

Patients' experiences of communication support in Japanese-English medical encounters

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A thesis submitted on 3 February 2017 for the degree of Doctor of Philosophy of
The Australian National University

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DECLARATION

I herewith declare that this thesis is my original work and has not been submitted in any form for another degree or diploma at any other tertiary education institute. Information derived from the published and unpublished work of others has been acknowledged in the text and a list of references is given in the bibliography.

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ACKNOWLEDGEMENTS

I would like to extend my sincere gratitude to the Chair of my PhD supervisory panel, Associate Professor Christine Phillips. She has been a tremendous mentor for me. I would also like to thank Dr Graham Fordham and Associate Professor Paul Dugdale for their valuable advice and unwavering support as the members of my supervisory panel throughout my candidature. I am extremely grateful to these wonderful thinkers.

I would also like to thank everyone I have met for the last four years, particularly Cathy Clutton, a valuable colleague of mine. Every single conversation with her was absolutely inspiring. I also want to thank all informants who kindly provided me with their invaluable thoughts through which I was able to see different sides of reality. I am also greatly indebted to the Australian Government for its generosity which allowed me to complete this thesis through the Australian Government Research Training Program.

Lastly, I would like to extend my heartfelt thanks to my family: my parents for amazing opportunities and support they have given me throughout my life, and my brother for his humour and open-mindedness. With my deepest gratitude, I would like to express my special appreciation to my son for his love and encouragement.

ABSTRACT

This thesis explores patients' experiences of cross-linguistic medical encounters, with a particular focus on encounters by Japanese speakers in the Australian health care system. It aims to identify the views and practices of Japanese speakers when negotiating communication, and their views on preferred communication supports. The thesis identifies gaps between the perceptions of health care interpreters held by patients through their real experiences and the idealised model of interpreter-mediated health communication which underpins the Australian language service industry and quality improvement in interpreter practice.

Language barriers are a major obstacle to accessing health care. In Australia, language service agencies send credentialed, professional interpreters to health care facilities. However, the uptake of their services is low, even in Australia which provides fee-free, rapid-access telephone interpreters to doctors in private practice, and where interpreter provision is an accreditation requirement for hospitals. The barriers are generally assumed to be lack of knowledge by clinicians, lack of supportive systems, or insufficient interpreters. There is little research on the perspectives of patients towards interpreters.

Australia and Japan are highly monolingual countries; thus visitors from each country to the other frequently need language support. Australia differs from Japan in that it has a highly developed, government-funded interpreter system which has been promoted to clinicians. I interviewed thirty-one adults who have experienced Japanese-English medical consultations, four doctors with extensive experience in cross-linguistic communication; attended as a participant observer seminars and workshops on health care interpreting in Japan and Australia, and a seminar for Japanese residents in Australia on how to access Australian health services; and analysed technical documents in English and Japanese used in the interpreting and health communication fields.

Most Japanese-speaking interviewees were reluctant to use interpreters. The socially constructed meanings which Japanese patients attach to the English language suggests that Japanese patients may feel humiliated if they find a professional interpreter has been arranged for them, leading them to further avoid interpreting services. The interpreter's flexibility to adopt different roles and their emotional proximity to the patient helped dismantle boundaries which patients draw to exclude outsiders. Preference for relationship-centred communication interventions over professional interpreting services was particularly prominent among Japanese women who have English-speaking partners, irrespective of how fluent the partner's Japanese was.

The ideal model promoted in the Australian code of ethics for interpreters emphasises accurate rendition of verbal statements and detachment of the interpreter from the speakers. There is a discrepancy between this ideal model held by the interpreting profession and the expectations of interpreters' engagement in communication held by patients and medical practitioners. Japanese patients often expect an interpreter to render their tacit messages which often carry culturally nuanced connotations. Doctors often assume that interpreters are able to recognise these tacit messages, too.

Many multicultural health policies in Australia warn health professionals of the risks of using interpreters who do not have professional credentials. Findings from this study suggest the necessity for revisiting this position and focusing on relationship-based care in cross-linguistic medical encounters, incorporating interpreters and other language support.

PUBLICATIONS AND CONFERENCE PRESENTATIONS GENERATED FROM THIS THESIS

1. Matsumoto, N 2016, Relationship-Centred Care in Cross-Linguistic Medical Encounters, ICIT 2016: 18th International Conference on Interpreting and Translation, London, UK, oral presentation.
2. Matsumoto, N, Phillips, CB 2016, *Trust and Health-Care Interpreting: Toward Relationship-Centred Care in Cross-Linguistic Health Care Encounters*, The 21st WONCA World Conference of Family Doctors, Rio de Janeiro, Brazil, oral presentation.
3. Matsumoto, N 2015, *Cultural Variance in Respect to the Significance of Social Harmony and Professional Impartiality when Using an Interpreter in English-Japanese Cross-linguistic Medical Encounters*, The Inaugural Conference on Migration, Social Disadvantage and Health 2015, Melbourne, Australia, oral presentation.

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Chapter 1 Introduction

This thesis explores patient experiences of cross-linguistic medical encounters, with a particular focus on Japanese-English cases in Australia. This chapter sets out the background, rationale and aims of this research. Firstly, it sets out the connections between speaking a language other than the country's dominant language, access to health care and health outcomes. It then explores the literature on the contribution of health care interpreters to overcoming health inequities in access to, and quality of, health care. In both the health care literature and the academic literature from the field of interpreter studies, individuals who provide communication mediation and who do not hold professional credentials for interpreting are generally positioned as the inferior alternative to professional interpreters. Although consumers are the ultimate stakeholders of both language and health care services, there is a dearth of research into the experiences of patients using interpreters.

Health care interpreters continue to be used in only a small proportion of cross-linguistic consultations. Language support in many consultations continues to come from family members or from members of the language-speaker's community. I explore how the research done into family or ad hoc interpreters tends to be framed around a 'risk' perspective, rather than exploring why people may choose such language support, and how clinicians may most effectively work with non-professional interpreters.

The chapter then sets out the rationale for exploring the experience of Japanese speakers using professional and non-professional interpreters in medical consultations. Japan is a highly monolingual country where the acquisition and deployment of English skills is a matter of personal pride. Many Japanese persons in Australia choose not to use professional interpreters in health care consultations for a variety of complex reasons. Understanding these throws light on the cross-linguistic health consultation as a complex human, relational act.

1.1 Health care and language

Patients who speak a language other than the country's dominant language are more likely to experience limited access to health care and negative health outcomes. A cohort study at forty-one regional and acute care facilities in Australia by Juergens and his colleagues (2016) compared acute coronary syndrome outcomes between patients whose first language is English and those who speak English as a second language. Their study found that the latter group had poorer health outcomes, with higher in-hospital and post-discharge mortality.

A comparative study between white, black and Hispanic women in Los Angeles on the use of mammography by Fox and Stein (1991) found insufficient patient-doctor communication was the cause of low mammography use. The analysis of 1,057 telephone interviews found that language barriers (English and Spanish) were a significant obstacle for clinicians and Hispanic patients to communicating necessary information. Interviewed Hispanic women indicated that they were as motivated as those in the other ethnic groups to undergo mammography if their clinicians referred them.

A survey of over 1,000 children and families in Boston found that children whose parents have limited English proficiency tend to have poor health status, and a greater risk of reduced access to health care (Flores, Abreu & Tomany-Korman 2005). The researchers confirmed that parents' limited English proficiency, rather than speaking languages other than English at home, was likely to be a key determinant of children's poor health status.

A systematic review of the impact of parents' limited English proficiency on the access to care of children with special health care needs found that limited English proficiency was an independent determinant of poor access to care and insufficient care (Eneriz-Wiemer et al. 2014). An analysis by Yu and her colleagues (2006) of data collected in the 2001 California Health Interview Survey indicated that children whose parents have limited English

proficiency are less likely to have health insurance and go to doctors, and more likely to rely on other countries for health care.

Health care interpreting to overcome language barriers

Overcoming language and other communication barriers is key to favourable health outcomes. The provision of effective interpreting services is one of the solutions to these barriers (Flores 2005; Perez et al. 2016). Research which recommends using health care interpreting services tends to focus on the differences in outcome, satisfaction and accuracy between professional and non-professional interpreters.

In a systematic review on the impact of professional and non-professional interpreters on the quality of psychiatric care for non-English speaking patients, Bauer and Alegría (2010) found that while for both groups there was a positive impact on the quality of the assessment, use of professional interpreters may be associated with improved disclosure in patient-provider communications, referral to specialty care, and patient satisfaction. Ribera and her colleagues (2008) conducted a systematic review and narrative synthesis exploring the impact of professional and non-professional interpreters on quality of care, satisfaction, cost-effectiveness and equity. Although this study is limited by its failure to clarify its search strategy or how it rated the quality of included studies, it nevertheless provides some preliminary evidence that equity may improve with the use of professional interpreters. In a systematic review of the literature on health outcomes of interpreters, Karliner and her colleagues (2007) concluded that professional interpreters “appear to decrease communication errors, increase patient comprehension, equalize health care utilization, improve clinical outcomes, and increase satisfaction with communication and clinical services for limited English proficient patients” (*ibid.*: 748).

Informal, or non-professional, interpreters are used frequently even in countries with established and subsidised health care interpreter systems. In Australia, they are used in

17.7% of general practice consultations (Bayram et al. 2016). Giacomelli (1997) conducted an audit exploring use of interpreters in hospitals and health services within an Area Health Service in NSW. Of 2,126 occasions of services, 311 (14.6%) were for non-English-speaking patients. Of these encounters, no interpreter or an untrained interpreter was used in 297 (95.5%) cases. In most cases, the clinicians were unaware that there was a health sector policy to use professional interpreters.

In a survey of approximately 900 clinicians in Wellington, New Zealand (Gray et al. 2011), while over 80% of respondents indicated that they knew how to access professional interpreters, only 14% reported that they always used an interpreter (where this category included family interpreters). A subsequent questionnaire by the same researchers of 20 health professionals found high levels of use of patients' family members in cross-linguistic consultations (*ibid.*). In a survey of 347 physicians treating women with breast cancer in Los Angeles (Rose et al. 2010), 86% of respondents also reported the use of patients' friends or family members as interpreters.

The stated dangers of using a non-professional interpreter are legion. Royal Australian College of General Practitioners (2010) give the following factors as a rationale for avoiding speaking through patient family members: subjective, inaccurate interpretation and the potential co-opting of children (for example in the use of minors as interpreters). In its policy document on interpreter use, the Government of the Australian Capital Territory states that a patient's family member "may not have the ability to interpret accurately or objectively on health or medical matters" (ACT Government 2015: 4).

The California Healthcare Interpreters Association warned that using untrained interpreters "compromises ethical aspects of healthcare between providers and patients. These include... the loss of confidentiality, potential misdiagnosis, and invalid informed consent" (2002: 17 – original emphasis). Family members are held to be more likely to breach

confidentiality (Juckett 2005), may be technically incompetent (Glenn-Vega 2002), limit the ability of the doctor to explore sensitive areas such as sexuality and domestic violence (Juckett 2005) and “weaken the doctor patient relationship” (Herndon & Joyce 2004: 39).

In a report on medico-legal costs in the USA as a result of failure to use a competent interpreter, Quan (2010) presented several cases in which patient family members acted as interpreters. Out of thirty-five cases analysed in this report, twelve involved a patient’s family member(s) in the communication. However, many of them were cases in which the decision to use a family interpreter was seriously flawed, and the family interpreter must be regarded as having been co-opted into the consultation. In the following case, the seriously ill patient herself was expected to interpret to her parents.

In the Tran case, the patient, a 9-year old Vietnamese girl, died from a reaction to the drug Reglan [metoclopramide]. Her parents primarily spoke Vietnamese, yet no competent interpreter was used throughout Ms. Tran’s encounters with the medical system. Instead, records show that the 9-year-old patient and her 16-year-old brother served as interpreters during the medical encounter. The physician and hospital in this case settled for \$200,000 in aggregate, while the Carrier paid legal fees of \$140,000 (*ibid.*: 4)

The sixteen-year-old brother was subsequently used by the doctors to interpret to his parents the information that his sister had died of an apparent heart attack.

In the following case, the problem again relates to the clinician’s failure to use a competent language support service, and excessive expectations of a family member with limited English.

The patient presented with a workplace injury after heavy metal rollers fell on his foot. He later alleged that the physician negligently treated his injury thereby causing the amputation of his lower leg. The patient spoke both English and Spanish at home. The patient’s wife was born and educated in Mexico until she was 21 years old. Although she understood a little bit of English and used some at work, she was more comfortable using Spanish. No mention was made in the medical records of any use of a competent interpreter. (*ibid.*: 18).

Many of the studies defining the competence of the professional interpreter rely upon linguistic studies of communication accuracy. A comparison between interpreters with different levels of experience in simulated Japanese-English medical consultations found that interpreters with less than one year of experience made a larger number of information omissions compared to those with one or more years of experience (Anazawa, Ishikawa & Kiuchi 2012).

Flores and his colleagues (2003) analysed thirteen audio-recorded Spanish-English medical consultations in paediatric care in a Massachusetts hospital. The researchers found no significant difference in the total number of errors between interpreters employed by the hospital and untrained interpreters. However, the researchers assessed that out of 165 errors made by untrained interpreters, 127 (77%) had potential clinical consequences. On the other hand, 123 (53%) out of 231 errors made by interpreters employed by the hospital were assessed to have potential clinical consequences.

[A]n interpreter error was also considered to have potential clinical consequences if it altered or potentially altered 1 or more of the following: 1) the history of present illness; 2) the past medical history; 3) diagnostic or therapeutic interventions; 4) parental understanding of the child's medical condition; or 5) plans for future medical visits (Flores et al. 2003: 7).

Kilian and her colleagues (2014) analysed errors made in thirteen psychiatric consultations in a South African hospital mediated by interpreters who did not hold interpreting qualifications. They found fifty-seven errors in total made by the non-professional interpreters. The researchers concluded from an analysis of the errors that 'informal' interpreters are likely to contribute to the deterioration of the patient's condition. The researchers recommended training for 'informal' interpreters to improve their linguistic accuracy.

1.2 Trust relationships and professional and non-professional interpreting

Some studies have argued that the family interpreter may have a legitimate role in the cross-linguistic consultation. Interviews with nineteen Canadian physicians who watched the videos of their own interpreter-mediated consultations with migrant patients found that participants had different expectations of professional interpreters and family interpreters (Rosenberg, Leanza & Seller 2007). Professional interpreters were expected to act as cultural brokers, whereas family interpreters were viewed as caregivers (*ibid.*: 288).

Green, Free and Bhavnani (2005) interviewed young immigrants in Vietnamese, Kurdish, Bangladeshi and Eastern European communities in London about their experiences of acting as interpreters for their family members and occasionally other people with the same linguistic backgrounds. The researchers found that young people are often a preferred option when their family members access health services because they can act as representatives or advocates for their family members. Contrary to the accounts of child interpreters as co-opted, flawed interpreters, young people in this study reported feeling enabled and useful when interpreting.

These young people “rarely saw themselves as ‘inadequate translators’ or exploited children, but as skilled mediators, helping to bridge misunderstandings between family members and the public sector” (Green, Free & Bhavnani 2005: 2108). They were proud of serving as communication mediators for their family members and other people in their communities. Their interventions appeared to form a grounding for the families’ sense of togetherness.

