons and adaptable models for informing future applications, particularly in the context of Türkiye.

2.2.2. Exemplary Countries for Video Remote Interpreting in Healthcare Services

The incorporation of video remote interpreting (VRI) into national healthcare systems has increasingly emerged as a transformative solution for addressing language barriers in interpreter-mediated communication during healthcare service provision. Several leading countries have integrated VRI tools into their healthcare systems as a critical mechanism for ensuring equitable access to healthcare services, particularly for linguistically diverse populations. As much as their advanced technological infrastructure allows, these nations put efforts to improve their healthcare systems by enhancing the accuracy, efficiency, and accessibility of healthcare interpreting services for such populations. This section explores the implementation of VRI practices in the top four exemplary countries' national healthcare systems with a particular focus on the role of governmental support and legal frameworks, which are key success factors in VRI implementation. Each country's example will begin with an overview of the general context, followed by an examination of the relevant legal frameworks and key implementing institutions, and will conclude with a discussion of the current state of video remote interpreting practices within the national healthcare system, also presenting the results from some country-specific articles.

2.2.2.1. The USA

The provision of interpreting services in healthcare settings has become considerably essential to address linguistic barriers and ensure equitable access to required services in the USA due to its substantial migrant population. The USA has a well-established legislative framework that provides a robust foundation for the provision of interpreting services in healthcare. The available policies and regulations help the government ensure language access in an equitable manner for the entire population and drive the adoption of VRI in healthcare services. Furthermore, the involvement of key institutions supporting the implementation of these legal instruments plays a crucial role in facilitating the effective integration of VRI into the national healthcare system.

“Affordable Care Act (ACA)” is the first legal framework that can be presented as a remarkable documentation, as the most extensive implementations of VRI in healthcare are driven by its mandate. It highlights the importance of equal language access for all patients. Despite the fact

that this framework does not directly refer to video remote interpreting services, it has implications which may form a basis for its implementation, stating that “appropriate use of health information technology under the plan or coverage” to ensure the quality of care. This helps healthcare institutions to provide more language-sensitive healthcare services for “populations underserved because of special needs such as language barriers” just as defined in the mentioned Act (2010, p.135, p.801).

Another legal framework which has referrals for access to healthcare services for linguistically diverse populations is “Title VI of the Civil Rights Act of 1964” and it aims to support people who are Limited English Proficient (LEP) which may experience lower quality health care services due to their linguistic differences. Even though federal and state laws mandate the use of qualified language interpretation services, they do not directly address any specific modalities, such as video remote interpreting and that allows the healthcare providers flexibility in the way they meet this requirement.

Moreover, a number of non-binding documents with no force or effect of law have been published under this Act with the aim of clarifying the requirements of existing law and policies. The first of these documents is “Tips and Tools for Reaching Limited English Proficient Communities in Emergency Preparedness, Response, and Recovery” which was published in 2016 by the Federal Coordination and Compliance Section, Civil Rights Division, U.S. Department of Justice. This document aims to address the needs of individuals with Limited English Proficiency who apply emergency-related healthcare services and ensure non-discrimination against this population. It also promotes meaningful language access to federally assisted programs and services. Another legal document published under this Act is “Guidance to State and Local Governments and Other Federally Assisted Recipients Engaged in Emergency Preparedness, Response, Mitigation, and Recovery Activities on Compliance with Title VI of the Civil Rights Act of 1964” which was published in 2020 by the U.S. Department of Justice. It supports federally assisted entities in ensuring nondiscrimination in emergency-related activities and also addresses the needs of individuals with Limited English Proficiency, along with other protected groups. Despite the fact that these publications do not explicitly refer to any type of remote interpreting services, they

establish a foundational basis upon which institutions can develop systems that adequately respond to the needs of linguistically diverse populations.

“The Civil Rights Act” also offers a range of language access materials that provide valuable guidance for addressing language barriers in various sectors, but not limited to healthcare. One of them is the Law Enforcement Language Access Initiative (LELAI), launched by the Department of Justice and this nationwide program helps law enforcement agencies address language barriers in their daily operations. Additionally, as another comprehensive resource, the Federal Interagency website offers extensive information on language access services, laws, and policies. This Act is further supported by “Executive Order 13166”, which supports individuals with Limited English Proficiency for improving their access to services. Relevant to this Act, “Enforcement of Title VI of the Civil Rights Act of 1964 - National Origin Discrimination Against Persons with Limited English Proficiency (LEP Guidance)” is another policy guidance document, as issued under authority granted by “Executive Order 12250” and Department of Justice Regulations. All these efforts collectively reinforce the importance of language access in upholding the nondiscrimination principles.

Moreover, the “National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice” (2013) is a primary resource center which contains various guidelines on interpreting services provided during the healthcare services provision and this comprehensive legal framework has been developed by the U.S. Department of Health and Human Services Office of Minority Health. This document is commonly referred to as “the CLAS Standards” and it serves as a practical guide for supporting healthcare organizations to implement culturally and linguistically appropriate services (CLAS) effectively. This document also highlights the importance of providing effective communication for individuals with Limited English Proficiency (LEP) and those with specific communication needs, such as individuals who are deaf or hard of hearing despite the fact that no direct referral is available to encourage the adoption of technological tools in interpreting service provision.

Focusing more extensively on the provision and regulation of video remote interpreting services, the “Americans with Disabilities Act (ADA)” explicitly identifies video remote interpreting as a communication tool, and this Act also underlines its role to provide accessibility for individuals with disabilities to electronic and information technology. ADA stipulates the obligation to ensure effective communication for individuals who are deaf or hard of hearing, thereby encouraging the integration of advanced technologies, such as video remote interpreting, into healthcare settings. It urges healthcare providers to supply auxiliary aids and services to support effective communication, including but not limited to VRI, American Sign Language interpreters, captioning, accessible electronic and information technology, and other comparable tools.

Furthermore, the ADA's official resources include practical examples of communication challenges and corresponding solutions, further illustrating their practicality in real-world scenarios. This emphasis highlights the Act's commitment to secure accessibility in an equal manner, and opportunities for people with disabilities in healthcare and other public settings.

Even though most of the legal frameworks listed above do not have explicit reference to video remote interpreting practices, their common emphasis on the provision of culturally and linguistically appropriate services for the population with special needs, health equity, effective communication strongly supports the adoption of technological tools into healthcare services. Advocating innovative, flexible, adaptable and patient-centered approaches to meet the various needs of individuals with limited language proficiency, these legal frameworks provide a foundational basis that may support seamless integration of VRI into healthcare settings. These principles implicitly promote the adoption and usage of advanced technologies to overcome language and cultural barriers, thereby ensuring equitable access to healthcare and cultivating an environment where all patients can receive healthcare services in an equal manner.

In addition to all these above-listed legislative frameworks, the market also serves a substantial supply of language support services through numerous private companies (Boostlingo, LanguageLine Solutions, Languagers, Spoken Here, Cyracom, Stratus Video). There are no legislative restrictions or limitations regarding the use of interpreters or any web portal to receive support for interpreter-mediated communication during the telemedicine (healthcare service

provided remotely) sessions. These private companies offer web platforms specifically designed to meet the needs of foreign patients who are in need of linguistic assistance. In parallel, these platforms often provide comprehensive resources and detailed guidance on the effective utilization of their tools, which facilitates accessibility to healthcare services in their native languages, thereby promoting equality for diverse patient populations.

The services include pre-scheduled video remote interpreting sessions, helping participants to join direct video calls through secure web-based portals, which eliminates the requirement for expensive video hardware. These portals also offer on-demand connection capabilities to facilitate real-time language support, mobile application integration for greater user convenience, and the ability to send direct session invitations via email, SMS, or secure links. Moreover, they support the collection of relevant client information ahead of sessions, allowing interpreters to prepare effectively. Additional features such as in-session chat and post-session feedback mechanisms, including a call rating function, contribute to service quality by assessing user satisfaction and promoting continuous improvement in session delivery.

Drawing on real-life success stories, Stratus Video Company released a case study in collaboration with Carolinas Healthcare System, highlighting key outcomes such as over \$1.5 million in cost savings and various advantages associated with the adoption of the Stratus Video Interpreting system. The report also includes a testimonial reflecting previous user experiences, as illustrated below (2017, p. 2):

“A deaf woman presented at the Emergency Department at a CHS Behavioral Health facility. The providers called for an onsite interpreter, but the patient was left without communication while she waited. A nearby tech noticed something amiss with the patient, and grabbed a video remote interpretation device in order to communicate more quickly. Through VRI hospital staff came to learn that their patient was suicidal. Treatment was initiated immediately, something that would not have been possible without access to on-demand video interpreters”

Video remote interpreting services are also offered at all Cleveland Clinic hospitals and the majority of Family Health Centers. As a healthcare institution at the forefront of VRI implementation, the Cleveland Clinic places strong emphasis on enhancing patient satisfaction. To support this objective, an interpreter evaluation form is available on the official website, enabling

patients to share their feedback regarding the quality of interpretation services they receive. The form is used to assess several critical aspects such as the interpreter's punctuality, comprehension of the consultation subject and the patient's health concerns, presence throughout the entire consultation, and any additional comments or suggestions from the patient. This structured feedback mechanism plays a key role in continuous quality improvement in language support services.

Given the comprehensive efforts undertaken at the national level, it is evident that the United States has established a robust infrastructure to advance equitable healthcare access through culturally and linguistically appropriate services, underpinned by legislative frameworks and innovative approaches. By leveraging advanced technological solutions and incorporating patient feedback into service delivery, healthcare institutions effectively demonstrate how such initiatives can address communication barriers and enhance patient satisfaction. The U.S. model serves as a compelling example of flexible and scalable language access strategies, offering valuable insights for countries aiming to improve equity within their healthcare systems.

In support of this analysis, the subsequent discussion draws on academic literature that explores specific instances of language access service implementation within the U.S. healthcare system.

2.2.2.2. Australia

Australia has established extensive policies and practices aimed at facilitating effective communication between healthcare professionals and patients with limited English proficiency or specific communication needs, considering the linguistic heterogeneity of its population. These initiatives are grounded in a robust legislative framework and are complemented by the use of advanced technologies, including video remote interpreting. The legislative foundations, effective key institutions and practical implementations that put Australia in a position as a prominent example of successfully integrating language access services into healthcare reflect its broader commitment to multiculturalism and equitable healthcare provision.

First, the Australian immigration service introduced the audio-mediated interpreting service in 1973 with the aim of improving access to public services and reducing the cost of language support

(Braun, 2019, p.275). Building upon these initial steps up to the recent years, Australia's healthcare system currently utilizes VRI extensively to serve its multicultural population.

In Australia, the provision for language access services, including video remote interpreting, is supported through a combination of federal legislation, national policies, and respective frameworks. First of all, the "Disability Discrimination Act 1992 (DDA)" requires the elimination of barriers to communication for individuals with disabilities, including those who are deaf or hard of hearing. Also, the "National Disability Insurance Scheme (NDIS)" supports individuals with disabilities, including communication impairments and it aims to ensure they have access to services as part of a coordinated system of services and support. Moreover, the "Health Practitioners Regulation National Law (2009)" is a legal framework that urges healthcare practitioners to address language and communication barriers in order to safeguard effective patient care and treatment.

In addition to listed legislative measures, the "National Accreditation Authority for Translators and Interpreters (NAATI)" serves as a key institutional actor in Australia's language services landscape. NAATI is responsible for developing and maintaining national standards for the translating and interpreting profession and holds exclusive authority to grant credentials and certifications to individuals seeking careers in this field. Its main mission is to the availability of the required number of qualified and certified professionals capable of addressing the evolving needs and linguistic diversity of Australia's multicultural society.

Beyond the establishment of national standards, it is equally important to examine how language access services, including translating and interpreting practices, are implemented in daily healthcare settings across Australia. Looking further at institutional actors, the Medical Board of Australia (2017) has a pivotal role in ensuring access in equity manner for the people with linguistic varieties. This Medical Board, on its official governmental website, offers comprehensive information on the Translating and Interpreting Services (TIS National) provided by the Department of Home Affairs for these people. These services primarily target individuals with limited English proficiency, as well as organizations and businesses requiring communication with non-English speaking clients. Drawing on more than 75 years of experience in language

service provision and a network of over 2,700 interpreters covering more than 150 languages, TIS National delivers a wide range of services, including but not limited to video remote interpreting.

As an important example of national guidelines, the “Pre-booked telephone, video remote and on-site interpreting guide for agencies” provides a step-by-step explanation of how to book interpretation sessions through the online automated booking tool called “TIS Online”. This platform supports the users to request, manage, and monitor bookings online, while allowing interpreters to select and manage their assignments.

Alongside providing general user guidance, the official website of TIS National elaborates on the responsibilities of video remote interpreters and refers to the Code of Ethics developed by the Australian Institute of Interpreters and Translators (AUSIT). The platform shares practical recommendations to facilitate effective interpreter collaboration, such as conducting a pre-session briefing, properly positioning interlocutors, speaking clearly and concisely, and allowing strategic pauses to support comprehension. The “AUSIT Code” serves as a framework for regulating interpreter conduct in Australia, encompassing principles such as ethical behavior, confidentiality, professional competence, impartiality, accuracy, clearly defined role boundaries, maintenance of professional relationships, continuous professional development, and mutual support within the profession.

A prominent example of Australia’s effective integration of remote interpreting into healthcare is the “Healthdirect Video Call portal” (n.d.) which offers extensive information on the delivery of healthcare services via video consultations. This government-supported initiative is led by Healthdirect Australia—a government-funded helpline service providing approved health information—and was developed in collaboration with the South Brisbane Primary Healthcare Network, the Refugee Health Network, and the Translation and Interpreting Service (TIS) National. Together, these partners enabled the involvement of approximately 2,000 TIS interpreters in remote health consultations.

Serving as a comprehensive digital resource, the Healthdirect portal includes a dedicated section on interpreter services and associated workflows, where all relevant processes are explained in

detail. It provides a user-oriented, step-by-step guide designed to assist healthcare professionals in managing interpreter assignments. The guide includes instructions for accessing the waiting area dashboard (see below Figure), identifying interpreters within the system, selecting the required language, and specifying additional preferences such as the gender of the interpreter.



Figure 13: An example showing how interpreter information appears in the waiting area before a video remote interpreting session is initiated.

Moreover, the portal features a collection of case studies and informative articles to enhance user understanding of available workflows, thereby supporting more efficient communication in interactions. Individuals seeking remote interpreting support are directed to choose between services such as TIS National—which assists patients for whom English is not the first language—or on-demand interpreters available through the platform.

Healthdirect Video Call also supports multi-way video consultations, allowing easy inclusion of specialists, interpreters, caregivers, and family members located in different places. The system outlines various practical scenarios to further familiarize users with its functions and workflow options.

Australia has also implemented several initiatives to support refugees and migrants, with a particular focus on ensuring equitable access to essential services for individuals with limited or no proficiency in English. One key initiative is the “Free Interpreting Services” program, launched by the Department of Home Affairs, which aims to provide fair and equal access to critical services such as healthcare, social services, and government assistance.

The Australian Government, also known as the Commonwealth Government, is a federal parliamentary constitutional monarchy and comprises six states and two territories: New South Wales, Victoria, Queensland, South Australia, Western Australia, Tasmania, the Northern

Territory, and the Australian Capital Territory. Each of them maintains its own legislative framework independently. Among them, the State Government of Victoria stands out as a leading example in the provision of language access services, particularly due to its legislative efforts that acknowledge the state's rich cultural and linguistic diversity.

As Australia's most culturally diverse state, Victoria's population was 6.5 million in 2021 census, and 27.6% of its total population speaks a language other than English at home, while Mandarin, Italian, and Greek are taking the lead in the foreign languages spoken in the state (Victorian State Government, n.d). In response to this diversity, the Victorian Department of Health offers a wide range of resources aimed at improving health outcomes for individuals from culturally and linguistically diverse (CALD) backgrounds. These resources are publicly available on the Department's official website and include key policy documents such as the Cultural Diversity Plan, the Language Services Policy, information on language service innovation grants, and various tools developed for CALD communities.

Given the linguistic diversity of the state, with over one-quarter of the population speaking a language other than English at home, the Department of Health remains committed to ensuring that healthcare services are inclusive and accessible for multicultural communities. The department's "Language Services Policy" and accompanying guidelines, "How to work with interpreters and translators: a guide to effectively using language services" were released in 2017 but regularly updated the Victorian Government and the last update is released in respectively February and March 2025.

First, "Language Services Policy" aims to ensure the provision of quality interpreting and language services, identify the essential elements of language services provision, and detail implementation support measures taking people with low English proficiency into consideration. This policy supports the department and its funded services to respond to the needs of linguistically diverse people, consisting of migrants, refugees, and asylum seekers, and those using sign language. The document touches upon many important issues, such as policy and legislative context, essential considerations for language services provision, and the process of engaging interpreters in public services (State of Victoria, 2023a, p.17). The legislative requirements section

refers to the requirements and obligations imposed by “Multicultural Victoria Act 2011”, “Racial Discrimination Act 1975”, “Disability Act 2006”, “Health Service Act 1988”, “Disability Discrimination Act 1992”, “Equal Opportunity Act 2010”, “Charter of Human Rights and Responsibilities Act 2006” and “Racial and Religious Tolerance Act 2001” and the Policy document acknowledges that the policy document is underpinned by all those legislative requirements (ibid, 7).

Even though this policy document provides generic information on all forms of interpreting (face-to-face, telephone, and video-conferencing), it allocates a specific section for video remote interpreting services provided by the state government. The use of video remote interpreting is briefly explained, while it also throws light on its further use in sign language interpretation (Auslan interpretation). The content table of the document is presented for a better comprehension of what is covered under its language policy (ibid., p.6-7):

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Figure 14: The content page of “Language Services Policy” Document which provides tremendous information for language services provided in the Victorian State Government

The document also guides the users on how to engage an interpreter/translator through the language service providers. In brief, language services providers can be found on the National Accreditation Authority for Translators and Interpreters (NAATI) website, which is a reliable institution. A step-by-step guide is provided regarding how to arrange an interpreter, identify the interpreter, assess the English proficiency of the service receiver, and make a booking through a language service provider.

The language policy also encourages departmental services and funded organizations to promote language services through various communication methods, such as signage displaying the National Interpreters Symbol and Victorian Interpreter card (ibid, p.12) providing non-verbal easy access to people in need (see the below figure) along with various posters, and brochures to be used in public areas.



Figure 15: The representation of National Interpreters Symbol and Victorian Interpreter Card to help reducing the stress of people with limited language proficiency seeking for public services support

As an accompanying guideline to the Interim Language Services Policy, “Interim Guidelines: How to Work with Interpreters and Translators – A Guide to Effectively Using Language Services” explicitly addresses the application of video remote interpreting within the healthcare system. The guideline outlines detailed, step-by-step procedures for patients seeking to access language services—from initiating an interpreter booking to completing a VRI session—illustrating the government's proactive efforts to improve equitable healthcare access through innovative solutions. One significant component of the Interim Guidelines is the section concerning the use of family members and friends as interpreters. It underscores the necessity of

engaging professionally qualified interpreters, highlighting that informal interpreters may lack sufficient language skills, impartiality, and adherence to professional ethical standards. By drawing this distinction, the document reinforces the government's emphasis on maintaining quality and accountability in VRI service delivery and affirms its broader commitment to culturally competent and inclusive healthcare provision (2023b, p.9).

In alignment with the commitment to accessible and high-quality language services, the Victorian Department of Health and Human Services also funds video remote interpreting to support individuals with disabilities. This service is delivered through the Victorian Interpreting and Translating Service (VITS) in collaboration with Auslan (Australian Sign Language) Connections—a joint initiative between the Victorian Deaf Society (Vicdeaf) and Deaf Services Queensland. Department-funded organisations, as well as departmental staff, are granted access to VRI services through the Department's Language Services Credit Line. On its official website, the Department highlights the key advantages of VRI, including access to NAATI-accredited professional interpreters and the facilitation of effective communication between Deaf individuals who use Auslan as their primary language and hearing individuals.

In a similar vein, Service NSW—a government agency affiliated with the New South Wales Department of Customer Service—also offers video remote interpreting services. According to its official website, Auslan VRI is available at all service centres and is provided free of charge. The platform outlines basic instructions on accessing this service, further demonstrating state-level efforts across Australia to enhance inclusivity and equitable communication for linguistically and sensory diverse populations.

Another key policy document is the “Cultural Responsiveness Framework – Guidelines for Victorian Health Services”, published in 2009 by the Department of Health's Rural and Regional Health and Aged Care Services. The framework defines *cultural responsiveness* as the provision of healthcare that respects and reflects the cultural and linguistic needs, beliefs, and practices of diverse patient populations (Rural and Regional Health Services, 2009, p.12). It outlines six core standards, with Standard 3 specifically requiring the provision of accredited interpreters for patients in need. This standard is supported by two measures and eleven sub-measures designed to

facilitate effective communication between healthcare providers and service users. The framework also draws on the “Health Services Cultural Diversity Plan (2006)”, which aims to enhance service quality for culturally and linguistically diverse (CALD) communities by promoting the effective use of language services aligned with Standard 3.

Unsurprisingly, the Australian market demonstrates a strong supply of video remote interpreting services, particularly aimed at meeting the needs of individuals who prefer to access healthcare in their native language. Prominent providers such as Expression Australia, Translationz, and DeafConnect (specializing in Auslan interpretation) offer a range of professional VRI solutions, thereby contributing to the broader goal of ensuring equitable access to healthcare for linguistically diverse populations.

In conclusion, Australia’s comprehensive and well-coordinated approach to video remote interpreting reflects its ongoing commitment to fostering equitable healthcare access for its multicultural population. Through the integration of VRI into healthcare via robust government frameworks, innovative service platforms, and targeted state-level policies, Australia has emerged as a leading example in promoting linguistically inclusive health systems. Within this national landscape, the State of Victoria stands out as a particularly strong model, offering detailed legislative frameworks, practical guidelines, and institutional support mechanisms that demonstrate how language services can be effectively embedded into public healthcare delivery.

2.2.2.3. The UK

As another multicultural country with its migrants, there is a quite high number of people without English proficiency. According to the 2011 Census Analysis, nearly 1 in 13 people, which equals 8% out of 4.2 million people, had a primary language other than English in England and Wales, and only two-thirds (65%) of non-proficient people who could not speak English well or at all had a lower proportion of “good” general health compared to native English speakers according to the analysis of proficiency in English by health (Office for National Statistics, 2013, p.1). Based on this data, the Office for National Statistics in the UK states that the number of people who cannot speak English is more likely to be in poor health.

The United Kingdom can be regarded as a notable example in the implementation of video remote interpreting, particularly within the healthcare sector, where significant efforts have been made to ensure inclusivity for both linguistically diverse and Deaf communities. This approach is grounded in the legislative commitments of the country and a variety of successful institutional practices.

The “Equality Act 2010” obliges service providers to make reasonable adjustments to accommodate individuals with disabilities, which includes the provision of appropriate communication support. Although the UK does not have a single, overarching law dedicated exclusively to VRI, the service has nonetheless become well-integrated and is routinely used across healthcare and other public service settings. This widespread adoption illustrates the UK strong dedication to equitable access and inclusive service delivery for populations with diverse linguistic and communication needs.

The National Health Service (NHS), the principal publicly funded healthcare provider in the United Kingdom, serves as a collective term encompassing NHS England, NHS Scotland, NHS Wales, and Health and Social Care in Northern Ireland. As the cornerstone of the UK healthcare system, the NHS is committed to improving health outcomes, enhancing patient experiences, reducing pressure on frontline services, and ensuring the efficient delivery of care across its constituent regions.

The “Guidance for Commissioners: Interpreting and Translation Services in Primary Care”, published by NHS England in 2018, provides a thorough and authoritative reference for service commissioners. It outlines practical recommendations for delivering high-quality interpreting and translation services, addresses key factors in the commissioning and contracting processes, and clarifies the legal entitlements of service users. The document highlights the importance of informing patients who require language support about the various interpreting modalities available to them, including face-to-face, telephone, and video remote interpreting/video relay services (p.6). It further notes that VRI is accessible not only for individuals with limited English proficiency but also for those with disabilities (p.7). This reflects the NHS’s active role in promoting VRI, particularly for British Sign Language (BSL) users, and reinforces its commitment to ensuring equitable communication access for Deaf patients in healthcare settings.

The document's detailed structure (see below figure) —covering core principles such as access, timeliness, interpreter booking, and safeguarding, as well as legal considerations for disabled individuals and non-English speakers—demonstrates its comprehensive approach to interpreting and translation services. These elements are particularly relevant to the effective integration of video remote interpreting, as they provide clear operational and ethical guidance for ensuring equitable and accessible communication across diverse healthcare settings.

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Figure 16: The scope and content of the official guidance released by NHS England in 2018

Furthermore, as the largest NHS-affiliated organization in Scotland, NHS Greater Glasgow and Clyde (NHSGGC) demonstrates a strong commitment to ensuring equitable access to healthcare services for all individuals. Communication support is provided to enable healthcare professionals

to deliver safe and effective care, particularly for patients whose first language is not English and who may require assistance during medical interactions. This support also extends to individuals who are Deaf, hard of hearing, blind, or deafblind. The document titled “Working with a Video Remote Interpreter”, developed in partnership with DA Languages Limited, is available on NHSGGC’s official website. It offers comprehensive guidance on each stage of the video interpreting process, including booking an interpreter, preparing for the session, initiating the appointment, managing communication during the consultation, and concluding the session. Additionally, the website highlights the availability of remote British Sign Language (BSL) interpretation, facilitated through the private service provider SignVideo.

Building on the supportive legal and policy frameworks established by the government, a parallel growth in private sector involvement has emerged, with various service providers offering video remote interpreting solutions tailored to the needs of healthcare and public service institutions. A number of private service providers—including InterpretersLive, Sign Language Interactions, SignSolutions, SignVideo, DA Languages, and LanguageLine Solutions—offer video remote interpreting services that are specifically designed to support the healthcare and public service sectors. These platforms enable on-demand access to qualified interpreters, thereby fostering inclusivity and improving the efficiency of communication in various service settings. Many of these providers also collaborate with the NHS to deliver integrated VRI solutions. While VRI is beneficial for individuals with limited English proficiency, it plays a particularly crucial role for Deaf and hard-of-hearing individuals by facilitating equitable access to essential services. This dual function highlights the broad relevance of VRI in addressing both language and accessibility needs within public service delivery frameworks.

In summary, the United Kingdom presents a multifaceted and evolving landscape in the provision of video remote interpreting, particularly within the healthcare sector. While the country lacks a single, unified legislative mandate specific to VRI, existing legal provisions, along with detailed institutional guidelines and public-private collaborations, collectively support the widespread use of VRI. The integration of these services by both national health authorities and private providers demonstrates a pragmatic and inclusive approach to addressing communication barriers.

2.2.2.4. Canada

Canada also serves as a noteworthy example of integrating video remote interpreting into its healthcare system, effectively addressing linguistic barriers and promoting equitable access for its culturally diverse population, including individuals who are Deaf. Through the support of strong legislative frameworks and innovative implementation practices, Canada utilizes technology and comprehensive interpreting services to enhance inclusivity and facilitate clear communication within healthcare settings.

The “Official Languages Act”, originally enacted in 1969 and subsequently amended, designates English and French as Canada’s official languages and requires all federal institutions to provide equal access to services in both. This legislation imposes explicit legal responsibilities on healthcare providers to utilize interpretation services in order to accommodate linguistically diverse populations. By enabling patients to receive care in their preferred official language, the Act helps minimize communication barriers and supports greater equity in health service delivery.

Video remote interpreting devices have been systematically implemented in emergency departments across multiple health authorities including Interior Health, Fraser Health, Northern Health, Vancouver Coastal Health, Providence Health Care, British Columbia Children's Hospital, and BC Women's Hospital. In addition to these deployments, various other programs and services integrate VRI as needed. Furthermore, BC Emergency Health Services has equipped paramedics with VRI-enabled devices to ensure effective communication with Deaf and hard-of-hearing individuals, reflecting a province-wide commitment to inclusive and accessible healthcare delivery.

The Provincial Health Services Authority (PHSA) in Canada plays a key role in advancing the use of video remote interpreting services to enhance healthcare access for linguistically diverse populations, particularly for individuals with Language Other Than English (LOTE) and those who are deaf or hard of hearing. As part of British Columbia’s broader commitment to equitable and culturally responsive healthcare, PHSA oversees the coordination and delivery of VRI services across the province. By integrating VRI technology into various healthcare settings, PHSA enables remote, real-time access to professional interpreters, thereby supporting clear communication between patients and healthcare providers. The authority has placed significant emphasis on

developing VRI infrastructure, providing staff training, and embedding these services into telehealth systems—especially in emergency departments, specialized medical clinics, and among underserved groups.

Another illustrative example of a publicly funded initiative delivered in collaboration with a private provider can be seen in the case of Island Health. In partnership with the company LanguageLine, Island Health offers on-demand access to medically trained interpreters through video or audio connections, utilizing iPads in acute care settings and iPhones for community care providers. These interpretation services are provided at no cost and ensure seamless communication across all Island Health programs. A visually informative poster published on the organization's official website outlines the steps for accessing VRI, emphasizing its deployment in emergency departments and outlining plans to expand the service across all units and care settings.

As in other leading examples, various private companies and initiatives in Canada—such as Assign, LanguageLine, and the BC Digital Health Atlas—contribute to the provision of video remote interpreting services, thereby complementing the work of public healthcare institutions. These entities play a key role in expanding access to professional interpretation by offering adaptable and technology-driven solutions that respond to a wide range of linguistic and accessibility needs, including those of the deaf and hard-of-hearing community. Together with government-supported programs, these private sector contributions help to ensure that VRI remains a vital component in reducing communication barriers across Canada's healthcare system, reinforcing the country's broader commitment to inclusive, equitable, and patient-centered care.

The examination of countries that have successfully integrated video remote interpreting into their healthcare systems demonstrates the critical role such services play in promoting equitable and inclusive access to care. These international examples offer valuable perspectives on how technology-driven interpreting solutions can effectively respond to the linguistic and cultural needs of diverse populations.

Ultimately, this cross-country review has demonstrated that the integration of VRI into healthcare systems offers valuable reference points for Türkiye, highlighting how such practices can

meaningfully contribute to improving language access and fostering more inclusive service provision within the national healthcare context.

In summary, this chapter has provided a comprehensive review of the existing literature on remote interpreting, with particular emphasis on the development and application of video remote interpreting in healthcare services. By examining both global trends and Türkiye's current position, as well as highlighting exemplary practices from countries such as the USA, Australia, the UK, and Canada, the chapter has illustrated the critical role of VRI in addressing linguistic barriers and promoting equitable healthcare access. This review not only underscores the practical relevance of VRI in linguistically diverse contexts but also lays the foundation for the following chapters, which will further explore the potential for integrating VRI into the Turkish healthcare system through empirical analysis and potential user perspectives.

CHAPTER 3

THEORETICAL FRAMEWORK

This chapter presents Actor-Network Theory and its application in translation and interpreting studies. Furthermore, it puts forth how this research made use of the Actor Network Theory in accordance with its objectives.

3.1. GENERAL OVERVIEW OF ACTOR-NETWORK THEORY

Actor-Network Theory is a sociology theory that was coined by Michel Callon and John Law and developed by Bruno Latour in 1986. It aims to define the social network through the actors and understand the dynamics and structures of networks. As a theory that was initially used to examine processes in studies related to science and technology, it today provides a framework for research in various fields such as architecture, business, and computer science. This chapter will explore the main concepts of Actor-Network Theory, including its specific terminology.