In New Zealand, a survey of GPs and nurses found that the respondents were highly satisfied with non-professional, mostly family, interpreters in on-the-day consultations (Gray, Hilder & Donaldson 2011). The researchers suggested that the trust relationship and cultural

advocacy for the patient may be as important as the accuracy of language rendition, particularly in primary health care.

In 2007 in the United Kingdom, the first national survey of GP patients found that minority ethnic groups, particularly people from Bangladeshi background, were significantly less satisfied with their access to general practice than other patients (Department of Health 2007). A formal review of access to health services by minority ethnic groups was commissioned by the Secretary of State for Health. The report found that “dysfunctional communication” (Lakhani 2008: 6) was rife between health care organisations and patients. Using a professional interpreter was not in itself a solution to this problem, in the absence of a trust relationship between the patient and the interpreter.

Professional interpreters can also help, but only where patients have confidence in the interpreter and the advice they receive, and both parties are informed about the role of the interpreter.

Patient advocates can play a vital role in helping practices develop a better understanding of the language requirements of the community, so that they can respond positively to patients’ needs (Lakhani 2008: 12).

Trust also emerged as a key issue in a study of the accounts of patients, interpreters, clinicians and other health staff in UK primary care (Greenhalgh, Robb & Scambler 2006). Participating patients expressed concern about the interpreter’s confidentiality when an external professional interpreter was used. Participating family members acting as interpreters indicated that the trust relationship between themselves and the patients as well as their knowledge of the patients’ history made them better interpreters than external professional interpreters.

These studies point to the challenge of cross-linguistic health encounters, which are embedded culturally and socially, and play out, in a complex relational terrain between the patient, the clinician, the language assistant and sometimes in addition an advocate.

Drawing on a two-year ethnographic study of health care interpreters in Northern California,

Angelelli (2004) concluded that health care interpreters are not invisible attendants who neutrally convert one language to another. Health care interpreting is deeply embedded in the social context and the relationship between the speakers.

The following comment by Gill and his colleagues in their observations of interpreter-mediated communications in British asylum appeal hearings aligns with the above findings: “[I]nterpretation, done well, is not simply a matter of mechanically matching words in one language with words in another” (Gill et al. 2016: 18). While the researchers warned that interpreters deviating from grammatically faithful language rendition “wield an inappropriate, invisible and unchecked degree of power over the client” (*ibid.*: 20), they found that the involvement of an interpreter from the same cultural background as that of the appellant in hearings alleviated the appellant’s stress and nervousness. The interpreter’s cultural identity and knowledge generated this positive effect.

Inoue and her colleagues (2016) also pointed to the cultural aspect of cross-linguistic communication in health care. The researchers interviewed seven Japanese women in New South Wales, Australia on their views on using sexual health services. Findings suggested the importance for the patient and the clinician to communicate culturally unique perspectives and attitudes in a cross-linguistic medical encounter.

It is unrealistic to expect Australian GPs to be aware of the cultural practices of people from all ethnic minorities, but it is unhelpful for them to assume that all ethnic minorities share the same dominant attitudes. Our study highlights the need for GPs to use interpreters when needed, and to be proactive in finding out their patients’ attitudes and beliefs about sexual health issues rather than making assumptions or waiting for them to initiate the discussion (Inoue et al. 2016: 527).

1.3 The evolving profession of interpreting

The profession of health care interpreting is relatively young. Two enactments of difference have informed the development of the profession: the need to differentiate professional interpreters from non-professional interpreters, in order to improve the authority of

interpreters in the medical consultation; and the distinction in the interpreting profession between 'conference' and 'community' interpreters. These two historical strands are sometimes at odds with one another. While the professional/non-professional interpreter dichotomy privileges the health care interpreter, the conference/community interpreter dichotomy underplays the skills of the community interpreter – including health care interpreters – compared to the linguistic skills of the simultaneous interpreter.

The conference/community interpreter distinction has emerged from the interpreting studies field. Interpreting studies is a relatively new field of academic endeavour.

Conferences such as the NATO Symposium and Language Interpretation and Communication in Venice in 1977 (*eds. Gerver & Sinaiko 1977*), and the International Conference on Interpreting: What do we know and how? in Turku in 1994 (*eds. Gambier, Gile & Taylor 1997*) are historically important turning points (Garzone & Viezzi 2002). These conferences introduced interpreting in community service settings as an issue of academic interest. However, the focus of these conferences was mostly on the linguistic aspects of interpreting, centring on an instrumental approach to language (*eds. Gambier, Gile & Taylor 1997; Gran & Dodds 1989*).

The typology of interpreting that has emerged consists of two broad categories: 'conference interpreting' and 'community interpreting'. Conference interpreting tends to use the simultaneous mode, and is presented as the more reputable type of interpreting (Nicholson 1994: 81). Interpreting in health care and in legal procedures are subcategories of community interpreting (Gentile 1997; Hale 2007), and tend to use the consecutive interpreting mode. Categories do not simply refer to the difference in settings or modes of communication; they also reflect perceived difficulty of the work.

This hierarchy is reflected in academia and in the language service industry in Australia. The National Accreditation Authority for Translators and Interpreters (NAATI), for instance,

distinguishes conference interpreting from other types of interpreting by setting higher requirements for the former type (National Accreditation Authority for Translators and Interpreters [NAATI] 2010). Australian universities such as Macquarie University, University of Queensland and Monash University have courses dedicated to conference interpreting with stricter entrance requirements than for other courses on interpreting.

Community interpreting has attracted little attention both as a topic of scholarly work and as a profession, despite the fact that it is “the oldest ‘type’ of interpreting in the world” (Roberts 1997: 7 – original emphasis). A number of scholars have raised concerns about the academic neglect, and the low public recognition, of interpreting in community services (Niska 1995; Mikkelsen 2004). Gentil (1997) criticised the labelling of ‘community interpreting’ for having generated the second-class image of this occupation.

Hale (2011b) advanced the following reasons for the low recognition by academics and the general public of interpreters specialising in community services: the immature structure of the industry, insufficient formal training opportunities, the lack of professional identity among interpreters, and indifference to the complex nature of interpreting among non-professional interpreters. The shared concern among these scholars is that the users of interpreting services incorrectly believe or consider that community interpreting requires no special skills other than decent proficiency in two languages.

Scholars in interpreting studies have argued for the establishment of context-specific assessment and credentialing systems, dedicated to interpreting in health care and legal settings (Bancroft et al. 2013). A systematic review and meta-ethnography exploring relational issues involved in working with interpreters in healthcare settings found that interpreters frequently switch their roles between simple translation and cultural brokerage, in order to address the complex nature of cross-linguistic health care communications (Brisset, Leanza & Laforest 2013). The researchers concluded that the recognition of health

care interpreting by health care organisations is “a sign of how society and its members, particularly healthcare administrators and practitioners, handle differences” (*ibid.*: 139).

A comprehensive review of Australian state and federal policies by Hale (2011a) recommended that special training programmes for community interpreters, particularly those specialising in legal settings, be set up. In a review of the Australian immigration processes, Barnett (2006) concluded that it is necessary to develop adequate professional standards, accreditation and professional development programs for interpreters who work in immigration procedures. These scholars showed different expectations of interpreters which vary depending on the context, and suggested creating additional interpreter qualifications and credentials.

Kaufert and Koolage (1984) studied the interpersonal aspect of interpreter-mediated health care communication through participant observations of medical consultations which involved interpreters, medical practitioners and indigenous Canadians in hospitals providing tertiary care. They identified four roles for which interpreters faced conflict: neutral language rendition, cultural brokerage, the provision of biomedical information, and patient advocacy. The researchers suggested that this role conflict undermines the interpreter’s confidence when they work with health professionals. The researchers pointed to the impact of the authority of clinicians on the role conflict faced by interpreters. The study concluded that endowing interpreters with authority and power by setting up training and credentialing programmes which incorporate the elements of informality and flexibility may prevent interpreters from being subject to the authority of clinicians.

Australia has pioneered such credentialing systems. It was the first country to develop a national system of accreditation for interpreters, the National Accreditation Authority for Translators and Interpreters (NAATI) (Australian Institute of Interpreters and Translators

[AUSIT] *n.d.* a). All interpreters who work in Australian health care services are required to hold credentials issued by NAATI, unless NAATI does not offer credentials in the language.

As part of this credentialing process, interpreters must also abide by the code of ethics of the Australian Institute of Interpreters and Translators (AUSIT) (AUSIT 2012). The AUSIT Code of Ethics sets out the following tenets for translators and interpreters: 1. professional conduct, 2. confidentiality, 3. competence, 4. impartiality, 5. accuracy, 6. clarity of role boundaries, 7. maintaining professional relationships, 8. professional development, 9. professional solidarity (*ibid.*).

Guidelines for interpreters and language services policies in Australia recommend using interpreters who hold NAATI credentials and avoiding relying on those who do not hold these credentials. In its language services policy, the Queensland Government defines “qualified interpreters” as interpreters who hold NAATI accreditations or equivalent qualifications, and states that “[i]n all circumstances the needs of the client should be the primary consideration. A nonqualified interpreter is not to be used unless the situation is urgent and/or life threatening and a qualified interpreter is not available” (Department of Aboriginal and Torres Strait Islander and Multicultural Affairs 2014: 5).

1.4 The underuse of professional interpreters

Despite evidence supporting the linguistic accuracy of professional interpreters, and credentialing systems that aim to ensure skills and ethical practice, professional interpreters are underused. In-depth interviews with internal medicine physician residents in the USA (Diamond et al. 2008) found that the underuse of interpreters is normalised in an urban hospital context. Participants indicated that they were aware of this underuse, and described the situation as “getting by” (*ibid.*: 258) through the use of family interpreters or their own second language skills.

Even in Australia, where health care interpreters are provided on a fee-free basis to private doctors, health care interpreters are underused. A sub-study in the Bettering the Evaluation and Care of Health (BEACH) program on GP consultations using validated methodology found that health care interpreters were used in 3 of 306 consultations (Bayram et al 2016). Many of these consultations (82.3%) in a language other than English were conducted by the multilingual GP, and in 17.7% of consultations, a family member acted as an interpreter. Participating GPs were quite sanguine about the low level of use of professional interpreters; they indicated that the use of professional interpreters would not have been appropriate for 89.0% of the consultations which involved languages other than English. Focus groups with refugee women in South Australia (Clark et al. 2014) also found that interpreters are often not used even when both the clinician and the patient were aware of the need of an interpreter.

Patients may be reluctant to request an interpreter for fear of being considered 'difficult' (Detsky & Baerlocher 2011). In a study using focus groups with patients in the San Francisco Bay Area, Frosch and his colleagues (2012) pointed to the implications of the image of 'good patients' on patients' engagement in decision-making in treatment. The researchers found that "participants believed that questioning the advice or recommendations of physicians implied questioning their expertise and, in some cases, challenging their authority, which in turn might foster resentment" (*ibid.*: 1032).

Even if a patient manages to request a professional interpreter, their request may not always be responded to. The account of a professional interpreter who works in the Boston area showed that medical practitioners may refuse professional interpreting services (Perez et al. 2016). The reasons indicated by the interviewed interpreter were because medical practitioners wanted to save time by avoiding using interpreting services and because they were confident that they could communicate with immigrant patients by using technology such as Google Translate (*ibid.*).

Given health policy documents, the research on the value of interpreters, and the existence of an industry with quality assurance mechanisms, it is perhaps not surprising that the research literature tends to read the underuse of professional interpreters as a problem to be corrected, usually through education. In this, the literature on solutions to under-utilisation functions as a discourse. Ferguson (1994) argued that a discourse is, regardless of whether it is true or not, “a practice, it is structured, and it has real effects which are much more profound than simply ‘mystification’” (Ferguson 1994: 18 – original emphasis). A politically and socially created discourse has strong power as it portrays the target populations of certain interventions and services in a way which rationalise such procedures (Ferguson 1994; Fordham 2015).

The discourse of health care interpreting focuses on ways of raising the consciousness of users (clinicians) through education, or making professional interpreters more available or more reputable. This discourse tends to elide the real world of cross-linguistic encounters, where non-professional family or community members are used more frequently than professional interpreters. The questions of what may be offered by non-professional interpreters and how to ensure the quality of these non-professional interpreters are rarely asked.

Studies by Gray and his colleagues (Gray et al. 2011; Gray, Hilder & Donaldson 2011) and Greenhalgh and her colleagues (Greenhalgh et al. 2006) suggested that the on-going trust relationship between the patient, the clinician and the interpreter may be an important determinant for the choice of communication mediator. A survey of GPs, nurses and midwives in New Zealand found that respondents appreciated both family interpreters and in-house interpreters for the on-going trust relationships they built with the clinicians and the patients, while they still rated in-house interpreters more highly than family interpreters for their professionalism and competence (Gray, Hilder & Donaldson 2011: 243).

Drawing on a telephone survey of GPs in Melbourne, Atkin (2008) found that 64% of 46 responding GPs knew about professional interpreting services. She attributed the low uptake of professional interpreters to the lack of knowledge held by patients, medical practitioners and general health staff about the advantages of using professional interpreters. The study concluded that it is necessary to educate and train GPs, in order to deepen their understanding of the importance of using professional interpreting service.

A correction to the notion of clinician ignorance of interpreters is provided by Bayram and her colleagues (2016). Of 303 consultations by Australian GPs which involved communication in languages other than English, “[a]t no consultation was lack of awareness or lack of availability of professional interpreter services reported” (2016: 10). This suggests that these GPs did not use health care interpreting services despite knowing the stated advantages of the services. When researchers asked clinicians about reasons for not using professional interpreters, they cited time constraints (Ribera et al. 2008) and administrative difficulties (Huang & Phillips 2009) associated with access as more pressing reasons for not using interpreters.

1.5 Towards a counter-discourse: on why people use non-professional interpreters

A legitimised assumption within a closed framework leads to the continual refinement of myopic views (Candlin & Candlin 2003). One of the challenges of researching the literature on health care interpreting and health outcomes is the fact that it is a partial and often partisan literature. Little research has looked into the perspectives and experiences of patients. Patients may have different understandings of language barriers and using an interpreter. Brisset, Leanza and Laforest argued that “future studies should give greater importance to the patient’s perspective on interpreted consultations and take the complex nature of these consultations into greater account” (Brisset, Leanza & Laforest 2013: 138).

Studies free from the influence of the professional/nonprofessional dichotomy may generate a solution which effectively bridges the perspectives of interpreters, clinicians and patients.

Much of the literature on health care interpreting is from Western countries, predominantly English-speaking ones. Although some studies have focused on pairs of non-English languages, the studies were conducted in Western countries. Examples include studies of non-German speaking patients in hospitals in Vienna (Pöchhacker 2000) and Switzerland (Leanza 2005), and interpreters working in hospitals in Spain and the US (Valero Garcés 2007), and a hospital in Sweden (Krupic et al. 2016).

That these studies are from Western countries is not the fundamental problem. The real problem is the implication of the results drawn within the closed discourse – the professional/nonprofessional dichotomy and a Western perspective. The implication in applying them to patients from non-Western or developing countries is that patients from developing countries seek health care consultations that look like those in Western countries, and reflect the same value systems.