While exploring this theory, specific terms used by Callon (1984) in his seminal article on the scallops and the fishermen of St Brieuc Bay will be elaborated to understand the basic logic behind this theory. Callon describes the emergence of an actor-network using the term '*translation*', which does not carry the widely known meaning of transferring a message from one language to another. Nonetheless, Callon and Latour (1981, p.279) define the translation term from the perspective of this theory as follows:

“all negotiations, intrigues, calculations, acts of persuasion and violence, thanks to which an actor or force takes, or causes to be conferred on itself, authority to speak or act on behalf of another actor or force.”

Callon (1984, p.196) has divided the translation, as described as a continuously changing process, into four stages, namely problematization, interessement, enrolment, and mobilization. He calls these stages 'moments' of translation, and he discerns those moments as attempts by central actors to impose themselves and their definition of the situation on other actors. At the initial stage, which is the *problematization*, a central actor positions itself as an '*obligatory passage point*' between the more extensive network and the actors it aims to represent or investigate. The second stage - *interessement* consists of a series of processes by which the actors raise their interest and

their involvement in the actor-network, and the central actor puts efforts into locking those actors into those roles. The third stage, *enrollment*, contains a set of strategies in which the central actor tries to define and interrelate the roles that have already been allocated to the other actors. The final stage, *mobilization*, indicates the methods used by this central actor to verify the roles allocated to the other actors to ensure that those actors can represent various relevant collectivities and that they do not betray those collectivities.

All in all, translation as a process in the ANT context can be considered as the enforcement where the inscriptions are circulated into the actor-network so that this network ultimately could protect the interests of the focal actor (Abdallah, 2012, p.24). As observed, Actor-Network Theory focuses on analyzing processes rather than products to explain the hybrid character of the products (Buzelin, 2005, p.196). Structure is not predetermined in Actor-Network Theory; notwithstanding, it is considered to emerge from action and the relations of the different actors. In other words, the translation process involves a multiplicity of mediators and does not enclose *black boxes*, which can be described as stable forms of knowledge, consensus, and presuppositions over what (good) translation includes in itself. The sum and substance of it, Actor-Network Theory helps us understand the complexity and the non-linear character of the translation process and the hybridity of the translating agent (ibid, p. 212).

An actor refers to any entity that can act or exert influence within a network. ANT does not limit its scope to only human individual actors but extends to *an actor* or *-actant-* to non-human, nonindividual entities (Latour, 1996, p. 369). Therefore, the network contains people, objects, institutions, technologies, and even concepts in itself, and those actors can induce an action, whether intentionally or not. Each actor, as encompassed in this network, has the potential to influence and be influenced by others within the network. Anything that has the power to act and to affect others can be an actor, which is the most radical feature of this theory. These actors are not limited to social entities, and more importantly, the definitions and identities of those groups are perpetually negotiated and shaped during the process of translation; in other words, these are not given and are introduced by certain actors, and they subsequently may be weakened, confirmed or transformed (Callon, 1984, p.228). Equal analytical importance is attributed to all actors, whether human or non-human, in Actor-Network Theory, and this is called the principle of

generalized symmetry of this theory. Namely, this principle contributes to comprehending how the networks are formed and maintained (ibid, p.200).

Actor-Network Theory enables us a framework to analyze the complexities of translation as a dynamic process by emphasizing the interconnectedness and equal importance of all actors engaged in networks. It seeks to understand how these networks are created, stabilized, and transformed through the interactions and negotiations of their diverse components. ANT offers a narrative form through which non-human actors can be endowed with agency by positioning them within a structure of functional relations. In this view, agency is not a fixed attribute but a relational position within a network (Ødemark et.al, 2024, p.65).

This theory allows the description of a complex structure with its heterogeneous elements and their relationships. (Abdallah, 2012, p.24). By its definition of a heterogeneous network, ANT posits that social, technological, and natural elements are all part of the same network, and it does not distinguish between human and non-human actors; both are seen as equally important in shaping outcomes. Law (1992, p.2) mentions the “process of *heterogeneous* engineering in which bits and pieces from the social, the technical, the conceptual and the textual are fitted together, and so converted (or “translated”) into a set of equally heterogeneous scientific products”.

3.2. ACTOR-NETWORK THEORY AND TRANSLATION & INTERPRETING STUDIES

Actor-Network Theory can provide a wide range of study areas for translation studies as it considers translation as a complex process in which a network of social, cultural, and technological interactions occurs rather than a mere interlingual transfer between text scripts. This perspective allows the researchers studying in the translation field to uncover the disregarded elements addressed through traditional studies. The following roadmap can be followed to apply this Actor-Network Theory to a translation study. First, all the actors involved in the translation process, including both human and non-human (such as people, text, institution, and technology), are identified, and their interaction is analyzed. Then, a network map presents the interconnections between those identified actors and how they influence the translation process. Later on, the impact of actors and their interconnections affects the dynamic process and decisions are examined. Last

but not least, how and to what extent the actors and networks within this translation process evolved over time and how this change can affect the heterogeneous products.

This theory can contribute to gaining a deeper understanding of the complex phenomenon of translation and it can be applied to numerous areas of translation studies such as translation training, history of translation, sociology and translation, translation and practice. This theory provides a great opportunity to investigate how technologies used in not only translation (through CAT tools, machine translation) but also interpreting (through telephone, remote interpreting) influence the translation process.

Unlike traditional approaches, actor-network theory provides a unique lens to analyze the complexities of the translation process. It allows researchers to gain a deeper understanding of the multifaceted nature of the translation process and reveal its dynamic and contingent nature. There are still not many studies carried out in the translation and interpreting field that employ actor-network theory; however, they will be presented below.

Despite the fact that the studies employing this theory in Türkiye are quite scarce, studies analyzing the entire translation process exist in different networks such as freelance translation, community/legal interpreting, and literary translation in the country context. First, Gürleyen and Uras (2023) analyze the translation process in the freelance translation network. This study aims to evaluate translators' positions identified as obligatory passage points in the freelance translation network and their decision-making authority by investigating their source preferences and process management through semi-structured interviews. The study finds that actors can incorporate different actors (computer-aided translation tools, online dictionaries, and artificial intelligence systems) into their network, where they all interconnect as much as their freedom boundaries allow in their network and the scope of power relations.

Another research employing this theory is a doctoral dissertation published by Mehtap Aral Duvar (2021), which presents an evaluation of court interpreting services provided for refugees in Türkiye in the context of community interpreting in the light of this theory. The study seeks to define the network and the actors involved in the network of court interpreting services provided in Türkiye. Moreover, it aims to explore whether the actors in the network influence perceptions

regarding the role and responsibilities of court interpreters. To this aim, the researcher conducted interviews with court interpreters, administered questionnaires to the judges, and carried out short interviews with the refugees seeking legal services from the Turkish public service system. This study presents observation notes extracted from the trials, diaries kept by the researcher, and existing legislative documentation as secondary data sources. Upon analyzing all data gathered, the study reveals that the networks have been established temporarily and varied in each trial. Also, it was observed that a deficiency in the procedures led the court interpreters to the creation of smaller and local networks before the provision of interpreting services in addition to these temporarily established networks. It also concludes that such factors as the bilingualism of the interpreters, the definition of the interpreter's duty in the related code, and pre-communication initiated between actors before interpreting might affect the human actor's perception of the position and duty of the court interpreters.

Another Ph.D. dissertation published in Türkiye is *In(Direct) (Re)Translations of Leftist Non-Fiction In Turkish (1921-2016): Actors And Networks* (2018), written by Muazzez Uslu. She uses actor-network theory as a part of the eclectic method to trace publishers and other actors while examining the retranslations of the Communist Manifesto as the most frequently translated work. She uses the concept of translation as a process indicated by Latour to explain that the first wave of retranslations was done from an intermediary language and the second wave was directly from the source language.

Looking at the leading studies in the literature, the research titled *Toplumsal bir Ağ içinde Çeviri ve Yayınevi* (Translation and Publishing House in a Social Network, 2005) released by Şehnaz Tahir Gürçağlar uses this theory to evaluate the literary translation network in *Kapılar*, her book exploring different approaches to translation history, published in Turkish. In this research, she aimed to map out the relationships among translators, publishing houses, text types, translation strategies, and translated authors despite their complexity. She also published *Chaos Before Order: Network Maps and Research Design in DTS*, at which she addresses translation network with the historical and sociological dimensions in *Meta Journal*, Volume 4, which was specifically attributed to “Translation and Network Studies,” which is of significant importance in terms of showing the increasing interest in investigating the network concept in translation studies by

researchers. Out of two studies focusing on Actor-Network Theory from 12 articles, the paper written by Tahir Gürçağlar (2007) examines how a “network” can broaden the scope of translation historiography by providing a more comprehensive inventory of translation-related phenomena during the initial stages of research, aiming to complement more critical approaches rooted in models of social causation. The case selected for this study is the field of popular translated literature in Türkiye in the 1960s and 2000s. This paper investigated the operations of Golden Books (Altın Kitaplar in the original language), a remarkable publishing house in Türkiye. Altın Kitaplar is considered the focal point of an extensive network that includes publishers, translators, authors, editors, readers, and governmental and literary institutions. A thorough analysis of its structure and activities provides a gateway into this network, which is explored in various directions, revealing a series of interconnections with other fields in the publishing industry that have been mainly unnoticed.

Moving to the examples presented in the literature at the international level, the introduction article written by Deborah Folaron and Hélène Buzelin is the other article published in *Meta Journal*, Volume 4, which focuses on Actor-Network Theory. This article, named *Connecting Translation and Network Studies* (2007), aims to present a multifaceted and multi-tiered historical trajectory of the term and concept “network,” which offers new conceptual tools for translation studies. While it discusses the foundations of network theories, their development, conceptual dimensions, and the intersections between network theories and Translation Studies, it also implies the inadequacy of Translation Studies' theories in investigating the translation process and the necessity of utilizing network theories. The core of all translation activity is characterized by the transmission and exchange of thought, ideas, messages, and information; hence, the relationship between translators and their work environment could not be considered outside of the translation process; it substantially contributes to the shaping of this process (*ibid*, p.632). To highlight the importance of this relationship, Folaron and Buzelin (*ibid*, p.605) state that:

... As connectivity and connectedness take on ever-important social organizing dimensions in a globalizing multilingual world, a translation-informed network approach as well as a network-informed translation theory approach may symbiotically help us better understanding human and social practices.

Continuing with the studies published by Buzelin as a remarkable researcher in the field, the paper “Unexpected Allies: How Latour’s Network Theory Could Complement Bourdieusian Analyses in Translation Studies?”, published by H       Buzelin as her seminal work, paved the way for introduction of actor-network theory into translation studies. Buzelin (2005) argues that this theory can offer a complementary perspective to Bourdieusian analyses, and together, both theories contribute to addressing certain limitations in Translation Studies. In addition to the fundamental concepts, goals, and achievements of this approach put forward by Latour, this paper explains how this theory can relate to or confront Bourdieu’s sociology.

Another study released by Buzelin (2006) is “Independent Publisher in the Networks of Translation,” and it examines how three independent publishing houses managed to sustain their translation activities during a challenging period for publishers in Canada and how this situation impacted the translations. Buzelin aims to explore “the range of actors involved in the process and how they interact,” from agreement to carry out the translation until its initiation, and it examines the interviews conducted with nine actors holding different roles in three publishing houses. The study also includes non-human actors such as translation contracts, brochures, translation drafts, critiques, and reviews in her study scope, and it incorporates an observational dimension by participating in the interactions between these actors. Through the examination of the interaction of both human and non-human actors, the study reveals that all actors are interconnecting with each other at each step of the process. Also, the publishing houses engage in collective publishing and translation activities with one another. Additionally, it presents that the roles of the actors constantly change according to the existing situation.

Another remarkable study is “Translations in Product on Networks: Reflections on Agency, Quality and Ethics” (2012), written by Kristiina Abdallah. The study data consists of interviews with eight Finnish translators, the author's observations, and students' attitudes. Three different theoretical frameworks—General Network Theory (Barab    ), Actor-Network Theory (Latour), and Agency Theory—were employed for each group. The study reveals that there are specific conflicts regarding perceptions of quality and ethics among the actors and issues of trust between them. Abdallah also concludes that (ibid, p.iv):

“.... translators’ currently restricted and narrow agency must be strengthened, so that translators have the opportunity to act as agents more effectively for themselves and the users, thereby improving translation quality.”

Another study that addresses literary translation networks is “Fields, Networks and Finnish Prose: A Comparison of Bourdieusian Field Theory and Actor-Network Theory in Translation Sociology” (2009), written by Raila Hekkanen. This article compares two sociological theoretical frameworks, Pierre Bourdieu’s field theory and the actor-network theory (ANT) put forward by Bruno Latour. This comparison has been carried out over a specific translation situation, the translation of Finnish prose literature into English in the UK. The article concludes that the ANT model is better suited to analyze the structural context in which translation activity takes place, while the Bourdieusian model provides better opportunities to analyze individual translators’ practices using the concept of habitus. The fact that the most in-depth results can thus be obtained by combining the two approaches is also highlighted in this article. In this regard, “Translation Agents and Networks, concerning the Translation of Contemporary Taiwanese Novels” (2009), published by Szu-Wen Cindy Kung, can be given as an example, considering that it adopts both sociological theories. This article also examines the agency of translation actors and networks concerning literary translation production, keeping the influence of translation actors, their social impact, and their relations to the final translation product. As a case study, it focuses on the role of social agents and networks in translation; however, it also pays special attention to lesser-known literature in a dominant culture. The cases in this study consist of the translations of contemporary Taiwanese novels in the United States after the 1980s. Kung identifies two groups of networks - translator-led (the ones focusing on translators themselves) and subvention networks (the ones focusing on financial sources)- and examines those networks by analysing paratexts and extratexts. The study pays particular attention to the role of social agents and networks in translating lesser-known literature in a dominant culture. The case study is of translations of contemporary Taiwanese novels in the United States after the 1980s. Translator-led and subvention networks are identified through the examination of paratexts and extratexts. Emphasis is placed on the subvention network in the source and target cultures. The study finds that this subvention network may effectively translate and export lesser-known literature, especially for the text selection and

the possibility of its publication; notwithstanding, the subvention network has restrictions regarding translation production, orienting the target culture in line with their expectations. The case study demonstrates that it is crucial to secure sufficient financial support, establish international connections, and foster good interpersonal relationships and cooperation if the intention for a lesser-known culture is to translate its literature and effectively enhance its image within a dominant culture.

Additionally, two studies can be presented as research in the interpreting field which uses actor-network theory as a framework. Firstly, a doctoral dissertation, *Technologies in Interpreter-Mediated Criminal Court Hearings: an Actor-Network Theory account of the interpreter's perception of her role-space* (2017), written by Jérôme Devaux, aims to examine the interpreter's role perception through the framework of actor-network theory along with role-space. She uses eighteen interviews conducted with the court interpreters as a data set in her study which was built on the available research carried out on the video conferencing interpreting in court. The study concludes that the perception on role-space of interpreters depends on whether they consider themselves, in Actor-Network Theory terms, as the main actor(s) in the network or not, alongside the role-space axes of presentation of self, participant alignment, and/or interaction management. This research also provides several recommendations as to how the court interpreter can re-align her role-space when interpreting supported through video-conferencing tools.

The other study in the interpreting field using Actor-Network Theory is "The Production Network of an Interpreted Lecture within the University Context" (2019), produced by Carmen Brewis. This doctoral dissertation employs Actor-Network Theory as it "allows the researcher to understand better the complexity and the non-linear nature of the process of interpreting." It examines the interpretation network through interviews conducted with translators, students, and the teaching faculty in a university educational setting. All human and non-human actors were analyzed using Actor-Network Theory. The study reveals that the language policy implemented during a specific period significantly influences the actions and compliance of interpreters. Additionally, the interpretation schedule was identified as a crucial actor that could impact what interpreters are able to manage. The research also shows that interpreters were not securely connected to the institution's networks, faced difficulties integrating into broader networks, and

formed a more isolated network. It emphasizes that a safer integration process might occur when interpreters' decisions and actions are not constrained by predefined norms (Brewis, 2019, as cited in Aral Duvan, 2021).

Each and every study previously carried out sheds light on a different perspective on translation studies with the framework of actor-network theory and how different actors – human and non-human - interact and interconnect with each other within different types of translation networks are presented.

Actor-Network Theory framing the methodology of this research

In the light of this theory, this research investigates the expectations of three groups of interlocutors taking roles in service provision, composed of both human actors - physicians, healthcare interpreters, and patients, and non-human actors – video remote interpreting tools driven by technology and legislative documents of the exemplary countries. Healthcare interpreters are inevitable actors in providing healthcare services for people with language barriers in an equitable manner and take an essential role in the service provision for doctors to perform their job effectively (Şan & Duru, 2020, p. 839) and for the patients to seek quality healthcare services. In this respect, the healthcare interpreting network, along with the range of actors involved therein, will be identified. Additionally, this research will explore how this network could be affected by a video remote interpreting tool, as a non-human actor, that would be newly introduced to the existing network, and the interconnectedness of all actors engaged in this network.

This chapter presented a general overview of Actor-Network Theory as well as its application in the field of translation and interpreting studies. It also put forth how this research made use of the Actor Network Theory in accordance with its objective. The next chapter will present the methodology of the study.

CHAPTER 4

METHODOLOGY

In this chapter, the methodology of the study will be elicited. The chapter consists of information on the design of the study, data sources and participants, procedure of the study, data collection instruments and data analysis techniques used to evaluate the outputs.

4.1. DESIGN OF THE STUDY

This research adopts a qualitative research design, which is used when a problem or issue needs to be explored, and when a group or population is to be studied rather than using predetermined information from literature. The chosen research design aims to provide a complex and detailed understanding of video remote interpreting practice, which is considered an emerging issue in the healthcare field. Such an understanding can be achieved only through communication directly with people, going to their homes or place of work, and “allowing them to tell the stories unencumbered by what we expect to find or what we have read in the literature” (Cresswell, 2007, p.40).

This research employs a qualitative exploratory design to investigate user expectations of video remote interpreting tools in healthcare settings. Aiming to ensure an in-depth exploration of the subject matter, the study employs triangulation, which is defined as the use of multiple methods or data sources in qualitative research to develop a comprehensive understanding of phenomena (Patton, 1999, p.1193). Among the four types of triangulation commonly used to ensure the credibility and validity of qualitative findings—(a) method triangulation, (b) investigator triangulation, (c) theory triangulation, and (d) data source triangulation—this study integrates two: method triangulation and data source triangulation, aiming to solidify data validation. Method triangulation is defined as the use of multiple methods of data collection about the same phenomenon in qualitative studies (Carter et al., 2014, p. 545); thus, the data sources of this study are composed of 1) semi-structured in-depth interviews, 2) research diaries, and 3) document reviews. Data source triangulation, on the other hand, involves collecting data from different types of people to gain multiple perspectives (ibid); therefore, the interviews are carried out with three interlocutor groups: physicians, healthcare interpreters, and foreign patients. The following parts

will provide detailed information on the components of these two types of triangulations utilized in the scope of the research.

4.1.1. Data Sources

The first data source comprises semi-structured in-depth interviews with questions tailored to each interlocutor group. These interviews serve as a core component of the data set, as they are designed to elicit participants' experiences, expectations, and evaluations of video remote interpreting in healthcare settings. Given their central role in the research process, it is essential to briefly outline the rationale for using interview studies in qualitative inquiry.

As one of the primary methods of qualitative social research, interview studies offer several practical advantages, such as collecting a large amount of on-target information, and the researcher does not have to wait until a phenomenon of interest emerges naturally (Have, 2005, p.5). They also allow researchers to have privileged access to a person's thoughts and opinions regarding a specific subject, which may not be possible to reach through direct observation of behavior (Saldanha & O'Brien, 2004, p.169).

Although interview studies typically involve a limited number of participants, thus, they can rarely be generalized to a wider range of population, they can be considered as a fact-finding exercise (ibid). In this light, an interview study was decided to be carried out to investigate the opinions and expectations of physicians, interpreters, and foreign patients as the potential users of a VRI system, which may be integrated into the Turkish healthcare system in the future.

Another challenge that can be encountered in interview studies is the potential for researcher bias during the interview process, which can be minimized by keeping the researcher as neutral as possible and structuring the interview schedules. Accordingly, this study employed semi-structured interviews to enhance neutrality while allowing for a guided yet flexible conversation flow. The decision not to use fully structured interviews stems from the advantages of the semi-structured format. This approach allows for more open-ended questions, and greater flexibility to allow variation in the order in which the questions are asked as well as the possibility of

introducing new questions (Saldanha & O'Brien, 2004, p.173). Detailed information about the interview questions is provided under the data collection tool section.

In addition to interviews, the second data source includes research diaries, which capture the researchers' reflections and insights gained from the field while collecting the data. Unlike quantitative methods, qualitative research recognizes the researcher's interaction with the field and its participants as an integral component of the knowledge production process rather than viewing it as an external influence. The subjectivity of both the researcher and the participants is embedded within the research context and contributes meaningfully to data interpretation.

Researchers' reflections on field experiences—including their observations, emotions, reactions, and emerging insights—are considered valuable data. These reflections are systematically recorded in research diaries or contextual notes in order to contribute to the interpretation of findings (Flick, 2009, p.16). As one of the research aids, research diaries help identify patterns and also keep track of the development of emerging ideas (Saldanha & O'Brien, 2004, p.227).

In this research, the research diary includes notes reflecting observations on various forms of evidence as well as impressions derived from interviews conducted with the recruited participants. Considering that “the researcher diary can be seen as an integral part of the development of the researcher and the construction of research knowledge” (Engin, 2011, p. 303), the diary served as a tool for documenting analytical reflections and facilitated critical awareness of the researcher's role throughout the data collection process conducted in a real-life healthcare setting.

Lastly, the third data source of this research consists of a review of legislative documents and regulations concerning video remote interpreting (VRI) for the identified exemplary countries. For this purpose, four countries—namely the United States, Australia, the United Kingdom, and Canada—were selected based on their demonstrated experience in integrating VRI into healthcare systems, the accessibility of official documents, and their relevance to informing potential applications within the Turkish context. After identifying the four countries, the research proceeded with a focused document analysis aimed at uncovering how legislative and administrative mechanisms support the integration of VRI in healthcare delivery. Reviews are

essential to contextualize the subject area and to provide insight into the respective research field, as also mentioned below by Snyder (2019, p. 339):

“Literature reviews play an important role as a foundation for all types of research. They can serve as a basis for knowledge development, create guidelines for policy and practice, provide evidence of an effect, and, if well conducted, have the capacity to engender new ideas and directions for a particular field. As such, they serve as the grounds for future research and theory”.

In light of Snyder’s remarks, conducting a literature review on VRI helps not only the reader to grasp the basic information about what VRI is but also the researcher to identify the remarkable country-specific examples where the VRI practice is successfully carried out in their national healthcare systems. Upon identifying those exemplary countries, the legislative documents and regulations on VRI in those countries were reviewed and presented in this study with the aim of illustrating how VRI is implemented in practice and to examine the extent to which these regulations shape its application in healthcare settings.

As previously discussed, integrating these three data sources aims to enable data source triangulation, enhancing the validity and depth of the study’s findings. The combined use of in-depth interviews, research diaries, and legislative document reviews was designed to support a comprehensive analysis, allowing for an understanding of VRI implementation from multiple perspectives.

4.1.2 Participants and Sampling Method

In qualitative research, it is essential to clearly articulate the procedures for participant sampling and recruitment as the sampling methods are not done using tried and tested procedures to ensure statistical representativeness. Instead, the reliability largely depends to a great extent on the transparency of the data elicitation process (Saldanha & O'Brien, 2004, p.183).

Given that the purpose of conducting interview-based qualitative studies is rarely to generalize to broader populations but rather to provide rich and diverse information from key participants, purposive sampling - where participants are selected based on principled criteria so as to cover the

key aspects of the research question- (ibid, p.180) is thought to be more effective to achieve this goal. Using purposive sampling techniques aims to focus on obtaining detailed and rich information from ‘fit-for-purpose’ (Sarfo et al., 2021, p.62) participants.

The participant recruitment process was initiated through the researcher's personal and professional network. Considering that contacting with the gatekeepers can be useful as they can guide the researcher and help to find the most appropriate people to interview (Morris, 2015, p. 86), the researcher established the initial contact with the “International Patient Services Director” in a private hospital located in Ankara that serves a significant number of international patients.

Following that the research topic was welcomed by management, and the necessary formal approval was obtained from the management through a formal letter. The directorate subsequently facilitated access to a list of potential participants under three main interlocutor groups, as detailed below, along with the relevant selection criteria:

1) Physicians

Selection Criteria: Currently providing healthcare services at the selected hospital and have previously examined foreign patients through an interpretation service (either in person or online).

2) Healthcare Interpreters

Selection Criteria: Currently delivering healthcare interpreting services to foreign patients seeking healthcare services at the selected hospital, with prior experience in interpreting within a healthcare context.

3) Foreign Patients

Selection Criteria: Patients who are unable to communicate in Turkish and require the assistance of a healthcare interpreter in order to access medical services at the selected hospital.

Data source triangulation was achieved by collecting data from three distinct interlocutor groups, enabling a comprehensive examination of the research topic from multiple perspectives. This

methodological strategy strengthens the study's depth and validity by capturing a range of diverse experiences and viewpoints.

When examining the issue of sample size in qualitative research, the literature presents a variety of perspectives, as sample size is largely shaped by the chosen research design and the specific objectives of the study. While some scholars offer general guidelines based on the type of qualitative design—for instance, narrative studies may include one or two participants, phenomenology typically involves 3 to 10, grounded theory 20 to 30, and case studies around four to five cases—these figures serve only as rough estimates rather than prescriptive rules (Creswell & Creswell, 2018, p.301). As an alternative and widely accepted approach, the concept of data saturation has been introduced to determine when to conclude the data collection. In this study, data saturation was adopted as the guiding principle for determining sample size, as it aligns with the exploratory and in-depth nature of the research design.

Saturation describes the point in which additional new data no longer provides new perspectives or reveals new characteristics in qualitative data collection, signaling that further interviews are unlikely to yield novel idea; therefore, it foresees that the researcher will stop collecting data when data saturation is reached (Creswell & Creswell, 2018, p.381; Creswell, 2013, p.289). In this study, data saturation was considered to be reached when no new views or themes emerged in relation to the four main analytical dimensions concerning the use of video remote interpreting. The number and distribution of interviews conducted are detailed in the findings section.

As Morris (2015, p.91) notes in his book - “A Practical Introduction to In-Depth Interviews”, after a series of interviews are conducted, the researcher can usually get an idea of whether sufficient data has been obtained to answer the research questions. However, gaps may still emerge during the analysis and writing stages, potentially requiring a return to the field for additional data collection. In this study, although the possibility of returning to the field was considered during data analysis, no such need arose, as the collected data were deemed sufficient to comprehensively address the research objectives.

4.2. PROCEDURE

(1) Prior to initiating the official procedures of this research, a Thesis Review Committee consisting of three members was established to evaluate the research proposal, provide constructive feedback throughout the thesis writing process, and ensure the feasibility of the research design and methodology in accordance with academic standards. The committee members, the researcher, and the thesis advisor convened a total of six times (27 September 2022; 19 January 2023; 16 June 2023; 12 January 2024; 5 June 2024; and 16 January 2025). During each meeting, the researcher presented completed work and outlined plans for the upcoming period. The committee members offered valuable guidance and feedback at every stage of the process.

(2) As an initial step, the literature review was conducted to provide foundational information on video remote interpreting (VRI). Relevant sources have been analyzed to identify and classify the key terminology and present the classification/taxonomy for the associated modalities. During this process, an ambiguity in terminology has been observed, and the taxonomy serving this study's purpose has been identified. Based on this identification, the research content table has been structured accordingly. Additionally, a brief English-Turkish glossary has been prepared in line with this classification and included as an annex to the study.

(3) The initial research topic was titled “Video Remote Interpreting in Telemedicine Services: The Case of Turkey”. The “Telemedicine” concept is defined as “the remote delivery of healthcare services by all healthcare professionals using information and communication technologies”. Türkiye was one of the countries that put initial seeds for capacity building with few telemedicine applications as physical interaction has become a severe risk factor for the spread of COVID-19. A pilot study was conducted in 2021-2022 in collaboration with the Ministry of Health and the World Health Organization. Also, the telemedicine application became official upon the legislation being effective on Digital Health Service Provision in Türkiye in February 2022.

Given these developments, the researcher initially intended to observe and examine the real-life application of VRI in consultation sessions provided through the telemedicine system. However, during the research process, telemedicine practice was not being implemented to the degree

expected. After a period of observation and communication with hospital managers and other relevant staff, the researcher was informed of various challenges hindering the system's broader implementation.

Consequently, the telemedicine component was decided to be excluded from the research scope, and the study was refocused solely on VRI. As the exclusion of the telemedicine component also resulted in the nonavailability of real-time exercises for VRI, the researcher shifted the focus to exploring the expectations of possible VRI users (who are identified as physicians, healthcare interpreters, and foreign patients) within the context of face-to-face healthcare delivery. The revised title of the study was defined as "Video Remote Interpreting (VRI): A New Dimension for Turkish Healthcare System".

(4) Chapter 2 – Literature Review was initially written in accordance with the first-identified research subject; therefore, it included an extensive discussion of telemedicine practices. It provided a detailed overview of how telemedicine has been implemented in the selected exemplary countries, including relevant legislation and previous studies. Following the revision of the research focus, this chapter was thoroughly updated to reflect the shift toward video remote interpreting (VRI) as the primary subject of investigation

(5) Shaped according to the original research focus, the data collection tool was initially designed as a questionnaire, reflecting the early emphasis on VRI practices within telemedicine services. However, the exclusion of the telemedicine component led to revisions in the design of the data collection tool as well. Upon the advice received from one scholar specialized in measurement and evaluation, particularly in the field of remote education, the format was shifted from a questionnaire to semi-structured interview questions. This change aimed to elicit deeper insights from participants regarding a brand new practice—video remote interpreting—that they may have had little or no prior experience with.

As a result, a set of in-depth interview questions titled "In-depth Interview Questions to investigate the expectations/opinions on video remote interpreting services that could be potentially integrated into the healthcare system in Türkiye" was developed by the researcher

under the supervision of the thesis advisor. Following its initial development, the tool was reviewed by two field experts, whose feedback was incorporated into the final version. The finalized tool was then submitted to the Hacettepe University Social Sciences and Humanities Research Ethics Board and received approval on 11 February 2025.

(6) Following the receipt of ethical approval, an official letter has been submitted to the management of the selected private hospital, where the research was planned to be conducted. The letter requested permission to conduct interviews with the participants to be selected from the hospital's staff and foreign patients.

(7) A pilot study has been performed through the administration of questions to one representative from each participant group at the same hospital. Based on the pilot results, no substantial revisions were deemed necessary; thus, these participants were included in the main sample group.

(8) Data collection was completed within five working days in April 2025. A total of 28 in-person interviews were conducted, including 11 healthcare interpreters, 10 physicians, and 7 foreign patients. The interviews with interpreters and physicians were conducted in Turkish. Among the seven interviews with foreign patients, two were conducted with the support of a healthcare interpreter, while the remaining five were conducted in English by the researcher.