Migration does not occur only from non-Western countries to Western countries. According to the International Organization for Migration, “the top migrant-sending and -receiving countries in the world are the United States, the Russian Federation, Ukraine and India” (International Organization for Migration 2013: 63). It should not be assumed that interpreter-mediated medical encounters always occur between Western clinicians and non-Western patients.

There is a risk of migrant patients being essentialised when the complexities of migration are not recognised. A salient example is the coining of the term, ‘Patients with Limited English Proficiency’ (LEP Patients). An increasing number of studies in the area of cross-cultural communication and multicultural health policies adopt this term to collectively refer

to patients who are assessed by someone else as having limited capability in undefined ways in English, assumed to be the country's dominant language (see Bocanegra et al. 2011; California Healthcare Interpreters Association 2002; Michalec et al. 2014; The National Council on Interpreting in Health Care 2005; Ngo-Metzger et al. 2007; Rodriguez et al. 2013; Yip et al. 2013).

The use of essentialising terms can mask diverse views held by people from different cultural backgrounds. This also contributes to exacerbating an unequal power balance between languages and between speakers of certain languages. Bourdieu and Thompson (1991) described the implication of this socio-linguistic phenomenon as the symbolic power of language.

By structuring the perception which social agents have of the social world, the act of naming helps to establish the structure of this world, and does so all the more significantly the more widely it is recognized, i.e. authorized." (*ibid.*: 105)

The term LEP positions Western, English-speaking, health care providers as the *Self* and patients with non-Western backgrounds, predominantly those from developing countries, seeking health care in Western countries as the *Other*. This symbolic positioning underpins much of the scholarship in this area.

Hage coined the sardonic term "third-world-looking people" (2000: 18) to describe how the Western society sees those who are categorised by the above essentialising terms.

Perceiving people with diverse ethnic backgrounds through such terms may give rise to a discourse in which patronising efforts are made to support uncivilised, backward migrants, in order for them to fit into civilised Western society. This is the "essentializ[ation] [of] notions that spuriously endow a people with eternal cultural qualities or over-value hegemonic ideologies by neglecting 'the politically fractured and contested character of culture'" (Sahlins 1999: 406).

Ono and Nojima (2014), for instance, compared major standards for health care interpreters in Japan against four corresponding ones in Canada, Australia and the US. They concluded that standards in these Western countries are the ideal model, and recommended that Japanese health care interpreter guidelines follow the model. The researchers also argued that it is necessary for health care interpreter standards in Japan to have items which promote the professionalisation of health care interpreters and those who work in other community settings, in line with the Western standards. Ishizaki, Borgman and Nishino (2004) recommended that the interpreter service system in Japan be modelled on US and Australian counterparts. Although the study is highly informative and provided detailed information on health care interpreting services in a number of US states, it did not clearly address why health care interpreting in Japan should be modelled on the US and Australian standards.

There is room for studies on interpreter-mediated health communication in Japan to explore social and cultural contexts unique to the country. In one of the few examples of such studies, Iida (2010) investigated interpreter-mediated communication between Chinese migrants in Japan and Japanese community service providers. Her study found that the practice of interpreting which focused on neutral language rendition and impartiality did not always bridge the needs of Chinese residents and the intention of Japanese community service providers. The researcher also pointed to the dilemma which interpreters faced between the roles of a neutral language conduit and a caring ally. Iida argued that in order to identify potential areas to which interpreting services can contribute, it is important to consider culturally and socially constructed perspectives held by the interpreters and the users of interpreting services.

1.6 The rationale for studying Japanese patients' consultations

Australia is one of the most popular migration destinations for Japanese people. The Australian Department of Immigration and Border Protection indicated that there was a 14.9 % increase in the number of Japan-born Australian residents from 30,779 in 2006 to 35,377 in 2011 (Department of Immigration and Border Protection [DIBP] 2015). The number of people who stated that they speak Japanese at home was 43,692 in 2011, showing a 24.4 % increase from 35,112 in 2006 (DIBP2014a). Out of 229 listed languages, Japanese is ranked as the 26th most spoken language at Australian homes (*ibid.*).

Newly arrived Japanese migrants in Australia are likely to face difficulties in accessing essential health services because of language and cultural barriers. There are three reasons for this. Firstly, English is one of the most difficult foreign languages for native Japanese speakers to master (Chiswick & Miller 2005). Secondly, most Japanese people have almost no opportunities or necessity for using English in communication within Japan. Thirdly, a number of significant cultural differences between Japan and Australia may complicate the ease of interaction of Japanese people with Australian locals.

Japanese census data (Statistics Bureau 2016a) shows that the number of residents in Japan who have neither Japanese ancestry nor Japanese citizenship accounts for 1.4% of the country's total population of approximately 127,000,000. The number of people who obtained Japanese citizenship between 2011 and 2015, except for naturalisation, was relatively constant at between 1,030 and 1,207 annually (Ministry of Justice *n.d.*).

A review of Japanese foreign language education policies by Liddicoat (2007) found that Japanese foreign language education, which solely focuses on English, is not designed to foster intercultural perspectives among Japanese and non-Japanese people. It is rather "strongly associated with developing the understanding of Japan among the non-Japanese through the expression of Japanese ideas, attitudes and opinions through the tool of

English” (Liddicoat 2007: 41). His study showed that foreign language education in Japan is designed to enhance the politically created Japanese cultural identity. Although Befu (2003) pointed to the adoption and creolisation of Western cultures and concepts in Japan, studies by Lebra (2004) and Liddicoat (2007) suggested that this phenomenon does not necessarily affect or change the core part of Japanese identity.

Most Japanese people are highly concerned about whether they are fully integrated in Japanese society (Lebra 2004). Peak’s study (1989) which consisted of observations of preschools in urban and rural areas in Japan, and interviews with the parents of children who are enrolled in the preschools found that study participants consider it extremely important to meet commonly held social expectations, in order for them to stay comfortable in Japanese society.

Peak (*ibid.*) found that it is more important for Japanese adults to behave in accordance with cultural expectations held by other Japanese people than to pursue unique self-images independent of such expectations. It is “‘all of your friends,’ ‘everyone else,’ or ‘group life’ that places limits on children’s ability to indulge their own desires” (*ibid.*: 122). The accounts of parents in his study suggest that Japanese people maintain this self-sacrificing attitude throughout their lives, for the sake of harmony in the social unit to which they belong. Japanese people start learning how to behave ‘appropriately’ in society from the very early stages of their lives. Peak suggested that this continuously generates profound fear in Japanese people of being isolated from, or punished by, peers in society even later in their lives (*ibid.*: 123).

Japanese residents in Australia share a large amount of information via local Japanese magazines, newsletters and online classifieds. They are all written in Japanese and dedicated to Japanese residents in Australia. Many questions related to life, including health concerns, are discussed and answered within the Japanese community through these media.

Hard copies of them are distributed at Asian groceries and restaurants. I have seen in these media questions about health care interpreting services and advertisements for degree programmes in translation and interpreting in Australian universities. This made me wonder why few Japanese residents are willing to use professional interpreting services in Australian health care, while a good number of them appear to be aware of the services. This suggests that there are understudied factors of their unwillingness to use health care interpreting services.

As of January 2016, the following eight institutions offer Japanese-English translation and interpreting courses which are approved by NAATI: Macquarie University, TAFE NSW - Northern Sydney Institute, UNSW Australia, Western Sydney University, University of Queensland, TAFESA, Monash University, RMIT University and Western Sydney University (NAATI 2015). This suggests that a fair number of qualified Japanese-English professional interpreters graduate from these institutions annually.

1.7 Reflection by an insider

I am also a Japanese migrant to Australia. I have been serving as a professional Japanese-English interpreter in Australia, specialising in health care. Through my personal and professional experience, I realised that many Japanese patients in Australia are hesitant or unwilling to use health care interpreting services. They tend to try to communicate without using language support or rely on their family members, particularly partners.

I have worked as a Japanese-English interpreter/translator for over a decade. With a number of years of experience in Japan, I came to Australia to undergo advanced training for Japanese-English interpreting. I studied at an Australian university and obtained NAATI credentials.

Through my work as a professional interpreter in Australian health care services, I learned first-hand that it is not always possible to apply techniques taught in the university course to practice. It goes without saying that almost no interlocutor says words in small chunks in a clear and simple manner as in model dialogues prepared for the purpose of practice and assessment. Except for a limited number of professionals who are experienced in using interpreters, almost no speaker makes statements in simple sentences. Most people express their opinions with imperfect grammar. Many of these often contain cultural implications which do not overtly express the intention of the speaker.

Although most Japanese patients I met expressed their gratitude about the fact that the health care facilities arranged professional interpreters, expressions of gratitude by Japanese people for services do not necessarily mean that they are satisfied with them or willing to use them. Their expressions of gratitude may simply be equivalent to the acknowledgement of the fact that an interpreter came to the consultation. The perplexity shown by Japanese patients to me at initial encounters struck me as a meaningful indication that they were not comfortable with the presence of a professional interpreter.

Professional interpreters are required to strictly maintain the professional role boundary which allows them to exclusively focus on language rendition. The problem with this orientation is that it barely takes into account the social and symbolic relationships between the interpreter and the speakers, and the speakers' culturally and socially constructed views and beliefs.

So far, I have given a background to this thesis. I pointed to the tendency for professional interpreters, scholars in interpreting studies and health care policy makers to focus on the technical aspects of interpreting. I raised the issue that they have failed to incorporate the socio-cultural aspects of cross-linguistic communication, particularly from the perspective of service users. While the number of professional interpreting services provided in Australia

has increased over the last decade at a statistical level, this is not necessarily due to an increase in demand from patients for the services.

1.8 Research questions

The ultimate stakeholders of health care interpreting are patients. There is little research which sufficiently incorporates their perspectives on interpreting and interpreters. Although using interpreters with professional credentials may reduce the number of grammatical errors in interpreting, there is much room for studies to take into account social, cultural and interpersonal factors. While linguistic accuracy in interpreting is important, some of the studies I have referred to in the preceding sections found that the role of health care interpreters can go far beyond a neutral conduit which deals with communication as the transmission of vocal sounds.

This thesis focuses on the perspective of patients. It also examines internalised struggles which patients may face in medical encounters outside their home cultures. Health is not simply a biomedical objective but an important part of the lived experience of the patient (Biehl 2005; Biehl & Morran-Thomas 2009; Taussig 1980). Messages exchanged in patient-doctor communication carry underlying complex beliefs and values which even the patient themselves may not be aware of. This thesis aims to find answers for the following research questions.

1. What are the experiences of Japanese patients in Japanese-English medical encounters?
2. How do Japanese-speaking patients and English-speaking patients understand the role of health care interpreters, and how does their understanding impact the relationship between the patient, the interpreter and the clinician?
3. What is the ideal health care interpreting model advocated in Australia, and is it relevant to Japanese speakers?

4. How does perceived English language proficiency affect the Japanese patients' perception of communication support in Japanese-English encounters?

1.9 Chapter Structure

This thesis consists of eight chapters. Chapter 2 sets out methodology for this thesis. After providing the rationale for selecting Japan and Australia for the sites of my fieldwork, I briefly explain the perceptions and history of the social integration of migrants and the development of language support services in these two highly monolingual countries. I then set out the methods used in data collection and analysis.

In Chapter 3, I investigate how patients understand the involvement of their family members in Japanese-English medical encounters. I challenge the received view of the necessary superiority of credentialed interpreters, and examine the positive implications of using a patient's family member, particularly their partner, on the perceived quality of the communication. I focus on patients' partners because collected interview data indicated a distinct tendency for Japanese-speaking women partnered to native English speakers to exclusively rely on their partners as the communication mediators in Japanese-English encounters. I look into the relationship between the informants and the individuals who acted as interpreters, and explore the possibility of incorporating this into the practice of health care interpreting.

Chapter 4 explores the implications of the perceptions held by patients of the English and Japanese languages on their perceptions of using Japanese-English interpreting services. I adopt Pierre Bourdieu's concept of *symbolic capital* to elucidate how the English language functions as a vehicle of Western values in Japan. I analyse the accounts of informants on receiving language support to help overcome English-Japanese language barriers. I analyse the implications of the symbolic power of English on informants' experiences of seeking care in the Japanese-English cross-cultural environment, comparing the views of Japanese informants with those of English-speaking informants.

Chapter 5 analyses the in-betweenness of communication mediators through the eyes of patients, and its impact on patients' experiences of Japanese-English medical encounters. I explore the accounts of informants who indicated that they perceived the plural social and cultural identities of the communication mediators in the cross-linguistic encounters. The communication mediators bridge messages from two different cultural and social perspectives which can be at odds with each other in certain contexts. Most standards and policies for using health care interpreters in Australia do not take into account this in-between agency of cross-linguistic communication mediators. I examine how communication mediators in the accounts of informants switched between different cultural, social and symbolic identities.

Chapter 6 examines how the professional practice of interpreting in Australia which rigidly complies with the AUSIT Code of Ethics intersects with views held by informants on Japanese-English medical encounters. I start this chapter by exploring how the notion of the professionalisation of interpreting is embedded in Australian society, through a comparison with traditional professions such as law and medicine. The professionalisation of interpreting, as in other occupations, centres on credentials and codes of ethics.

Professional organisations of interpreters, language service agencies and policy makers working on multicultural health assume that compliance with the Code by interpreters will always lead to optimal communication outcomes. This assumption may cause the interpreter to fail to effectively communicate culturally nuanced messages between speakers who do not share the same language and cultural identities.

In Chapter 7, I point to the efficiency-oriented language service industry in Australia and the relationship between the industry and interpreter credentialing and service systems. These systems are incorporated into a larger political structure, regulating the practice of interpreters in line with the neutral conduit model. Within the national interpreting service system, most health care interpreters work as casual contractors of language service

agencies. These agencies have been increasing the pool of credentialed interpreters through collaboration with NAATI and Australian education institutions. I draw on Johan Galtung's concept of *structural violence* to argue that the pursuit of efficiency by the state and the language service industry may essentialise cross-linguistic communication.

In the final chapter, I consider the positioning of communication mediators in cross-linguistic medical encounters, noting that interpreter-mediated medical encounters are after all human interactions, and are thus part of continuous reality which patients experience through their everyday lives. I conclude by drawing out the implications of findings in this thesis for developing patient-centred, trust-focused communication intervention strategies in medical encounters between Japanese patients and their English-speaking clinicians, emphasising the difference between human interpreters and speech-to-speech machine translation.

Chapter 2 Transforming fields – background information and methodology

This chapter explains the methodology of this thesis. I start with the explanation of the overarching theoretical framework for the thesis. I then provide contextual backgrounds, by describing similarities and differences between Japan and Australia in terms of attitude toward immigrants and languages, and explain the different policy and philosophical underpinnings of their national interpreter credentialing and service systems. This section provides a rationale for conducting a mirrored study in these two countries. Following this section, I set out the design of this study, data collection methods, and analysis.

2.1 The field of cross-linguistic medical encounters

This thesis adopts Pierre Bourdieu's concept of *field* (Bourdieu 1993), drawing on his notion that the social and political positions of works of literature and art are the subjective productions of the system in which they are situated.

The science of the literary field is a form of *analysis situs* which establishes that each position – e.g. the one which corresponds to a genre such as the novel or, within this, to a sub-category such as the 'society novel' [*roman mondain*] or the 'popular novel' – is subjectively defined by the system of distinctive properties by which it can be situated relative to other positions; that every position, even the dominant one, depends for its very existence, and for the determinations it imposes on its occupants, on the other positions constituting the field; and that the structure of the field, i.e. of the space of positions, is nothing other than the structure of the distribution of the capital of specific properties which governs success in the field and the winning of the external or specific profits (such as literary prestige) which are at stake in the field (Bourdieu 1993: 30).

The concept of field creates an analytical window into how people associate values, which are formed in accordance with the norms of the society, with the object of social science research. Bourdieu (1993) argued that the significance of such values and the power of those who define this significance mutually contribute to forming and strengthening a symbolic hierarchy within the given field. The majority of members of the culture or society

adopt such values without questioning their implications on their behaviour. Bourdieu (1992) explained this phenomenon by using the concept of *doxa*. He defined this concept as “undisputed, pre-reflexive, naïve, native compliance with the fundamental presupposition of the field” (1992: 68).

Patients’ values draw on specific properties, relations and beliefs in their culture of origin which may be lost in another culture. In this thesis, I set medical encounters in Japanese and English settings as the conceptual fields of analysis. Identifying the determinants, borders and constituent elements of a field in this study may help elucidate changes in the significance and power of values held by an individual in a cross-cultural environment. An individual may experience an unexpected reception to their expressed values in a foreign culture. The taken-for-granted meanings of cultural values may be challenged when the individual who holds the relevant values moves from a home field to a foreign field.

In order to explore the impact of the changing cultural environment in a foreign field on a patient’s experiences of cross-linguistic encounters, I compare experiences of Japanese-speaking informants in Australia and those of English-speaking informants in Japan. This comparative analysis aims to throw into relief certain aspects of Japanese cultural values and practices which may be at odds with the ways in which Australian users and deliverers of language services frame ‘good’ cross-linguistic communication, particularly in the domain of health.

Negotiating cultures in cross-linguistic medical encounters

Margaret Lock’s ethnography of East Asian medicine in Kyoto (1980) may be one of the most successful attempts at adopting culture as an instrument of inquiry into patients’ experiences of health services. Her study explored medical pluralism in contemporary Japan, where traditional medicine remains popular alongside the country’s national health care

system which is based on Western biomedicine. Lock explained how this phenomenon is explicable through cultural and social analysis:

Concepts of health and illness are based on, among other things, value systems and both individual and collective experiences; they are, therefore, culture-bound and subject to changes according to their historical and social context (Lock 1980: 1).

Lock emphasised that it is important for researchers to explore the individual experiences of illness through the prism of culture.

[S]ince the actual experience of illness, though influenced by others, is ultimately an individual event, any study that does not consider the relationship of the individual to the social and cultural milieu must be considered incomplete (*ibid.*: 11)

In Japanese health care, it is particularly important for the patient and their doctor to communicate with each other the subtle signs of illness with culturally nuanced expressions (*ibid.*). Japanese patients consult their doctors at a very early stage of illness when they may only feel a minor imbalance in their health. Lock observed that communication at this stage involved the descriptions of “nonspecific complaints” (*ibid.*: 245) for which Western medicine often does not have accurate terminology.

2.2 An ethnography of Japanese-English medical encounters

This study is an ethnography in the mirrored conceptual fields of Japanese and English encounters, in the physical fields of Japan and Australia. It includes semi-structured interviews with Japanese-speaking and English-speaking informants who have experienced Japanese-English cross-linguistic medical encounters, as well as Australian medical practitioners who are experienced in interpreter-mediated consultations; participant observations of seminars and workshops related to health care interpreting in Japan and Australia; a review of policy documents and guidelines on interpreting mainly in the area of health care in Australia and Japan, with some reference to those in the USA and Canada as

these countries also have advanced health care interpreting systems; and reflection on my own experience as a professional interpreter specialising in health care.

2.3 Describing the fields

Japan and Australia differ in important and illustrative ways in relation to language and interpreting. There is a significant difference in linguistic diversity between Japan and Australia. As I have shown in Chapter 1, the population of Japan has extremely limited ethnic diversity. The proportion of residents in Japan who have neither Japanese ancestry nor Japanese citizenship accounts for 1.4% of the total population of the country (Statistics Bureau 2016a). Languages other than Japanese are rarely spoken in Japan, and it is one of the most monolingual countries of the world (Heinrich 2012). In Australia, over 300 languages other than English are spoken at home by almost a quarter of the population (Australian Bureau of Statistics [ABS] 2011; ABS 2013). While Australia is one of the most linguistically diverse nations on earth, it is at the same time very monolingual (Wesley 2009). Three quarters of the population only speak English (ABS 2011).

Although the harnessing of our language and concomitant cultural resources is in keeping with good social policy, good economic management, and is good for diplomacy, Australia is caught in the grip of the monolingual mindset (Clyne 2006: 5).

Australia and Japan have contrasting approaches to social cohesion. Australia is a migrant country. In Australia, 46% of the population was born overseas or has a parent born overseas. The rate of marriage across ethnic groups is very high, with approximately 50% marrying across ethnic groups by the second generation for almost every ethnicity (Arunachalam & Karidakis 2016: 165). Approximately one third of registered marriages in Australia every year from 2005 to 2015 are of those who were born in different countries (ABS 2016b). On the other hand, around 95% of marriages registered in Japan from 1985 to 2014 are between Japanese men and Japanese women (Ministry of Health, Labor and Welfare *n.d.a*).

Australia is one of the most receptive countries in the world to immigration. A review of several national surveys in Australia by Markus (2016) found that 60% to 70% of Australians gave positive responses to accepting immigrants. Healy, Arunachalam and Mizukami described Australian multiculturalism as having started as “a social laboratory with the highest living standards in the world; born modern, egalitarian, and socially innovative” (Healy, Arunachalam & Mizukami 2016: 24). Healy, Arunachalam and Mizukami argued that despite the shift in the focus of its international economic relationship from the UK to Asian countries since the late 20th century, “Australia is, and always had been, ‘a nation of immigrants’” (*ibid.*: 25).

Although Japan also relies on immigrants for its economic growth, its immigration policy is different from Australian multiculturalism. Until the 1970s, the majority of immigrants in Japan were Korean, Chinese and Taiwanese nationals who were forced to migrate to Japan as unskilled labour force during World War II (Mori 1997: 34). When demand for unskilled workers exceeded domestic supply during the economic bubble in the 1980s, the Japanese government created a new visa category of ‘long-term resident’, which allows up to the third generation of Japanese emigrants to stay in Japan with no work restriction (Takenoshita 2016: 97-98).

The majority of these unskilled workers who migrated to Japan during this period are the second and third generations of Japanese migrants to South America (Tsuda & Cornelius 2004). Takenoshita argued that this “enabled the Japanese government to introduce unskilled workers from abroad to the Japanese economy without contradicting the basic principles of its immigration policies” (Takenoshita 2016: 98). Takenoshita also pointed to a trend in immigration in Japan from the beginning of the 21st century that there has been an increasing influx of women from other Asian countries through the support of local governments and marriage brokers to marry Japanese men (*ibid.*: 98). These women are

seen as alternatives to Japanese women, many of whom are highly educated and no longer wish to marry low-income Japanese men from conservative Japanese families (*ibid.*: 98).

Healy, Arunachalam and Mizukami argued that the high rate of international marriage in Australia is a critical element of forming a new identity of multicultural Australia (Healy, Arunachalam & Mizukami 2016: 26). The researchers compared Australia and Japan in relation to international marriage, stating that “[n]othing analogous to the Japanese expectation that the children of mixed marriages should be indistinguishable from Japanese exists in Australia” (*ibid.*: 27), where international marriage is often viewed as creating new hybrid ethnicities.

While Australia is different from Japan in its policy which officially celebrates multiculturalism, Hage (2014: 234) pointed to covert political racism in Australia which has eventually provoked explicit discriminatory attacks by members of the public to minorities in the country. Hunter (1993) argued that covert racism against Australian Indigenous people is deeply entrenched, structurally-reinforced racism.

The political transitions from protection, to assimilation, to self-determination/self-management, entailed not only shifts in intracultural power but a broadening of the range of individuals identifying as Aborigine as the oppressive restrictions were lifted and attitudes within the European population changed. The policies of assimilation appeared to present Aborigines with an opportunity to identify with the dominant culture. However, this was a unilateral and unidirectional process; it was Aborigines who were expected to change (Hunter 1993: 222-223).

Flowers (2014) pointed to the conceptual, overt exclusion of non-Japanese residents from Japanese society.

Japan’s immigration policy is based on the idea that Japan is not now and has never been an “immigration country.”... The Immigration Control and Refugee Recognition Act (ICRRA) does not mention and therefore does not recognize the existence of “immigrants” to Japan; instead, the policy speaks of “foreign nationals” (*gaikokujin*). (Flowers 2014: 73).

Another similarity between Japan and Australia other than being monolingual countries is that both countries have *de facto* national languages. Neither of them has defined the national language in its Constitution. Australia adopts English as part of the national identity. In order to sit the Australian citizenship test, for example, applicants must have a certain level of English proficiency. A document containing information on the citizenship test issued by the Department of Immigration and Border Protection sets out the case for the citizenship test only being in English.

The citizenship test is also designed to assess whether you have a basic knowledge of the English language. English is our national language. Communicating in English helps you to play a more active role in Australian society. It helps you to take full advantage of education, employment and the other opportunities Australia has to offer. (DIBP 2014c: 4)

Susan Butler, the editor of Macquarie Dictionary, a widely used reference on Australian English, comments on the centrality of the English language to the Australian national identity:

[Australian English] is dear to the hearts of those of us who are Australian — we know each other by the sound of the language we speak, by the special words we use, by the sense of shared experience and a common history that filters through it. [Australian English] therefore becomes one of the icons of our culture” (Butler 2001: 151).

Similarly, the Japanese language forms a significant part of the Japanese national identity. The Japanese language subject in the Japanese national school curriculum is referred to as *Kokugo* (the national language). Japanese students learn Japanese not only to acquire language skills but also to nurture ideologies and personalities which allow them to think and act in accordance with the received model of Japanese (Takahashi 2010). Japanese language is “a common bond between all Japanese since time immemorial, as well as a barrier between Japanese and non-Japanese. (Heinrich 2012: 172).

Heinrich argued that Japanese people who are inculcated with such ideologies “take pride in their national language and, by extension, their nation (*ibid.*: 175)”. He pointed to the shaping of homogenous Japan which centres on its monolingual ideology.

Ever since linguistic homogeneity was deemed to be a critical component of the Japanese nation-state, loss of linguistic diversity has occurred. Value was given to homogeneity and uniformity of language, while diversity and deviation from homogeneity were disparaged, and viewed as a problem. Accordingly, the creation and spread of modern Japanese has resulted in suppression and stigmatization of linguistic diversity in the form of both local languages and of local and social language varieties. At the same time, language ideology offered marginalized groups the chance to raise their status by subscribing to the dominant ideology and behaving according to the values it promoted, with further homogenization being the inevitable outcome (*ibid.*: 175-176).

The linguistic homogeneity in Japan seems to concentrate on the standard Japanese language through the segregation of local Japanese accents and dialects.

The standard form of Japanese, designed as such by the National Language Research Council in 1916 and spoken and understood throughout the country, is called *hyōjungo* and is based on the speech of the Tokyo dialect... Standard Japanese is used in writing and in formal speaking situations (Gottlieb 2005: 7).

In the early 20th century, the Japanese government stipulated that “the Japanese taught in schools would be that of middle- and upper-class Tokyo residents and subsequent textbooks had therefore begun to disseminate this throughout Japan” (Gottlieb 2005: 9). While various regional dialects are in casual use throughout Japan, there were times when speakers of some regional dialects were heavily stigmatised (Maeda 2014).

The ‘dialect tag’ (*hōgen fuda*), the most notorious measure in the policy of ‘dialect-correction’ (*hōgen kyōsei*), is said to have started in the mid-Meiji period [around 1900]... The methods used in the dialect tag system were similar across schools. Students had to wear a tag around the neck which read ‘I used the dialect’ (*watashi was hōgen o tsukaimashita*) as a means to stigmatize them for not speaking Standard Japanese. (Maeda 2014: 238-239).

While such a stigmatising measure no longer exists in the 21st century, Standard Japanese is still used as the ‘correct’, official Japanese language in TV and radio programmes

broadcasted by NHK, the Japanese national broadcasting corporation, and school textbooks throughout Japan (Gottlieb 2005: 8-9).

On the other hand, in Australia, regional dialects are neither taught nor overtly stigmatised in teaching English. The website of Board of Studies Teaching & Education Standards NSW states that English varieties, including Aboriginal English, are recognised as part of Australia's multiculturalism.

All students come to school speaking the language they have been brought up with. This may be a completely different language, or a different variety of English. Whether it is a different language or a different dialect, it is not wrong, it is just different (Board of Studies Teaching & Educational Standards NSW 2014).

The government-funded language services in Australia, TIS (Translating and Interpreting Service) National, was established in the 1970s, as part the country's multicultural policy for meeting language needs of new migrants (TIS National *n.d.*). This service also covers the domain of health care.

TIS National is operated by the Department of Immigration and Border Protection of the Australian Government. TIS National is the largest language service agency in Australia, and one of the largest in the world. The annual number of interpreting services provided by TIS National has been increasing, from 41,820 in the 2007/2008 fiscal year to 85,263 in the 2014/2015 fiscal year for on-site interpreting. For telephone interpreting, the annual number of services have increased from 626,714 in the 2007/2008 fiscal year to 1,251,696 in the 2014/2015 fiscal year (DIBP 2014b; DIBP 2015). TIS National sends professional interpreters to various different services in the public and private sectors, including health care. TIS National gives priority to the health care sector. The organisation has set up a special scheme called the Doctors Priority Line, which is dedicated to medical practitioners and allows access to professional interpreting services free of charge for private clinicians charging for a service funded through Medicare, the national insurer.

Australia also has a range of private interpreter companies, which compete with TIS National for contracts to provide state-funded or private industry services. The private interpreter industry operates in a similar fashion to TIS National, offering both on-site and telephone interpreters, usually at short notice. Australia was the first country to develop a national accreditation program for interpreters, oversighted by the National Accreditation Authority for Translators and Interpreters (NAATI). The objective of NAATI as stated in their strategic plan for 2015 to 2017 (NAATI *n.d.a*) is to ensure high standards of professional interpreting and translating services ultimately to meet language needs from the linguistically diverse residents of the country.

The mission of the Company, as outlined in the NAATI Constitution, is to set and maintain high national standards in translating and interpreting to enable the existence of a pool of accredited translators and interpreters responsive to the changing needs and demography of the Australian culturally and linguistically diverse society (NAATI *n.d.a*: 1)

NAATI's credentialing processes include Accreditation and Recognition. Its website gives the definitions of both. The following is the definition of Accreditation:

Accreditation is an acknowledgement that an individual has demonstrated the ability to meet the professional standards required by the translation and interpreting industry.

NAATI assesses translation and interpreting professionals against these standards so that English-speaking and non-English speaking Australians can interact effectively with each other, particularly when accessing medical, government and other services (NAATI *n.d.b*).