4.3. DATA COLLECTION TOOL

The very first draft of the data collection tool was inspired by the questionnaire used by Lazard et al. in their study titled “App Designs and Interactive Features to Increase mHealth Adoption: User Expectation Survey and Experiment” which aimed to elicit user expectations for 12 mobile health application features. In their study, participants rated applications for “increase in application choice, aesthetics, perceived ease of use, perceived usefulness, intentions to use the app, and perceived affordances or action possibilities with the application” (2021, p.2).

Building on this framework, four unique thematic categorizations which are “ease of use, usefulness, perceived affordances, and intentions to use” were made use of the basis for the data

collection tool developed in this research to investigate user expectations regarding the video remote interpreting tools in health care services. These four categories are defined as follows:

- (1) Ease of use: the degree to which a new video remote interpreting tool/system which results in adopting a process into the existing healthcare system can be utilized effortlessly and intuitively without requiring extensive effort.
- (2) Usefulness: The extent to which a new video remote interpreting tool/system effectively enables users to achieve their goals or fulfill specific needs.
- (3) Perceived affordances: The qualities or features of a new video remote interpreting tool/system that suggest or enable specific actions, as interpreted by users based on their prior experience and expectations.
- (4) Intention to use: The possible user's deliberate willingness to adopt and engage with a new video remote interpreting tool/system as a new technology in the future while providing or receiving health care services.

As indicated in the Procedure section, although the initial draft of the data collection tool was designed in the form of a Likert-scale questionnaire, the format was later converted into semi-structured in-depth interview questions. This transformation was made in recognition of the value of in-depth interviews as a highly effective method for obtaining rich and nuanced data in social research.

Considering that an interview allows the researcher “access to interviewees’ thoughts, reflections, motives, experiences, memories, understandings interpretations and perceptions of the topic under consideration”, this change in format transformation has given the researcher the opportunity to establish why people construct the world in particular ways and think the way they do”. Thus, in-depth interviews make possible to obtain an understanding of the social reality under consideration and, depending on the circumstances, collect rich data fairly rapidly” and the researcher can elicit the information or consideration that could not have been obtained in any other way (Morris, 2015, p.17-18).

As stated by Johnson and Rowlands (2012, p.103), careful planning and preparation form the basis of successful interviews; therefore, researchers should diligently complete all required steps before

initiating the process. In this context, considerable time was devoted to designing a well-structured data collection tool to ensure the elicitation of meaningful perception from participants and to generate a robust set of core data for the study.

Following an extensive design process, the data collection tool – titled “In-depth interview questions form to investigate the expectations/opinions on video remote interpreting services that could be potentially integrated into the healthcare system in Türkiye” was finalized. Separate versions were prepared for each participant group (physicians, healthcare interpreters, and foreign patients), with questions tailored to the perspectives of each interlocutor group (see Appendix 1).

The interview question forms are structured into 3 main sections:

Section 1- Socio-Demographic Information

This section includes questions adapted to each interlocutor group and collects basic socio-demographic data such as sex, age, educational status, and professional background.

Section 2- Current Practices and Experience

This section explores existing practices in situations where foreign patients require in-person language support to access healthcare services. It also examines participants’ familiarity with the concept of video remote interpreting (VRI), its potential use in healthcare, and whether they have any prior experience with VRI.

Section 3- Expectations/Opinions regarding the VRI practice

This section consists of questions tailored to each interlocutor group and aims to explore the expectations and opinions of potential VRI users in the Turkish healthcare system. The questions are structured according to four thematic dimensions: perceived ease of use, perceived usefulness, perceived affordances, and intention to use this new technology-mediated tool.

In general, those open-ended interview questions aim to reveal the expectations and opinions of the possible VRI users—namely physicians, healthcare interpreters, and foreign patients—who are already familiar with the in-person interpreting system currently practiced in Türkiye. The interviews offer a platform for participants to reflect on their existing knowledge and experience,

and to express how they would perceive and engage with such a brand-new system in case video remote interpreting tools were to be potentially integrated into the current Turkish healthcare system.

The data collection tool was specifically designed to address the second research question of the study. The information gathered from participants was analyzed to find the responses to these questions.

4.3.1. Validation of the Data Collection Tool

The in-depth interview questions were developed by the researcher in collaboration with the thesis advisor. In line with the definition of content validity as “the ability of an instrument to reflect the domain of interest and the conceptual definition of a construct” (Yasir, 2016, p.2), efforts were made to ensure content validity throughout the development process. “Although content validity is a subjective form of validity, assessing content validity with a panel of experts who evaluate the measure on objective criteria enables the researcher to make significant improvements to the measure prior to pilot testing the instrument” (Rubio, 2005, p.496).

In this regard, two expert opinions were solicited upon the completion of the questions. One of whom was an expert on assessment and evaluation and the other while the other is an expert in the Translation & Interpreting Department. Based on their feedback and suggestions, the interview questions were revised and finalized. Subsequently, ethical approval was obtained from Hacettepe University Social Sciences and Humanities Research Ethics Board. Pursuant to the ethics board’s approval, an official letter was submitted to the hospital management to request permission for data collection within the scope of this research.

Despite the fact that “the less predictable format of semi structured interviews means that pilot runs are not as helpful as in structured interviews”, Saldanha & O'Brien (2004, p.178) emphasize that “...when piloting is not possible, it is essential nevertheless to obtain feedback about the questions prepared, if possible, from people who fit the profile of the participants”. In this study, a pilot test was nonetheless conducted with one participant from each interlocutor group. As no

substantial changes were deemed necessary based on the pilot results, the questions were retained without revision.

4.4 DATA ANALYSIS

The first data set in this exploratory qualitative study consists of a document review that was conducted to address the first research question. The findings of this review are presented in Section 2.2.2, *Exemplary Countries for Video Remote Interpreting in Healthcare Services*. This section responds to the following research question introduced in the Introduction chapter:

- How do the exemplary countries perform video remote interpreting (VRI) services in their healthcare system in light of their available administrative documents?
 - a- Legislation and regulations
 - b- Practice

The document review aimed to identify the administrative documents available in exemplary countries where VRI has been successfully integrated into healthcare service provision and to highlight the best practices observed in these settings.

This study also employs a thematic analysis (TA) approach to systematically identify patterns and themes within the second qualitative data set, which was collected through semi-structured in-depth interviews. The aim of the analysis is to explore user expectations regarding video remote interpreting tools in healthcare settings, based on the perspectives of three interlocutor groups—physicians, healthcare interpreters, and foreign patients—as potential users of such tools.

The study applies thematic analysis, defined as “a method for identifying themes and patterns of meaning across a data set in relation to a research question” (Braun & Clarke, 2013, p.175). As a subtype of TA, experiential thematic analysis is adopted considering that it “focuses on the participant’s standpoint and how they experience and make sense of the world” (ibid).

The figure below outlines the steps followed to conduct the thematic analysis of the data collected through semi-structured interviews with the three interlocutor groups.

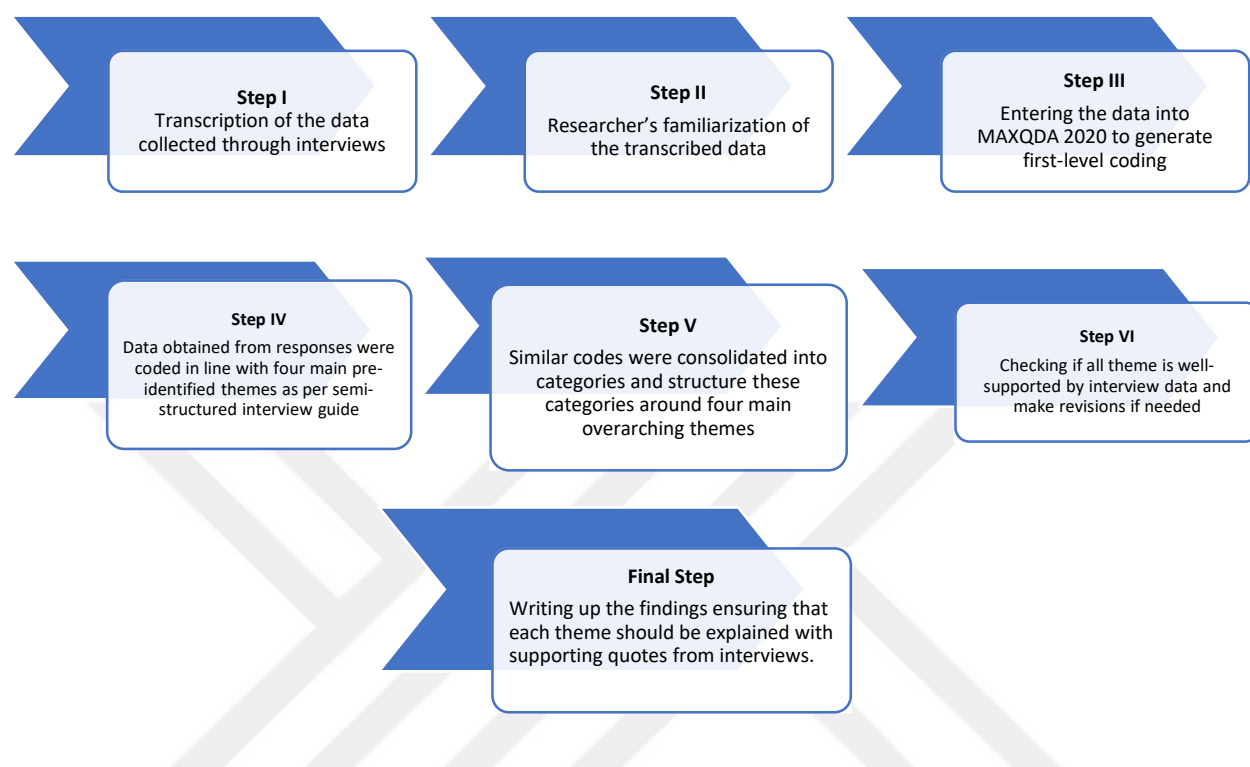


Figure 17: Steps followed in the thematic analysis of the collected data

As illustrated in Figure 13, the first step in the analysis process was the transcription of the interview data, followed by the researcher's familiarization with the transcribed content. According to Saldanha and O'Brien (2004, p.193), identification of initial thoughts, interesting patterns, or key statements helps the researcher at this initial stage to familiarize themselves with the collected data. Considering that remembering how thoughts and decisions were shaped and on what basis is important at the analysis step; thus, a research aid (ibid) can help to achieve this aim, a researcher's diary was kept as the third data set of the study. The diary notes were used to record insights and reflections and served as a reference point during the interpretation of findings.

Following the researcher's familiarization of the data, the interview transcripts were uploaded into MAXQDA 2020, a qualitative data analysis software, to be subjected to initial coding. This coding is defined as "a process of identifying aspects of the data that relate to the research question" (Braun & Clarke, 2013, p.206). The main aim of this initial coding is to have a meaningful segmentation of the text.

The data obtained from participant responses were initially coded in alignment with the predefined thematic framework; subsequently, similar codes were consolidated into categories, which were then systematically interpreted within the scope of each overarching theme.

The content analysis employed a primarily inductive approach, complemented by partial deductive elements. Although the main thematic framework was predefined based on the research questions as per a semi-structured interview guide (perceived ease of use, perceived usefulness, perceived affordances, intention to use) through a deductive approach, the content analysis mainly followed an inductive approach, allowing categories and codes to emerge directly from the data. The themes were predefined during the development of the interview questions, adopting a deductive approach that guided the researcher from general concepts to more specific inquiries aiming “not to test hypotheses but rather to propose new avenues for research, for example, new ways of looking at data” (Saldanha & O'Brien, 2004, p.64). This initial deductive structuring was subsequently complemented by an inductive process during data analysis, allowing for the emergence of new categories and codes grounded in participants' responses.

After a while, all those categories and themes have been reviewed to ensure whether they reflect the new insights in line with the responses and to revise them accordingly if needed. In addition to codes and categories shaped around the pre-identified themes, selected illustrative quotations from the respondents were included and presented as examples under the relevant categories. Upon the completion of these analytical steps, findings have been written and presented in this study.

Given the exploratory nature of this study, thematic analysis has been considered particularly suitable as it allows for the identification of patterns, themes, and insights across different participant groups, providing a comprehensive understanding of their perspectives.

The data collected through interviews and research diary are analysed with the aim to answer the second and third research questions of the study which indicated below:

- What are the expectations/opinions of interpreters, physicians, and patients from the potential implementation of the video remote interpreting (VRI) services in the Turkish healthcare system in terms of the below factors:
 - a- perceived ease of use
 - b- perceived usefulness

c- perceived affordances

d- intention to use

- What sort of a systematic structure can be the possible best example to provide a VRI service in the Turkish healthcare context?

Moreover, Actor-Network Theory (ANT) was employed as a theoretical framework to explain the relationships between actors in the discussion of the findings. As discussed in Chapter 3 (Theoretical Framework), prior research in Translation Studies has demonstrated that ANT is an effective approach for explaining the impact of both human and non-human actors on the interpreting process. In the context of this study, the theory was also considered valuable for examining how the introduction of a new non-human actor—namely, a video remote interpreting system—can reshape the dynamics between existing actors in healthcare interpretation settings. It also sheds light on how the relationships between these actors can be affected by this introduction.

CHAPTER 5

FINDINGS AND DISCUSSION

This chapter presents the findings obtained through a qualitative method involving three distinct participant groups, and the data are analyzed and demonstrated within the framework of categories and themes derived from the interview responses.

5.1. PARTICIPANTS PROFILE

This section presents the sociodemographic profiles of the participants, along with their levels of awareness and experience regarding video remote interpreting. Additionally, it provides an overview of the existing face-to-face interpreting system in the hospital where data were collected, including insights into the participants' satisfaction or dissatisfaction with the current system and how it functions in practice.

The study sample consisted of 28 participants, including 11 interpreters, 10 healthcare professionals (9 physicians and 1 dietitian), and 7 foreign patients. In the presentation of findings, the participants have been coded as T1, T2, etc. for interpreters, D1, D2, etc. for physicians, and H1, H2, etc. for patients to ensure clarity and maintain anonymity throughout the analysis.

Data collection continued until data saturation was reached, meaning no new relevant information emerged during interviews. This decision was based on the researcher's judgment given that data saturation (Creswell, 2013, p.289) occurred when additional data no longer provided new insights into the research questions. In addition to reaching data saturation, the researcher decided to conclude the interviews with the patient group at 7 participants, considering both the limited emergence of new data and potential adverse psychological effects that may be apt to emerge during further interviews.

Before delving into the thematic analysis, a general overview of the participants' sociodemographic characteristics will provide a contextual foundation for interpreting the findings.

Participants were diverse in terms of gender, with 10 females and 18 males in total, and ranged in age from 26 to 56 years. Almost all doctors and interpreters have more than five years of

professional experience in their respective fields and, also met the selection criteria for participation in this term. Furthermore, foreign patients participating in the study represented various linguistic and cultural backgrounds, reflecting the multicultural nature of the Turkish healthcare context. This diverse participant profile provided a comprehensive perspective on the potential integration of video remote interpreting services into the national healthcare system.

The detailed socio-demographic information along with their levels of awareness and experience regarding VRI per each interlocutor group is provided below.

5.1.1 Physicians

Nine physicians with their specialties in various departments, including gastroenterology, neurology, ophthalmology, orthopedics, general surgery, and emergency medicine, responded to the open-ended questions. Additionally, one dietitian participated in the study, offering a distinct perspective as her work is not structured around the appointment system like that of the physicians; therefore, the need for interpreters to be deployed for instant appointments arises without prior arrangements.

Looking at gender and age range, the participant group consisted of three female and seven male respondents, with an age range predominantly over 40 years. The youngest participant was 29 years old, while the oldest was 56 years old.

Regarding awareness of VRI services, four participants indicated that they are familiar with the service, while six stated that they are not informed about this type of service. In terms of experience regarding the use of VRI, eight participants stated that they had never experienced VRI previously. Among the two participants who reported having some form of experience, one had encountered the telephone-based version of remote interpreting during a training session in New Jersey, USA, in 2013. The other participant reported frequently providing consultancy services with the support of a remote interpreter connecting through telephone but not through video-based interpreter.

It is noteworthy that although participants responded the respective question that they had no prior experience with video remote interpreting, the researcher identified instances during the interview discussions where they referenced providing services through telephone interpreting as part of

their routine practice. This observation suggests a discrepancy between the participants' perceived experience with VRI and their actual engagement in remote interpreting through telephone-based methods.

5.1.2. Interpreters

The interpreter group comprised 5 males and 6 females, achieving a gender-balanced sample, which was facilitated by the researcher's direct access to their office. The age range of the participants varied from 26 to 46 years.

A notable aspect of the interpreter group was their relatively high educational background, with two holding doctoral degrees, one holding a master's degree, and eight holding bachelor's degrees. The fields of study were diverse, encompassing history, business administration, international relations, medical secretarial studies, biology, journalism, French Language and Literature, public relations, English linguistics, and electrical engineering. Despite the diversity of academic backgrounds, the predominant focus on language and communication-related disciplines suggests that educational qualifications and relevant expertise were significant considerations in the hiring process at the hospital.

Additionally, two participants holding managerial roles have provided valuable insights from a management perspective, which offered a broader understanding of expectations and perceptions regarding VRI implementation.

The native languages of the interpreters included Turkmen, Azerbaijani, Arabic, French, Farsi, and Somali. Additionally, some interpreters were born in Türkiye, making Turkish their native language, and they provide interpreting services across these languages.

The duration of residency in Türkiye among the interpreters varied considerably, with one having resided for less than 5 years, six for 10 to 20 years, and one for over 35 years while the remaining three were already born in Türkiye.

When examining the awareness and experience with VRI, the majority of the interpreter participants indicated that they were aware of such type of services. Five participants stated that

they had prior experience with VRI in their previous working places before recruited at this hospital. For instance, one interpreter reported using remote interpreting at a genetic centre through online consultations with international patients to generate genetic reports, also provision of interpreting services between the international genetic center doctors and the Turkish-speaking physicians. Another mentioned engaging in remote interpreting for international patient consultations to provide telemedicine services during COVID times, noting that the communication was not efficient between interlocutors. Another respondent referred to utilizing VRI to facilitate communication for a patient connecting from Iraq which may require via arrangements for a face to face interaction. The respondent stated that this remote session was so efficient as all procedures could be completed without losing any time for transportation and other arrangement therefore they successfully completed a consultation session with Internal Medicine department and even prescription was written for this patient with the support of remote interpreting.

For instance, one interpreter (T4) reported utilizing remote interpreting at a genetic center through online consultations with international patients to generate genetic reports. This also included providing interpreting services between the international genetic center doctors and Turkish-speaking physicians at the facility. Another participant (T5) described engaging in remote interpreting for international patient consultations to deliver telemedicine services during the COVID-19 pandemic, noting that communication between interlocutors was often ineffective.

A further example involved a respondent (T6) provided an example of VRI implementation stating that:

“We did it a couple of times, it was through video. It was last year, with the gynecology department. The patient came here for a consultation, but the test results were delayed, so she had to go back. Later, she couldn’t get time off work and asked if we could have a video session. We got permission from the doctor, and the patient took an hour off from work. We all sat down and connected at the agreed time.”

The participant also added that s/he also facilitated communication for a patient connecting from Iraq, whose circumstances might have necessitated visa arrangements for a face-to-face interaction. The participant noted that the remote session was particularly effective, as all

procedures were completed without the delays associated with transportation and logistical arrangements. The session included a consultation with the Internal Medicine department, during which a prescription was also successfully issued at the end of session with the support of remote interpreting.

Those who reported no direct experience with VRI noted that they had provided interpreting services via telephone or WhatsApp but not through video-based platforms.

Overall, as individuals actively engaged in interpreting services, the interpreter group provided the most informed and detailed perspectives regarding VRI, offering insights grounded in their extensive professional experience and their familiarity with remote communication practices.

5.1.3. Foreign Patients

The patient group was the most challenging to recruit, as the selection process was not based on predefined criteria. Instead, the researcher waited for international outpatients arriving at the International Patients Unit and coordinated with interpreters to identify potential participants.

Subsequently, inpatients who were deemed suitable to participate were approached in coordination with interpreters. Patients who were considered emotionally or physically unfit to participate were excluded from the scope of the research to ensure their well-being.

In light of the aforementioned conditions, a total of seven patients, comprising one female and six males, were included in the study.

The age range of the patient participants ranged from 28 to 58, reflecting a diverse distribution within the sample.

Some participants reported having resided in Türkiye for 2 to 3 years, while others stated that they were in this country solely for the duration of their healthcare services, ranging from 2–3 days to one week.

In these interviews conducted with patients from various nationalities, two were conducted through interpreters (Arabic and Mongolian), while the remaining five were carried out in English by the

researcher herself. However, it should be noted that in all interviews conducted in English, none of the participants were native speakers of English, and thus, potential language limitations should be considered.

Another point to consider is that the participants were neither refugees nor asylum seekers; rather, they visit Türkiye for health tourism purposes or voluntarily reside in the country for business-related reasons.

When examining the participants' prior knowledge and experience with VRI, only one participant indicated being aware of such a system. Furthermore, none of the participants reported having any prior experience with VRI, underscoring the unfamiliarity of video remote interpreting services within this particular patient group.

After presenting the sociodemographic characteristics and VRI knowledge/experience of the three participant groups, it would be valuable to provide an overview of how the existing face-to-face interpreting system operates in the hospital where the interviews were conducted and the related data were collected. This information will offer important contextual insights for understanding the current interpreting practices and to lay a foundation for the subsequent analysis.

5.2. THE AVAILABLE FACE-TO-FACE INTERPRETING SYSTEM

VRI services have not yet been implemented in Türkiye; therefore, data were collected from a private hospital where a F&F is available in order to explore the potential perspectives and expectations of prospective users if such a system were to be introduced. In this section, the operational structure of the existing face-to-face interpreting system at this hospital, how the service users and providers engage with this system, and their positive and negative perceptions of it will be outlined to provide a contextual basis for interpreting the subsequent analysis findings.

A manager-level interpreter (T1) provided a comprehensive overview of the operational structure of the face-to-face interpreting system at the hospital, particularly focusing on a patient healthcare service journey from the initial contact to post-treatment follow-up. According to the respondent, international patients typically initiate contact with the hospital remotely, either via telephone or messaging applications, to inquire about potential treatments. Following the submission of medical

reports, consultations with physicians are arranged, and patients are provided with a provisional cost estimate based on treatment complexity. If the patient decides to proceed, a medical visa invitation is issued to facilitate entry into Türkiye, and the interpreter coordinates all necessary logistical arrangements, including accommodation and transportation.

Upon the patient's arrival, the interpreter plays a central role in navigating the hospital processes, from initial consultations to diagnostic testing and treatment planning. The respondent emphasized that interpreters remain with the patient throughout all stages, from check-in at the reception to communication with medical staff and even such matters as arranging transportation or purchasing medication as per the prescription. Additionally, the interpreter underscored the importance of maintaining patient confidentiality and cultural sensitivity, particularly in gender-sensitive medical procedures, where gender-concordant interpreters are often requested.

In cases involving surgery or extended treatment, the interpreter assumes a quasi-coordinator role, managing post-operative arrangements such as follow-up appointments, discharge procedures, and ongoing communication with the patient even after they return to their home country. The respondent noted that some patients maintain contact with interpreters for years, with interpreters acting as informal patient liaisons for ongoing medical concerns or further treatment plans.

Furthermore, a comprehensive reception process is available for international patients. Upon arrival, they are directed to a designated waiting area — a spacious room where they are comfortably accommodated until their scheduled consultations. This centralized space not only facilitates efficient coordination between patients and healthcare providers but also serves as a welcoming environment for those unfamiliar with the hospital setting.

The interpreting services at the hospital operate on a structured schedule, with interpreters on weekdays, and also on Saturdays. Additionally, a night shift interpreter is assigned daily from 3:00 PM onwards to cover interpreting needs after the day shift ends. Meanwhile, one interpreter (T8) noted that in cases where interpreting is needed while they are away from the hospital, they remain reachable by phone and can provide interpretation services remotely when necessary.

While appointments for all departments, except the emergency and dietitian units, are scheduled in advance, urgent interpreting needs for these two units are addressed on an on-demand basis. Requests are directed to the interpreters at the International Patients Unit based on the required language, ensuring immediate response and allocation. Furthermore, T8 mentioned that if an interpreter is not deployed to the department where the patient is waiting, the desk staff do not allow the patient to enter the doctor's room unless the case is urgent.

In conclusion, the hospital operates a well-structured appointment system that effectively organizes interpreting services. Interpreters arrange all consultation appointments with the respective physicians and accompany patients during their sessions, ensuring that interpretation services are planned and coordinated in advance rather than provided in response to sudden or unanticipated needs. Consequently, concerns regarding deployment time are minimized, as interpreters are scheduled according to the pre-established appointment system.

The following explanations outlines the participants' perceptions regarding the existing face-to-face interpreting system, focusing on their satisfaction levels and the aspects they found particularly effective or challenging. The responses are categorized based on the three participant groups — physicians, interpreters, and foreign patients — to provide a comprehensive understanding of how each group experiences and evaluates the current system.

To begin with, the perspectives of physicians regarding the existing face-to-face interpreting system are presented to highlight their levels of satisfaction, perceived challenges, and overall experiences with the service. Without exception, all physicians expressed overall satisfaction with the current system, though a few participants provided additional remarks.

From a positive perspective, several physicians emphasized that not having to engage with an additional technological system expedites the consultation process. One participant (D10) noted that the physical presence of the interpreter enhances the sense of trust and assurance conveyed to patients. Additionally, some participants (D8, D9, D10) indicated that in cases where an interpreter was not available, they relied on telephone interpreting services to communicate with patients. They further stated that this alternative mitigates potential disruptions caused by interpreter unavailability, contributing to their overall satisfaction with the existing system.

Regarding the perceived challenges, two physicians (D3, D4) explicitly expressed concerns about whether their statements were accurately conveyed to patients, indicating occasional doubts regarding the completeness of the interpreted information. It is also worth noting that another physician, who was excluded from the study due to her inability to allocate time for a full interview, mentioned that her primary reason for considering VRI positively was the potential for more accurate and complete communication through AI-supported interpreting, as opposed to human interpreters.

Following the physicians' perspectives, the insights provided by the interpreters regarding the existing face-to-face interpreting system are presented, with a focus on their levels of satisfaction, perceived benefits, and potential challenges, as all interpreters expressed overall satisfaction with the current system despite a few participants providing additional remarks. In terms of positive aspects, several participants emphasized that face-to-face interpreting fosters a sense of sincerity and trust in the service provided. Additionally, they highlighted that the use of gestures, facial expressions, and body language facilitates comprehension, enabling the intended message to be more effectively conveyed. This, in turn, was perceived to enhance the emotional expression of the patient and make it easier to assess the patient's psychological state during the interaction. Moreover, the uninterrupted nature of communication in face-to-face settings was considered beneficial in expediting the consultation process.

One participant (T4) further noted that face-to-face interpreting offers greater professional satisfaction, as it allows for more direct interaction with both patients and healthcare professionals. Another participant (T5) added that being physically present in the consultation room and sharing a joint office with their colleagues also provides a valuable learning environment for interpreters, an opportunity that may not be as readily available in remote interpreting settings.

Although the majority of interpreters expressed positive views, a few participants mentioned minor drawbacks. These included corridor conversations or certain patients' non-interpreting-related requests, which occasionally distracted interpreters and led to time loss. Additionally, one participant suggested that an online system might be more advantageous in terms of maintaining hygiene and minimizing physical contact during interactions.

Following the interpreters' perspectives, the viewpoints of patients regarding the existing interpreting system reveal a consistently high level of satisfaction, with no negative remarks reported. Moreover, their responses centered around specific aspects that contributed to their positive experiences.

In expressing their positive views regarding the existing interpreting system, patients emphasized several key aspects that contributed to their overall satisfaction. The physical presence of interpreters was perceived as a source of comfort and reliability, as one participant remarked that such interaction fostered a stronger sense of connection and trust.

Several participants also expressed appreciation for the interpreters' supportive and approachable attitude, indicating that without their assistance, navigating the healthcare system would have been significantly more challenging. Flexibility and availability were further emphasized, with patients praising the interpreters' immediate responsiveness to various requests and their 24-hour accessibility. This perceived professionalism and attentiveness were consistently associated with a heightened sense of security and reassurance throughout the treatment process.

In summary, the findings regarding the existing interpreting system at the hospital indicate a generally high level of satisfaction among the participant groups, with physicians, interpreters, and patients each emphasizing distinct yet interconnected aspects of the current face to face interpreting services.

Having outlined the operational structure and user perceptions of the existing interpreting system, the subsequent section will delve into a thematic analysis of the data, categorizing key insights under specific themes to further explore the potential implications of implementing VRI in the healthcare context.

5.3 THE ANALYSIS OF CATEGORIES AND THEMES

This section presents the analysis of the data based on the predefined categories and themes, highlighting the key findings and opinions derived from the participants' responses in relation to video remote interpreting services.

The analysis is structured around four main themes, at which the respective categories were inductively developed from the participants' responses and are illustrated through representative quotations¹. The categories were shaped under the pre-defined themes can be seen below:

Theme	Category
Perceived ease of use (Kullanım kolaylığı algısı)	- Scheduling and time management - Situational factors - Human Interaction - Technical Convenience
Perceived usefulness (Yararlılık algısı)	- Healthcare service quality - Suitability for elderly and persons with disabilities - Time efficiency - Health policy and technological integration
Perceived affordances (Uygunluk algısı)	-Task assignment and planning -Confidentiality and data security concerns -Communication quality -Workload and efficiency
Intention to use (Kullanma isteği)	- Positive Intention - Negative Intention

Figure 18: Themes and respective categories in the content analysis of in-depth interviews

The findings will be presented based on overarching thematic patterns observed across the dataset, synthesizing the perspectives of physicians, healthcare interpreters, and foreign patients to provide a comprehensive understanding of the identified themes. While the thematic analysis primarily focuses on commonalities across participant groups, role-sensitive thematic interpretations will also be offered to highlight variations in perceptions among participant groups.

¹ All participant quotes included in this research have been translated by the researcher to maintain consistency and ensure accurate representation of the original statements.

The thematic structure of the data analysis is outlined in the following table, presenting the main categories and their respective subcategories along with the frequency of coded references for each theme. This framework serves as the basis for the subsequent analysis and interpretation of findings.

Codes		387
▼	Perceived Ease of Use	0
>	1-Scheduling and Time Management	30
>	2- Situational Factors	26
>	3- Human Interaction	34
>	4- Technical Convenience	16
▼	Perceived Usefulness	0
>	1- Healthcare Service Quality	26
>	2- Suitability for Elderly and Disabled People	21
>	3- Time Efficiency	25
>	4- Health Policy and Technological Integration	10
▼	Perceived Affordances	0
>	1-Task Assignment and Planning	20
>	2- Confidentiality and Data Security Concerns	29
>	3- Communication Quality	32
>	4- Workload and Efficiency	68
▼	Intention to Use	0
>	1-Positive Intention I would intend to use	24
>	2- Negative Intention - I would not intend to use	13

Figure 19: Thematic coding generated upon qualitative data analysis

Following the thematic coding process, the identified categories and themes are discussed in detail in the subsequent sections, structured under distinct headings to facilitate a comprehensive analysis.

5.3.1. Perceived Ease of Use

This theme examines participants' perceptions regarding the expected ease of using a video remote interpreting system compared to face-to-face consultations. Participants were asked to reflect on the potential for reduced effort, appointment flexibility, and overall usability of such a system.

While several participants recognized the potential advantages of video remote interpreting services in healthcare settings, others expressed reservations about its use, highlighting a preference for traditional face-to-face interactions. These differing views are not seen as contradictions but rather as meaningful contributions that reflect the diverse expectations, experiences, and contextual considerations of stakeholders. Far from weakening the thematic analysis, such perspectives enhance its depth by drawing attention to the potential challenges, limitations, and conditions under which VRI may or may not be perceived as effective or appropriate.

5.3.1.1. Scheduling and Time Management

Scheduling and time management emerged as a significant theme in the analysis, reflecting participants' perceptions of how interpreting services are planned and executed, particularly in terms of appointment coordination and interpreter availability.

Based on observations during the research process, the process of scheduling appointments with interpreters for foreign patients at the study hospital was highly structured and well-coordinated. Therefore, participants were asked to respond to the relevant questions by considering not only the specific conditions at this hospital but also general conditions in other settings.

The analysis of data under the scheduling and time management category reveals mixed perspectives regarding the efficiency and practicality of VRI compared to the existing face-to-face interpreting system. While some of the participants acknowledged the potential advantages of VRI in providing flexibility, particularly during night shifts or when in-person interpreters are unavailable.

They suggested that VRI could be advantageous in urgent or after-hours situations, as it allows for online connection even during night shifts and reduces the need for interpreters to be physically present. This was perceived as particularly beneficial for hospitals with a limited number of interpreters or during periods of increased demand. D2 stated that "Sometimes we have to wait for an interpreter, but with VRI, we could connect online even at night, which would be much more convenient."

Some participants expressed that while the current face-to-face interpreting system is generally effective, the introduction of VRI could potentially offer a more predictable work schedule by allowing interpreters to plan their sessions in advance. One interpreter (T10) explained this perspective, stating that:

“If it were online, it would be more predictable, and I could establish a clear work schedule accordingly, conducting sessions one after another. But with face-to-face interpreting, it depends on patient requests. When we are available, they can come directly, and that sometimes creates a backlog. Issues like these can occur.”

For participants who expressed neutral views regarding the scheduling advantages of VRI, the primary focus was on the perceived level of scheduling flexibility. These participants noted that while VRI theoretically allows for remote access to interpreters without waiting for their physical arrival, the current workload in the hospital is already manageable, and therefore, there is no pressing need for further scheduling adjustments.

In addition to positive and neutral perceptions, some participants also expressed concerns about coordination challenges. They emphasized that while VRI could theoretically facilitate immediate access to interpreters without waiting for physical arrival, practical challenges such as time zone differences and difficulties in synchronizing multiple parties simultaneously were mentioned as potential barriers.

T1 emphasized the logistical challenges associated with coordinating VRI sessions:

“...The time zone difference must also be considered; for instance, a patient in the UK may have a different time frame. Aligning these three schedules could create significant difficulties.”

Additionally, the existing face-to-face system was perceived as more straightforward and easier to manage in terms of scheduling, with participants highlighting that they could directly coordinate with interpreters without the added complexities of virtual platforms.

Overall, the data indicates that while VRI has the potential to streamline scheduling, reduce waiting times, and provide better time management, particularly during night shifts or when interpreters are not physically available, logistical challenges related to time zones, coordination,

and system availability must be addressed to ensure effective implementation. Additionally, participants emphasized that VRI could facilitate more predictable scheduling, minimize delays caused by interpreter unavailability, and offer flexibility for urgent cases, provided that technological infrastructure is adequately developed and maintained.

5.3.1.2. Situational Factors

Situational factors refer to the contextual conditions that impact the perceived ease of use of VRI in the context of healthcare interpreting. These factors include user-specific contexts (e.g., interpreter, patient), device type (tablet or wheeled screen), healthcare setting (physician room, lab, operation room, delivery room), and type of health service (consultation, examination). By examining situational factors, this study aims to understand how certain conditions or contexts influence users' perceptions of the ease of use, highlighting differences based on role, setting, and service type.

A prominent theme in this category was the perceived ease of use of VRI under certain service-specific conditions. Several participants indicated that VRI could be particularly beneficial in departments where consultations are more structured, such as **consultancy sessions**. D1 suggested that VRI may offer more opportunities if applied specifically to consultancy services, where immediate and structured communication is essential with these statements “I think online interpreting would be easier for consultancy sessions, but it wouldn’t be suitable for physical examinations or treatment” (D1) and added:

“For instance, with cancer patients, (it would be beneficial.) Once (at the hospital where I worked previously), a patient arrived for whom we couldn’t provide effective treatment, we had to inform him and send him back to their country. But if he had connected with us online beforehand, we could have assessed whether coming here would be beneficial or cost-effective before he made the trip to Türkiye.”

A similar statement was expressed by an interpreter (T3), who stated:

“I would recommend the online system, but only for certain areas like dietetics and nutrition. The field of service is crucial; for example, surgery definitely requires face-to-face communication. However, after the surgery, online or telephone follow-ups could be beneficial to monitor the patient’s condition. So, it really depends on the situation.”

While the general tendency is more positive for consultancy sessions as potentially suitable for VRI, participants expressed hesitations regarding its effectiveness in other areas, particularly in more hands-on or physically intensive healthcare settings.

Additionally, the **availability of interpreters** was noted as a significant factor affecting VRI's practicality. Participants emphasized that VRI could be advantageous if a large number of interpreters are accessible remotely, reducing waiting times and facilitating quicker access to interpreting services. One participant (D4) noted, "If the interpreter is readily available on the screen as soon as I bring the patient in, then it would be more effective. But there should be enough interpreters to meet all these requests". The participant further emphasized the importance of having a diverse range of language options, stating,

"It would be more advantageous if we could find interpreters for a variety of languages, including dialects like Kurdish. If the network is extensive, it would be more beneficial. Otherwise, if it's only for common languages, it won't make much difference — we already have that in place."

Another situation affecting user perception is **the device type**, and participants expressed varying opinions in this regard. Participants also noted that healthcare services are not solely provided in doctors' offices but are distributed across various locations such as blood testing rooms, ECG rooms, and operating theaters. They emphasized that if the devices are not easily portable, this could further complicate the process of providing interpretation services in multiple locations. One participant (D8) expressed that

"If it's a wheeled device, it would be difficult to manage. We would be tied to a single device. In that case, that wheeled system would need to be available everywhere — in patient rooms, physicians' room, in the operating room, and so on. It wouldn't be practical, nor financially sustainable. But if it's a tablet with a mobile application, then yes, it would be much easier."

Overall, while participants acknowledged the potential convenience of mobile and easily transportable devices in facilitating VRI, concerns remained regarding the practicality and financial feasibility of implementing such systems across multiple healthcare settings, highlighting the need for a well-planned infrastructure.

The **patient healthcare condition** was another notable consideration. Participants noted that VRI could be more challenging to use for patients in a weakened physical state, such as those who are very ill or unable to effectively engage with a screen. One patient stated that “Imagine that I am so sick, I will not have enough energy to speak loudly enough to get heard by the virtual interpreter. Sometimes, when I am so sick, I need my in-person interpreter to understand even my body language (H6)”. In other words, the existing face-to-face system was perceived as more user-friendly for patients, as it allows for more direct, hands-on communication. Nevertheless, if the patient’s condition is stable or the consultation is more routine — such as during check-ups or follow-up appointments — VRI could still be a viable option, offering a practical alternative for less intensive interactions.

From the interpreters’ perspective, the perceived ease of use of VRI varied. While some viewed it as a less physically demanding alternative to in-person interpreting, others questioned its suitability and efficiency for patient interactions. One interpreter (T5) explained, “From the interpreter’s perspective, sitting and providing interpreting services is easier and requires less effort. But in my opinion, it wouldn’t be beneficial for the patient” (T5).

However, some participants acknowledged that VRI could still provide practical advantages in **urgent or unexpected situations** where immediate interpreting support is needed. For instance, one interpreter (T2) noted, “Even if the interpreter has to leave suddenly due to an urgent matter, it would still be possible to connect online” (T3). Moreover, the perceived efficiency of VRI in critical moments was not only highlighted by interpreters but also by physicians. As one physician (D8) suggested, “Sometimes, before fully positioning the patient in the operating room, the doctor may need to ask something urgently. In such cases, a mobile application would be much more convenient. Otherwise, contacting the interpreter and waiting for them to respond could cause delays” (D2).

Thus, while the overall consensus suggested that VRI may not be as suitable for routine patient interactions, it was perceived as potentially beneficial for time-sensitive or urgent needs, providing immediate access to interpreters and enhancing overall efficiency.

Several participants indicated that while VRI may not be suitable as a sole method for interpreting in all situations, it could be effectively integrated as part of a **hybrid approach**. Considering the potential impact on service recipients, participants suggested that a hybrid model could provide a more balanced approach, addressing concerns related to patient trust and the perceived seriousness of the service. One participant emphasized that some patients do not perceive VRI as seriously as face-to-face interpreting, which could undermine its effectiveness, stating, “Some patients do not take VRI as seriously; therefore, I would prefer to use it as hybrid” (D10). Another participant (T4) echoed this statement, explaining:

“The patient may not accept it. But if it’s a hybrid model, it could be beneficial, and I would prefer it. Of course, it may not work for everything (every type of services). Sometimes, you need to look at the patient face-to-face to understand and communicate. Patients want to feel secure. That’s why some patients may say no, they don’t want it. It has its advantages, but it’s not suitable for every situation, and not everyone would agree to (use) it.”.

The type of service provided was also emphasized as a critical factor in determining the appropriateness of VRI. Participants noted that certain healthcare services may be more suitable for VRI, while others may necessitate face-to-face communication due to their complexity or sensitivity.

Thus, a hybrid model involving both VRI and face-to-face interpreting was perceived as a potentially effective strategy to balance the convenience of remote interpreting with the personal connection and immediacy offered by in-person interactions.

Overall, the analysis of situational factors highlights the complex interplay between service-specific conditions, interpreter availability, device type, patient condition, and the potential applicability of a hybrid model. While VRI was perceived as advantageous in structured, routine consultations and in cases where interpreters could be accessed remotely, its practicality was questioned in more hands-on, physically intensive settings. The type of device emerged as a significant factor, with participants emphasizing the importance of mobility and ease of use, particularly in departments with multiple service points. Additionally, patient condition was cited as a critical determinant, as some participants expressed concerns about the effectiveness of VRI

for patients in a weakened state or those requiring close physical interaction. The hybrid model was suggested as a practical approach to integrate VRI while still accommodating service-specific needs and ensuring effective communication in more sensitive situations.

5.3.1.3. Human Interaction

In the context of human interaction, participants consistently highlighted the value of face-to-face communication in establishing trust and sincerity, conveying emotions, and facilitating effective interaction, particularly in sensitive healthcare settings.

A dominant perspective was that face to face interpreting fosters a closer and more sincere connection between the patient and the interpreter, enhancing the overall sense of security and comfort. Several participants stated that face to face interpreting is more effective in conveying emotions, as it enables direct eye contact and closer physical proximity and is perceived as more sincere and trustable. One participant (T3) clearly stated that:

“VRI might work in other sectors, but healthcare sector is different. Consultancy can be done online, but when it comes to medication or surgery decisions, explaining why they are necessary wouldn’t convince (the patient) through an online system. If it were online, it would feel robotic. (The patient) need to feel close ... ; otherwise couldn’t fully trust them. It’s almost like a relationship — (they) need to believe in that person and connect with them regarding (their) health condition.”

Additionally, the importance of non-verbal cues was emphasized as a key component of effective communication, particularly in conveying empathy and understanding the patient’s condition. Participants frequently mentioned that body language, facial expressions, and physical presence in face to face interpreting play a crucial role in ensuring that the patient’s emotional state is accurately perceived. For instance, one participant stated, “There are different intonations. For example I have African accent, my wife does not. It would be good to see body language and to read the lips in person (H6). Similarly, the ability to interpret physical directives was considered more effective in face to face settings, where the interpreter is physically present to observe and respond to patient cues. One participant (T10) provided an example to illustrate the challenges of using VRI in more physically interactive consultations, stating, “For instance, there was a patient who came in for a general check-up, and the doctor asked them to perform several physical

movements such as -come here, walk, sit, stand up-. There were many directives. Trying to explain and demonstrate these actions through an online platform would have been quite challenging. This is particularly true for cases that involve more physical activities.”

In terms of trust and familiarity, multiple patient participants expressed that they would prefer to work with face to face interpreters due to existing relationships and prior acquaintance. One patient (H7) clearly stressed that:

“Our current interpreter is smart enough and we believe that he can solve every problem. Face to face allows us to be empathetic and use some comfortable words.”

This familiarity was particularly emphasized in sensitive cases where the patient’s emotional state required closer attention.

Additionally, interpreters highlighted that the shared cultural and linguistic background with patients often fosters a deeper emotional connection, creating a sense of familiarity and empathy that may be difficult to replicate through VRI. One interpreter described this experience, stating, “When I provide interpreting in Arabic or French, it’s usually for people from my own country, and that creates a very different feeling” (T4). This sense of cultural affinity was perceived as a unique aspect of face to face interpreting, contributing to the overall emotional resonance of the interaction.

Based on the findings, the emphasis on human interaction within the existing face to face interpreting system underscores a significant barrier to the acceptance of VRI among participants. The prevailing view that VRI may lack the necessary emotional connection and physical proximity to effectively convey trust and understanding indicates a critical area of concern for potential integration efforts.

While face to face interpreting was generally perceived as more effective in establishing trust and emotional rapport with patients, the perspectives of some physicians revealed a contrasting concern regarding the trustworthiness of human interpreters in accurately conveying information. Several physicians expressed doubts about whether interpreters faithfully communicated their statements to patients, particularly in critical or complex medical cases.

To address this issue, a few participants suggested the integration of AI-supported interpreting systems, viewing them as a potentially more reliable and consistent alternative to human interpreters. One physician (D4) highlighted his/her concerns, stating, “As doctors, we want everything we say to be conveyed exactly as it is. But we don’t know if that’s happening, and it’s always a question mark in my mind” (D4). Another physician (D3) expressed a similar statement, explaining,

“Sometimes, the patient says a lot, but the interpreter tells us very little. I feel like it’s not being conveyed exactly as it was said. I think they summarize it in their own way” and added “If there were AI on the screen instead of a human, then I would prefer that (VRI).”

Additionally, a physician who was excluded from the main study due to time her/his constraints also emphasized a preference for AI over human interpreters in a potential VRI system. When asked whether they would consider using VRI, the participant (excluded participant) stated “If it’s AI on the screen instead of a human, then yes, I would use it. Otherwise, let the current system stay as it is”.

Thus, while the general tendency among participants was to value the emotional connection and personal interaction offered by face-to-face interpreting, the concept of trust emerged as a nuanced issue. While patients and interpreters mainly tended to associate trust with the physical presence of interpreters, some physicians emphasized the importance of accuracy and consistency in information transfer, leading them to consider AI as a viable alternative that could potentially mitigate concerns about interpreter reliability in sensitive healthcare contexts.

In conclusion, although the findings in this section predominantly highlight negative perceptions of VRI, such insights are equally valuable as they pinpoint areas requiring further consideration and adjustment. Addressing these concerns could serve as a guideline for developing a more effective and context-sensitive VRI system in healthcare settings.

5.3.1.4. Technical Convenience

Technical convenience emerged as a significant theme in the discussions regarding the implementation of VRI in healthcare settings. Participants expressed diverse views on how

technological aspects could either facilitate or hinder the perceived ease of use of VRI systems. While some saw potential advantages in terms of access and flexibility, many highlighted specific technical challenges that could impede effective communication through VRI.

Participants frequently emphasized the technical difficulties associated with VRI implementation. Several respondents noted that VRI might increase the effort required to establish a connection due to potential technical complications such as internet stability or device setup. In this respect, video remote interpreting was described as requiring more effort, as it depends on technological setups or online connections and it has technical necessities like connecting to the internet, setting up the PC. Similarly, the time spent for setting up a VRI session was considered as a potential offset for perceived scheduling advantages.

Moreover, the lack of reliable infrastructure in the hospital setting, such as weak internet or outdated systems, was perceived as a significant barrier to smooth VRI operation. This was particularly emphasized in cases where connection instability could directly affect the interpreting process and the overall patient experience.

Furthermore, technical convenience also intersected with the payment system, as difficulty handling payment processes in a VRI setting was mentioned particularly for international patients. This aspect was highlighted by one participant (T1) who stated,

“They (the physicians) wouldn’t know how to collect the payment. We shouldn’t just consider developed countries; for instance, receiving an EFT transfer from a less developed country would be very difficult, whereas it would be much easier for a developed country.”

While technical challenges were frequently emphasized, proper planning and system integration were identified as critical areas to be reinforced to ensure that VRI functions effectively. For instance, one participant (D7) highlighted the importance of structured planning to prevent connection issues, stating,

“It needs to be planned properly. Otherwise, if suddenly the patient tries to connect, it doesn’t work. It (technical set-up and infrastructure) needs to be arranged accordingly.”

This perspective suggests that with well-coordinated scheduling and infrastructure, the potential barriers related to VRI's technical aspects might be mitigated, allowing for more efficient use in specific scenarios.

In conclusion, the analysis of technical convenience indicates that while VRI presents potential benefits in terms of accessibility and digital integration, its successful implementation in healthcare settings is highly contingent on the resolution of technical barriers. Issues such as internet stability, device mobility, and payment processing emerged as significant challenges, particularly in the context of ensuring seamless communication between patients, interpreters, and healthcare providers. Thus, to effectively integrate VRI, addressing these technical concerns must be prioritized, as they represent critical areas that could either facilitate or hinder the effectiveness of VRI.

In summary, the analysis of perceived ease of use indicates that while VRI offers certain practical advantages, such as potentially reducing waiting times and enabling remote access, participants generally expressed reservations about its overall convenience compared to F2F interpreting. Scheduling flexibility was perceived as a potential benefit, yet concerns about practical challenges related to time zones, coordination, and system availability emerged as notable barriers. Additionally, the impact of situational factors, such as device type, patient condition, and service-specific contexts, highlighted that perceived ease of use is not a uniform concept but rather contingent on various contextual elements. Thus, while some participants acknowledged VRI's potential for streamlining certain processes, the predominant view emphasized the challenges and complexities associated with its implementation, suggesting that the perceived ease of use may remain limited unless these contextual factors are adequately addressed.

5.3.2. Perceived Usefulness

This theme explores participants' perceptions regarding the anticipated usefulness of a potential video remote interpreting system integrated into the Turkish healthcare context. Participants were asked to reflect on the potential impacts of such a system in terms of improving the quality of healthcare services provided to foreign patients, enhancing service accessibility for vulnerable groups such as individuals with disabilities and the elderly, and reducing average waiting times

and facilitating more efficient appointment scheduling in healthcare settings. Additionally, physicians were specifically asked to consider whether the implementation of VRI could contribute to achieving broader healthcare targets and objectives, as they are the primary providers of healthcare services and are thus positioned to assess the potential impact of such systems more directly and comprehensively.

5.3.2.1. Healthcare Service Quality

Participants presented diverse views on the potential impact of VRI on healthcare service quality. While some emphasized its advantages in providing instant access to interpreting services, others expressed concerns about the potential decline in service quality compared to face-to-face interpreting.

Several participants highlighted that VRI could potentially enhance healthcare quality by providing immediate access to interpreters, particularly in situations where face-to-face interpreters might not be readily available. One respondent (D4) noted that the availability of enough number of interpreters could significantly contribute to maintaining consistent service quality, stating that

“If there are a thousand interpreters available, then it could work. But if there are only five interpreters and we still have to wait, then it won’t be effective. The number of interpreters must be significantly high.”

However, a contrasting perspective emerged from a quite deal of respondents, who asserted that face to face interpreting was more effective in ensuring healthcare quality, primarily due to the physical presence of the interpreter, which fosters a more sincere and reassuring communication environment. As one participant (H7) emphasized,

“The face to face is easy to explain the problem, easy to understand the solution and easy to have fast answer. The most important is to focus on my main problem and this is possible with face to face one. The online one may create misunderstanding”.

This perspective highlights the perceived superiority of face-to-face interpreting in maintaining healthcare quality, particularly in terms of accurately conveying medical information and ensuring patient understanding. The interpreter’s physical presence not only facilitates more effective communication but also reduces the risk of misunderstandings.

In addition to concerns regarding patient comprehension, participants also raised issues related to language barriers extending beyond the consultation room, suggesting that VRI might not fully address these challenges. As one participant (D2) noted:

“If this were Amsterdam, it would work because everyone speaks English. But here, once the patient steps outside the consultation room, even the receptionist doesn’t speak the language. And we can’t communicate either.”

This observation underscores the importance of providing comprehensive language support throughout the entire continuum of healthcare services, from the initial encounter to discharge, suggesting that VRI may not be sufficient to maintain consistent healthcare quality in settings where multilingual communication is not widespread.

Moreover, some participants expressed concerns that the quality of interpreting through VRI could be compromised due to the lack of facial expressions, gestures, and other non-verbal cues, which play a vital role in conveying healthcare information accurately. The absence of these elements in a VRI setting was perceived as a significant drawback, potentially hindering effective communication and reducing overall service quality.

On the other hand, there were also neutral views indicating that the perceived impact of VRI on healthcare quality might not be significant, as the quality of care was considered to primarily depend on the service provider’s performance rather than the interpreting method itself. Also, the mode of interpreting does not matter as the important thing in communication is the accessibility. This perspective underscores that regardless of the interpreting modality, the competence and professionalism of the interpreter remain key determinants of service quality.

In conclusion, while the potential for VRI to improve access and provide timely interpreting services was acknowledged, the prevailing sentiment favored face to face interpreting for maintaining a higher standard of healthcare quality. The importance of emotional connection, physical presence, and effective follow-up emerged as pivotal factors contributing to this preference, suggesting that any transition to VRI should carefully consider strategies to mitigate these perceived shortcomings.

5.3.2.2. Suitability for Elderly and Persons with Disabilities

Among the thematic categories, the suitability of VRI for elderly and persons with disabilities emerged as one of the few areas where participants predominantly perceived VRI as advantageous. Many participants highlighted the potential of VRI to bridge accessibility gaps for those with mobility limitations or chronic conditions, positioning it as a practical solution to facilitate healthcare access without requiring physical presence. During the discussions, participants were also prompted to consider scenarios in which elderly and persons with disabilities might also connect online, subtly framing the potential applicability of VRI for these groups. However, the extent of perceived usefulness was contingent upon specific contextual factors.

While the majority of participants perceived VRI as beneficial for elderly and persons with disabilities, some emphasized that its effectiveness would depend on certain conditions. Factors such as the type of healthcare service, the nature of the disability, and the presence of a caregiver to assist with system navigation were highlighted as critical determinants in assessing the suitability of VRI for these groups. One participant (H6) stressed, “For disabled people, it depends on the type of disability. If the person is in a wheelchair, it does not matter much. However, if the patient is in an emergency or surgery situation, it is not the same; it would be more difficult”. The same participant further elaborated,

“They (people with disabilities or elderly) don’t have much energy to raise their voice. It would be more difficult for them. If there is a third party accompanying the disabled person, they may support them. However, in that case, the disabled person will say something, and then the third party will convey this message. There might be loss of information in that case”.

These observations underscore the potential limitations of VRI in effectively serving elderly and persons with disabilities, particularly in complex medical scenarios where precise communication is critical. Therefore, while VRI is acknowledged for its accessibility benefits, ensuring comprehensive support systems and minimizing potential information loss during communication remain essential considerations for optimizing its use in healthcare contexts.

The information on availability home care services already providing interpreter support for patients within Türkiye has been noted and it was acknowledged that VRI could still offer

additional benefits in certain cases. It was indicated that VRI could serve as a valuable supplementary option, particularly when immediate access to an interpreter is required or when physical visits are not feasible. As one participant (T1) stated, “Of course, it would be beneficial, but if the person is within Türkiye, we already have home care services. As part of these services, interpreters also visit patients at home”. This perspective suggests that integrating VRI alongside existing services could provide a more comprehensive language access framework, ensuring continuity of care regardless of the patient’s location.

Despite the predominantly positive perspectives regarding the potential benefits of VRI for elderly and disabled individuals, a minority of participants expressed reservations about its practical applicability. Some noted that VRI might not significantly enhance service delivery for these groups, particularly considering that face-to-face home care services are already available, as previously mentioned. Additionally, a few participants raised concerns that VRI could potentially introduce further difficulties for elderly or disabled patients, especially those with limited physical capabilities. As one participant explained, “For disabled people, it depends on the type of disability. If the person is in a wheelchair, it does not matter much. However, if the patient requires emergency care or surgery, it is not the same; it would be more difficult” (H7).

Overall, while the majority of participants acknowledged the potential benefits of VRI for elderly and people with disabilities, particularly in terms of accessibility and convenience, it remains essential to consider the concerns raised by a minority of participants regarding specific conditions and contextual limitations. These differing perspectives underscore the importance of adopting tailored approaches in line with the type of disability and user-specific needs to ensure effective and inclusive implementation of VRI for these vulnerable groups.

5.3.2.3. Time Efficiency

Time efficiency specifically addresses the impact of VRI on the duration and flow of patient interactions, as well as potential reductions in waiting times. This category examines how the implementation of VRI may influence the time spent waiting for interpreter services, the perceived speed of service delivery, and overall time optimization for both patients and healthcare providers.

Time efficient emphasizes key factors such as appointment overlap, interpreter response time, and patient waiting periods.

Time efficiency emerged as a key area where the majority of participants perceived VRI as notably advantageous. The potential for reducing patient waiting times was frequently emphasized, with several participants highlighting how VRI could eliminate the time spent waiting for the interpreter's arrival and departure, thereby streamlining the consultation process and allowing for more immediate arrangements. Moreover, the ability to align multiple schedules simultaneously without the need for physical coordination was also cited as a significant time-saving benefit.

Despite the generally positive outlook on the time efficiency of VRI, some participants raised concerns regarding potential scheduling disruptions and the impact of delays on patient satisfaction. Unlike the face-to-face setting, where patients can physically observe ongoing consultations and gauge the reason for any delays, VRI was perceived as potentially creating uncertainty in cases of extended waiting times. As one participant (T8) explained,

“Patients might feel uneasy if they receive the service later than expected. In face-to-face settings, they can see that the doctor is with another patient and feel reassured that they haven't been neglected. But online, any delay could be perceived negatively”.

This perspective suggests that while VRI may reduce waiting times under optimal conditions, ensuring transparent communication about potential delays will be crucial to maintaining patient trust and satisfaction.

In addition to that the majority of participants emphasized the potential of VRI to reduce waiting times, a few participants remained neutral, expressing that they did not anticipate any significant change in patient waiting times with the introduction of VRI.

In conclusion, while VRI is widely regarded as a promising tool for enhancing time efficiency, particularly in reducing waiting periods and facilitating quicker consultations, its effectiveness will largely depend on consistent coordination and clear communication regarding potential delays. Addressing these factors could play a pivotal role in maximizing the perceived time-saving benefits of VRI in healthcare settings.

5.3.2.4. Health Policy and Technological Integration

The theme of health policy and technological integration elicited a range of responses from participants, with a notable focus on how VRI could align with broader healthcare services objectives at both institutional and national levels. While the overall perspective pointed out specific conditions and limitations in this regard.

Several participants perceived VRI as a potential contributor to broader healthcare targets, particularly in the context of expanding access to healthcare services for international patients, given the hospital setting in which the study was conducted, which is heavily oriented towards health tourism. However, it was indicated that VRI could facilitate health tourism, especially for consultancy sessions rather than more intensive or complex medical services. Additionally, some participants suggested that a hybrid model, combining both VRI and face-to-face interpreting, could be a more feasible approach in addressing the specific needs of international patients without compromising service quality.

On the other hand, the importance of persuasive communication in the context of healthcare service delivery was mainly emphasized by the most participants, particularly in relation to the differences between face-to-face and online interactions. One participant (T1) highlighted the significant impact of physical presence in patient consultations, stating,

“Because marketing is crucial in the healthcare sector, you can convince about 60% of patients through online methods, but with face-to-face interactions, the persuasion rate can go up to 90%.”

Furthermore, a notable perspective emerged regarding the potential discrepancy between the current face-to-face system and a fully digital interpretation model. The perceived inability of VRI to fully replicate the assurance and trust associated with face-to-face interpreting was emphasized highlighting concerns that the communicative advantages provided through face-to-face interactions may not be effectively conveyed through a digital format.

In conclusion, while some participants acknowledged the potential benefits of VRI in expanding access to healthcare services, the broader integration of VRI into health policy frameworks was not perceived as entirely favorable, particularly from a marketing-oriented perspective. The

findings suggest that VRI may be more effectively positioned as a supplementary tool, potentially integrated as a hybrid model or limited to specific services such as consultancy.

As a noteworthy consideration, these findings underscore the importance of conducting similar research in healthcare settings beyond the current hospital, where the focus on marketing may not exert as strong an influence on participants' perceptions. Such an approach would provide a more comprehensive understanding of how VRI could align with national health policy objectives in contexts less driven by profit-oriented frameworks.

5.3.3. Perceived Affordances

This section examines participants' perceptions of how a potential video remote interpreting system could provide practical advantages or present challenges within the Turkish healthcare setting. The focus was placed on understanding how VRI might impact aspects such as access time to interpreters, availability of professional interpreting services, privacy and confidentiality during communication, reduction of logistical and transportation costs, communication quality, interpreter workload, sense of involvement in communication (specifically directed to interpreters), and overall work intensity under existing healthcare conditions. Notably, for patients, the primary focus areas were access time to interpreters, availability of professional interpreting services, and privacy and confidentiality during communication.

5.3.3.1. Task Assignment and Planning

Task assignment and planning emerged as a significant theme in the perceived affordances of VRI, particularly in terms of interpreter deployment duration. The majority of participants expressed positive views regarding the potential for VRI to expedite interpreter deployment. Among those who supported this perspective, some emphasized that VRI could facilitate quicker deployment of interpreters, provided that certain conditions are met — namely, the establishment of a well-structured and well-planned system, alongside reliable technological infrastructure and stable connection networks. Other participants stating positive opinions acknowledged VRI could be particularly beneficial for interpreter deployment only in particular cases, such as during emergencies or when the in-person interpreter is already engaged with another patient. In such

cases, VRI was perceived as a valuable alternative to mitigate potential waiting times and ensure continuity of service.

This indicates that while VRI holds promise for more efficient interpreter deployment, its practical effectiveness is contingent upon the implementation of robust planning and technological systems to support seamless transitions between in-person and remote interpreting contexts.

As another dimension, logistical advantages associated with VRI were also emphasized, particularly in terms of reducing the time interpreters spend commuting between hospital departments or locations. This reduction in travel time was perceived as a notable advantage, allowing interpreters to manage multiple assignments more efficiently and potentially increasing overall task completion rates. As one interpreter (T4) explained,

“It would be advantageous in terms of time. During the COVID period, we sometimes worked from home. We experienced remote work. For example, if I have a patient at ... Hospital, instead of physically going there, I could do it online and not waste time on the road. It would also be beneficial for managing other tasks”.

This perspective highlights how VRI could streamline interpreter scheduling and optimize resource allocation, contributing to more effective task management in scenarios where time is a critical factor.