The following is the definition of Recognition:

NAATI recognition is granted in emerging languages or languages with very low community demand for which NAATI does not offer accreditation. The granting of NAATI recognition is an acknowledgement that an individual has recent and regular experience as a translator and/or interpreter with no defined skill level (NAATI *n.d.c*).

As of November 2016, NAATI gives Accreditation to 65 languages (NAATI 2016). It gives Recognition for all languages for which Accreditation tests are not available (NAATI *n.d.c*).

In Japan, there is no interpreter credentialing and service system equivalent to those in Australia. Local not-for-profit organisations recruit and dispatch volunteer interpreters to health care facilities in the country (Kawauchi 2011). The Japanese national interpreter licence is referred to as the Guide Interpreter Licence. This licence is stipulated by the *Licensed Guide Interpreters Act 1949*. The objective of this licence system is different from that of the Australian national interpreter and translator credentialing system.

[The objective of the Act is] to set the guide interpreter system and to ensure its appropriate implementation, with the aim of improving the quality of hospitality services for overseas visitors to Japan and of contributing to the promotion of inbound tourism” (*Licensed Guide Interpreters Act 1949* – translated by the author).

The Japan National Tourism Organization, a Japanese national government organisation, assesses the skills of applicants who wish to work as tour guide interpreters. As of 2016, examinations for the guide interpreter licence are available in English, French, Spanish, German, Chinese, Italian, Portuguese, Russian, Korean and Thai (Japan National Tourism Organization 2016). The examination is designed to test the applicant’s knowledge of the history, geography, politics and culture of Japan, as well as proficiency in their chosen language (*ibid.*).

The concept of health care interpreting differs between Japan and Australia. In Australia, health care interpreting is conducted by credentialed generalist interpreters. There is no specific training or qualification in health care interpreting. In Japan, health care interpreters are volunteer interpreters who may also work as professional ‘tour guide’ interpreters. Volunteer health care interpreters are unpaid or receive compensation for travel expenses, and work with non-Japanese residents who seek health care in community health service settings (Kawauchi 2011; Nadamitsu 2008); whereas health care interpreters associated with the tourism industry are not volunteers, and work with businesses for inbound medical tourism (Ministry of Economy, Trade and Industry 2014; Ministry of Health, Labor and Welfare 2016). In the 2016 fiscal year, the Japanese government allocated 135,973,000JPY

(approximately 1.6 million AUD) to a project dedicated to promoting inbound medical tourism and associated health care interpreting services (Ministry of Health, Labor and Welfare 2016).

2.4 Study design

This study is an ethnography in the mirrored fields of Japanese and English medical encounters, in the physical fieldwork sites of Japan and Australia. The ethnography consists of semi-structured interviews, participant observations, document reviews and reflection on my own experience. This study was approved by the Human Research Ethics Committee of the Australian National University (Protocol Numbers 2013/556 and 2015/109). Approval for the two protocols covers the entire data collection process both in Australia and Japan.

Semi-structured interviews were chosen as the primary data collection method to allow informants to freely give their accounts in their own words, and to allow me to probe informants' experiences in line with their responses. The eligibility criteria for patient informants were: being aged at least twenty years at the time of giving informed consent to participate in the research, and having experienced Japanese-English medical encounters. The eligibility criterion for Australian medical practitioners was that they were regular users of interpreters in their practices.

The purpose of the participant observations of seminars and workshops was to gain the understanding of: the up-to-date knowledge of the norms of health care interpreting in Australia and Japan; how the relevant organisations design and implement training programmes for health care interpreters; and issues which interpreters, training organisations and language service agencies face in providing health care interpreting services. The purpose of a document review was to provide insights into the official norms and expectations in relation to interpreter use. I anticipated that a combination of multiple methods would help me perform a multi-faceted analysis.

Reflection on my experience as a professional interpreter was an add-on to an analysis of data collected from the above sources. The purpose of incorporating my own reflection was to align the analysis with the reality of interpreter-mediated medical encounters, in order to draw valid conclusions. This was a small but important part of this study particularly because I did not directly observe actual interpreter-mediated medical consultations. I aimed to add an insider's perspective to data analysis.

Recruitment of participants and research setting

The period of fieldwork was from November 2013 to December 2015. During this period, I recruited sixteen Japanese-speaking patients, fifteen English-speaking patients and four Australian medical practitioners in Japan and Australia. Prior to the fieldwork, I held a pilot interview with one English-speaking patient in Canberra in October 2013. I used snowball sampling to recruit interview participants. Patients were recruited in Canberra and Melbourne in Australia; and in Tokyo, Saitama and Fukushima in Japan. Australian medical practitioners were recruited in Sydney and Canberra.

Tokyo is the capital of Japan, located near the centre of the country. In its small land area of 2,188 km², the metropolitan city has a population of over 13 million (Statistics Division 2016). Saitama is a neighbouring prefecture to Tokyo. The prefecture mainly consists of residential areas in which those who commute to Tokyo for work and study live. Its population is approximately 7.3 million (Saitama Prefectural Office 2015). Fukushima is in the northern part of Japan, facing the Pacific Ocean. The prefecture has the third largest area in Japan, with a population of approximately 1.9 million (Fukushima Prefecture 2015). Fukushima has abundant natural beauty and resources, and its main industries are agriculture and fisheries. The prefecture is also known as a popular ski resort destination.

Melbourne is the capital of the State of Victoria. The majority of its population reside in Melbourne, which is the second most populous city in the country, following Sydney. As of

March 2016, the population of Melbourne is 4,529,500, and that of Sydney is 4,921,000 (ABS 2016a). Canberra, the national capital, is in the Australian Capital Territory and is located between Melbourne and Sydney, slightly close to the latter.

I received support from Japanese local international exchange associations based in Koriyama-City and Aizuwakamatsu-City in Fukushima Prefecture. I used to work for the Koriyama International Exchange Association as an interpreter and an English teacher. The recruitment of patients in the Fukushima area owes its success to generous support from these organisations.

A description of patients is given in Tables 1 and 2. All patients are referred to with pseudonyms in this thesis. All Japanese-speaking informants were born and raised in Japan. Thirteen Japanese-speaking patients currently reside in Australia. They moved to Australia at the age of twenty years or older. Out of a total of fifteen English-speaking patients, ten were born and raised in Australia. The rest were raised in other predominantly English-speaking countries. Nine English-speaking patients currently reside in Japan. They moved to the country at the age of twenty years or older. Twelve Japanese-speaking patients are partnered to native English speakers; and seven English-speaking patients are partnered to native Japanese speakers. These patients were thus able to provide first-hand experiences of receiving communication support from family interpreters in Japanese-English encounters.

Seven out of fifteen English-speaking patients have undergone formal Japanese language training, whereas all but one Japanese informant have undergone formal English training. While a few English-speaking patients described their proficiency in Japanese by referring to the certificates and degrees they held, no Japanese-speaking patients described their English proficiency by referring to any objective measurements.

There was a significant gender imbalance in the group of Japanese-speaking informants. Out of a total of sixteen participants, fourteen were women. The gender balance was almost even in the group of English-speaking informants. I did not purposively recruit female informants for Japanese-speaking patients. The fact that I am a female researcher might have influenced the gender balance of participants. However, this does not explain the significant difference in the gender balance between the Japanese-speaking group and the English-speaking group.

Statistical data issued by the Australian and Japanese governments suggest that it was unlikely that the gender balance of the participants would be even, even after excluding the influence of my gender, or gender influences on the snowball recruitment method. In the 2011 Australian Census (ABS 2011), there were 25,822 women, and 17,870 men who spoke Japanese at home. In the 2015 Japanese Census, there were 6,672 Australian men and 3,002 Australian women residing in Japan (Statistics Bureau 2016b). The preponderance of males was also found among British residents in Japan (male: female ratio, 3.04: 1), and Canadian residents (male: female ratio, 2.42: 1) (*ibid.*). I am also giving the numbers for British and Canadian residents here because one of the English-speaking patients who are partnered to native Japanese speakers in this thesis was originally from the UK (Matt), and two were from Canada (Nick and Ray).

Australian clinicians who participated in interviews are indicated in this thesis with alphabetic letters, namely Doctors G, J, K and P. These letters are not associated with their real names. All these doctors are working at health care facilities which patients with diverse linguistic backgrounds visit. Doctor P is based in a northern suburb of Canberra; and the other three doctors are in northern suburbs of Sydney. The gender balance of the participating clinicians was even: two men and two women. One of them is originally from Japan; and another has a Chinese background. These two clinicians use English in

consultations. The remaining two are from Australia, and native English speakers. All work as medical practitioners on a full time basis.

As I am fluent in both Japanese and English, I interviewed informants in whichever was their preferred language. This helped me avoid being subject to what Obeyesekere called the “interpreter effect” (1981: 11) in anthropological research, whereby interpretation by a third party can cloud the analysis. I interviewed twenty-two patients in-person; and nine patients remotely; one Australian clinician in-person; and three Australian clinicians remotely. Most face-to-face interviews were held at cafés over drink or lunch. One of the interviews was held at a play area in a shopping centre because the patient was with her toddler child. Some interviews were held on the premises of the organisations to which the informants belonged. A few informants kindly invited me to their homes for interviews, where I had an opportunity to greet and talk to their family members as well. I used Skype, an online communication application, for most remote interviews. Otherwise I interviewed informants by telephone. All participants were literate, and gave written informed consent prior to the interviews. I interviewed a number of informants multiple times following formal interviews.

The aim of semi-structured interviews was to ask informants to share the broad narratives of their first-hand experiences of cross-linguistic medical encounters. The interview schedules I prepared for patients and doctors consisted of open questions. I did not ask the same questions to all informants. The questions varied depending on how the conversation progressed. I also paid attention to building a rapport with each informant, in order to hear their honest thoughts.

I asked the patients to tell me broadly what they thought of Japanese-English medical encounters; how they think language barriers affected their access to health services; what they thought of the individuals who mediated the Japanese-English communication; and

their views on their own proficiency in English or Japanese, and its impact and importance. I asked Australian medical practitioners about difficulties which they face in cross-linguistic medical encounters in general; their views on the impact of involving a third party as an interpreter in the consultation; what they think is the difference between interpreters practicing as professionals and non-professional interpreters; and the nature and importance of accurate and impartial interpreting. None of the Australian clinicians mentioned other types of non-professional interpreters than patient family members.

Interviews were audio-recorded. In face-to-face interviews, the device was placed between the interviewee and was visible to both of us for the entire duration of the interview. In remote interviews, I briefly explained to the informant prior to the start of each interview that I would use a portable device to audio-record the conversation. I also made contemporaneous notes and used them to reflect on the interviews. I transcribed interviews within a week following each interview. For interviews in Japanese, I first transcribed in Japanese, and then translated the record of interviews into English. All data from Japanese informants are presented in English in this thesis.

Name	Gender	Age	Raised in	Formal English training Y/N	Recruited in	Partner is native English speaker Y/N	Mode of interview
Miho	F	40s	Japan	Y	Australia	Y	In-person
Aki	F	30s	Japan	Y	Australia	Y	In-person
Yoko	F	30s	Japan	Y	Japan	N	In-person
Chika	F	40s	Japan	Y	Australia	Y	In-person
Saki	F	50s	Japan	Y	Australia	N	In-person
Sanae	F	40s	Japan	Y	Australia	Y	In-person
Yuta	M	70s	Japan	N	Japan	N	Remote
Emi	F	30s	Japan	Y	Australia	Y	Remote
Chie	F	40s	Japan	Y	Australia	Y	In-person
Ryo	M	40s	Japan	Y	Australia	N	In-person
Yuri	F	30s	Japan	Y	Australia	Y	In-person
Miwa	F	40s	Japan	Y	Japan	Y	Remote
Miki	F	30s	Japan	Y	Australia	Y	Remote
Kaori	F	30s	Japan	Y	Australia	Y	Remote
Yumi	F	40s	Japan	Y	Australia	Y	In-person
Haruka	F	40s	Japan	Y	Australia	Y	In-person

Table 1: The profiles of Japanese-speaking patient informants

Name	Gender	Age	Raised in	Formal Japanese language training Y/N	Recruited in	Partner is native Japanese speaker Y/N	Mode of interview
Kate	F	20s	Australia	N	Australia	N	In-person
George	M	30s	Australia	N	Australia	N	In-person
Emma	F	30s	USA	N	Australia	N	In-person
Andrew	M	20s	UK/ Netherland	N	Australia	N	Remote
Matt	M	40s	UK	N	Japan	Y	In-person
Audrey	F	30s	Australia	Y	Japan	Y	In-person
Nick	M	30s	Canada	N	Japan	Y	In-person
Ray	M	40s	Canada	N	Japan	Y	In-person
Hamish	M	60s	Australia	Y	Japan	Y	In-person
Adam	M	40s	Australia	Y	Japan	Y	In-person
Jo	F	30s	Australia	N	Japan	N	Remote
Sharon	F	40s	Australia	Y	Australia	Y	In-person
Cathy	F	30s	Australia	Y	Japan	N	Remote
Will	M	30s	Australia	N	Japan	N	Remote
Ben	M	40s	Australia	N	Australia	N	In-person

Table 2: The profiles of English-speaking patient informants

Participant observations

I attended a number of seminars and workshops relevant to health care interpreting both in Japan and Australia. They reflected the general understanding of the role of health care interpreters in each country. The target audience of all but one of them was interpreters and those involved in the provision of health care interpreting services. The exception was a seminar for elderly Japanese residents in Australia on how to access Australian health care services.

In all seminars and workshops for interpreters I attended either in Japan or Australia, I observed that no speaker was a practising interpreter. The speakers were coordinators and directors of Australian language service agencies and Japanese not-for-profit organisations, executives of NAATI and researchers in linguistics. The organisers of seminars in Japan were local not-for-profit organisations which recruit health care interpreters. I saw around eighty to one hundred participants in each seminar. The main content of the seminars was descriptions of successful cases from a number of local non-profit-organisations demonstrating collaboration with the city councils and the local health care organisations. The seminars generally emphasised that it is important for a health care interpreter to deepen medical knowledge, an understandable focus since most health care interpreters had received training through the tourism guide system. Although some of the speakers mentioned the Japanese version of the code of ethics for health care interpreters, they did not refer to its content, noting simply that a number of non-profit-organisations jointly created the code, and that it is designed to help the work of health care interpreters.

The organisers of seminars and workshops in Australia were AUSIT and language service agencies. They were smaller than those in Japan, with about twenty to forty participants at each event. Some of the events were not specifically about health care interpreting but interpreting in Australia in general. In most of these events, the participants were given

some time to discuss the importance of complying with the AUSIT Code of Ethics and ethical challenges interpreters can face in interpreting assignments.

In addition to seminars and workshops for interpreters, I attended a seminar for senior Japanese residents in Australia. The purpose of the event was to provide the participants with detailed information in Japanese on the Australian health care system. I was invited to this seminar as a speaker. I was asked to give an explanation of the professional interpreter service system in Australia. Talks by the other speakers covered topics such as difference between public and private health care services, Medicare and bulk billing schemes and how to make an appointment with a specialist through referral from a GP. This seminar, particularly Q&A sessions following each talk, allowed me to observe what factors may give rise to barriers for Japanese residents in accessing Australian health care services.

Review of policy documents and guidelines for health care interpreting

The purpose of reviewing policy documents and guidelines for health care interpreters was to gain an understanding of the prescribed role of health care interpreters in Australia, Japan and countries in which health care interpreting is frequently addressed. The purpose of this document review was also to examine the potential gap in the provision and promotion of health care interpreting, through a comparison between the prescribed role of health care interpreters and the accounts of patients and clinicians. I searched the grey literature for relevant documents with combinations of key words including but not limited to: 'interpreter', 'health care', 'policy', 'standard', 'guideline', 'professional interpreter', 'ad-hoc interpreter', 'qualification', 'credential', 'language service' and 'code of ethics'.

I found over thirty relevant documents in Australia, Japan, the USA, the UK and Canada. I narrowed them down to those which give the most relevant information for this thesis. I referred to fifteen policy documents and guidelines in this thesis. A list of these documents is given in Table 3. I referred to guidelines from the USA and Canada as well as those from

Japan and Australia for this study. They provided different perspectives from those given by the Australian and Japanese counterparts. They helped me perform a more comprehensive analysis than I would have otherwise. From amongst the websites of all Australian State and Territory governments, I found the largest number of relevant policy documents and guidelines on the website of the Queensland Government.

Title of document	Year	Issuing organisation
Australia		
Procedure: language services – interpreters	2015	The ACT Government
Queensland language services policy	2014	The Queensland Government
Working with interpreters: guidelines	2007	The Queensland Government
Interpreting in healthcare: guidelines for interpreters	2014	The NSW Government
Ethics of interpreting and translating: a guide to obtaining NAATI credentials	2013	the National Accreditation Authority for Translators and Interpreters
AUSIT code of ethics and code of conduct	2012	The Australian Institute of Interpreters and Translators
The Standards for general practice	2010	The Royal Australian College of General Practitioners
AUSIT recommended guidelines for health professionals working with interpreters	2007	The Australian Institute of Interpreters and Translators
Language services policy	2005	The Victorian Government
Japan		
<i>Byoin no tameno gaikokujin kanjya no ukeire sankosho</i> (A reference book for hospitals for accepting international patients)	2014	The Government of Japan
Standard for medical interpreters	2010	Committee to Review Standards for Medical Interpreters
Canada		
Code of ethics	2015	Society of translators and interpreters of British Columbia
The national standard guide for community interpreting services	2007	The Healthcare Interpretation Network
USA		
A national code of ethics for interpreters in health care	2004	The National Council on Interpreting in Health Care
National standards of practice for interpreters in health care	2005	The National Council on Interpreting in Health Care
California standards for healthcare interpreters: ethical principles, protocols, and guideline on roles & intervention	2002	California Healthcare Interpreters Association

Table 3: Policies and guidelines referred to in this thesis

2.5 Data analysis

The analysis of interview data relied on the informants' subjective statements. They were a window through which I explored Japanese-English medical encounters. In my analysis, I sought to explore how culture may show or mask certain values which are situated in their interrelation with the people, history, environment and many other aspects. My understanding of culture is based on the following description by Geertz:

Believing, with Max Weber, that man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning (Geertz 1973: 5).

I also keep in mind the risk of disorientation resulting from the overconfidence about my experience and from the misapplication of the concept of "thick description" (Geertz 1973:3). Wacquant criticised this concept for being the possible cause of "*disembedded reconstructions* by the analyst that do not fully recognize themselves as such" (1995: 491 – original emphasis).

There is a thin line between merely showcasing a series of peculiarities of a field and providing new insights which dispel dominant views and norms in the field. The aim of this thesis is "opening up new possibilities of thought and theory concerning the human condition that were closed to other disciplines" (Kapferer 2000: 182). Merely showcasing the peculiarities of the field as "a merchant of the strange" (Kapferer 2013: 827) risks the kind of exoticisation that, some critics argue, underpins the increasingly popular, but ambiguous, concept of 'cultural competency' in health care in the multicultural environment (Kleinman & Benson 2006).

I intentionally chose patients and medical practitioners to be the informants of this study because their views have been underrepresented in existing literature. The analyses of

interview data involved the transcription of all recorded interviews and the translation of Japanese transcripts into English. Since I conducted all these processes by myself, I thoroughly engaged in the entire accounts of the informants. Emergent concepts were tested for relevance through discussion with my supervisors, and through specific search for examples that did not support the emerging analysis, in order to bring extra depth and nuance to the analysis. These processes also helped me avoid cherry-picking specific parts of the interviews to make a predetermined set of points.

This thesis also adopts Bourdieu's idea of "objectiviz[ation] [of] the subjective relation to the object" (Bourdieu 2003: 282). This is not simply a 'gaze afar' approach but objective reflection by the researcher on the subjective relation of themselves to the object of the research. I objectivise my own experience as a Japanese-English interpreter while sharing with informants their subjective views. Bourdieu's objectivisation is, instead of being ignorantly subject to the world the study is exploring, to be "equipped with your theoretical and methodological tools, with the full store of problematics inherited from your discipline, with your capacity for reflexivity and analysis, and guided by a constant effort... *to objectivize this experience and construct the object*" (Wacquant 2011: 87 – original emphasis). My position in this thesis is an objective outsider who also has the perspective of an insider.

2.6 Limitations of the study

The main limitation of this study is that I employed snowball sampling in recruiting informants. Possibly as a result, the members of participant groups had similar socio-economic backgrounds. Most of them are university-educated, middle-class, between the ages of 30 and 60, relatively healthy and have deeper interest in Japanese and English than in any other languages and cultures. I was fortunate that I was still able to recruit a number of informants who had different characteristics from the majority. They were, for example,

high school leavers, over 60 years old, or people suffering from life-threatening or severe chronic illness.

Informants I interviewed do not represent the entire socio-cultural and demographic distributions of either Japanese-speaking people in Australia or English-speaking people in Japan. In fact, I have seen as an interpreter Japanese migrants to Australia who had much lower socio-cultural backgrounds. I have interpreted for a number of Japanese women, for instance, who were having difficulties in finding a job and a place to live in Australia following separation from their Australian spouses, and were now living in poverty. Compared to the informants of this study, people like these women appeared to be facing financially and emotionally more challenging situations. They appeared to have little understanding of what they are entitled for and how to stand for themselves in Australia. There would have been richer insights had I been able to incorporate experiences of such people in this study.

There is a significant gender imbalance between English-speaking informants and Japanese-speaking informants. As mentioned in the section on study design, this imbalance in fact represents the gender distribution of each group. The large proportion of Japanese migrants living in Australia permanently is Japanese women married to Australian men. This also explains the difference in profile between English-speaking informants and Japanese-speaking informants. Although informants in both groups represent each population, it is possible that this affected the analysis of data. In order to avoid biases in data analysis, particularly for data from Japanese-speaking informants, I included comparative cases which are in contrast to those of Japanese women partnered to English-speaking men.

2.7 Summary

This chapter set the overarching research framework for this thesis. I explained how I apply Pierre Bourdieu's concept of *field* to an ethnography of Japanese-English medical

encounters. I then provided backgrounds to the mirrored conceptual fields of Japanese and English medical encounters and the mirrored physical fields of Japan and Australia. I pointed to the similarity and difference between these two countries as the rationale for choosing these countries for my fieldwork.

The research in this thesis is designed as an ethnography consisting of semi-structured interviews with patients and clinicians; participant observations of relevant seminars and workshops; a review of policy documents and guidelines for using interpreters including but not limited to the area of health care; and the reflection of my own experience as a professional interpreter.

In the next chapter, I explore the views of Japanese-speaking and English-speaking patients on the best communication intervention in cross-linguistic medical encounters. I compare the accounts of informants between those with different cultural and social backgrounds and different genders, in order to investigate how Japanese cultural, social and gender norms influence Japanese-speaking patients' decision about the use of health care interpreters.

Chapter 3 Relationship-centred interpreting in Japanese-English medical encounters

In this chapter, I investigate Japanese patients' understandings of the best communication support for cross-linguistic medical encounters, drawing on their own experiences. I

describe the experiences of Japanese-English medical encounters by Japanese-speaking patients from different, although predominantly middle-class, backgrounds. I also compare accounts of such experiences between Japanese-speaking informants and English-speaking informants. Most Japanese-speaking informants used their partners (in all cases, Japanese women receiving support from their English-speaking partners) when they communicated with English-speaking clinicians, while few English-speaking informants used their partners in consultations where the clinicians spoke Japanese.

The chapter begins with a consideration of gendered behaviours in relationships, reviewing why Japanese migrant women may prefer to use their partners. This preference in part reflects cultural aspects of communication in medical encounters. Drawing on the ethnographic literature, I make a case that a Japanese patient may regard an external presence in the consultation as *yokeina osewa* (unwelcomed help). I link this analysis to broader Japanese understandings of social and relational coherence in interactions, considering the case of Japanese-speaking patients who challenge norms about gender, as well as those of English-speaking informants.

3.1 The good Japanese woman and her non-Japanese partner

Japanese-speaking informants in this study included a preponderance of women partnered to English-speaking men (twelve out of sixteen – 75%). English-speaking informants included two women (Sharon and Audrey) married to Japanese-speaking men, and five men married to Japanese-speaking women (Matt, Nick, Ray, Hamish and Adam).

Japanese-speaking women partnered to English-speaking men showed a strong preference for their partners over professional interpreters in English consultations, whereas the other Japanese-speaking informants did not indicate a specific preference for family interpreters. Out of twelve Japanese-speaking women partnered to native English speakers, eleven stated that they have received communication intervention by their partners in medical encounters conducted in English. Out of seven English-speaking informants partnered to native Japanese speakers, two (Matt and Ray) stated that they received communication intervention by their Japanese wives in medical encounters in Japan. No English-speaking patients indicated particular preference for the type of communication mediator.

Eight Japanese-speaking women said, without prompting, that their partners acting as interpreters gave them *anshin* (peace of mind). They indicated that they did not intend using health care interpreting services in the future. Sanae conceded that she would have used a health care interpreter if she had a life-threatening condition, but no other informant made this point. No Japanese-speaking women pointed to the accuracy of language rendition as a reason for preferring their English-speaking partners. The levels of proficiency of the informants and their partners in the two languages were irrelevant to their preference.

While Miki did not explicitly use the term *anshin* to refer to her partner's involvement, her actions implied it. She audio-recorded the conversation with her Australian doctor. After she went home, she had her English-speaking partner listen to the recorded conversation, in order to clarify the details of the consultation. As with other Japanese-speaking women, Miki said that she would not use a professional interpreter. While Miki relies on her partner for English communication, her partner is not always happy to help her with English communication.

I speak with my boyfriend in English. I leave everything with my boyfriend. He says that my attitude is a problem. He said that it's not good that I don't try to resolve issues by myself.

Miki's action and statement as well as the other Japanese women's exclusive preference for their English-speaking partners may appear puzzling to those who are not familiar with the culturally framing of the good Japanese women.

In an ethnography of the lives of Japanese women in Japan, Morley (1999) argued that the Japanese concept of gender is rooted in sexism, and that Japan's male-dominant society has created a subordinate position for Japanese women. Drawing on interviews with over one hundred women in Japan, together with her own analysis of Japanese novels, Morley argued that "[f]or centuries, Japanese men have chosen to think that Japanese women come in two different models: mothers and whores" (1999: 104). Morley gave as an example of Japanese sexism a semi-official statement by the then Chief Cabinet Secretary Misoji Sakamoto at a meeting in the Japanese National Diet on the Equal Employment Opportunity Law that "sexual harassment was not a problem in Japan" (*ibid.*: 120).

In an online news article on Japanese women being the victim of daily groping in commuting trains in Tokyo, Mealey explained that groping in trains in Japan has not decreased over decades because "women were treated as second-class citizens in Japan and not enough was done to deter gropers and protect female commuters" (*ABC News* 7 January 2017). Japanese women seldom raise an official complaint because "Japanese girls believe that they are somehow boasting about their own looks if they tell someone they have been groped" (*ABC News* 7 January 2017).

Another example is an official statement by the then Minister of Health, Labor and Welfare Hakuo Yanagisawa in January 2007. In a speech on health and welfare to the Liberal Democratic Party of Japan, Yanagisawa referred to women as "child-bearing machines" (*The Japan Times* 28 January 2007). While his statement invoked outrage among some Japanese women, the general public, including Japanese female TV stars, were largely tolerant (*J-CAST News* 5 February 2007). A lawyer and the former Governor of the Osaka prefecture Toru Hashimoto also defended the Minister by stating that his expression was appropriate for the

context (*ibid.*). The minister faced no career setback related to this statement, and completed his term.

In an analysis of a serious domestic violence case committed by a Japanese diplomat in Canada, Yoshihama quoted a comment by the sergeant in charge that, "...the accused pledged guilty to the charge of assault. I believe he is alleged... to have said that beating one's wife is not a crime in Japan" (1999: 76). There is another case of domestic violence in 2012 committed by a Japanese diplomat in the USA. The diplomat "stabbed [his wife] with a screwdriver, hit her on the head with a laptop and dragged her from a parked car" (Huet 2012: 1). In response to a question by prosecutors asking why she did not immediately report to the police, the wife stated that "[p]eople in Japan don't call the police when it is a fight between a man and a wife" (*ibid.*: 2).

In male-dominant Japanese society, there have been limited opportunities for women to be independent. Marriage has traditionally been the only means for Japanese women to secure financial stability and pursue happiness (Yoshizumi 1995: 183). Becoming a housewife by marrying a man with financial stability has been considered to be the most sensible decision for Japanese women.

After World War II women's status showed considerable improvement, yet, with the exception of a select few, women continued to find it difficult to maintain stable, financially sustaining jobs throughout their lives... Many young women rushed into marriage, regardless, in many cases, of their partners' suitability (*ibid.*: 184).

Yoshizumi argued that Japanese women still face "numerous psychological and cultural, as well as legal, residues of the prewar family system which stand as obstacles to the realization of a truly egalitarian relationship between wife and husband" (*ibid.*: 196).

The current Japanese *Civil Code* 733.1, which was introduced in 1896, may be an example.

The Code prohibits women from remarrying before one hundred days have passed since the day of dissolution or rescission of her previous marriage while it places no restriction on

men. Prior to its recent amendment in June 2016, the period of prohibition was for six months. The rationale for this rule is to avoid confusion in the family line and difficulties in identifying the biological father of the baby in the case that the woman was pregnant at the time of break-up (Gotoh 1992: 180).

Kelsky (2001) argued that an increase in the number of Japanese women who study in Western countries, have jobs in international firms and marry Western men indicates their desire to liberate themselves from the restrictive cultural image of Japanese women.

[These Japanese women] construct the West as a site of rescue for Japanese women whose ambitions and abilities are thwarted in Japan... [W]omen's "defection" is not precisely to the West, but to an idea of West, which is synonymous with the international. In their most utopic forms, narratives of internationalism argue for an alliance with the "universal" ideals of Western modernity and require not so much women's physical displacement overseas as an absorption of that modernity into Japan (2001: 4).

Haruka, a Japanese woman in her forties in my study, is a good example of Japanese women's attraction to the idea of the West. Haruka wanted to be fluent in English without going outside Japan. She is now married to an English-speaking man and living in Australia.