The last but not the least important matter is the role and responsibilities assigned to interpreters in the existing face-to-face system, a point emphasized by a substantial number of participants. The interpreter's role extends beyond the consultation room; they are responsible for accompanying patients throughout the entire healthcare journey — from admission to discharge — assisting with communication at various points such as reception, examination rooms, payment desks, and even transportation coordination. This comprehensive role underscores the complexity of task management in interpreter services. As one participant (T8) explained:

“There are verbal instructions given during procedures like blood tests or imaging scans, such as ‘hold still’ or ‘breathe in.’ The interpreter needs to be physically present not just in the doctor’s office but throughout these processes to convey these directives to the patient. For example, forms like MRI consent or admission consent require patient approval. They ask for

our assistance in understanding and signing these documents, and we are there to support them every step of the way.”

This extensive role expectation was cited as a major reason why many participants remained hesitant about fully embracing VRI, as the current system's comprehensive scope of interpreter responsibilities is perceived as difficult to replicate in a remote format.

In summary, while VRI was perceived as potentially advantageous for reducing interpreter deployment duration and minimizing transportation cost and duration, the extent of its effectiveness remained a subject of debate among participants. Although some highlighted the logistical benefits of remote deployment, particularly in emergency situations or when the in-person interpreter is occupied, others emphasized that such advantages would only be realized under well-coordinated systems with robust technological infrastructure. Additionally, the comprehensive role of interpreters in the existing face-to-face system, encompassing tasks far beyond mere medical consultation, emerged as a critical barrier to fully embracing VRI. This role, which includes accompanying patients throughout the entire healthcare process and assisting with various procedural and administrative tasks, was cited as difficult to replicate remotely. Thus, despite the potential logistical advantages of VRI, its integration into current interpreter workflows would require substantial adjustments to maintain service quality and effectively address patient needs.

5.3.3.2 Confidentiality and Data Security Concerns

The theme of confidentiality and data security in the context of VRI elicited a range of responses from participants, reflecting varying perspectives on how remote interpreting might impact patient comfort and perceived data protection.

For some participants, the medium of interpretation — whether face-to-face or remote — was considered irrelevant in terms of confidentiality, as both settings inherently involve a third-party interpreter. Additionally, some emphasized that in the existing face-to-face system, interpreters are often positioned behind a partition, preventing direct visual contact and thereby maintaining privacy.

On the other hand, some participants suggested that VRI could potentially enhance patient comfort in certain scenarios, particularly for sensitive matters involving gender dynamics or for patients who might feel more at ease speaking to an interpreter who they have never met before or will have to be in contact afterwards. Therefore, the patients might prefer the anonymity offered by VRI, perceiving it as less intrusive than having a physical interpreter in the room. In this respect, one participant (D8) stated that:

“...it could be better. For instance, if there is someone else next to the patient and the patient wants to share something private — whether good or bad — they might feel uncomfortable because they already know the interpreter they just met two minutes ago. But an online interpreter is just a voice. In that sense, the patient wouldn’t feel judged and could speak more comfortably. They might open up more easily to someone they don’t know and wouldn’t fear being judged.”

However, concerns regarding patient comfort and perceived data security were also raised. Some participants expressed doubts about where data might be stored and how confidential information would be protected in a remote setting. Additionally, the uncertainty regarding the interpreter’s physical surroundings during a VRI session was noted as a potential source of discomfort, as patients might feel uneasy not knowing whether the interpreter is alone or accompanied by others. This opinion was captured by one participant (H6), who remarked:

“But if the virtual interpreter has an office at the hospital, and the hospital ensures that all is confidential, then it is okay. But if the virtual interpreter has their own place, then the face-to-face is better in that terms.”

A significant concern raised by participants was the potential difficulty in establishing patient trust through VRI, particularly in cases involving sensitive or confidential information. The lack of physical presence may create a sense of detachment, making it more challenging for patients to feel secure in disclosing personal health information to an unseen interpreter. This concern was particularly emphasized for certain medical specialties where confidentiality is paramount. As one participant (D4) noted:

“Patients may not trust the person connecting online. In some specialties, they might hesitate to share confidential information with someone they can’t see and might even react negatively. I am not sure if it would be necessary to introduce the interpreter beforehand or obtain consent in advance”.

Overall, the analysis underscores the importance of establishing clear guidelines and robust data protection measures to alleviate potential patient concerns and foster trust in VRI as a secure and confidential mode of communication.

In summary, participants expressed diverse perspectives on the implications of VRI for confidentiality and patient comfort. Some viewed VRI as no different from face-to-face interpreting, emphasizing that a third party is already involved in both settings and that interpreters often operate from behind partitions in the current system. Others suggested that VRI might even offer a sense of anonymity that could make patients feel more at ease, particularly in cases involving sensitive information or gender-related issues. However, concerns were also raised regarding potential discomfort stemming from the lack of control over the interpreter's physical environment, with some participants questioning whether the interpreter might be accompanied by others or whether the data might be stored or shared without clear assurances of privacy. Thus, addressing these concerns through robust data protection protocols and transparent communication about interpreter settings could be vital for fostering patient trust and ensuring the perceived confidentiality of VRI services.

5.3.3.3. Communication Quality

Communication quality emerged as a particularly critical theme, with the majority of participants expressing concerns about the potential limitations of VRI in comparison to face-to-face interpreting. The lack of facial expressions and body language, the absence of pre-session interaction between patients and interpreters, and perceived difficulties in persuading patients to accept treatment were all cited as significant barriers to effective communication in a VRI context.

A notable perspective was shared by an interpreter who drew a parallel between everyday digital communication and VRI, emphasizing the limitations in conveying emotions and intentions without non-verbal cues. As expressed (T9):

“Even when talking with friends on WhatsApp, it is difficult to understand without emojis. ... technologies are prone to misinterpretation; they do not effectively convey emotions”.

Adding to these concerns, a participant (T3) shared a specific negative experience related to remote interpreting, underscoring the confusion that can arise when multiple interlocutors are involved simultaneously:

“Face-to-face interpreting is of higher (healthcare) quality. The other day, I provided interpretation over the phone. The patient’s mother, the patient, and I were all connected at the same time. Everyone started talking simultaneously, and everything became chaotic”.

On the other hand, some participants suggested that the communication quality in VRI may largely depend on specific conditions, particularly the interpreter’s proficiency in medical terminology. Additionally, some emphasized that the overall communication quality is directly linked to the interpreter’s performance regardless of the mode of interpretation. A physician (D3) underscored this perspective, stating:

“Medical knowledge is challenging for interpreters. If they are specialized and have good command of the medical language, communication quality can be improved. As doctors, we want everything we say to be conveyed accurately. But I always have a question mark in my mind, wondering if it was fully conveyed. (Also) foreign patients are paying for the service, and if the interpretation is not accurate, they do not get what they paid for”.

In the context of communication quality, interpreters were specifically asked how they would feel about their sense of involvement if VRI were implemented in interpreting sessions. The majority indicated that VRI could potentially enhance their sense of involvement, but only if the technological infrastructure ensured immediate and seamless connection to the consultation setting. However, in the absence of such technological readiness, they did not foresee significant improvements in communication quality in VRI- supported interaction.

In conclusion, while communication quality was generally perceived as a challenge in VRI, some participants acknowledged the potential for improvement if specific conditions — such as interpreter expertise in medical terminology and immediate access to the consultation environment — were met. However, the dominant sentiment remained that the absence of non-verbal cues and the inherent limitations in conveying emotions remotely could impede effective communication, thereby requiring careful consideration in the design and implementation of VRI systems.

5.3.3.4. Workload and Efficiency

The theme of workload and efficiency generated diverse perspectives among participants, highlighting both potential advantages and concerns associated with the implementation of VRI in healthcare settings.

A notable perspective that emerged was the potential for VRI to reduce the time spent per patient, thus potentially increasing the number of patients to whom interpreters could serve within a given timeframe. Participants noted that the elimination of physical movement between departments could theoretically provide more time for interpreters to handle a greater number of consultations. However, this perceived advantage was also seen as a double-edged sword. Rather than resulting in reduced workload, some participants emphasized that this could lead to an increased work burden as interpreters might be expected to cover more cases in a shorter period, thereby intensifying both physical and mental fatigue.

Additionally, the in-hospital coordination role that interpreters currently undertake in the face-to-face system, such as assisting patients in navigating through multiple hospital departments, was considered as a time-consuming yet essential part of their responsibilities. With the introduction of VRI, some participants suggested that this role could be diminished, as the interpreter would no longer need to accompany the patient physically. Nevertheless, there was concern that the reduction of coordination tasks could inadvertently pressure interpreters to attend to more patient cases within a compressed timeframe, effectively increasing their workload. One participant (T5) stated that:

“From a managerial perspective, it is all about the number of patients. If the duration an interpreter spends per patient decreases in an online setting, it means they can handle more patients overall. Administratively, instead of employing five interpreters, we could work with three, but that would inevitably increase the workload per interpreter” .

This perspective highlights a critical concern among participants that while VRI may optimize interpreter deployment in terms of patient numbers, it could simultaneously intensify the workload, potentially leading to increased physical and mental strain on interpreters.

While the interpreters primarily emphasized the potential increase in workload due to reduced time spent per patient, other participants approached the matter from a managerial perspective, perceiving VRI as beneficial in terms of cost-efficiency and resource allocation. As one physician (D6) noted,

“Of course, it would be beneficial. Instead of maintaining permanent staff, it would be more reasonable to implement a pay-per-use model. Rather than paying (for example) 50,000 (TRY) per month to a full-time employee, a usage-based payment system would make more sense.”

Regarding workload, while interpreters emphasized the potential increase in their work burden, physicians also highlighted that under certain conditions, VRI could indeed offer advantages. However, some expressed concerns that if the system is not well-structured, it could have the opposite effect, as one physician (D4) stated that

“If I am the one waiting for the interpreter to connect online, it would actually increase my workload. The interpreter should be the one waiting for me, not the other way around.”

Another dimension addressed under this category is the potential of VRI to facilitate the documentation and tracking of patient progress. Given physicians’ direct involvement in clinical record-keeping and patient follow-up processes, this question was directed exclusively to them.

Opinions were mixed, with some expressing partial positive or neutral views. However, skepticism regarding VRI’s capacity to enhance documentation processes was prevalent, as the existing hospital record system already serves this purpose effectively. Thus, the necessity of introducing a separate platform for tracking patient progress through VRI was also questioned.

This range of perspectives underscores the need for further exploration of how VRI systems could be aligned with existing clinical record-keeping frameworks to maximize their effectiveness without creating redundant systems or disrupting established workflows.

Another key aspect discussed under this category was the perceived impact of interpreter professionalism on the effectiveness of VRI. Participants emphasized that the effectiveness of VRI would largely depend on the professional qualifications of the interpreters, particularly in terms of

their expertise in medical terminology. Several respondents noted that if the VRI system could provide access to a pool of highly qualified, medically trained interpreters, it could offer substantial benefits. However, in the absence of such specialized personnel, participants expressed skepticism about whether VRI would provide any additional advantage over the current face-to-face system.

In summary, the analysis of workload and efficiency revealed a complex interplay of potential benefits and challenges associated with VRI implementation in healthcare settings. While some participants perceived VRI as a tool that could reduce interpreter deployment time and facilitate resource allocation, concerns emerged regarding the potential increase in interpreters' work burden due to the expected rise in patient numbers per interpreter. Furthermore, while some saw the reduction of in-person coordination tasks as a time-saving measure, others cautioned that it could inadvertently intensify the workload, particularly if interpreters were expected to cover more cases in less time. Additionally, the potential for VRI to support patient record-keeping received mixed responses, with some participants questioning the necessity of a separate documentation platform, given the already established hospital record system. Finally, the perceived efficacy of VRI was closely linked to the professionalism and medical expertise of the interpreters, underscoring the need for specialized personnel to effectively manage complex medical consultations. Thus, while VRI presents possibilities for optimizing workload distribution, its successful implementation will require careful consideration of interpreter deployment strategies, integration with existing hospital records, and the availability of highly trained interpreters to ensure effective service delivery.

5.3.4. Intention to Use

This theme explores participants' intention to use a video remote interpreting system if integrated into the Turkish healthcare context. Participants were requested to express whether they would be willing to utilize such a system in the framework of all discussed points above if it is offered to them in hospital where the interviews were conducted, reflecting on their expectations, hesitations, or conditions that might influence their decision.

The participants' intentions to use VRI demonstrated notable variation across the three respondent groups, with differing levels of openness and concerns based on specific conditions and perceived benefits.

Among patients, 5 out of 7 expressed negative intentions towards VRI use, primarily attributing their reluctance to the sense of disconnection associated with remote interactions. This perspective was particularly prevalent among foreign patients, who emphasized the continuity of interpreter support from initial contact to discharge hospital in the existing face-to-face system. Conversely, 2 participants indicated a willingness to use VRI under specific circumstances.

In contrast to patients as service recipients, physicians exhibited a more conditional stance with more positive approach. Only 2 out of 10 were unequivocally opposed to adopting VRI, while the remaining 8 expressed potential interest in its use, provided that specific conditions were met — such as the establishment of a structured and well-planned system, integration of AI support, or the limitation of VRI to consultancy or other non-critical sessions.

For interpreters, the division was more nuanced. While 3 of the 11 interpreters explicitly stated that they would not use VRI, citing concerns regarding the quality of service they could provide in a remote setting, the remaining 8 interpreters conveyed a conditional willingness to adopt the system. This willingness was contingent upon factors such as the establishment of a hybrid system or restricting VRI to specific departments.

In the following section, the positive intentions expressed by each participant group will be examined in detail, highlighting the specific conditions and perceived advantages that shaped their openness to adopting VRI.

5.3.4.1. Positive Intention

The analysis of participants' positive intentions to use VRI revealed varying levels of openness across the three respondent groups, each presenting specific conditions under which they would consider adopting the system.

Among patients, the ones stating their positive opinions expressed potential willingness to use VRI, albeit under specific circumstances. One participant (H6) highlighted the importance of having multiple interpreters readily available to avoid waiting times and implying the age range may be also determinant for preference stating that:

“As a young guy, I would use virtual. But it depends on how many interpreters are available. For example, I will go to lab(oratory). Would the virtual one be available there? The interpreter is needed everywhere (lab, desks, doctor etc.) Personally, it does not matter the interpreter is physically present or not; however, if the patient is so sick, s/he may want somebody in person with herself.”

However, it was also acknowledged that this might not be suitable for older or severely ill patients. Another patient (H2) suggested that VRI could serve as a secondary option, viewing it as a backup plan to the primary face-to-face method.

For physicians, the overall reception towards VRI was relatively more positive, with conditional acceptance. The positive intentions to use VRI among participants were largely contingent upon such specific conditions as its use primarily for preliminary consultations or follow-up sessions, the simultaneous availability of both patient and physician to connect online (telemedicine services), implementation through a user-friendly, mobile-based system rather than a stationary device to ensure practical usage, and integration within a well-structured and effectively planned system. As one example, one physician (D8) replied the respective question stating that:

“Yes, I would want it. But only if it would offer a practical use. The system should not depend a stationary device or a device with wheels to move. I would gladly use an online system that is not dependent on a single device”.

Additionally, one participant (D4) expressed that while they would not opt for VRI in the current hospital setting where in-person interpreters are readily available, they would consider its use in a facility without dedicated interpreter staff.

The concept of a hybrid system emerged as a recurring theme among physicians. Some physicians suggested that VRI could complement, rather than replace, the existing face-to-face system. It was indicated that VRI can be utilized particularly when there is a concern about the accuracy of the face-to-face interpretation, even AI-supported interpreting has been offered as viable option under

such conditions. Such a hybrid model was also considered more appropriate, as some patients might not take online consultations seriously.

Interpreters' perspectives also revealed a mix of conditional acceptance and cautious optimism. While many interpreters perceived VRI as potentially beneficial for their own work planning and time management, they simultaneously expressed doubts regarding its effectiveness for other users, particularly patients and physicians, given the distinct communication dynamics in healthcare settings. The potential for hybrid implementation was also frequently mentioned as a more feasible option.

Some interpreters (T6, T7, T11) viewed VRI as a tool that could facilitate more efficient work scheduling, allowing them to manage their time more effectively without being physically present in the hospital noting that it could provide remote work options or even connect with patients abroad. However, they also acknowledged that certain user groups, such as physicians and patients, might be less receptive to the system. Concerns were raised regarding the potential for VRI to disrupt the existing dynamics of in-person interpreting, particularly for patients accustomed to the face-to-face model or to decrease the efficiency of the healthcare service provided. As one interpreter (T7) stated:

“From a time management perspective, I would prefer it, honestly. Because it would provide a structured appointment system and the opportunity to manage my schedule independently. I could even engage in other work to develop myself. For instance, if I have five planned sessions and it's a rainy day, some patients might cancel and not show up. But if it's online, when a session is canceled, you're still at home and can occupy yourself with other tasks. Whereas (in face to face structure), if a session is canceled, you're stuck and can't leave. But some patients feel more valued (and respected) when it's face-to-face.”

This dichotomy between perceived benefits in work planning and the potential for compromised patient engagement highlights the complexity of integrating VRI into the current system, indicating that while interpreters may perceive personal workplan advantages, the broader implications for maintaining patient-centered communication efficiency require careful consideration.

Moreover, similar to physicians, the hybrid model remained a recurring theme among interpreters, as well. It was stated that VRI could be advantaged only for specific types of consultations or under specific conditions, such as routine follow-ups or less complex cases. However, face-to-face interpreting remains the primary mode for sensitive or complex medical interactions, where nuanced communication is critical.

Overall, while the general tendency among participants indicated a cautious approach toward the adoption of VRI, the identified positive intentions suggest a conditional openness to its implementation under specific circumstances. Thus, the findings underscore the importance of strategic planning and tailored implementation to align VRI's perceived benefits with the practical needs and expectations of various user groups.

5.3.4.2. Negative Intention

The majority of negative responses regarding the intention to use VRI predominantly centered around concerns related to the quality of healthcare service, the established trust in face-to-face interactions, and the role of interpreters as comprehensive support providers throughout the patient journey.

Among patients, five out of seven expressed a firm preference for continuing with face-to-face interpreting services, emphasizing that interpreters play a crucial role not only in language facilitation but also in accompanying them throughout the hospital process. The notion that interpreters provide vital assistance at every step, from reception to discharge, was underscored, suggesting that VRI could disrupt this established support system and potentially diminish the perceived quality of care.

From the physicians' perspective, two out of ten respondents explicitly stated that they would not prefer VRI, perceiving the face-to-face model as more comfortable and effective for communication, particularly in conveying sensitive health-related information. The emphasis on maintaining personal interaction as a fundamental component of patient care emerged as a significant theme.

Interpreters who were opposed to VRI also voiced substantial reservations. While some acknowledge that VRI might offer logistical advantages for themselves, they simultaneously expressed concerns about the potential decline in service quality. For instance, some interpreters emphasized that VRI could impede their ability to assess patients' psychological and physical conditions effectively, potentially undermining the quality of communication and patient trust. Additionally, the unique role of interpreters as not just language facilitators but also as patient companions throughout the hospital journey was frequently highlighted, suggesting that VRI might fail to replicate the comprehensive support currently provided in face-to-face settings.

One stated that:

“I wouldn’t prefer it. The reason is (understanding) the patients’ psychological and physical condition. Communication could become more challenging (through VRI). There are many factors at play. ... When I interact with patients face-to-face, I can better assess their psychological state and pain levels. For instance, a patient might say they want to see a cardiologist, but based on their complaints, I might sense that their issues are actually neurological. In such cases, I leave the choice to the patient, but I can also guide them to the appropriate specialist as an interpreter. Face-to-face is also safer for the patient in this regard. They learn the real cause of their complaints and get directed to the right doctor, saving both time and money by avoiding unnecessary consultations.”

The participant also mentioned the importance of establishing trust, particularly in the context of health tourism, conveying genuine care through in-person communication beyond financial motives is essential to reassure patients and foster a sense of security.

Overall, the reluctance to adopt VRI among these participants appears to stem primarily from concerns about maintaining the continuity of care, ensuring patient comfort, and preserving the established support role of interpreters throughout the healthcare process.

Bringing together the insights from both positive and negative intentions to use VRI, the findings illustrate a complex landscape of varying perspectives among participants. While interpreters and physicians generally expressed conditional openness to adopting VRI under specific circumstances — such as hybrid implementation, structured scheduling systems, or limited use for preliminary consultations — patients remained more apprehensive. The reluctance among patients underscores

the importance of addressing concerns related to trust, communication quality, and the perceived adequacy of remote interactions compared to the established face-to-face model, where interpreters are perceived not only as language support providers but also as integral companions who guide patients through each stage of the healthcare process. Thus, while the potential integration of VRI into the Turkish healthcare system appears feasible for service providers, a targeted approach that thoroughly considers patient apprehensions will be critical to achieving broader acceptance and ensuring equitable access to quality care.

Having explored participants' perceptions regarding the perceived ease of use, usefulness, affordances, and intention to use VRI, the subsequent section delves into a another perspective, examining how VRI could be positioned as a new non-human actor within the existing healthcare network and the potential implications of its integration.

5.4. VRI AS A NEW NON-HUMAN ACTOR IN HEALTHCARE NETWORK

The existing structure of face-to-face interpreting in the healthcare network, detailed in Section 5.2, highlighted the established roles, power dynamics, and interactions among interpreters, physicians, and patients. In this section, the lens shifts toward conceptualizing Video Remote Interpreting (VRI) not merely as a technological supplement, but as a new, non-human actor that enters and reconfigures the network of interactions. Through Actor-Network Theory (ANT), this section analyzes how the introduction of VRI initiates shifts in the structure of healthcare network by repositioning roles, disrupting previous alignments, and introducing new obligatory passage points.

Actor-Network Theory emphasizes that both human and non-human entities—referred to as actants—play active roles in forming and transforming networks. In this context, VRI becomes a mediating force rather than a passive tool, as it enacts certain changes in how actors relate to one another, how knowledge is translated, and how services are delivered. Its insertion into the network does not simply add another element; it intervenes in the existing configuration, reorders relationships, and generates new possibilities and constraints.

VRI's Positioning in the Network

The concept of positioning within ANT refers to the way an actor—human or non-human—is situated within a web of interactions. VRI, as introduced into the healthcare system, is positioned at the intersection of linguistic mediation, technological mediation, and clinical decision-making. Rather than merely supporting pre-existing processes, VRI redefines them by enabling new modes of interpreting that are detached from physical co-presence.

For interpreters, the position of VRI seems ambiguous, as on one hand, it is perceived as an ally in reducing the burden of physical presence and increasing access; on the other, it is seen as a disruptor of traditional workflow and interpersonal trust due to its nature. The introduction of VRI requires interpreters to renegotiate their role—not only as linguistic mediators but as technological intermediaries who must adapt to new modes of engagement, timing, and task assignment. Thus, interpreters are repositioned from embodied entities to remote service providers, affecting their perceived legitimacy, control, and emotional engagement.

Physicians' positioning also changes, as VRI reduces their dependence on physically present interpreters while increasing their reliance on digital infrastructure. Some participants viewed this positioning favorably in the context of time-sensitive or routine consultations; others expressed discomfort due to the loss of cues essential to patient evaluation. In both cases, VRI inserts itself between the physician and the interpreter, subtly altering the one who controls the flow of interaction and how decisions are made.

Reordering the Healthcare Interpreting Network

Reordering describes how the relationships between actors are reconfigured when a new actor enters the network. The introduction of VRI necessitates a redistribution of agency, authority, and responsibility. It alters the temporal and spatial dimensions of interpreting by enabling immediate linguistic access.

This reordering is particularly evident in the interpreter–patient relationship. In face-to-face settings, interpreters were often seen as both linguistic and emotional intermediaries who provided reassurance, clarified procedures, and occasionally advocated for patients. In contrast, VRI

reshuffles this dynamic by removing spatial intimacy and delaying or reducing relational cues. Patients' testimonies reflected this shift, with many having perceived a diminished sense of trust and security when interacting through a screen.

This reordering extends to logistical arrangements. Physicians, who previously relied on scheduled appointments with in-person interpreters, are now able to initiate sessions on-demand. While this increases flexibility, it also accelerates the pace of interactions, placing pressure on interpreters to perform under tighter constraints. Consequently, organizational routines and expectations around interpreting are reordered, moving from planned and embodied sessions to spontaneous and digitized exchanges.

Network Disruption and Resistance

The integration of VRI into the healthcare interpreting network brings about notable shifts that can be understood through the concept of network disruption in Actor-Network Theory. This concept highlights how the introduction of a new actor—human or non-human—may destabilize existing alignments, prompting actors to reconfigure their roles, practices, and expectations. In this context, VRI does not simply add a new layer to established workflows but invites a rethinking of emotional, procedural, and institutional norms traditionally associated with face-to-face interpreting.

Patients' responses illustrate that such transitions may not be uniformly smooth. For many, face to face interpreters serve as not only linguistic facilitators but they are also perceived as emotional supports and cultural intermediaries. The shift to video remote interpreting may, in some cases, be experienced as a reduction in relational proximity, potentially affecting the sense of comfort and trust that patients associate with interpreter-mediated encounters. While not rejecting the utility of VRI outright, these perspectives reflect concerns about whether digitally mediated communication can fully replicate the relational depth of in-person interaction.

Similarly, interpreters and physicians have noted areas where adjustment is needed. Interpreters mentioned that the flexibility offered by VRI is accompanied by increased expectations in terms of case volume and response time, which may introduce new forms of pressure. Physicians, on the other hand, acknowledged the potential of VRI to improve access, particularly in urgent or

resource-limited situations, but also expressed caution regarding technological reliability and the subtle challenges of interpreting non-verbal cues in remote settings. These shifts suggest that the introduction of VRI creates a transitional period in which all stakeholders are negotiating new patterns of engagement.

Rather than a crisis or breakdown, this moment of reconfiguration can be seen as part of an evolving network realignment, wherein actors gradually develop new routines, norms, and collaborative strategies. In this sense, VRI functions not as a disruptor in the negative sense but as a catalyst for transformation, prompting the healthcare network to adapt to emerging communicative and technological conditions.

Intervention and Mediation

ANT conceptualizes intervention as the act of an actor changing the nature or outcome of interactions among other actors. VRI, as a technological entity, intervenes in the conventional model of healthcare interpreting by mediating not just language but presence, timing, and access.

Rather than acting as a neutral medium, VRI translates information across time and space in ways that carry implications for interaction quality. In this sense, VRI is not an inert device but a mediator—an actor that transforms the meaning and impact of messages rather than simply transmitting them. Its intervention in clinical settings modifies how trust, clarity, and empathy are established.

Additionally, the deployment of VRI affects scheduling protocols, staff workflows, and even physical infrastructure (e.g., camera placements, software platforms), extending its mediating role into the material dimensions of healthcare environments. These interventions create ripple effects across institutional policies and routines, prompting discussions around new protocols and training needs.

Intermediaries, Allies, and Hybrid Roles

Within the framework of Actor-Network Theory, a distinction is drawn between *intermediaries*, which transmit meaning without modification, and *mediators*, which actively transform, reinterpret, or reconfigure meaning during the process of transmission. VRI can be conceptualized

as occupying both roles within the healthcare communication network. As an intermediary, VRI facilitates the direct transmission of linguistic content across spatial and temporal distances, thereby enabling immediate and accessible interpretation. However, in its role as a mediator, VRI extends beyond mere transmission by shaping the conditions under which communication unfolds—altering not only the temporal dynamics (e.g., the immediacy or delay of interactions) but also the relational and affective dimensions of interpreter-mediated encounters. In doing so, it contributes to a redefinition of communicative practices and reconfigures the broader ecology of clinical interaction.

In Actor-Network Theory, *allies* are understood as actors that contribute to the stabilization and consolidation of new network configurations. In the case of VRI, such allies may include institutional stakeholders such as information technology (IT) departments, physicians who are receptive to technological innovation, and policymakers who promote digital health solutions. These actors facilitate the integration of VRI into existing healthcare routines by offering technical expertise, advocating for its institutional legitimacy, and enabling capacity-building through training and policy alignment.

Importantly, as not all allies are human, technological artefacts such as stable internet infrastructure, intuitive digital platforms, and responsive software systems also function as critical non-human allies. Their presence enhances the reliability and usability of VRI, thereby supporting its sustained incorporation into healthcare workflows. Conversely, when these infrastructural and technical elements are unreliable or inconsistent, they may lead to resistance or undermine the intended trajectory of integration, introducing instability and jeopardizing the coherence of the emerging sociotechnical configuration.

Furthermore, the diffusion of VRI gives rise to hybrid roles and redefined actor positions. Interpreters, for instance, increasingly assume responsibilities that extend beyond linguistic mediation to include technical navigation and digital platform management. Physicians, similarly, are required to engage with new interfaces and functionalities, positioning them as both clinical decision-makers and technology users. These evolving roles challenge conventional occupational boundaries and underscore the dynamic, co-constructed nature of actor-networks in which human and non-human elements continuously negotiate meaning, function, and authority.

Obligatory Passage Points in Healthcare Network

Within the dynamics of interpreter-mediated healthcare, multiple actors may compete for central roles in structuring communicative and procedural flows. Drawing on the Actor-Network Theory concept of the *obligatory passage point* (OPP), which designates a node that other actors must pass through to achieve their objectives (Ødemark et.al, 2024, p.148), this section explores how both physicians and VRI may assume such central positions—albeit under different conditions and with varying degrees of authority.

Physicians, by virtue of their institutional position and clinical responsibilities, frequently act as de facto gatekeepers in interpreter-mediated interactions. They initiate the need for interpretation, select the communication modality (e.g., face to face, telephone or video remote interpreting), and interact with both technological systems and human intermediaries. In doing so, they effectively become passage points through which decisions, information, and relational cues must pass. Their preferences and routines substantially influence the interpretive process, shaping not only the timing and structure of communication but also the perceived legitimacy of the tools and modalities employed. This central role positions physicians as powerful coordinators within the healthcare network, whose alignment or resistance can significantly affect the stabilization of new actors like VRI.

This coordinating function was clearly reflected in the empirical findings of the study. Several physicians reported that this new tool can routinely lead them to take rapid decisions regarding the mode of interpreting based on urgency, case complexity, and available resources. In emergency departments, for instance, the unavailability of face-to-face interpreters may lead physicians to find practical alternative solution like remote interpreting. However, in more emotionally sensitive or complex diagnostic conversations, many physicians expressed a preference for face-to-face interpreting due to its perceived capacity to preserve relational depth and non-verbal nuance. These patterns highlight the physicians' central role not only in activating interpretive services but also in defining the communicative norms of each encounter.

Building on these observations, it becomes evident that while physicians often serve as initial gatekeepers, under specific institutional and logistical conditions, VRI itself can come to function

as an obligatory passage point within the healthcare communication network under certain conditions. VRI itself can evolve into an obligatory passage point—particularly in multilingual clinical environments, emergency situations, or rural contexts where access to face to face interpreters is limited or logistically unfeasible. In these scenarios, VRI becomes the default or only viable pathway through which interpreter-mediated communication can occur. Its centrality is further reinforced when supported by institutional policies, sufficient technological infrastructure, and user competence. Once stabilized, VRI can shape the temporal, spatial, and interactional dimensions of healthcare delivery, structuring how and when actors engage with one another. Nonetheless, the legitimacy of VRI as an OPP remains conditional. For it to be widely accepted as a central node in the network, it must be perceived as reliable, efficient, and non-disruptive to the human dimensions of care, such as empathy, trust, and rapport. In the absence of these qualities, VRI may fail to achieve full stabilization and remain a contested actor—valued for its logistical utility yet limited in its ability to fully replace or reconfigure existing relational infrastructures.