I was interested in the USA and a little in the UK. I wasn't thinking about studying English overseas. I didn't think about living overseas. I'd never thought I would be able to do so. I was not so keen on leaving Japan. I just wanted to be able to use English, in order to enjoy English films while living in Japan.

An ethnography of Japanese housewives who accompanied their Japanese husbands on postings to the UK suggested that the physical displacement to the West barely changes these women's perception of the culturally constructed role of Japanese housewives (Martin 2007). The lives of Japanese housewives in the UK gave them a certain degree of freedom from cultural burden while they were still engaging in essentially the same work they had performed in Japan. They were freed from tasks which were physically impossible to be performed outside Japan, such as close interactions with other Japanese mothers at kindergartens and schools, taking care of elderly parents, and traditional childbirth-related

rituals at shrines. The Japanese wives of Japanese men in Martin's study devoted themselves to maintaining symbolic links with Japan.

... the important role of wives in providing a comfortable family home environment that maintains links with Japan during the overseas transfer process. This is considered to be the most important role in accompanying a husband to the UK, along with taking care of the health of the family (2007: 74).

Martin (2007) suggested that marriage to Japanese men may bind Japanese women to the traditional image of 'good mothers', which is the opposite end of the spectrum from 'whores'.

Most Japanese women in this thesis are examples of "internationalist Japanese women" (Kelsky 2001: 5). In interviews conducted by Kelsky, 'internationalist Japanese women' showed disgust for the persistent Japanese norm which links marriage and the human value of women.

The most important life stage transition for women is the move from the single to the married state within a narrowly defined period of "marriageable years" (*tekireiki*). In concrete terms, this means that women should be married by age thirty or thirty-five, and those who are not are seen as aberrations and "inferior goods" (*ibid.*: 94).

When I was in my early twenties and working in a Japanese company, I heard my colleagues using the disparaging metaphor of 'Christmas cakes' to describe Japanese women in their late twenties or older. In Japan, the prices of Christmas cakes are halved from the 26th of December. This metaphor means that women over twenty-five years old experience a significant loss in their value as potential wives for Japanese men.

Yoshizumi also pointed to this age-related pressure on Japanese women.

If a woman wanted to marry prior to the "marriageable age," it was opposed on the grounds that she was "too young", yet, when she reached the marriageable age, she was urged to marry soon or else remain "an unsold good" (1995: 154).

In an ethnography of Japanese women exploring changes in their notion of self in the context of gender over three decades from the 1970s to 1990s, Rosenberger (2001) argued that the roles of men and women in Japan are separated between the front stage and the back stage.

The ideal middle-class man was a "salaryman" working in a company to support his family, while the ideal middle-class woman was a "full-time housewife" sacrificing herself to provide a warm home for husband, children, and elders if necessary. His work was front stage and hers was backstage; ideologically both were vital, but the wife was dependent on her husband's earning power... women were bound more tightly within the home-centered nurturing styles considered to be Japanese (Rosenberger 2001: 17).

An old Japanese saying, "Women should follow their men three steps behind" aptly describes the public performance of gender. My experience of playing a back-stage role in a Japanese company was washing tea pots and preparing tea and coffee for male colleagues every morning, while I was working as a sales representative. All young women in the office were expected to come around thirty minutes earlier than their official starting time to do this back-stage job for front-line male colleagues who held positions at the same level as them.

Teapot washing and tea preparation were not part of my official role. Whether young women fulfil this role or not had a significant impact on the male colleagues' impression of them. This impression often resulted in differential treatment of young female employees, although the treatment was often not related to career but to sexual desirability.

Traditionally for most young Japanese women, no matter what kind of job titles they are given, working in an office was a means of meeting husband candidates with financial stability. A Japanese expression "*koshikake* (sedentary)" disparages young Japanese female office workers. It means that they are only sitting in the office until they catch men. On the other hand, women who continue to pursue careers when they are over thirty years old

often become the targets of ridicule by male and younger female colleagues behind their backs.

A comment by Chika in my study explicates the Japanese interpersonal culture between men and women.

What your husband says does not bother you. However, exactly the same words could bother you if they were said by someone else.

This comment points to the connection between the Japanese gendered role performance, and the trust relationship between the members of a couple. This cultural preference may influence Japanese women's choice of using their English-speaking husbands as interpreters in interactions with health professionals outside the home.

Martin (2007) observed that Japanese housewives in the UK sent their children to full-time or Saturday Japanese schools. The most compelling reason for Japanese mothers to do so is to prevent their children from being 'behind' in preparation for passing "crucial examinations if they are to enter the high school of their choice in Japan and subsequently enter a good university" (Martin 2007: 88). Keeping their children 'on track' in the Japanese education system is one of the most important roles of Japanese housewives overseas.

I observed in Australia that Japanese women married to Australian men also send their children to Saturday Japanese schools. They do so to maintain the cultural tie to Japan even though the children have no intention of living in Japan in future. Sending children to the Japanese schools is more relevant to the Japanese mothers. Marrying English-speaking men does not completely westernise their subjectivities as Japanese women.

My child has attended a few different Japanese schools in Australia. There I met over 200 Japanese mothers married to native English speakers. Although there are a few exceptions, it is almost always Japanese mothers that take their children to the Japanese school, not

English-speaking fathers. Over the last six years, I have seen a handful of couples of Japanese men and English-speaking women at Japanese schools. I saw either of the members of these couples taking their children to the Japanese school at the same frequency.

The Japanese school community is broadly divided into two groups. One consists of Japanese mothers married to Japanese men. Most of the Japanese husbands are researchers or the expatriate employees of Japanese companies or the Japanese government. The other consists of Japanese mothers married to Australian men. The typical question women in either group ask when they meet a Japanese mother who is new to the school is “What is your husband’s job?”. An answer to this question reveals the nationality of the husband. My answer, “I don’t have a husband” often stuns them. It generates from them empathy, expressions of pity and apologies for asking the question.

With the exception of Miho, Japanese women partnered to English-speaking men in this thesis had had no established professions before they met their partners. Most of them continually moved between education, industries and holidays every few years. They studied in language schools and had working holidays in English-speaking countries, and went to private English conversation schools in Japan while working as part-time administrative or shop floor staff. According to Bailey (2006), Kelsky (2001) and Kubota (2011a), this life trajectory is common among Japanese women who find in the West a fantasy object of modernity. The researchers argued that this is an “eroticized practice” (Bailey 2006: 106) driven by their image of white, Western men in the “exotic fantasy space - romantic desire” (Kubota 2011a: 481), and is the merger of “the discourses of internationalism and erotic desire” (Kelsky 2007: 152).

Despite years of English training, Japanese women indicated that they have little confidence in engaging in complex conversations in English. Instead of using a professional interpreter,

their only preferred option is to use their husbands as language mediators. While this reflects the Japanese understanding of gendered behaviour in public interactions, it also may reflect broader cultural understandings of intrusiveness and contamination of the social order. In the next section, I examine Japanese cultural concepts of *uchi/soto* (inside/outside), and how they may apply to the behaviour of Japanese-speaking patients in medical consultations.

3.2 The Japanese concept of 'inside' and 'outside': 'family' and 'others'

Bachnik (1994) argued that the concept of *uchi/soto* is a significant behavioural determinant for Japanese people. According to Bachnik, it does not simply carry a spatial meaning in the same way as in its Western use. It defines the relational identity of each individual in Japanese society, in accordance with the social unit to which they belong (Bachnik 1992). With reference to Bachnik (1994), Ashby (2013) explained that the concept of *uchi/soto* is an important foundation of social interactions in Japanese culture.

[I]n the *uchi-soto* dynamic, the relationship between individuals and social order is mutually constitutive and contextual. It influences participants' speech and other behavior, including topics of conversation; but, these latter things also shape the social setting, so behavior and context constitute one another (Ashby 2013: 258).

In her fieldwork in rural Japan, Bachnik (1994) described a mother's shriek when she was informed by her son that he and his wife-to-be were arriving at her house several hours earlier than the scheduled time. For this mother, the sudden visit by a non-family member was disturbance to the social order because she was unexpectedly deprived of a gradual introductory phase in which she would have redefined a comfortable positioning for each participant of the communication. A visit by a non-family member outside the scheduled time overwhelmed the mother's ability to determine her behaviour within the given social context.

In an ethnography of patient-doctor communication in clinics and hospitals in western Japan, Ohnuki-Tierney (1984) drew on the concept of family and others as inside and outside to explain why the involvement of a patient's family in treatment is an important part of the Japanese health care culture. Ohnuki-Tierney described how Japanese patients and doctors make treatment decisions.

Decisions in Japan are often made collectively; sometimes even family members and close friends make major decisions for individual adults... In Japanese society, then, a diagnosis can be given to the family, which then takes the responsibility for the patient (1984: 67).

Observations of, and interviews with, post-stroke rehabilitation specialists in Japan by Slingsby (2006) also provided relevant findings. Slingsby found that relationship-centred care is indispensable to maintaining the patient's motivation for participating in the rehabilitation program, and that the successful involvement of the patient's family is the key to building a trust relationship between the patient and specialists in this setting.

Through an ethnography of organ transplantation in Japan, Lock (2002) found that the family is often the decision maker at the end of the life of the patient. Lock observed that "more often than not in Japan, it is patients' families, not physicians, who decide when the ventilator should be turned off once brain death has been declared" (Lock 2002: 39). While Japan is one of the countries which have adopted the most advanced technologies and techniques of Western medicine, it is often difficult to explain Japanese people's attitude toward health communication by drawing on Western norms about medical practice.

'Family' and 'others' as 'pure' and 'dirt' in the Japanese concept of health

Ohnuki-Tierney (1984) argued that there is a clear line between family and others in Japanese culture. She described how Japanese people treat family differently from non-family.

The Japanese attitude toward strangers is easily seen by the neglect or disregard of strangers in public places, such as on the bus. People seldom even exchange smiles or short conversation, unless it is a request for directions or has some definite purpose (Ohnuki-Tierney 1984: 40).

Ohnuki-Tierney (1984) drew on Mary Douglas's concept of *purity and danger* (1969) in exploring patient-doctor communication and the involvement of patient family members in health care in Japan. Ohnuki-Tierney (1984) argued that the line Japanese people draw between family and others divides the world into the pure and the contaminated.

[D]irt and germs, which the Japanese abhor, are those elements they can acquire through contact with *hitogomi* (people dirt). It is the other people's 'germs' that one tries not to inhale by using a mask. It is the dirt left by other people on money and in public places that is unclean" (Ohnuki-Tierney 1984: 49).

Many Japanese people wear facemasks in public spaces and public transportations. Ohnuki-Tierney explained this custom as "[i]t is the other people's 'germs' that one tries not to inhale by using a mask" (Ohnuki-Tierney 1984: 49). In Japan, facemasks with a wide range of scents, sizes and colours are available at supermarkets and general retail shops throughout the year (See Figure 1). The purpose of wearing a facemask for Japanese people is not only to protect themselves from other people's germs, but also to prevent themselves from spreading germs.



(Photo taken by the author)

Figure 1: A wide variety of masks available at a local Japanese shop throughout the year

Martin (2007) also pointed to the Japanese concept of purity and contamination, with reference to the account of a Japanese housewife who said that she does not like “other people’s dirty children” (Martin 2007: 82). An example of how the ‘family/others’ and ‘pure/dirty’ concepts are embedded in Japanese society is that second hand items are traditionally shunned by most Japanese people because they previously belonged to people outside their family, and are thus dirty. In particular, second-hand books used to be believed to be a source of tuberculosis¹ infection.

In contrast, the circulation of items within the members of a family is imbued with a completely different meaning. Passing hand-me-down clothes within a family, for instance, is part of Japanese tradition. Adults sometimes praise children wearing such clothes as being respectful of the family bond and considerate of the family’s finance. In Australia, I have seen the uniform shops of local schools selling second-hand items donated by the current and former students. I never saw this happening in schools in Japan during nearly thirty years of my life in the country. Instead, I saw as a school student some of my classmates wearing and using uniforms and items which used to belong to their older siblings.

While Ohnuki-Tierney linked Japanese people’s dirt-avoidance and their fears for infections from strangers, in Douglas’s words, the avoidance of dirt does not necessarily derive from fears for infection or contamination (Douglas 1969). Douglas posited pure as order and dirt as disorder.

In chasing dirt, in papering, decorating, tidying, we are not governed by anxiety to escape disease, but are positively re-ordering our environment, making it conform to an idea. There is nothing fearful or unreasoning in our dirt-avoidance: it is a creative movement, an attempt to relate form to function, to make unity of experience (Douglas 1969: 3).

¹ Given the established evidence that TB is an air-borne disease, this belief exemplifies metaphorical meanings associated with the disease - see Susan Sontag’s *Illness as Metaphor* (1983).

According to Douglas, the avoidance of dirt is a positive act of reordering the environment, rather than protection from the violation of order.

It is commonly seen in Japan that a patient sends their family member in place of them to their doctor. Ohnuki-Tierney (1984) observed a number of patients sending their family members to their doctors on their behalf. The doctors prescribed medicine for the patients and gave their representatives prescriptions in the same way as they usually do directly to the patients. The doctors accepted such an arrangement as part of their normal procedures insofar as they had previously seen the patients in person and had been familiar with their health issues. Ohnuki-Tierney described this arrangement as “surrogate patients” (*ibid.*: 179). The relationship between the patient’s proxy and the doctor is an extension of the relationship between the patient and the doctor, and *vice versa*. The custom of ‘surrogate patients’ is a constructive act through collaboration between the patient, the patient family member and the doctor. It maintains and reinforces social coherence in the interaction.

3.3 External interpreters: disturbance to order

Saki’s account suggests that a Japanese patient can become confused and feel a great deal of stress when an individual who does not belong either to the patient’s family or the health care organisation is involved in the treatment procedure. Saki is a mother of two teenage girls. She has been in Australia for over a decade since her Japanese husband found a job in this country. Saki was not proficient in English, and therefore had often faced communication difficulties in Australia.

One evening, Saki’s younger daughter had an asthma attack, which required urgent treatment. She visited a GP, who said she was so unwell that she needed an immediate ambulance. Saki’s offer to drive the child to hospital herself was overruled, as the GP called the ambulance. On the way to the local hospital by ambulance, a member of the ambulance

staff asked Saki whether she would like them to call an interpreter. Saki turned down the offer. She explained to me why she made this decision.

I was confused, and didn't want them to call an interpreter. I wonder what they meant. Would it have been on the phone? It was an emergency situation. I don't think that an interpreter could come in time. I didn't know how long it would take for an interpreter to come. It was an emergency situation. I could tell that the GP's face suddenly changed. I thought that there was no time to call an interpreter. I was asked again whether I would need an interpreter after an oxygen mask was put on my daughter. I answered, "No".

In this account, Saki gives a number of reasons why she declined a professional interpreter, saying "I can speak for myself". She is aware that her daughter is very sick, and the situation itself is rapidly changing – an ambulance has come to the GP surgery, and her offer to take the child to hospital herself has been rejected. Saki is in fact aware that there are telephone interpreters who can be accessed rapidly, but she declines this offer.

The social and contextual position of each individual in the ambulance was clear to Saki. If an external interpreter had been called, Saki would have needed some time to redefine the relational social positions of the parties in the ambulance. This is similar to the scene of the mother's shriek in Bachnik's study (1994).