Co-Constructing the Future of Healthcare Interpreting

The analysis demonstrates that the integration of VRI into the healthcare network involves far more than technological substitution. It constitutes a socio-technical reconfiguration involving interventions, disruptions, and negotiations. VRI does not simply fill a gap; it transforms the conditions under which communication occurs.

Understanding VRI through ANT provides a nuanced appreciation of its role not just as a tool, but as a co-actor in a dynamic, evolving network. It calls attention to the multiple translations—of roles, expectations, and practices—that occur when non-human entities enter human-centered domains. In doing so, it highlights the importance of strategic planning, stakeholder alignment, and the careful positioning of VRI as a complement rather than a replacement.

The consideration of hybrid models, supported by AI-driven systems for specific tasks and human interpreters for more nuanced and emotionally sensitive interactions, could reflect a pathway to sustainable integration. Such an approach balances efficiency with empathy and acknowledges the distributed agency that characterizes contemporary healthcare communication.

CONCLUSION

This study explored the overall opinions and expectations regarding the potential integration of video remote interpreting services into the Turkish healthcare system from the perspectives of healthcare providers, professional healthcare interpreters, and foreign patients. Preliminary findings revealed nuanced perceptions shaped largely by institutional conditions, interlocutor roles, and familiarity with current systems.

In response **to the first research question**, which addressed how VRI services are currently structured in other countries, the findings revealed that successful implementation is often underpinned by strong legislative frameworks and practical service models. Countries such as the United States and Australia have established regulatory mandates that guarantee language access as a patient right, supported by national accreditation systems, video remote interpreter networks, and institutional policies. These frameworks ensure both the legal justification and operational functionality of VRI in healthcare, making them important reference points for adaptation in other contexts, including Türkiye.

The second research question explored potential user's opinions and expectations regarding the use of VRI in Turkish healthcare. Findings from 28 semi-structured interviews with interpreters, physicians, and foreign patients revealed nuanced perspectives shaped by institutional context, user roles and responsibilities, and technological considerations.

- Perceived Ease of Use:** The analysis of perceived ease of use within the context of VRI implementation underscores the multifaceted nature of user experiences, shaped by four key sub-themes: scheduling and time management, situational factors, human interaction, and technical convenience. Participants acknowledged that VRI could potentially streamline scheduling, particularly by offering greater flexibility during night shifts and urgent cases; however, logistical challenges such as time zone coordination emerged as critical barriers. Situational factors further underscored the context-dependent nature of VRI's perceived ease of use, with participants indicating that while it may be more suitable for structured services such as consultancy sessions or urgent situations, its practicality was questioned in more physically interactive or emotionally sensitive services that may still

require face-to-face communication. The availability of a high number of interpreters was also considered a key factor influencing positive opinions. Additionally, the perceived ease of use was shaped by device type, the feasibility of a hybrid model along with integration of AI, and the patient's healthcare condition, all of which were seen as critical to effective implementation. Human interaction remained a focal point, as many participants expressed concerns about the potential loss of emotional connection and non-verbal cues, underscoring the importance of trust and familiarity in healthcare settings. Finally, technical convenience was identified as a double-edged sword: while VRI could theoretically facilitate quicker access to interpreting services, technical challenges related to internet stability, device mobility, and payment processing were perceived as significant impediments.

- Perceived Usefulness:** The analysis of perceived usefulness underscores a nuanced perspective regarding the anticipated benefits of VRI in the Turkish healthcare context, as participants expressed mixed views across four key sub-themes: healthcare service quality, suitability for elderly and people with disabilities, time efficiency, and health policy and technological integration. While VRI was generally perceived as a valuable tool for expanding access to interpreting services and potentially reducing waiting times, its perceived impact on healthcare service quality was more contentious. Participants acknowledged the potential for timely access to interpreters but raised concerns about the loss of non-verbal cues and the emotional connection typically facilitated by face-to-face interactions. The suitability of VRI for elderly and disabled patients was largely welcomed; however, contextual factors such as the nature of the disability, the availability of caregiver support, and the specific type of healthcare service provided were emphasized, highlighting the need for tailored approaches to ensure effective and inclusive implementation for these vulnerable groups. Regarding time efficiency, VRI was perceived as beneficial for minimizing delays in less intensive healthcare services; however, concerns about potential scheduling disruptions and patient dissatisfaction in cases of unforeseen delays were also noted. Finally, while some participants recognized the potential alignment of VRI with broader health policy objectives, particularly in the context of health tourism, others

emphasized the broader integration of VRI into health policy frameworks was not perceived as entirely favorable, particularly from a marketing-oriented perspective.

- **Perceived Affordances:** The analysis of perceived affordances underscores the complex relationship between potential logistical advantages and operational challenges associated with VRI implementation in the Turkish healthcare context, as discussed across four key sub-themes: task assignment and planning, confidentiality and data security concerns, communication quality, and workload and efficiency. In the context of task assignment and planning, logistical advantages such as minimizing travel time and facilitating quicker interpreter deployment were noted; however, the comprehensive role of interpreters in face-to-face settings — extending beyond mere language support to encompass tasks ranging from patient admission to discharge, assisting with medical procedures, document processing, and transportation coordination — was perceived as difficult to replicate remotely. Regarding confidentiality and data security, some participants viewed VRI as potentially less intrusive for sensitive consultations, particularly for patients seeking greater anonymity, while others raised concerns as regard where data is stored and the interpreter's physical surroundings during remote sessions. In terms of communication quality, doubts were expressed about the potential limitations in conveying emotions and non-verbal cues remotely, which could impede effective communication. In terms of workload and efficiency, while some participants perceived VRI as a tool for optimizing workload distribution and increasing task efficiency, others cautioned against the risk of heightened work intensity, as interpreters might be expected to handle more cases in less time due to the reduction in deployment time and resource allocation. Additionally, the perceived efficacy of VRI was closely linked to the professionalism and medical expertise of interpreters, underscoring the need for specialized personnel to effectively manage complex medical consultations.
- **Intention to Use:** The analysis of intention to use VRI in the Turkish healthcare context reveals a spectrum of perspectives shaped by specific conditions, perceived benefits, and existing service expectations. The overall inclination to use the system varied notably among patient, physician, and interpreter groups. Patients predominantly expressed

reluctance, citing concerns about losing the continuity of in-person interpreter support throughout their hospital journey and the perceived decline in service quality due to the absence of direct interpersonal interaction. Physicians, however, exhibited more conditional openness, with most indicating that they would consider using VRI for preliminary consultations, follow-up sessions, or in facilities lacking in-person interpreters, provided that the system is well-structured and user-friendly. Interpreters displayed a more nuanced stance, recognizing potential logistical and scheduling advantages while simultaneously expressing reservations about communication quality and the potential intensification of workload if the system were to replace comprehensive in-person support.

Furthermore, the hybrid model emerged as a recurrent theme, with many participants suggesting that a combination of VRI and face-to-face interpreting could address contextual concerns while still offering logistical benefits. Thus, while VRI is perceived as a potentially valuable supplementary tool in specific contexts, broader acceptance will likely depend on targeted implementation strategies that effectively address patient trust, communication quality, and the comprehensive support role currently provided by in-person interpreters.

Overall, while some participants acknowledged VRI's potential to enhance service delivery under specific conditions, the prevailing consideration across all groups highlighted concerns related to infrastructure, communication quality, emotion conveyance and trust-building. Collectively, these findings suggest that while VRI holds promise for enhancing certain aspects of service delivery, its successful integration into healthcare settings will require comprehensive strategies to address these intersecting contextual factors effectively.

The third research question sought to explore the ideal system structure for VRI in Türkiye. The findings indicate that a hybrid, context-dependent model would be most appropriate—one that blends in-person and remote interpreting based on setting, patient needs, and technological capacity. While high-functioning private institutions may maintain with face-to-face systems, public healthcare settings with less interpreter availability may benefit significantly from VRI, provided that robust technical and human resource infrastructures are adequately established.

In summary, the study concludes that a successful VRI integration in Turkish healthcare system requires user-centered planning, strong infrastructural investment, and adaptable implementation models tailored to the distinct needs of public and private healthcare sectors.

RECOMMENDATIONS FOR FURTHER STUDIES

Based on the findings of this study, several recommendations can be made to guide the potential integration of video remote interpreting services into the Turkish healthcare system in a way that is both effective and contextually appropriate.

1. Develop a strong legislative and institutional framework: International examples show that the successful and sustainable implementation of VRI services can be strengthened by clear legal mandates and national standards. Türkiye should consider establishing language access as a formal patient right and ensure that interpreter services, including remote modalities, are addressed in healthcare legislation. This should be supported by national-level standards and accreditation systems similar to those in countries like the USA and Australia.

2. Implement VRI as a flexible, hybrid model based on context: Given the high satisfaction with in-person interpreting in structured institutions and the variation in technological infrastructure across healthcare settings, a one-size-fits-all approach is not recommended. A hybrid system—using VRI in settings where in-person services are logistically difficult or resource-limited, and maintaining face-to-face options in others—would better address user needs and institutional capacity.

3. Prioritize infrastructure and technological readiness: Many participants noted that VRI could only be effective if devices are easily accessible, connection quality is reliable, and platforms are user-friendly. Investment in digital infrastructure, especially in public hospitals, is essential. Mobile or tablet-based systems should be piloted to improve scheduling flexibility and interpreter availability.

4. Engage all stakeholder groups in the planning and implementation process: Interpreters, physicians, and patients each have distinct concerns and priorities regarding the use of VRI.

Policies and pilot implementations should be developed in consultation with all these groups to ensure that the service design is user-centered and accounts for emotional, operational, and cultural factors.

5. Provide training and technical support: Any VRI system must be accompanied by training for healthcare professionals and interpreters, and by tailored orientation and assistance for patients—particularly those with low digital literacy or language barriers. This support will be critical to encouraging user confidence and improving uptake.

6. Expand research in diverse healthcare settings: This study was conducted in a private hospital where a well-structured appointment system is available for healthcare service seekers in Türkiye but who do not speak Turkish. Future research should explore perceptions in public hospitals and rural settings, where interpreter access may be more constrained. This will allow for a more comprehensive understanding of the challenges and potential of VRI across Türkiye's healthcare system.

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APPENDIX 1

ENGLISH SEMI-STRUCTURED IN-DEPTH INTERVIEW QUESTIONS

Interview Questions to investigate the expectations/opinions on video remote interpreting services that could be potentially integrated into the healthcare system in Türkiye

Interview questions for physicians

These interview questions have been prepared to evaluate the user expectations and opinions of physicians regarding a video remote interpreting service that could be potentially integrated into the healthcare system in Türkiye in the future. The study will contribute to the development of this practice from the perspective of service providers anticipating its potential future implementation in healthcare institutions. The interview will take approximately 25-30 minutes to complete, and the interview will be audio-recorded if you permit, on the condition that the collected data will be used exclusively for this Ph.D. dissertation. The data will be saved in an encrypted folder in the researcher's private computer and will not be used for any other purposes. The names and all information that may indicate the identity of the participants in the data used within the scope of the study will remain confidential. You are not expected to provide your name, and there are no right or wrong answers to the questions. The care and sincerity you demonstrate while answering the interview questions are crucial for the success of the study.

Thank you for your participation and contributions.

A- Socio-demographic Information

1. Your Gender: ☐ Female ☐ Male ☐ Prefer not to state
2. Your date of birth: (Specify as a year)
3. Please indicate your professional speciality (if any)

B- Current practice and experience status

To begin with, I would like to ask you questions on the current interpreting services status:

4. When providing healthcare services to foreign patients through in-person interpreting, which is currently used
 - a) How does the process work?
 - b) Are you satisfied with the current interpreting service system and what are its positive aspects?
 - c) What difficulties do you encounter in the current interpreting service system, how are they handled when you have difficulties in terms of operation, is it sufficient, are there any aspects that are not sufficient?
5. Are you aware of the concept/availability of remote interpreting practices that can be integrated into healthcare service provision for your foreign patients?

If yes, please explain?

If yes, have you ever used video remote interpreting to provide healthcare service?

-The researcher explains to the participant what the VRI application is.

C- Expectations/Opinions regarding the VRI practice

6. If you assume that a valid video remote interpreting services that might be integrated to the Turkish healthcare system is available today, how would you think/expect that the following metrics to be changed in terms of **perceived ease of use**?
 - a) Requirement of less effort than onsite consultations
 - b) Flexibility in the arrangement of appointments
 - c) Easy practice to use as a doctor working in the Turkish healthcare system
7. If you assume that a valid video remote interpreting services might be integrated to the Turkish healthcare system is available today, how would you think/expect that the following metrics to be changed in terms of **perceived usefulness**?
 - a) Improvement of the quality of services delivery to foreign patients in Türkiye
 - b) Access to services for foreign patients experiencing difficulties, such as the ones with disabilities, the elder population
 - c) Useful practice to meet healthcare goals
 - d) Decrease in average waiting time in queues at healthcare settings and a better-planned scheduling system
8. If you assume that a valid video remote interpreting services might be integrated to the Turkish healthcare system is available today, how would you think/expect that the following metrics to be changed in terms of **perceived affordances**?
 - a) Interpreter's deployment duration (*For clarification: What do you think about the difference between time spent while accessing an interpreter in face-to-face consultations and instant access to interpreting services via video?*)
 - b) Accessibility to a professional interpreter (*For clarification: What do you think about the difference between intervention by patient relatives and family members as ad-hoc solutions when a professional translator is not available, and providing professional interpreting services via video?*)
 - c) Confidentiality in communication (*For clarification: What do you think about the advantages of ensuring privacy through the provision of video interpreting services, such as the deactivation of video monitors to prevent visibility of the patients by the interpreter and/or adjustable voice settings in VRI systems when needed, also interpreting service to be provided by a professional interpreter instead of a family member?*)
 - d) Transportation and logistics cost of the interpreters (*For clarification: What do you think about the decrease in travel duration and expenses of the interpreter?*)

- e) Communication quality (*For clarification: What do you think about the clear presentation of patient problems and clear understanding of doctor recommendations?*)
 - f) Effect on the work burden as a doctor under the current Turkish healthcare system circumstances (*For clarification: What do you think about the duration spent during one consultation provided by either face-to-face interpreting or video interpreting?*)
 - g) Easier tracking of patient progress /more control over health information recording (*For clarification: What do you think about the impact of the ability to record -video and/or audio-online sessions on tracking patient health records and status?*)
 - h) Easiness to reach the daily obligatory patient quota to be fulfilled by each physician in the Turkish health system (*For clarification: What impact do you think video interpreting services will have on the pay-for-performance system, compared to face-to-face interpreting services?*)
9. If you assume that a valid video remote interpreting services might be integrated to the Turkish healthcare system is available today, would you **intend to use** such services to increase the quality of healthcare services?
(For clarification: What features would increase your desire to use it, and what could be the factors that would increase or decrease your desire to use such a system, what could make this practice user-friendly for you? What should be considered when developing such a system?)
10. Is there any idea/opinion you would like to add about this VRI practice? Please declare your positive or negative opinions on this practice. (For example, from the doctor's perspective, what kind of difficulties might video remote interpreting pose for the doctor? What could be the biggest contribution of VRI to the doctor?)

Interview questions for the patients with linguistic and cultural differences

These interview questions have been prepared to evaluate the user expectations and opinions of physicians regarding a video remote interpreting service that could be potentially integrated into the healthcare system in Türkiye in the future. The study will contribute to the development of this practice from the perspective of service receivers anticipating its potential future implementation in healthcare institutions. The interview will take approximately 25-30 minutes to complete, and the interview will be audio-recorded if you permit on the condition that the collected data will be used exclusively for this Ph.D. dissertation. The data will be saved in an encrypted folder in the researcher's private computer and will not be used for any other purposes. The names and all information which may indicate the identity of the participants in the data used within the scope of the study will remain confidential. You are not expected to provide your name, and there are no right or wrong answers to the questions. The care and sincerity you demonstrate while answering the interview questions are crucial for the success of the study.

Thank you for your participation and contributions

A- Socio-demographic Information

1. Your Gender: ☐ Female ☐ Male ☐ Prefer not to state
2. Your date of birth: (Specify as a year)
3. What is the highest degree or level of school you have completed?
4. For how many months have you been in Türkiye all in all disregarding any intervals? months

B- Current practice and experience status

To begin with, I would like to ask you questions about the current interpreting services status:

5. When receiving healthcare services through in-person interpreting, which is currently available
 - a) How does the process work?
 - b) Are you satisfied with the current interpreting service system, and what are its positive aspects?
 - c) What difficulties do you encounter in the current interpreting service system, how are they handled when you have difficulties in terms of operation, is it sufficient, are there any aspects that are not sufficient?
6. Are you aware of the concept/availability of remote interpreting practices that can be integrated into healthcare service provision for foreign patients?

If yes, please explain.

If yes, have you ever received healthcare service through video remote interpreting?

-The researcher explains to the participant what the VRI application is.

C- Expectations/Opinions regarding the VRI practice

7. If you assume that valid video remote interpreting services might be integrated to the Turkish healthcare system is available today, how would you think/expect that the following metrics to be changed in terms of **perceived ease of use**?
 - d) Requirement of less effort than onsite consultations
 - e) Flexibility in the arrangement of appointments
 - f) Easy practice to use as a foreign patient seeking healthcare in the Turkish healthcare system
8. If you assume that valid video remote interpreting services might be integrated to the Turkish healthcare system is available today, how would you think/expect that the following metrics to be changed in terms of **perceived usefulness**?
 - a) Improvement of the quality of services delivery to foreign patients in Türkiye
 - b) Access to services for foreign patients experiencing difficulties, such as the ones with disabilities, the elder population
 - c) Decrease in average waiting time in queue at healthcare settings and a better-planned scheduling system
9. If you assume that valid video remote interpreting services might be integrated to the Turkish healthcare system is available today, how would you think/expect that the following metrics to be changed in terms of **perceived affordances**?
 - a) Interpreter's deployment duration (*For clarification: What do you think about the difference between time spent while accessing an interpreter in face-to-face consultations and instant access to interpreting services via video?*)
 - b) Accessibility to a professional interpreter (*For clarification: What do you think about the difference between intervention by patient relatives and family members as ad-hoc solutions when a professional translator is not available, and providing professional interpreting services via video?*)
 - c) Confidentiality in communication (*For clarification: What do you think about the advantages for ensuring privacy through the provision of video interpreting services, such as the deactivation of video monitors to prevent visibility of the patients by the interpreter and/or adjustable voice settings in VRI systems when needed, also interpreting service to be provided by a professional interpreter instead of a family member?*)
10. If you assume that valid video remote interpreting services might be integrated to the Turkish healthcare system is available today, would you **intend to use** such services to increase the quality of healthcare services?

(For clarification: What features would increase your desire to use it, what could be the factors that would increase or decrease your desire to use such a system, and what could make this practice user-friendly for you? What should be considered when developing such a system?)

- 11.** Is there any idea/opinion you would like to add about this VRI practice? Please declare your positive or negative opinions on this practice. (For example, from the foreign patient's perspective, what kind of difficulties might video remote interpreting pose for a patient? What could be the most significant contribution of VRI to the patient?)



Interview questions for health care interpreters

These interview questions have been prepared to evaluate the user expectations and opinions of physicians regarding a video remote interpreting service that could be potentially integrated into the healthcare system in Türkiye in the future. The study will contribute to the development of this practice from the perspective of service providers anticipating its potential future implementation in healthcare institutions. The interview will take approximately 25-30 minutes to complete, and the interview will be audio-recorded if you permit, on the condition that the collected data will be used exclusively for this Ph.D. dissertation. The data will be saved in an encrypted folder in the researcher's private computer and will not be used for any other purposes. The names and all information that may indicate the identity of the participants in the data used within the scope of the study will remain confidential. You are not expected to provide your name, and there are no right or wrong answers to the questions. The care and sincerity you demonstrate while answering the interview questions are crucial for the success of the study.

Thank you for your participation and contributions

A- Socio-demographic Information

1. Your Gender: ☐ Female ☐ Male ☐ Prefer not to state
2. Your date of birth: (Specify as a year)
3. Please indicate your education level?
 - a) Primary school graduate b) Secondary school graduate c) High school graduate
 - d) Upper high school e) Bachelor's degree f) Higher levels
4. In what field and which year did you complete your education?
.....
5. What is your mother language?
.....
6. a) What languages do you know, and what are their levels?

Language	Beginner	Intermediate	Advanced

- b) What are the language pairs you provide interpreting services?

7. From which date do you live in Türkiye (specify as a year):

B- Current practice and experience status

To begin with, I would like to ask you questions about the current interpreting services status:

8. When providing face-to-face interpreting services to foreign patients, which is currently available
 - a) How does the process work?
 - b) Are you satisfied with the current interpreting service system, and what are its positive aspects?
 - c) What difficulties do you encounter in the current interpreting service system, how are they handled when you have difficulties in terms of operation, is it sufficient, are there any aspects that are not sufficient?
9. Are you aware of the concept/availability of remote interpreting practices that can be integrated into healthcare service provision for your foreign patients?

If yes, please explain.

If yes, have you ever provided video remote interpreting services in any health care setting?

-The researcher explains to the participant what the VRI application is.

C- Expectations/Opinions regarding the VRI practice

10. If you assume that valid video remote interpreting services might be integrated to the Turkish healthcare system is available today, how would you think/expect that the following metrics to be changed in terms of **perceived ease of use**?
 - g) Requirement of less effort than onsite consultations
 - h) Flexibility in the arrangement of appointments
 - i) Easy practice to use as a health care interpreting working in the Turkish healthcare system
11. If you assume that valid video remote interpreting services might be integrated to the Turkish healthcare system is available today, how would you think/expect that the following metrics to be changed in terms of **perceived usefulness**?
 - a) Improvement of the quality of services delivery to foreign patients in Türkiye
 - b) Access to services for foreign patients experiencing difficulties, such as the ones with disabilities, the elder population
 - c) Decrease in average waiting time in queues at healthcare settings and a better-planned scheduling system
12. If you assume that valid video remote interpreting services might be integrated to the Turkish healthcare system is available today, how would you think/expect that the following metrics to be changed in terms of **perceived affordances**?

- a) Interpreter's deployment duration (*For clarification: What do you think about the difference between time spent while accessing an interpreter in face-to-face consultations and instant access to interpreting services via video?*)
- b) Accessibility to a professional interpreter (*For clarification: What do you think about the difference between intervention by patient relatives and family members as ad-hoc solutions when a professional translator is not available, and providing professional interpreting services via video?*)
- c) Confidentiality in communication (*For clarification: What do you think about the advantages of ensuring privacy through the provision of video interpreting services, such as the deactivation of video monitors to prevent visibility of the patients by the interpreter and/or adjustable voice settings in VRI systems when needed, also interpreting service to be provided by a professional interpreter instead of a family member?*)
- d) Transportation and logistics cost of the interpreters (*For clarification: What do you think about the decrease in travel duration and expenses of the interpreter?*)
- e) Communication quality (*For clarification: What do you think about the clear presentation of patient problems and clear understanding of doctor recommendations?*)
- f) Effect on the work burden as a doctor under the current Turkish healthcare system circumstances (*For clarification: What do you think about the duration spent and effort exerted during one consultation provided by either face-to-face interpreting or video interpreting?*)
- g) The state and feeling of being involved in communication (*For clarification: What do you think about the positive or negative impact of the preliminary interaction between the doctor and the patient/patient's relative on the interpretation process until the interpreter arrives in the room or joins the communication in face-to-face interpreting?*)
- h) The impact on the daily workload of an interpreter working under the conditions of the Turkish healthcare system (*For clarification: How do you think the difference between face-to-face interpreting services and video remote interpreting services affects the effort you put into providing interpretation for a consultation, the status of fatigue, the number of people you need to reach daily (if applicable), and your monthly salary?*)

13. If you assume that a valid video remote interpreting services might be integrated to the Turkish healthcare system is available today, would you **intend to use** such services to increase the quality of healthcare services?

(For clarification: What features would increase your desire to use it, what could be the factors that would increase or decrease your desire to use such a system, what could make this practice user-friendly for you? What should be considered when developing such a system?)

14. Is there any idea/opinion would you like to add about this VRI practice? Please declare your positive or negative opinions on this practice. (For example, from the interpreters' perspective, what kind of difficulties might video remote interpreting pose for the interpreter? What could be the biggest contribution of VRI to the interpreter?)

APPENDIX 2

TÜRK SAĞLIK SİSTEMİNDE VIDEO ARACILIĞIYLA ÇEVİRİ UYGULAMASI KONUSUNDA BEKLENTİ/GÖRÜŞLERE YÖNELİK YARI YAPILANDIRILMIŞ DERİNLEMESİNE GÖRÜŞME SORULARI

Doktorlar için sorular

Bu soru formu, Türkiye'de sağlık hizmeti sistemine entegre edilebilecek video sistemi yoluyla uzaktan çeviri hizmetine yönelik doktorların, yabancı hastaların ve tercümanların görüşlerini ve beklentilerini değerlendirmek amacıyla hazırlanmıştır. Çalışma, sağlık hizmet kuruluşlarında ilerleyen zamanlarda uygulanması muhtemel olan bu uygulamanın personel açısından da geliştirilmesine katkı sağlayacaktır. Görüşmenin tamamlanması yaklaşık 25 ila 30 dakika sürecektir ve izin vermeniz halinde sadece bu çalışma kapsamında yararlanmak üzere sesli kayıt cihazı ile kaydedilecektir. Bu kayıtlar, araştırmacının kişisel bilgisayarında şifreli dosyada saklanacak ve çalışma dışında herhangi bir amaçla kullanılmayacaktır. Çalışma kapsamında kullanılan verilerde isimler ve katılımcı kimliğini belirten tüm bilgiler gizli kalacaktır. İsim yazmanız gerekmemektedir ve sorular için herhangi bir doğru ya da yanlış cevap bulunmamaktadır. Formu doldururken göstereceğiniz özen ve samimiyet çalışmanın amacına ulaşması açısından son derece önemlidir.

Katılım ve katkılarınız için teşekkür ederiz.

A- Sosyo-demografik bilgiler

11. Cinsiyetiniz: ☐ Kadın ☐ Erkek ☐ Belirtmek istemiyorum
 12. Doğum tarihiniz: (Yıl olarak belirtiniz)
 13. Lütfen mesleki uzmanlığınızı belirtiniz:

B- Mevcut uygulama ve tecrübe durumu

Öncelikle, size mevcut durum hakkında sorular sormak istiyorum:

14. Yabancı hastalara hâlihazırda yararlanılan yüz yüze çeviri yoluyla sağlık hizmeti sunarken;
 a) Süreç nasıl işliyor?
 b) Mevcut çeviri hizmeti sisteminden memnun musunuz, olumlu yönleri nelerdir?
 c) Mevcut çeviri hizmeti sisteminde karşılaştığınız zorluklar nelerdir, işleyiş açısından zorluk yaşadığınızda bu durum nasıl ele alınıyor, yeterli oluyor mu, yeterli olmayan yönleri var mı?

15. Yabancı hastalara sunulan sağlık hizmetlerine entegre edilebilecek video yoluyla çeviri uygulamasına yönelik bir bilginiz/fikriniz var mı?

Cevabınız evet ise açıklayınız:

Cevabınız evet ise hiç uzaktan video çevirisi uygulaması aracılığıyla sağlık hizmeti sundunuz mu?
Açıklayınız:

- Katılımcıya VRI uygulamasının ne olduğu araştırmacı çalışmacı tarafından açıklanır.

C- Uzaktan video çevirisi uygulamasına yönelik beklentiler/düşünceler

16. Türk sağlık sistemine entegre edilebilecek bir video yoluyla çeviri uygulamasının yürürlükte olduğunu varsayarsanız, **kullanım kolaylığı algısı** bakımından aşağıda sayacağım konular doğrultusunda düşünceleriniz/beklentileriniz neler olurdu?

- a) Yüz yüze konsültasyonlardan daha az çaba gerektirmesi
- b) Randevuların düzenlenmesinde esneklik
- c) Türk sağlık sisteminde çalışan bir doktor olarak uygulamayı kullanım kolaylığı

Ekleme istediğiniz hususlar:

17. Türk sağlık sistemine entegre edilebilecek bir video yoluyla çeviri uygulamasının yürürlükte olduğunu varsayarsanız, **yararlılık algısı** bakımından aşağıda sayacağım konular doğrultusunda düşünceleriniz/beklentileriniz neler olurdu?

- a) Türkiye'deki yabancı hastalara sunulan sağlık hizmetinde kalitenin artması
- b) Engelliler, yaşlı nüfus vb. gibi yüz yüze konsültasyonlara katılmakta zorluk çekebilecek yabancı hastaların hizmete erişimi
- c) Ülkenin sağlık hedeflerine ulaşmasına yönelik kullanışlı bir uygulama olması
- d) Sağlık kurumlarında ortalama randevu sırası bekleme/ kuyrukta bekleme süresinde azalma ve daha iyi planlanmış randevu sistemi

18. Türk sağlık sistemine entegre edilebilecek bir video yoluyla çeviri uygulamasının yürürlükte olduğunu varsayarsanız, **uygunluk algısı** bakımından aşağıda sayacağım konular doğrultusunda düşünceleriniz/beklentileriniz neler olurdu?

- a) Tercümana erişim süresi (*Açıklama gerekirse: Yüz yüze yapılan konsültasyonlarda tercümana erişim için harcanacak süre ile video yoluyla çeviri hizmetine anında erişim arasındaki süre farkı konusundaki düşünceleriniz nelerdir?*)
- b) Profesyonel bir tercümana erişilebilirlik (*Açıklama gerekirse: Profesyonel olarak çalışan bir tercümana erişilememesi sonucu aile yakınlarının desteği gibi geçici çözümlerin devreye sokulması ile video yoluyla nitelikli çeviri hizmeti arasındaki farka yönelik düşünceleriniz nelerdir?*)
- c) İletişimde gizlilik (*Açıklama gerekirse: Video yoluyla çeviri hizmeti sunumu sırasında tercümanın görmemesi amacıyla video kısmının kapatılabilme özelliği, çevrenin duymaması açısından ses düzeyinin kullanıcı tarafından ayarlanabilmesi, çevirinin aile bireyleri yerine profesyonel tercüman ile yapılması gibi mahremiyeti sağlayan avantajlara yönelik düşünceleriniz nelerdir?*)

- d) Tercümanın ulaşım ve lojistik maliyeti (*Açıklama gerekirse: Yolda geçen süre ve ilgili masrafların azaltılmasına yönelik düşünceleriniz nelerdir?*)
- e) İletişim kalitesi (*Açıklama gerekirse: Hasta sorunlarının net bir şekilde ortaya konması, doktor tavsiyelerinin net bir şekilde anlaşılmasına yönelik düşünceleriniz nelerdir?*)
- f) Türk sağlık sistemi koşullarında çalışan bir doktorun iş yüküne etkisi (*Açıklama gerekirse: Yüz yüze çeviri hizmeti ile video yoluyla çeviri hizmetine anında erişim arasındaki farkın bir konsültasyonda geçirdiğiniz süreye etkisi konusunda düşünceleriniz nelerdir?*)
- g) Hastanın sağlık durumundaki ilerlemesinin daha kolay takibi (*Açıklama gerekirse: Yapılan online görüşmelerin -ses ve/veya görüntü - kayıt edilebilme özelliğinin hasta takibinize etkisine yönelik düşünceleriniz nelerdir?*)
- h) Günlük ulaşılacak konsültasyon sayısına daha kolay ulaşım (*Açıklama gerekirse: Bu açıdan yüz yüze sunulan çeviri hizmetine kıyasla video yoluyla çeviri hizmetinin, performansa dayalı ücretlendirme sistemine yönelik nasıl bir etkisi olacağını düşünüyorsunuz?*)

19. Türk sağlık sistemine entegre edilebilecek bir video yoluyla çeviri uygulamasının yürürlükte olduğunu varsayarsanız, sunulan sağlık hizmetinin kalitesini artırmak amacıyla bu tür bir uygulamayı **kullanmayı ister misiniz?**

(Açıklama gerekirse, hangi özellikler bulunursa kullanmaya yönelik isteğiniz artar, böyle bir sistemi kullanma isteğini artıracak veya azaltacak unsurlar neler olabilir, bu uygulamayı sizin için kullanıcı dostu olacağı hale neler getirebilir? Bu program geliştirilirken nelere dikkat edilmelidir?)

20. Uzaktan video yoluyla çeviri konusunda eklemek istediğiniz bir husus var mıdır? Bu hizmete yönelik olumlu veya olumsuz görüşlerinizi belirtiniz. (Örneğin, doktor açısından bakıldığında; video yoluyla çeviri uygulaması doktor için nasıl bir zorluk getirebilir? Video yoluyla çeviri uygulamasının doktora en büyük katkısı ne olabilir?)

Dilsel ve kültürel farklılıkları olan hastalar için sorular

Bu soru formu, Türkiye'de sağlık hizmeti sistemine entegre edilebilecek video sistemi yoluyla uzaktan çeviri hizmetine yönelik doktorların, yabancı hastaların ve tercümanların görüşlerini ve beklentilerini değerlendirmek amacıyla hazırlanmıştır. Çalışma, sağlık hizmet kuruluşlarında ilerleyen zamanlarda uygulanması muhtemel olan bu uygulamanın hizmet kullanıcıları açısından da geliştirilmesine katkı sağlayacaktır. Görüşmenin tamamlanması yaklaşık 25 ila 30 dakika sürecektir ve izin vermeniz halinde sadece bu çalışma kapsamında yararlanmak üzere sesli kayıt cihazı ile kaydedilecektir. Bu kayıtlar, araştırmacının kişisel bilgisayarında şifreli dosyada saklanacak ve çalışma dışında herhangi bir amaçla kullanılmayacaktır. Çalışma kapsamında kullanılan verilerde isimler ve katılımcı kimliğini belirten tüm bilgiler gizli kalacaktır. İsim yazmanız gerekmemektedir ve sorular için herhangi bir doğru ya da yanlış cevap bulunmamaktadır. Formu doldururken göstereceğiniz özen ve samimiyet çalışmanın amacına ulaşması açısından son derece önemlidir.

Katılım ve katkılarınız için teşekkür ederiz.

A- Sosyo-demografik Bilgiler

1. Cinsiyetiniz: ☐ Kadın ☐ Erkek ☐ belirtmek istemiyorum
2. Doğum tarihiniz: (Yıl olarak belirtiniz)
3. Tamamladığınız en yüksek okul derecesi veya seviyesi nedir?
4. Ne kadar süredir Türkiyede yaşıyorsunuz (Ay olarak belirtiniz)

B- Mevcut uygulama ve tecrübe durumu

Öncelikle, size mevcut durum hakkında sorular sormak istiyorum:

5. Hâlihazırda yararlandığınız yüz yüze çeviri yoluyla sağlık hizmeti alırken;
 - a) Süreç nasıl işliyor?
 - b) Mevcut çeviri hizmeti sisteminden memnun musunuz, olumlu yönleri nelerdir?
 - c) Mevcut çeviri hizmeti sisteminde karşılaştığınız zorluklar nelerdir, yeterli oluyor mu, yeterli olmayan yönleri var mı?

6. Yabancı hastalara sunulan sağlık hizmetlerine entegre edilebilecek video yoluyla çeviri uygulamasına yönelik herhangi bir bilginiz/fikriniz var mı?

Cevabınız evet ise açıklayınız:

Cevabınız evet ise hiç uzaktan video çevirisi uygulaması aracılığıyla sağlık hizmeti aldınız mı?
Açıklayınız:

Katılımcıya VRI uygulamasının ne olduğu araştırmacı çalışmacı tarafından açıklanır.

C- Uzaktan video çevirisi uygulamasına yönelik beklentiler/düşünceler

7. Türk sağlık sistemine entegre edilebilecek bir video yoluyla çeviri uygulamasının yürürlükte olduğunu varsayarsanız, **kullanım kolaylığı algısı** bakımından aşağıda sayacağım konular doğrultusunda düşünceleriniz/beklentileriniz neler olurdu?
- a) Yüz yüze konsültasyonlardan daha az çaba gerektirmesi
 - b) Randevuların düzenlenmesinde esneklik
 - c) Türk sağlık sisteminde sağlık hizmeti alan bir yabancı hasta olarak uygulamayı kullanım kolaylığı
8. Türk sağlık sistemine entegre edilebilecek bir video yoluyla çeviri uygulamasının yürürlükte olduğunu varsayarsanız, **yararlılık algısı** bakımından aşağıda sayacağım konular doğrultusunda düşünceleriniz/beklentileriniz neler olurdu?
- a) Türkiye'deki yabancı hastalara sunulan sağlık hizmetinde kalitenin artması
 - b) Engelliler, yaşlı nüfus vb. gibi yüz yüze konsültasyonlara katılmakta zorluk çekebilecek yabancı hastaların hizmete erişimi
 - c) Sağlık kurumlarında ortalama randevu sırası bekleme/ kuyrukta bekleme süresinde azalma
9. Türk sağlık sistemine entegre edilebilecek bir video yoluyla çeviri uygulamasının yürürlükte olduğunu varsayarsanız, **uygunluk algısı** bakımından aşağıda sayacağım konular doğrultusunda düşünceleriniz/beklentileriniz neler olurdu?
- a) Tercümanın erişim süresi (*Açıklama gerekirse: Yüz yüze yapılan konsültasyonlarda tercümana erişim için harcanacak süre ile video yoluyla çeviri hizmetine anında erişim arasındaki süre farkı konusundaki düşünceleriniz nelerdir?*)
 - b) Profesyonel bir tercümana erişilebilirlik (*Açıklama gerekirse: Profesyonel olarak çalışan bir tercümana erişilememesi sonucu aile yakınlarının desteği gibi geçici çözümlerin devreye sokulması ile video yoluyla nitelikli çeviri hizmeti arasındaki farka yönelik düşünceleriniz nelerdir?*)
 - c) İletişimde gizlilik (*Açıklama gerekirse: Video yoluyla çeviri hizmeti sunumu sırasında tercümanın görmemesi amacıyla video kısmının kapatılabilme özelliği, çevrenin duymaması açısından ses düzeyinin kullanıcı tarafından ayarlanabilmesi, çevirinin aile bireyleri yerine profesyonel tercüman ile yapılması gibi mahremiyeti sağlayan avantajlara yönelik düşünceleriniz nelerdir?*)
10. Türk sağlık sistemine entegre edilebilecek bir video yoluyla çeviri uygulamasının yürürlükte olduğunu varsayarsanız, sunulan sağlık hizmetinin kalitesini artırmak amacıyla bu tür bir uygulamayı **kullanmayı ister misiniz?**

(Açıklama gerekirse, hangi özellikler bulunursa kullanmaya yönelik isteğiniz artar, böyle bir sistemi kullanma isteğini artıracak veya azaltacak unsurlar neler olabilir, bu uygulamayı sizin için kullanıcı dostu olacağı hale neler getirebilir? Bu program geliştirilirken nelere dikkat edilmelidir?)

11. Uzaktan video yoluyla çeviri konusunda eklemek istediğiniz bir husus var mıdır? Bu hizmete yönelik olumlu veya olumsuz görüşlerinizi belirtiniz. (Örneğin, hasta açısından bakıldığında; video yoluyla çeviri uygulaması hasta için nasıl bir zorluk getirebilir? Video yoluyla çeviri uygulamasının hastaya en büyük katkısı ne olabilir?)

Tercümanlar için sorular

Bu soru formu, Türkiye'de sağlık hizmeti sistemine entegre edilebilecek video sistemi yoluyla uzaktan çeviri hizmetine yönelik doktorların, yabancı hastaların ve tercümanların görüşlerini ve beklentilerini değerlendirmek amacıyla hazırlanmıştır. Çalışma, sağlık hizmet kuruluşlarında ilerleyen zamanlarda uygulanması muhtemel olan bu uygulamanın personel açısından da geliştirilmesine katkı sağlayacaktır. Görüşmenin tamamlanması yaklaşık 25 ila 30 dakika sürecektir ve izin vermeniz halinde sadece bu çalışma kapsamında yararlanmak üzere sesli kayıt cihazı ile kaydedilecektir. Bu kayıtlar, araştırmacının kişisel bilgisayarında şifreli dosyada saklanacak ve çalışma dışında herhangi bir amaçla kullanılmayacaktır. Çalışma kapsamında kullanılan verilerde isimler ve katılımcı kimliğini belirten tüm bilgiler gizli kalacaktır. İsim yazmanız gerekmemektedir ve sorular için herhangi bir doğru ya da yanlış cevap bulunmamaktadır. Formu doldururken göstereceğiniz özen ve samimiyet çalışmanın amacına ulaşması açısından son derece önemlidir.

Katılım ve katkılarınız için teşekkür ederiz.

A- Sosyo-demografik Bilgiler

1. Cinsiyetiniz: ☐ Kadın ☐ Erkek ☐ Belirtmek istemiyorum
2. Doğum tarihiniz: (Yıl olarak belirtiniz)
3. Lütfen eğitim seviyenizi belirtiniz.
a) İlkokul mezunu b) Ortaokul mezunu c) Lise mezunu d) Lisans mezunu f) Lisansüstü mezunu
4. Eğitiminizi hangi alanda ve hangi yılda tamamladınız?
.....
5. Ana diliniz nedir?
.....
6. a) Bildiğiniz diller ve düzeyi nedir?

Dil	Başlangıç düzeyi	Orta düzey	İleri düzey

- b) Çeviri yaptığınız dil çift(ler)i nelerdir?
.....

7. Hangi tarihten beri Türkiye'de yaşıyorsunuz (yıl olarak belirtiniz):

B- Mevcut uygulama ve tecrübe durumu

Öncelikle, size mevcut durum hakkında sorular sormak istiyorum:

8. Hâlihazırda sunduğunuz yüz yüze çeviri hizmeti verirken;
 - a) Süreç nasıl işliyor?
 - b) Mevcut çeviri hizmeti sisteminde memnun musunuz, olumlu yönleri nelerdir?
 - c) Mevcut çeviri hizmeti sisteminde karşılaştığınız zorluklar nelerdir, yeterli oluyor mu, yeterli olmayan yönleri var mı?

9. Yabancı hastalara sunulan sağlık hizmetlerine entegre edilebilecek video yoluyla çeviri uygulamasına yönelik bir bilginiz/fikriniz var mı?

Cevabınız evet ise açıklayınız:

Cevabınız evet ise hiç uzaktan video çevirisi uygulaması aracılığıyla sağlık sektöründe çeviri hizmeti sundunuz mu? Açıklayınız:

.....

Katılımcıya VRI uygulamasının ne olduğu araştırmacı çalışmacı tarafından açıklanır.

C- Uzaktan video çevirisi uygulamasına yönelik beklentiler/düşünceler

10. Türk sağlık sistemine entegre edilebilecek bir video yoluyla çeviri uygulamasının yürürlükte olduğunu varsayarsanız, **kullanım kolaylığı algısı** bakımından aşağı yer alan konular doğrultusunda düşünceleriniz/beklentileriniz neler olurdu?

- a) Yüz yüze konsültasyonlardan daha az çaba gerektirmesi
- b) Randevuların düzenlenmesinde esneklik
- c) Türk sağlık sisteminde çalışan bir tercüman olarak uygulamayı kullanım kolaylığı

11. Türk sağlık sistemine entegre edilebilecek bir video yoluyla çeviri uygulamasının yürürlükte olduğunu varsayarsanız, **yararlılık algısı** bakımından aşağı yer alan konular doğrultusunda düşünceleriniz/beklentileriniz neler olurdu?

- a) Türkiye'deki yabancı hastalara sunulan sağlık hizmetinde kalitenin artması
- b) Engelliler, yaşlı nüfus vb. gibi yüz yüze konsültasyonlara katılmakta zorluk çekebilecek yabancı hastaların hizmete erişimi
- c) Sağlık kurumlarında ortalama randevu sırası bekleme/ kuyrukta bekleme süresinde azalma ve daha iyi planlanmış randevu sistemi

12. Türk sağlık sistemine entegre edilebilecek bir video yoluyla çeviri uygulamasının yürürlükte olduğunu varsayarsanız, **uygunluk algısı** bakımından aşağı yer alan konular doğrultusunda düşünceleriniz/beklentileriniz neler olurdu?

- a) Tercümanın erişim süresi (*Açıklama gerekirse: Yüz yüze yapılan konsültasyonlarda tercümana erişim için harcanacak süre ile video yoluyla çeviri hizmetine anında erişim arasındaki süre farkı konusundaki düşünceleriniz nelerdir?*)
- b) Profesyonel bir tercümana erişilebilirlik (*Açıklama gerekirse: Profesyonel olarak çalışan bir tercümana erişilememesi sonucu aile yakınlarının desteği gibi geçici çözümlerin devreye*

sokulması ile video yoluyla nitelikli çeviri hizmeti arasındaki farka yönelik düşünceleriniz nelerdir?)

- c) İletişimde gizlilik (Açıklama gerekirse: Video yoluyla çeviri hizmeti sunumu sırasında tercümanın görmemesi amacıyla video kısmının kapatılabilme özelliği, çevrenin duymaması açısından ses düzeyinin kullanıcı tarafından ayarlanabilmesi, çevirinin aile bireyleri yerine profesyonel tercüman ile yapılması gibi mahremiyeti sağlayan avantajlara yönelik düşünceleriniz nelerdir?)
- d) Tercümanın ulaşım ve lojistik maliyeti (Açıklama gerekirse: Yolda geçen süre ve ilgili masrafların azaltılmasına yönelik düşünceleriniz nelerdir?)
- e) İletişim kalitesi (Açıklama gerekirse: Hasta sorunlarının net bir şekilde ortaya konması, doktor tavsiyelerinin net bir şekilde anlaşılmasına yönelik düşünceleriniz nelerdir?)
- f) Türk sağlık sistemi koşullarında çalışan bir tercümanın iş yüküne etkisi (Açıklama gerekirse: Yüz yüze çeviri hizmeti ile video yoluyla çeviri hizmetine anında erişim arasındaki farkın bir konsültasyona sağladığınız çeviri hizmetinde geçirdiğiniz süreye ve gösterdiğiniz çabaya etkisi konusunda düşünceleriniz nelerdir?) workload
- g) İletişime dahil olma durumu ve duygusu (Açıklama gerekirse: Yüz yüze çeviride çevirmen odaya ulaşana/çevirmen iletişime dahil olana kadar doktor ve hasta/hasta yakını arasında oluşan ön etkileşimin çeviri sürecine olumlu veya olumsuz etkisi konusunda ne düşünüyorsunuz?)
- h) Türk sağlık sistemi koşullarında çalışan bir tercümanın günlük çalışma yoğunluğuna etkisi (Açıklama gerekirse: Yüz yüze çeviri hizmeti ile video yoluyla çeviri hizmetine anında erişim arasındaki farkın bir konsültasyona sağladığınız çeviri hizmetinde sarfettiğiniz çabaya, var ise ulaşmanız gereken günlük kişi sayısına, aylık maaşınıza etkisi konusunda düşünceleriniz nelerdir?)

13. Türk sağlık sistemine entegre edilebilecek bir video yoluyla çeviri uygulamasının yürürlükte olduğunu varsayarsanız, sunulan sağlık hizmetinin kalitesini artırmak amacıyla bu tür bir uygulamayı **kullanmayı ister misiniz?**

(Açıklama gerekirse, hangi özellikler bulunursa kullanmaya yönelik isteğiniz artar, böyle bir sistemi kullanma isteğini artıracak veya azaltacak unsurlar neler olabilir, bu uygulamayı sizin için kullanıcı dostu olacağı hale neler getirebilir? Bu program geliştirilirken nelere dikkat edilmelidir?)

14. Uzaktan video yoluyla çeviri konusunda eklemek istediğiniz bir husus var mıdır? Bu hizmete yönelik olumlu veya olumsuz görüşlerinizi belirtiniz (Örneğin, tercüman açısından bakıldığında; video yoluyla çeviri uygulaması tercüman için nasıl bir zorluk getirebilir? Video yoluyla çeviri uygulamasının tercümana en büyük katkısı ne olabilir?)

APPENDIX 3

ARAŞTIRMA GÖNÜLLÜ KATILIM FORMU

Bu çalışma, “Türkiye’de Sunulan Sağlık Hizmetlerinde Video Yoluyla Çeviri” başlıklı bir doktora düzeyi araştırma çalışmasıdır.

Çalışmanın amacı: Doktor ve hastanın aynı ortamda bulunduğu ancak tercümanın hizmet sunumuna uzaktan bağlantı yoluyla dahil olduğu bir sistemin, tüm tarafların yüz yüze aynı ortamda bulunduğu mevcut sisteme entegre edilmesi konusunda doktorların, hastaların ve tercümanların görüşlerini ve beklentilerini değerlendirmektir.

Çalışmanın katkısı: Bu şekilde, yabancı hastalara sağlık hizmeti sunumu sırasında dil desteği için çeşitli nedenlerle tercümana yüz yüze ulaşamadığı zaman, uzaktan tercüme yoluyla daha etkin, hızlı ve profesyonel bir hizmet olanağı sağlanarak sağlık sistemine hayati bir katkı sunacağı düşünülmektedir.

Çalışmanın katılımcıları: Yukarıda açıklanan hizmetten yararlanacak olan doktorlar, tercümanlar, hastalar bu çalışma kapsamına dahil edilmiştir.

Çalışma kapsamına giren katılımcılardan bilimsel veri elde etmek amacıyla hazırlanan görüşme soruları, Sıla Saadet TOKER tarafından, Prof. Dr. Aymil Doğan danışmanlığında yürütülen Doktora çalışması kapsamında yönlendirilecektir.

Araştırmanın yapılması için Hacettepe Üniversitesi Sosyal ve Beşeri Bilimler Araştırma Etik Kurulu’ndan izin alınmıştır.

- Bu çalışmaya katılımınız gönüllülük esasına dayanmaktadır.
- Çalışmanın amacı doğrultusunda, derinlemesine görüşme soruları sizlere araştırmacı tarafından yüz yüze yönlendirilecektir.
- İsminizi yazmak ya da kimliğinizi açığa çıkaracak bir bilgi vermek zorunda değilsiniz; araştırmada katılımcıların isimleri gizli tutulacaktır.
- İzin vermeniz halinde görüşmeler sesli kayıt cihazı ile kaydedilecektir.
- Araştırma kapsamında toplanan veriler, sadece bilimsel amaçlar doğrultusunda kullanılacak, araştırmanın amacı dışında ya da bir başka araştırmada kullanılmayacak ve gerekmesi halinde, sizin (yazılı) izniniz olmadan başkalarıyla paylaşılmayacaktır.
- İstemeniz halinde sizden toplanan verileri inceleme hakkınız bulunmaktadır.
- Sizden toplanan veriler araştırmacının kişisel bilgisayarında şifreli dosyada saklanacak ve araştırma bitiminde imha edilecektir.

- Veri toplama sürecinde size rahatsızlık verebilecek herhangi bir soru/talep olmayacaktır. Yine de katılımınız sırasında herhangi bir sebepten dolayı rahatsızlık hissederseniz çalışmadan istediğiniz zamanda ayrılabilirsiniz, rahatsızlığın giderilmesi için gerekli yardım sağlanacaktır. Çalışmadan ayrılmanız, tarafınıza hiçbir sorumluluk getirmeyecektir; sizden toplanan veriler çalışmadan çıkarılacak ve imha edilecektir.
- Veri toplama sürecinde sormak istediğiniz herhangi bir soru olursa çekinmeden araştırmacıya sorularınızı yöneltebilirsiniz.
- Görüşmenin yaklaşık 25-30 dakika sürmesi planlanmaktadır.

Gönüllü katılım formunu okumak ve değerlendirmek üzere ayırdığınız zaman için teşekkür ederim. Çalışma kapsamı ve sonuçları ile ilgili sorularınızı Hacettepe Üniversitesi İngilizce Mütercim Tercümanlık Bölümü Öğretim Üyesi Prof. Dr. Aymil Doğan’a veya şahsım, Sıla Saadet Toker’e yöneltebilirsiniz.

Araştırmacı Adı: Prof Dr Aymil Doğan
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İngilizce Mütercim Tercümanlık Anabilim Dalı
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Araştırmacı Adı: Sıla Saadet Toker
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Bu çalışmaya tamamen kendi rızamla, istediğim takdirde çalışmadan ayrılabilceğimi bilerek verdiğim bilgilerin bilimsel amaçlarla kullanılmasını kabul ediyorum.

(Lütfen bu formu doldurup imzaladıktan sonra veri toplayan kişiye veriniz.)

Tarih:

Katılımcı Ad ve Soyadı:

Adres:

E-posta adresi:

Telefon:

İmza:

APPENDIX 4

ARAŞTIRMACI GÜNLÜĞÜ

9 Nisan 2025 tarihinde saat 11.00 civarında çalışmayı yürütmek için onay aldığım özel hastaneye geldim. Öncelikle Uluslararası Hasta Hizmetleri Direktörü'nün odasına girdim ve veri toplamaya başlamadan önce kendisiyle görüştim. Direktör, doygun veri gelebilecek kişilere beni yönlendirmesi ve görüşme yapacağım kişilerle aramda koordinasyon sağlaması amacıyla beni odak kişisi ile tanıştırdı.

Bu odak kişisi beni Uluslararası Hasta Hizmetleri odasına alarak kısaca sistemin nasıl işlediğini anlattı. Hastanede İngilizce, Fransızca, Rusca, Arapça başta olmak üzere pek çok dilde çeviri hizmeti sağlandığını, pek farklı yurt dışı misyondan ve büyükelçiliklerden hastaların geldiğini anlattı. Ayrıca tercümanların bu odada oturduğunu, yazılı tercüme gerektiğinde orada çalıştıklarını belirtti. Tercüme hizmetine ihtiyaç duyan yabancı hastaların ilk olarak bu odaya geldiğini, orada bulunan bekleme odalarında vakit geçirdiğini anlattı. Odaya baktığımda, oldukça geniş bir alanda her tercümanın kendine ait bir masası ve bilgisayar olduğunu gözlemledim. Ayrıca oldukça geniş bir bekleme alanı ve bekleme alanı yanında hastalara ikram edilmek üzere çay kahve ve atıştırmalıkların bulunduğu bir alan bulunuyordu. Bu alanın başında ise servis için ayrı bir yardımcı personel daimi olarak orada bulunuyordu. Ben gözlemlediğim esnada 3 hasta orada beklemekteydi. Odak kişinin açıkladığı kadarıyla hastalar ilk hastaneye vardıklarında buraya geliyordu ve sonuç, MR, EKG gibi randevu sırasını bekleme gibi gerekliliklerde burada vakit geçiriyordu.

İlk olarak bir tercümanla görüşmeye başladım, kendisine çalışmamın kapsamını anlattım ve çok sıcak karşılayarak masasına buyur etti. Çay ve su ikram etti. Uzun yıllar bu kurumda çalışmakta olduğu için çok tecrübeliydi ve tercümanlığa ek olarak yönetici rolünde olduğunu öğrendim. Tüm sağlık terminolojisine, örneğin ameliyat için gerekli tetkiklerin tek tek neler olduğu gibi işlemlere oldukça hakimdi. Tecrübesi ışığında hastanede bir yabancı hastanın girişinden çıkışına kadar geçen süreci tüm detaylarıyla uzun uzun anlattı. (Hatta ankette yer alan mevcut sürecin nasıl işlediğine dair soruyu oldukça detaylı açıkladığı için diğer tercüman katılımcılara bu soruyu tekrar yöneltememe kararı aldım.) Tercümanın sık sık telefonu çalıyor, Whatsapp üzerinden istekler geliyordu, yani bir hem tercüman hem yönetici olarak çok yoğun çalışan bir personeldi, ancak

buna rağmen hala bana yardımcı olmaya çalıştığı için bu kişinin oldukça yardımsever ve sıcakkanlı olduğu fikrindeyim. Görüşmeleri yaparken de hastane adına bir konuyu aktarırken biz diye konuşuyordu, bu söylemden işine kendini adanmış ve özverili bir çalışan olduğu anlaşılıyordu. Öğle arası saati olmasına rağmen görüşmemizi kesmeyerek bana vakit ayırdı ve görüşmeyi tamamladık.

Bu görüşmenin ardından odak kişisi beni iki doktora yönlendirdi. Her doktorun odasına girmeden önce odak kişisi önden bir çalışma yapıyor olduğumu açıkladı ve ardından doktorun uygun görmesi halinde içeri girdim. Birinci doktorla görüşmeyi tamamladıktan sonra ikinci doktora giderek çalışmayı anlattığımda uzun süre vaktinin olmadığını eğer beş dakika ise görüşebileceğini aksi takdirde hastası olduğu için vakit ayıramayacağını belirtti. Bunun üzerine her farklı fikir önemli olacağı için kendisine sadece video yoluyla çeviri uygulamasını anlatarak böyle bir uygulama mevcut sisteme entegre edilirse fikrinin ne olacağını sordum ve genel fikrini iletti, çok kısa vakti olduğu için genel görüşlerini not ettim ve ayırdığı vakit için teşekkür ederek odasından ayrıldım.

Daha sonra üç ayrı tercüman ile görüşmelerimi gerçekleştirdim. Her birinin farklı dillerde çeviri yapıyor olmasının ve daha önce de farklı kurumlarda çalışmış olmalarının sorulara değişik bakış açılarından cevap verebilmeleri açısından çok faydalı olduğu kanattımdedir. Hastanede tercüme hizmeti sürecinin baştan sona oldukça yapılandırılmış ve hastanın en baştan tercümanlarla iletişim halinde olduğu öğrendikten sonra katılımcılara sadece bu hastanedeki deneyimleriyle sınırlı kalmayıp tüm tecrübelerine dayalı olarak soruları yanıtlamalarını istedim.

Son katılımcı, şu an tercüme yapmadığını ve yönetici pozisyonunda olduğunu belirtti, ancak bu hastanede tercüman olarak çalıştığı dönemleri ve daha önceki deneyimlerini değerlendirerek soruları cevapladı. Aynı zamanda tercümanların koordinasyonunu sağlayan bir yöneticinin bakış açısından, böyle bir uygulamanın tercümanları nasıl etkileyebileceğini dinleyebilme fırsatı sunduğu için bu görüşmenin oldukça faydalı olduğunu düşünüyorum.

Gözlemlediğim kadarıyla tercümanların eğitim düzeyi oldukça yüksekti. Doktora yapan birden fazla tercüman benim halimden anlayacağını söyleyip gülümseyerek çalışmaya katılmayı kabul ettiler. Mesai bitimi saatine yaklaşılması sebebiyle bugünü sonlandırıp ertesi gün tekrar erkenden gelmem üzerine anlaşarak odak kişisi ile vedalaştım. Vedadan önce kendisini 5 dakika beklemem

gerekti. Bu süreçte odadaki etkileşimleri gözlemlene fırsatı buldum. Tercümanların hasta doktor görüşmesinden sonra hastalara, doktorun görüşü doğrultusunda önerilen hizmetler için fiyat bilgisi iletmeye yönelik rol ve sorumluluğunun olduğunu gördüm. Bu süreçte bir yöneticinin bir tercümana tercih edilmeleri için önceliklerinin fiyatlandırma değil sunulan hizmetin kalitesi olması gerekliliğine değinmesi, hastanenin yabancı hasta memnuniyetine ve tercüme hizmet kalitesine ne kadar önem verdiklerini ortaya koyduğunu ve bu kaliteyi elde edilen kazancın önünde tuttuklarını ortaya koyması açısından önemli olduğunu düşünüyorum. Yönelttiğim sorulardaki sağlık hizmeti kalitesi ve iletişim kalitesi ile ilgili soruların da bu doğrultuda cevaplandığını gözlemledim.

10 Nisan 2025 tarihinde saat 9.00'da tekrar Uluslararası Hasta Hizmetleri odasına gittim. Tercümanlar önceden bilgilendirilmiş olduğu için görüşme için hazırды. Üç tercümanla görüştüm, hepsi çok sıcakkanlıydı ve samimiyetle sorularımı cevapladılar. Daha sonra bir tercümanın yatış yaptıracığı hastası bekleme alanında bekliyordu. Tercümana bu hastayla görüşme yapıp yapamayacağımı sorduğumda gayet yardımcı bir şekilde hastaya katılıp katılmak istemediğini yabancı dilde sordu ve hasta kabul etti. İngilizce iletişim kurup kuramayacağımı sorduk ve hasta görüşmeyi İngilizce yapabileceğini belirtti. Görüşmeye başladık, çalışmayı açıkladım ve gönüllü katıldığını belirten onam formunu imzalamasını istedim. Hasta onam formunu çok detaylı bir şekilde uzun uzun okudu. Yabancı biri olarak farklı bir ülkede imzalaması için bir doküman verince tedirgin olduğunu hissettim ve formu detaylıca açıkladım. İmzaladı ve görüşmeye başladık, ancak görüşme esnasında hastada dil kısıtlılığı olduğunu gördüm, maalesef çalışmaya dahil edecek hasta bulmak oldukça zor olduğu için bu şekilde ek açıklamalarla tane tane konuşarak görüşmeyi tamamlamak durumunda kaldık.

Öğle arası odak kişisini beklerken tercümanlardan bana yardımcı olabilecek, akademik çalışma yapma tecrübesi olan doktorları önerdi ve onlara gidebileceğimi belirtti. Öğleden sonra odak kişisi ile iki doktora daha gittik. Aynı bölümde olan iki doktorun da hastalarının girip çıkmasını bekledim. Müsait olduklarında ikisine de sırayla girip görüştüm. Dışarı da başka hastalar da bekliyorken ben beklediğim için ikisi de beni aradan almayı kabul ettiler ancak görüşmeleri hızlı bir şekilde tamamlamak durumunda kaldık. Daha sonra tercümanların odasına gidip tekrar iki tercümanla daha görüştüm, yine kendileri oldukça sıcakkanlı bir şekilde görüşlerini detaylı şekilde vererek çalışmaya katıldılar. Artık yavaş yavaş görüşlerin tekrarlamaya başlamış olduğunu

gözlemlediğim için tercüman grubu ile yapacağım görüşmeleri on kişi ile tamamlamaya karar verdim. Bugün veri toplamayı sonlandırmadan önce odak kişisi beni son olarak bir doktor ile daha görüştirdi. Kapıda bekleyen hasta olmadığı için kendisiyle görüşmeyi biraz daha rahat tamamlama fırsatımız oldu. Günün sonunda odak kişisiyle hatsaneye gelebileceğim diğer günleri de planladıktan sonra hastaneden ayrıldım.

12 Nisan 2025 tarihinde saat 09.30 sularında hastaneye tekrar geldim. Tercüman odasından birisi, beni iki doktorla görüştürmek üzere doktorların yanına götürerek kendilerinden görüşme için onay aldı. Haftasonu olduğu için hasta sayısı oldukça fazlaydı. İlk doktorla görüşme yaparken acil bir hasta geldiği için görüşmeyi çok hızlı tamamlamak durumunda kaldık. İkinci doktorla daha detaylı görüşebildik. Daha sonra odak kişisi beni iki doktora daha götürdü ve kendileri çok güzel ve detaylı cevaplar vererek oldukça güzel veriler elde etmeme katkıda bulundu. Oldukça değerli bilgiler verdiler. Daha sonra acil bölümünde bir doktorla görüşmeye gittim. Acil kısmı olduğu için doktora hasta geldikçe odadan çıktım ve onlar çıkınca sonrasında tekrar girdim, bu şekilde görüşmeyi bölümler halinde tamamlamak durumunda kaldık. Ama randevulu hasta olmadan tercüme hizmeti alan bir doktordan geri bildirimler almak açısından bu görüşmenin çok yararlı olduğunu düşünüyorum. Daha sonra hastanenin sağlık profesyoneli çeşitliliği sağlamak amacıyla bir diyetisyen ile görüştim, yabancı hastaları kendisi ile etkileşimi diğer doktorlar gibi önden randevulu olmadığı ve anlık başvurular aldığı için uzaktan çeviri desteğini kullanması açısından yaşıntılarının bulunması ve bu hizmeti kıyaslama açısından kıymetli veriler sağlaması açısından çok faydalı bir görüşme oldu. Farklı alanlarda hizmet veren sağlık çalışanlarından yeterince veri topladığıma karar vererek doktor grubu için veri doyuluğuna ulaşıldığına karar verdim ve hastalardan veri toplamak için çalışmalarına devam ettim.

Odak kişisine hastalara geçebileceğimiz konusunda bilgi verince beni bir tercüman yatan hastasının yanına götürdü. Hastanın odasına gidip hastalığı ile ilgili bilgilerden de haberdar olmak durumunda kalınca bu görüşmenin duygusal yükünün de olduğunu belirtmek isterim. Tercümanın hastayla ilgili sadece iletişim desteği sağlamadığını, hastanın yüz yüze tercüman olarak görevlendirilmiş kişiye her alanda (sigorta ile fiyat ve ödeme koşullarını görüşme, iş yeriyle hastalığının seyri ve tedavisi için gerekli koşulları görüşme vb.) ihtiyaç duyduğunu gözlemledim. Özellikle yurt dışından gelen hastaların tüm süreçlerinden baştan sonra tercümanın sorumlu

olduğunu bizzat gördüm. Bu hastayla görüşmemi tamamlayıp odadan ayrıldım, tabii bu görüşmeleri İngilizce olarak tercümansız bizzat gerçekleştirdiğimi ve İngilizcenin hastalar için ikinci dil olduğunu ve kendi ana dilleri gibi bir konuşma akışının oluşamadığını belirtmek isterim.

Sonra saat 15.00 itibarıyla gece tercümanı göreve başladı ve onunla yabancı yatan hastaların odalarını sırayla kontrol etmek ve çalışmaya katılıp katılmayacaklarını sormak için katları gezmeye başladık. Bir hastaya girdik, kendisinin Türkçe konuşabildiğini ancak ailesinin tercüman aracılığıyla iletişim kurması gerektiğini söylediler. Bunun üzerine kendisine görüşme sorularını yönlendirmedim ancak genel olarak fikrini almak için odasına girip genel sorular sordum, kendisi çok genç olduğu için değişik ve yeni teknolojilere açık görüşlerini bana ilettiler, bu açıdan bu görüşmenin de faydalı olduğunu düşünüyorum. Kalan hastalar belirli sebeplerle çalışma kapsamına alınamadığı (18 yaş altı, ameliyattan yeni çıkma etc) için hastane turunu tamamladık. Yukarıdaki notlarımda belirttiğim gibi bir önceki gün tercümanlarla yaptığım görüşmelere veri doygunluğuna ulaştığımı düşünerek tamamlama kararı almıştım ancak gece tercümanının farklı bir rotasyonla çalıştığını göz önünde bulundurarak farklı veriler elde edebileceğimi düşünerek kendisine çalışmayı anlatarak görüşmeye katılıp katılmayacağına dair fikrini sordum ve yardımsever bir şekilde kabul etti. Kendisiyle de görüşmemi tamamladım ve ileriki günlerde hastası olursa bana haber vermesini rica ederek hastaneden ayrıldım. Bu aşamadan sonra hasta bulabilmek için ara sıra hasta odasına giderek bekleyeceğim veya tercümanlarla iletişim kurarak hastaları olup olmadığını kontrol etmem gerekecek.

21 Nisan 2025 tarihinde öğleden sonra hastaneye hasta görüşmeleri için tekrar gittim. Artık birimdeki tercümanları tanıyordum, hepsiyle selamlaştık ve bugün hastaları olup olmadığını sordum. İçlerinden bir tercüman, bekleme alanında bekleyen hastalardan birinin İngilizce bilmediğini ancak tercüman konusunda yardımcı olabileceğini sıcakkanlılıkla söyledi. Tercüman aracılığıyla bekleyen hasta ile görüşmemi tamamladım. Başka bir tercüman hastasının geleceğini ve İngilizce konuştuğunu, hastanın gelmesini bekleyebileceğini söyledi. Hasta eşi ve çocuğuyla gelmişti, tercüman onlara bekleme odasında bir kahve içebileceklerini o sırada uygun görürlerse sorularımı yanıtlamayı kabul edip etmeyeceklerini sordu. Onlar da çalışmaya katılmayı kabul ettiler ve bekleme alanında İngilizce olarak görüşmeyi tamamladık. Akşam tercümanı gelince beni yatan hastalardan birisine götürdü, Arapça konuşuyorlardı dolayısıyla yine tercüman aracılığı ile

görüşmeyi gerçekleştirdik. Tercüman daha önce, tercüman grubuyla yaptığım görüşmelere katılım sağladığı için sorulara oldukça hakimdi. Hasta ek açıklama istediğinde bana çevirmeden doğrudan açıklama yaptığını gözlemledim. Çok yardımsever biçimde ilgiyle soruları cevapladılar. Tercümanları kendi dilinden konuşan, onları anlayan, her işini halleden biri gibi gördüklerini ve normalde beni cevaplayacakları halden daha candan ve samimi cevapladıkları da gözlemlerim arasında yer aldı. Ek görüş belirtmek isteyip istemediklerine dair yönelttiğim soruya, hastanedeki hizmetten çok memnun olduklarını ve herkese teşekkür etmek istediklerini benim aracılığım ile aktarmak istediklerini söylemeleri mevcut sistemden oldukça memnun olduklarını göz önüne seriyordu. Gece nöbetçisiyle bir hastanın yanına daha uğradık ancak duygusal yükü ağır bir operasyondan çıkmış olduğunu hemşireden öğrenince bu hastayla görüşme yapmamanın daha etik olacağı düşüncesiyle bu hastayı çalışma kapsamı dışında bırakma kararı aldım. Mesai saati biterken hastaneden ayrılmak üzere olan tercümanlara ertesi gün hastalarının olup olmayacağını sordum ve randevularının olduğunu öğrendiğim için ertesi gün de hastaneye gelmek üzere oradan ayrıldım.

22 Nisan 2025 tarihinde sabahdan hastaneye gittim. Dün geleceğini haber aldığım hastayı yaklaşık bir saat bekledikten sonra görüşmeyi yapabildik. Kendisinin İngilizcesi çok iyi olduğu ve vakti olduğu için sorularımı sıcakkanlılıkla ve büyük bir dikkatle cevapladı, oldukça değerli veriler elde ettiğim bu görüşmeyi tamamladıktan sonra öğleden sonra geleceğini haber aldığım bir başka hastayı beklemeye başladım. O sırada bir tercümanın bir ülkeden aradığı şikayeti üzerine doktorlar, fiyat verme birimi ve hasta arasında pek çok telefon diyalogları sonucu hastanın Türkiye'ye gelmek üzere randevusunun oluşturulduğuna şahit oldum. Bu süreçte tercümanın sadece dil bariyerlerini aşmak amaçlı hizmet sunmadığını aynı zamanda hastanedeki doktor ve mali birimler aralarında koordine sağlama görevinin de olduğunu gözlemledim. Öğleden sonra tercümanın desteğiyle bir hasta ile daha görüşmemi daha tamamladım ve hastaneden ayrıldım.

APPENDIX 5

RESEARCHER'S DIARY

On April 9, 2025, at around 11:00 a.m., I arrived at the private hospital where I had obtained permission to conduct my research. I first visited the office of the Director of International Patient Services and spoke with this person before beginning data collection. The director introduced me to a focal point staff member who would assist me in identifying potential participants and coordinating interviews.

This focal point took me to the International Patient Services office and briefly explained how the system operates. S/he described that the hospital offers interpreting services in several languages—including English, French, Russian, and Arabic—serving patients from various foreign missions and embassies. S/he also noted that interpreters work from this office and perform written translations as needed. Foreign patients requiring interpretation services first arrive at this office and wait in the designated waiting area. I observed that each interpreter had a dedicated desk and computer in a spacious room, and the waiting area included a refreshment section with tea, coffee, and snacks, attended by a staff member. At the time of my observation, three patients were waiting there. According to the focal point, patients spend time in this area while awaiting test results, MRIs, or other appointments.

I began my interviews with one interpreter, explaining the scope of my study. S/he welcomed me warmly, offered tea and water, and invited me to sit at her/his desk. Having worked at the institution for many years, s/he was highly experienced and also held a managerial role. S/he demonstrated extensive knowledge of medical terminology and procedural workflows, such as pre-surgical evaluations. Drawing from her/his experience, s/he provided a comprehensive account of a foreign patient's journey through the hospital system—from admission to discharge. (In fact, s/he explained the process-related question from the questionnaire so thoroughly that I decided not to repeat the same question with the remaining interpreter participants.) Although s/he was constantly receiving phone calls and WhatsApp messages, s/he still prioritized assisting me, which made her seem particularly helpful and committed. S/he frequently used the pronoun “we” when referring to hospital operations, reflecting a strong sense of institutional ownership and dedication.

Despite it being lunch break, s/he generously continued the interview and helped me complete the session.

After this interview, the focal point directed me to two physicians. Before entering their offices, s/he briefly explained my study to each doctor and asked for their consent. The first interview was completed successfully. When I approached the second doctor, s/he stated that s/he was short on time and could only speak for five minutes. Given the value of every perspective, I quickly introduced the concept of video remote interpreting (VRI) and asked for her/his general opinion if such a system were to be integrated into the hospital. I noted her/his overall remarks and thanked for her/his time.

I subsequently interviewed three more interpreters. The diversity of languages they worked with and their previous experiences at other institutions enriched their perspectives. Upon learning that the interpreting service in the hospital is highly structured and that patients engage with interpreters from the outset, I asked participants to reflect not only on their experiences in this hospital but also on their broader professional experience.

One of the interpreter participants, who now works in a managerial role, shared insights based on her/his previous experiences as a translator, both in this hospital and elsewhere. His/her dual perspective—as a former interpreter and current coordinator—provided valuable information on how the introduction of such technologies might affect interpreters institutionally.

Based on my observations, interpreters at this hospital had a high level of education. Several were pursuing doctoral degrees and jokingly remarked that they empathized with my research work, which helped establish rapport. Since the workday was ending, I agreed with the focal point to return the next morning and said goodbye. Before leaving, I waited a few minutes in the office and had the chance to observe the interpreters interacting with patients. I noted that they also explained service prices and payment conditions after consultations. One manager emphasized to an interpreter that service quality should take precedence over price in promoting the hospital, reflecting the institution's commitment to patient satisfaction and translation service quality. This orientation also seemed to influence participants' responses to questions on healthcare and communication quality.

On April 10, 2025, I returned to the International Patient Services office at 9:00 a.m. The interpreters had been informed in advance and were ready for interviews. I spoke with three interpreters, all of whom were very welcoming and answered my questions sincerely. One interpreter had a patient waiting to be admitted and offered to assist in asking whether the patient would agree to participate. After confirming that the patient could proceed in English, I introduced the study and asked for consent. The patient carefully read the consent form, and sensing her/his hesitation as a foreigner being asked to sign a document in another country, I took time to explain it thoroughly. Although I noticed a slight language barrier, we managed to complete the interview slowly and clearly.

While waiting for the focal point during lunch break, one of the interpreters recommended several physicians with experience in academic research. In the afternoon, the focal point accompanied me to meet two more doctors. After waiting for their patients to exit, I briefly introduced myself, and both kindly agreed to fit me in despite the busy clinic. As time was limited, both interviews were concise. I later interviewed two additional interpreters, who again responded warmly and in detail. As I noticed that responses were beginning to repeat, I decided to conclude interviews with interpreters considering that data is saturated after ten participants.

Before ending the day, the focal point introduced me to one last doctor. With no patients waiting outside, I was able to conduct a more relaxed and extended interview. At the end of the day, I discussed my future visit schedule with the focal point and left the hospital.

On April 12, 2025, I returned to the hospital around 9:30 a.m. An interpreter from the office took me to meet with two physicians and obtained their consent for participation. Since it was the weekend, the patient volume was significantly higher. During my interview with the first doctor, an urgent patient arrived, and we had to conclude the interview quickly. However, I was able to speak in more detail with the second physician. Later, the focal point took me to two additional doctors, both of whom provided thoughtful and detailed responses, contributing valuable insights into the study.

After that, I visited the emergency department to interview a physician there. Due to the nature of the department, I had to pause the interview each time a patient entered and resume once they left.

Despite the fragmented format, this interaction was particularly beneficial, as the physician did not require an appointment in regular practice to provide interpreting services and offered spontaneous feedback. I also interviewed a dietitian to diversify professional profiles within the study. Given her/his experience with walk-in patients and the need for on-the-spot interpreting support, her/his insights were very helpful for understanding the comparative use of remote interpreting. Having collected sufficient data from healthcare professionals across different disciplines, I concluded that data saturation had been reached for the physician group and proceeded to focus on patients.

Once I informed the focal point that I was ready to begin patient interviews, an interpreter accompanied me to visit one in-patient. Upon entering the room, I learned details about the patient's medical condition, and I must note the emotional weight of this particular interview. I observed that the interpreter not only facilitated communication but also supported the patient across multiple areas—such as negotiating with insurance providers and discussing treatment logistics with employers. Especially for international patients, the interpreter played a continuous and central role throughout the care process. I conducted the interview in English without an interpreter, but I must emphasize that for the patients, English was a second language, which sometimes prevented a natural flow of conversation.

Around 3:00 p.m., the night-shift interpreter came to the office to start his/her shift. Together, we visited the wards to ask hospitalized foreign patients if they would be willing to participate in the study. In one room, we encountered a patient who could speak Turkish but noted that his/her family relied on the interpreter to communicate. I decided not to ask the structured questions but did have a brief conversation to gather general opinions. Since the patient was young, her/his feedback on new technologies was especially open-minded and useful. Other patients were excluded from the study due to various factors such as being under 18 or being recently out of surgery. As previously noted, I had decided that data saturation was reached for the interpreter group, but recognizing the different working patterns of the night-shift interpreter, I asked whether s/he would be also willing to participate. S/he kindly agreed, and I completed my interview with her/his. Before leaving, I asked if s/he could inform me of any new patients in the coming days, and s/he agreed. From that point forward, I planned to either wait near patient rooms or coordinate with interpreters to identify potential participants.

On April 21, 2025, I returned to the hospital in the afternoon to continue patient interviews. By this time, I had become familiar with the interpreter team and greeted them warmly. I asked if any had patients available for interviews that day. One interpreter kindly informed me that a patient waiting in the lobby did not speak English and offered to help facilitate communication. I conducted that interview with the interpreter's support. Another interpreter mentioned that her/his patient would arrive soon and could speak English. When the patient arrived with their spouse and child, the interpreter kindly offered them coffee while asking whether they would be willing to participate. They agreed, and we conducted the interview in the waiting area in English.

When the night-shift interpreter arrived, s/he took me to interview a hospitalized patient who spoke Arabic. We conducted this interview with through interpreter's language assistance. As s/he had already participated in the study previously, s/he was very familiar with the questions. I noticed that s/he sometimes provided explanations to the patient directly without translating back to me, which reflected her/his attentiveness and efficiency. Both the interpreter and the patient were warm and eager to share their thoughts. I observed that patients perceived interpreters not merely as language supporters but as trusted individuals who understood them and helped with everything, which led them to respond more openly and sincerely than they might have otherwise. When I asked if they had anything to add, they expressed deep satisfaction with the hospital services and asked me to extend their thanks to the entire staff. Later, the night-shift interpreter and I visited another patient's room, but after learning from the nurse that the patient had just undergone an emotionally intense procedure, I decided it would be not convenient to proceed with the interview and excluded this case from the study. As the shift ended, I asked the day-shift interpreters whether they had appointments with patients the next day. Upon learning that they did, I made plans to return to the hospital once again.

On April 22, 2025, I arrived early at the hospital. I waited approximately an hour for a previously identified patient, who eventually agreed to participate. As the patient was fluent in English and had time, he thoughtfully and sincerely answered all of my questions, yielding very valuable data. In the afternoon, while waiting for another patient, I witnessed a complex communication exchange initiated by an interpreter receiving a call from abroad. The call involved coordination between physicians, the pricing unit, and the patient, ultimately leading to the scheduling of an

appointment for the patient to travel to Türkiye. This situation made it clear that interpreters in this hospital are not only responsible for bridging language barriers but also play a key role in coordinating communication between clinical and administrative departments. Later that day, with the support of another interpreter, I completed one final patient interview and concluded my data collection for the day.



APPENDIX 6

HACETTEPE UNIVERSITY SOCIAL SCIENCES AND HUMANITIES
RESEARCH ETHICS BOARD CLEARANCE LETTERTarih: 26/02/2025 15:34
Sayı: E-66777842-300-0004064778

00004064778

HACETTEPE ÜNİVERSİTESİ
SOSYAL VE BEŞERİ BİLİMLER ARAŞTIRMA ETİK KURULU

KURUL KARARI

<u>TOPLANTI TARİHİ</u>	<u>TOPLANTI SAYISI</u>
11 Şubat 2025	2025/03

Üniversitemiz Sosyal Bilimler Enstitüsü Mütercim Tercümanlık Anabilim Dalı İngilizce Mütercim Tercümanlık Doktora Programı öğrencilerinden **Sıla Saadet TOKER**'in, **Prof. Dr. Aymil DOĞAN** danışmanlığında yürüteceği *“Video-Remote Interpreting (VRI) In Telemedicine Service: The Case Of Turkey (Uzaktan Sağlık Hizmeti Sunumunda Uzaktan Video Çevirisi: Türkiye Örneği)”* başlıklı tez çalışması Üniversitemiz Sosyal ve Beşeri Bilimler Araştırma Etik Kurulunun **11 Şubat 2025** tarihinde yapmış olduğu toplantıda incelenmiş olup, etik açıdan **uygun bulunmuştur**.

Prof. Dr. İsmet KOÇ
Kurul Başkanı

Prof. Dr. Özgür
TEOMAN
Kurul Üyesi

İZİNLİ
Prof. Dr. Selda
ÖZDEMİR
Kurul Üyesi

Prof. Dr. Özge
ÖZYALÇIN OSKAY
Kurul Üyesi

Doç. Dr. Pınar
ÖZDEMİR ŞİMŞEK
Kurul Üyesi

Prof. Dr. Tuğça POYRAZ
Kurul Üyesi

İZİNLİ
Doç. Dr. Arife Berna
AYTAÇ
Kurul Üyesi

Doç. Dr. Gülçin Cankız
ELİBOL
Kurul Üyesi

İZİNLİ
Doç. Dr. Pınar ARPINAR
AVŞAR
Kurul Üyesi

Doç. Dr. Gülsüm DEPELİ
SEVİNÇ
Kurul Üyesi

Doç. Dr. Tülay BAĞCI
BOŞİ
Kurul Üyesi

Dr. Öğr. Üyesi Onur
URAZ
Kurul Üyesi

APPENDIX 7

ORIGINALITY REPORT

	HACETTEPE ÜNİVERSİTESİ SOSYAL BİLİMLER ENSTİTÜSÜ	Doküman Kodu Form No.	FRM-DR-21
		Yayın Tarihi Date of Pub.	04.01.2023
	FRM-DR-21 Doktora Tezi Orijinallik Raporu <i>PhD Thesis Dissertation Originality Report</i>	Revizyon No Rev. No.	02
		Revizyon Tarihi Rev. Date	25.01.2024

HACETTEPE ÜNİVERSİTESİ
SOSYAL BİLİMLER ENSTİTÜSÜ
İNGİLİZCE MÜTERCİM VE TERCÜMANLIK ANABİLİM DALI BAŞKANLIĞINA

Tarih: 19/06/2025

Tez Başlığı... **Video Yoluyla Uzaktan Çeviri: Türk Sağlık Sistemi için Yeni Bir Boyut**

Tez Başlığı (Almanca/Fransızca)*:.....

Yukarıda başlığı verilen tezin a) Kapak sayfası, b) Giriş, c) Ana bölümler ve d) Sonuç kısımlarından oluşan toplam 216 sayfalık kısmına ilişkin, 19/06/2025 tarihinde şahsım/tez danışmanım tarafından Turnitin adlı intihal tespit programından aşağıda işaretlenmiş filtrelemeler uygulanarak alınmış olan orijinallik raporuna göre, tezin benzerlik oranı % 9'dur.

Uygulanan filtrelemeler**:

- ☐ Kabul/Onay ve Bildirim sayfaları hariç
- ☒ Kaynakça hariç
- ☒ Alıntılar hariç
- ☐ Alıntılar dâhil
- ☒ 5 kelimedenden daha az örtüşme içeren metin kısımları hariç

Hacettepe Üniversitesi Sosyal Bilimler Enstitüsü Tez Çalışması Orijinallik Raporu Alınması ve Kullanılması Uygulama Esasları'nı inceledim ve bu Uygulama Esasları'nda belirtilen azami benzerlik oranlarına göre tezin herhangi bir intihal içermediğini; aksinin tespit edileceği muhtemel durumlarda doğabilecek her türlü hukuki sorumluluğu kabul ettiğimi ve yukarıda vermiş olduğum bilgilerin doğru olduğunu beyan ederim.

Gereğini saygılarımla arz ederim.

SILA SAADET TOKER

Öğrenci Bilgileri	Ad-Soyad	SILA SAADET TOKER	
	Öğrenci No	N19148489	
	Enstitü Anabilim Dalı	İNGİLİZCE MÜTERCİM TERCÜMANLIK	
	Programı	DOKTORA PROGRAMI	
	Statüsü	Doktora ☒	Lisans Derecesi ile (Bütünleşik) Dr ☐

DANIŞMAN ONAYI

UYGUNDUR.
(Unvan, Ad Soyad, İmza)

*Tez Almanca veya Fransızca yazılıyor ise bu kısımda tez başlığı **Tez Yazım Dilinde** yazılmalıdır.

**Hacettepe Üniversitesi Sosyal Bilimler Enstitüsü Tez Çalışması Orijinallik Raporu Alınması ve Kullanılması Uygulama Esasları ikinci bölüm madde (4)/3'te de belirtildiği üzere: Kaynakça hariç, Alıntılar hariç/dahil, 5 kelimedenden daha az örtüşme içeren metin kısımları hariç (Limit match size to 5 words) filtreleme yapılmalıdır.

	HACETTEPE ÜNİVERSİTESİ SOSYAL BİLİMLER ENSTİTÜSÜ	Doküman Kodu Form No.	FRM-DR-21
		Yayın Tarihi Date of Pub.	04.01.2023
	FRM-DR-21 Doktora Tezi Orijinallik Raporu <i>PhD Thesis Dissertation Originality Report</i>	Revizyon No Rev. No.	02
		Revizyon Tarihi Rev. Date	25.01.2024

**TO HACETTEPE UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
DEPARTMENT OF ENGLISH TRANSLATION AND INTERPRETATION**

Date: 19/08/2025

Thesis Title (In English): Video Remote Interpreting (VRI): A New Dimension for Turkish Healthcare System

According to the originality report obtained by myself/my thesis advisor by using the Turnitin plagiarism detection software and by applying the filtering options checked below on 19/08/2025 for the total of 215 pages including the a) Title Page, b) Introduction, c) Main Chapters, and d) Conclusion sections of my thesis entitled above, the similarity index of my thesis is 9 %.

Filtering options applied**:

- ☐ Approval and Declaration sections excluded
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- ☐ Quotes included
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I hereby declare that I have carefully read Hacettepe University Graduate School of Social Sciences Guidelines for Obtaining and Using Thesis Originality Reports that according to the maximum similarity index values specified in the Guidelines, my thesis does not include any form of plagiarism; that in any future detection of possible infringement of the regulations I accept all legal responsibility; and that all the information I have provided is correct to the best of my knowledge.

I respectfully submit this for approval.

SILA SAADET TOKER

Student Information	Name-Surname	SILA SAADET TOKER	
	Student Number	N19148489	
	Department	İNGİLİZCE MÜTERCİM TERCÜMANLIK	
	Programme	DOKTORA PROGRAMI	
	Status	PhD ☒	Combined MA/MSc-PhD ☐

SUPERVISOR'S APPROVAL

APPROVED
(Title, Name and Surname, Signature)

**As mentioned in the second part [article (4)/3] of the Thesis Dissertation Originality Report's Codes of Practice of Hacettepe University Graduate School of Social Sciences, filtering should be done as following: excluding reference, quotation excluded/included, Match size up to 5 words excluded.

APPENDIX 8

GLOSSARY

- **E-health - E-sağlık:** Tıp bilişimi, halk sağlığı ve ticaret ile internet ve ilgili teknolojiler aracılığıyla sağlanan veya geliştirilen sağlık hizmetlerinin ve bilgilerin kesiştiği yeni bir alandır (Sağlık Bakanlığı)
- **Telehealth - Tele sağlık:** Uzun süreli hastalığı olan hastaların (kronik hastalar) teşhis, takip, yönetim ve güçlendirilmesine yardımcı olmak üzere hastaları sağlık hizmeti sunucularıyla bir araya getiren sistem ve hizmetler bütünü (Sağlık Bakanlığı)
- **Telemedicine - Uzaktan sağlık hizmeti:** Tarafların aynı mekânda yer almadığı durumlarda sağlık hizmetlerinin bilgi ve iletişim teknolojilerinin kullanımı aracılığıyla sunulması (Sağlık Bakanlığı)
- **Distance Interpreting- Genel Uzaktan Çeviri:** Bağlantı kurulan platform (telefon veya video linki) veya konum farketmeksizin çevirmenin ve kullanıcıların uzaktan bağlanarak iletişim kurduğunu ifade etmek için kullanılan terimdir.
- **Remote Interpreting - Uzaktan Çeviri:** Çevirmenin diğer kullanıcılardan farklı bir konumda bulunarak hizmet sunduğu çeviri türüdür.
- **Telephone (Audioconference) Interpreting -Telefon Çevirisi:** Kullanıcıların, çevirmene telefon üzerinden bağlanarak hizmet aldığı çeviri türüdür.
- **Videoconference Interpreting - Videokonferans çevirisi:** Tüm veya en az iki kullanıcının aynı konumda olduğu ve çevirmenin kullanıcılardan birinin yanından bağlanarak video link aracılığıyla sunulan çeviri türüdür.
- **Teleconference Interpreting - Telekonferans çevirisi:** Çevirmen hariç diğer katılımcıların farklı konumlardan bağlantı kurduğu, çevirmeninse bu katılımcılardan birinin yanından hizmet sunduğu çeviri türüdür.
- **Video Remote Interpreting - Video yoluyla Uzaktan Çeviri:** Çevirmenin farklı bir konumdan bağlandığı ve diğer katılımcıların ayrı veya aynı konumda bulunarak tüm katılımcıların video linki üzerinden hizmet alıp verdiği çeviri türüdür.

APPENDIX 9

CODE MATRICES FOR COLLECTED QUALITATIVE DATA

a) Code Matrix with values

Code System	Patients	Physicians	Interpreters	SUM
▼  Perceived Ease of Use				0
>  1-Scheduling and Time Management	3	10	17	30
>  2- Situational Factors	4	11	11	26
>  3- Human Interaction	10	7	17	34
>  4- Technical Convenience	3	4	9	16
▼  Perceived Usefulness				0
>  1- Healthcare Service Quality	7	9	10	26
>  2- Suitability for Elderly and Disabled People	3	8	10	21
>  3- Time Efficiency	4	9	12	25
>  4- Health Policy and Technological Integration	1	9		10
▼  Perceived Affordances				0
>  1-Task Assignment and Planning	3	8	9	20
>  2- Confidentiality and Data Security Concerns	7	12	10	29
>  3- Communication Quality	1	12	19	32
>  4- Workload and Efficiency	2	28	38	68
▼  Intention to Use				0
>  1-Positive Intention I would intend to use	2	11	11	24
>  2- Negative Intention - I would not intend to use	6	3	4	13
 SUM	56	141	177	374

b) Heatmap Code Matrix with values

Code System	Patients	Physicians	Interpreters	SUM
▼ Perceived Ease of Use				0
> 1-Scheduling and Time Management	3	10	17	30
> 2- Situational Factors	4	11	11	26
> 3- Human Interaction	10	7	17	34
> 4- Technical Convenience	3	4	9	16
▼ Perceived Usefulness				0
> 1- Healthcare Service Quality	7	9	10	26
> 2- Suitability for Elderly and Disabled People	3	8	10	21
> 3- Time Efficiency	4	9	12	25
> 4- Health Policy and Technological Integration	1	9		10
▼ Perceived Affordances				0
> 1-Task Assignment and Planning	3	8	9	20
> 2- Confidentiality and Data Security Concerns	7	12	10	29
> 3- Communication Quality	1	12	19	32
> 4- Workload and Efficiency	2	28	38	68
▼ Intention to Use				0
> 1-Positive Intention I would intend to use	2	11	11	24
> 2- Negative Intention - I would not intend to use	6	3	4	13
Σ SUM	56	141	177	374

c) Code Matrix with percentages

Code System	Patients	Physicians	Interpreters	SUM
▼ Perceived Ease of Use				
> 1-Scheduling and Time Management	0.8%	2.7%	4.5%	8.0%
> 2- Situational Factors	1.1%	2.9%	2.9%	7.0%
> 3- Human Interaction	2.7%	1.9%	4.5%	9.1%
> 4- Technical Convenience	0.8%	1.1%	2.4%	4.3%
▼ Perceived Usefulness				
> 1- Healthcare Service Quality	1.9%	2.4%	2.7%	7.0%
> 2- Suitability for Elderly and Disabled People	0.8%	2.1%	2.7%	5.6%
> 3- Time Efficiency	1.1%	2.4%	3.2%	6.7%
> 4- Health Policy and Technological Integration	0.3%	2.4%		2.7%
▼ Perceived Affordances				
> 1-Task Assignment and Planning	0.8%	2.1%	2.4%	5.3%
> 2- Confidentiality and Data Security Concerns	1.9%	3.2%	2.7%	7.8%
> 3- Communication Quality	0.3%	3.2%	5.1%	8.6%
> 4- Workload and Efficiency	0.5%	7.5%	10.2%	18.2%
▼ Intention to Use				
> 1-Positive Intention I would intend to use	0.5%	2.9%	2.9%	6.4%
> 2- Negative Intention - I would not intend to use	1.6%	0.8%	1.1%	3.5%
Σ SUM	15.0%	37.7%	47.3%	100.0%