The ambulance staff probably did not perceive an external interpreter, who could be obtained over the telephone in under five minutes, in the same way as Saki did. For the ambulance staff, externally sourced language support was nothing more than part of inter-professional health care delivery. As in the case of the mother's shriek in Bachnik's study, it is difficult for those, including some Japanese people, who are outside this kind of social boundary to notice how much effort is required for this re-definition work. Thinking about redefining the relational balance between the involved parties was an extra burden on Saki. She did not consider that a professional interpreter would simply be a source of language support. For her, they would be a cause of confusion and stress.

Saki's rejection of the offer did not necessarily mean that she needed no communication support, although the ambulance staff probably interpreted her response in this way. Her concerns lay in a different domain. Saki was more concerned about the issue of comfort within the social boundary. The suggested means of communication intervention by the ambulance staff was not aligned with Saki's intuitive expectations of communication in her perceived social order. Her rejection of the offer was an act of maintaining order.

Prior to this instance, Saki had on one other occasion, spoken through a professional interpreter on the telephone. The conversation was not about health issues but government-funded English lessons to which newly arrived permanent residents in Australia are entitled. The English speaker to whom Saki was talking called an interpreter. In this instance, Saki learned what it was like to speak through an external, professional interpreter. Saki did not like the interpreting service.

It was really confusing. The person I was speaking to on the phone suddenly said that she was going to call an interpreter. She said, "One moment, I'll call an interpreter", and an interpreter joined the conversation. I got more confused [laughs]. The interpreter spoke very fast, and was interpreting quite literally. I kind of understood what he was saying. However, I was confused, not knowing who I should respond to. I was speaking to an Australian lady. She decided to call an interpreter. I'm not sure whether the interpreter was a volunteer or professional. It suddenly started, without any introduction. The Australian lady suddenly decided to call an interpreter without explaining anything to me. The interpreter suddenly cut in. The conversation just began like a storm. I was surprised and wondering, "What on earth is this?". I would have understood the conversation if I had been calm. I was really confused because there was an English-speaking person and a Japanese-speaking one. My brain literally stopped working. I was only wondering, "Who are you?". I remember that I was drained after the conversation. I remembered nothing following the conversation.

Saki's vivid account – peppered with repeated expressions of wonderment that a Japanese speaking person had suddenly intruded on the conversation without any warning – does not question the technical skills of the interpreter. The interpreter provided a prescribed service competently. The reason for Saki's negative impression of the interpreter was because of

the disturbance which she thought the interpreter brought to the social balance in the interaction.

This is a typical telephone interpreting session in Australia. While this communication method was familiar to the English speaker and the interpreter, it was not to Saki. She had no idea about how she was supposed to act in the conversation. She was so confused that she could not even think of asking the interpreter or the English speaker how she was supposed to speak. In contrast to this unpleasant experience with an external interpreter, Saki has also experienced successful mediation by a different type of communication mediator. The determinant of success in this encounter was not the technical skills of the mediator but her position which Saki recognised logically – in a Japanese sense – situated in the social context.

In this encounter, a Japanese-English bilingual woman helped Saki communicate with her daughter's paediatrician. The woman who acted as an interpreter was a daughter of the paediatrician seeing Saki's daughter. The paediatrician's daughter was not a credentialed interpreter. When the paediatrician realised that Saki is Japanese, he rang his daughter to ask for communication support.

It was when our second daughter underwent surgery. Her paediatrician said, "You might want to speak in Japanese because you are Japanese". He said that his daughter was in Japan, and that she was fluent in Japanese. He offered that he would ring her. I said, "No thanks". Perhaps he just wanted to talk to his daughter. We ended up speaking with her on the phone. We just had a general chat [laughs]. It helped us create a rapport. We understood that the doctor didn't have discrimination against us and that he was relatively friendly.

Saki thought that this intervention made her less nervous. The paediatrician's daughter did not actually 'interpret' the conversation. Instead, she helped Saki and her daughter's paediatrician build a rapport through friendly intervention. Saki did not recognise this interpreter as similar to the telephone interpreter in the previous instance. Saki positioned the paediatrician's daughter inside the boundary of family. This positional definition of

social dynamics has a crucial impact on the relationship between the Japanese patient, the interpreter and the clinician. Once all the sources of disturbance to order were removed, Saki was able to communicate with the paediatrician with little difficulty. This example suggests that what a Japanese-speaking patient needs may not always be accurate and impartial language rendition, but a set of signs and actions to redefine the positions of the involved parties in the social context.

3.4 Reliance on English-speaking partners

Saki, who is married to a Japanese husband, is willing to use her daughters as interpreters if need be. None of the Japanese-speaking women married to native English speakers indicated a possibility of speaking through family members other than their husbands. Most women said that they would never use a professional interpreter. Chika stipulated a number of requirements for a professional interpreter, including the accuracy of language rendition. She was nevertheless not willing to choose this option over her husband. Emi, another Japanese-speaking informant married to an English-speaking man, criticised a professional interpreter she met for her lack of accuracy in interpreting, while she did not mention this aspect when she described interpreting by her husband. The accounts of Chika and Emi on cross-linguistic medical encounters provided a different perspective which deepens an insight into the suggestion from Saki's account that Japanese women tend to avoid disturbance to the social cohesion in the context.

Trust relationships and social boundaries in cross-linguistic medical encounters

Chika has experienced several Japanese-English medical encounters in the USA and Australia. When she was in the USA, her young son was diagnosed by his paediatrician with Blount's disease (*tibia vara*), a condition in which a young child may have a bowleg deformity (LaMont, Fragomen & Rozbruch 2015). Her son was then referred to an orthopaedist.

The orthopaedist told me that our son had to wear a brace to straighten the legs. I wasn't really convinced. The orthopaedist never took into account the possibility that his legs might become straight without wearing a brace. He was afraid of being responsible for the consequence if his legs would end up remaining bent as a result of not wearing the brace. The orthopaedist insisted on an immediate start for the procedure. He only mentioned the risk of deterioration. He said, "Your child has to start wearing the brace; otherwise, his legs will be more bent. We might end up having to perform osteotomy to straighten them". This was a totally different idea from what I would expect to hear from a Japanese doctor. If it was in Japan, I'm sure that the doctor would say that they would leave the legs as they are for now. They would observe them to see how it goes. They would ask you about your familial history and other related questions. My husband also had bent legs when he was little.

Chika thought that the orthopaedist's opinion reflected his own interests, not care for her child.

I think that the orthopaedist didn't want to be sued by us in the case if my son's legs remained bent when he grows up. He didn't want us to sue him, saying that it was his fault that he didn't perform an appropriate procedure. People told me later that doctors in the USA would choose the safest option. They need to be prepared for lawsuit cases so that they can provide the evidence of what they have done.

Chika did not want to accept the orthopaedist's opinion because a physical intervention is the last resort in Japanese culture. Chika was concerned about the social implications of wearing a brace on her son's life. A brace would make him visually conspicuous, and different from other people.

Being different from others in Japan, no matter whether it is in a positive or negative way, is likely to have adverse social implications. A Japanese saying, "The nail that sticks out gets hammered in" suggests that being unique is not a valued characteristic in Japanese culture. Instead, being the same as other Japanese people is the most valued concept. A prominent example is the "marriageable age" – an expectation that all women should marry at a certain age. Other examples include the mass recruitment of new graduates by Japanese companies in April every year², and the *nenkō jyoretsu* (the age-based order) promotion system, in which promotions occur at certain ages, irrespective of merit. In Japan, university

² In Japan, students graduate from schools and universities in March.

students start applying for jobs more than a year before graduation and secure the positions more than six months prior to graduation to be ready to start working all together in April. If they miss this time, their career start will be postponed to the subsequent year. If a student fails to secure a job to commence in the coming April, the unemployment period will have a critically negative impact and significantly reduce their competitiveness in the job market. Some students therefore intentionally fail university courses to postpone graduation to keep them as competitive as possible. Many Japanese companies pay attention to whether the applicant still belongs to the university at the time of job application, more than the applicant's academic achievement.

Most Japanese people start developing a sense that being the same as everyone else is a virtue, through group education from preschool ages. Peak (1989) found that Japanese children learn to refrain from expressing their independent desires so as not to disturb harmony in the group to which they belong. Peak described this group-focused notion that “[i]ndividuals are expected to assume these appropriate attitudes and behavior, almost as one would a suit of clothes, for the duration of their active participation in the group” (Peak 1989: 94). Differences and diversity are considered to be the cause of disharmony in a Japanese group environment (*ibid.*).

Chika's husband was present at the consultation about her son's knees. He understood the reason why Chika did not want to accept the doctor's opinion. He explained Chika's opinion to the doctor. I asked Chika whether she would consider using a professional interpreter. She has never used a professional interpreting service. Although she did not clearly reject this option, she was not enthusiastic about the option. Chika explained to me the difference she sees between an external, professional interpreter and her husband.

The members of a couple regularly communicate with each other. What your husband says does not bother you. However, exactly the same words could bother you if they were said by someone else. We have the same stance towards our children's health. We both want to take what we believe the best possible option.

But I wouldn't know the background of a professional interpreter. They wouldn't know the patient's background, either.

Chika did not consider that an external interpreter would understand or communicate her concerns about the cultural implications of being different on the life of her son. As in the paediatrician's daughter acting as a communication mediator in Saki's case, the communication intervention by Chika's husband was not through accurate language rendition. She relied upon him because they shared contextual knowledge and a view toward health. Chika's trust in her husband allowed him to effectively mediate the communication which did not leave her in doubt that she might have been treated unfairly because of the language barrier.

This finding resonates with that from a study conducted by Legido-Quigley, McKee and Green (2014) on the relationship of trust between the English-speaking British patients and their Spanish doctors. Their study showed that trust is the important foundation of the relationship between the patient and their doctor and between the patient and the entire health system. In their study, interviewed patients did not show deep trust in a professional interpreter. The informants considered that a professional interpreter "may be rationally trusted to do a competent job but, given that the task was undertaken in an exclusively service relationship, the faith element indicated by making an effort could not be demonstrated" (*ibid.*: 1251). Their study indicated that the Spanish doctors gained trust from their British patients by showing their commitment and sincerity by making an effort to provide care to the patients.

The accounts of Saki and Chika suggest that a Japanese-speaking patient may consider it important to maintain social and relational cohesion in the context, by avoiding disturbance which they think an external interpreter may cause. In the cases of both Saki and Chika, the concept of order/disorder was a useful tool of inquiry into the choice of the interpreters by Japanese-speaking patients. The difference between Saki and Chika is the degree of

exclusiveness in choosing a communication mediator. While Saki is relatively open to a wide range of possibilities, Chika has an exclusive preference for her husband. I observed the same tendency as that of Chika in other Japanese-speaking women in this thesis. The following section analyses their exclusive preference for their English-speaking husbands as the communication mediators.

Accuracy of language rendition and interpreter preference

Emi is a Japanese woman in her thirties. She has communicated with her English-speaking doctors with the help of her English-speaking husband and also professional interpreters on different occasions. Emi said that her husband fully understood her needs and intention as well as her symptoms, and therefore effectively communicated them to her English-speaking doctor. She criticised professional interpreters she used for failing to do so. Emi described a case in which she lost her trust in a professional interpreter when she found that the interpreter summarised what she said.

I know it's offensive to say, but I have a doubt about the interpreter's English and interpreting skills. I asked the interpreter to tell the doctor what I want to say, but it's never fully understood. My husband was listening to us and was not happy. He said, "Why does that interpreter get paid? You would communicate better if you would directly talk to the doctor by yourself". Although I asked the interpreter to tell the doctor that I underwent angiography and many other investigations in the past, she couldn't come up with the equivalent words, and just said, "I did all that I could do". At that time, I didn't want the interpreter to say, "I did all that I could do". I wanted her to say specifically what I underwent because I thought that it would be important to let the doctor know this specific information.

Emi did not consider that shortcomings in the Japanese proficiency of her husband affected the effectiveness of his communication intervention, whereas she thought that an error – the summarisation – by a professional interpreter did.

Chika also mentioned the language proficiency of an external interpreter when she answered my question about whether she would consider using a professional interpreter.

If a total stranger simply does interpreting, the communication depends on the interpreter's technical skills. It's difficult to interpret complex conversation. In particular, an interpreter cannot do interpreting unless they understand the two languages, and the fine nuance of Japanese and that of English, right? In medicine, if it hurts, an interpreter needs to say how it hurts such as it is *jin-jin* [a Japanese onomatopoeia describing dull pain accompanied by numbness] or *zukin-zukin* [a Japanese onomatopoeia describing strong pain continuing intermittently].

Emi and Chika prioritised trust they felt in their husbands over communication accuracy.

Emi's husband spoke halting Japanese; and Chika's husband, while fluent in everyday Japanese, did not have the technical language skills of a professional interpreter. Both Emi and Chika held professional interpreters to a higher standard of linguistic competence than they expected of their husbands, and justified rejecting professional interpreters on this basis.

An interpreter is not a machine or dictionary, and it is often the case that they come across technical words that are beyond their vocabulary. This is particularly the case in Australia given that there are no recognised specialist categories of practice for professional interpreters. There are situations in which an interpreter may need to pause and consult a dictionary or ask the speaker to paraphrase a technical term with simpler words. They may also need to adopt the next closest words to the original statement if they cannot come up with an equivalent term within a few seconds. Emi's account suggested that a Japanese woman partnered to a native English speaker may view modifications to statements by a professional interpreter differently from modifications by her partner.

The difference between Saki, who is married to a Japanese man, and Chika and Emi, who are married to English-speaking men, was the strength of the social boundaries they established in cross-linguistic encounters. All of them recognise a professional interpreter as an 'outsider' to their social boundary, and therefore the cause of disorder to social and relational coherence within the boundary. Compared to Saki, Chika and Emi were essentially

willing to accept communication intervention only by their English-speaking husbands.

Boundaries they drew are slightly different from those drawn by Saki.

Saki was more open to communication intervention by different kinds of people, such as the doctor's daughter. She also described how her bilingual daughters communicate in English-Japanese cross-linguistic conversations. Although Saki did not clearly indicate that she relies on her daughters in cross-linguistic medical encounters, her account carried a slightly different nuance from that which Japanese women partnered to English speakers did. They gave little or no description of how other members of their family, including their Japanese-English bilingual children, communicate in Japanese-English encounters.

While many Japanese women partnered to English-speaking men in this study probably have 'liberated' themselves, in the words of Kelsky (2001), through international marriage, their exclusive reliance on their partners suggested that they may still be subject to the culturally constructed gendered image of Japanese women. They may be unconsciously, and paradoxically, reinforcing their liberation through 'marriage' to 'Western' men, by choosing only their husbands as interpreters.

Good Japanese wives as quiet attendants to their English-speaking husbands

So far, I have analysed the accounts of Japanese-speaking patients through considering and applying the concepts of order and disorder and the gendered role of Japanese women. I now provide comparative cases of English-speaking patients married to Japanese women. Their accounts shed light on differences in two aspects between these English-speaking informants and Japanese-speaking ones. The first aspect is the concept of social and relational coherence; and the second is the gendered perception of communication support.

Hamish is an Australian man in his sixties. He has undergone surgery several times at a few different hospitals in Japan. Hamish is married to a Japanese woman. He said that his wife

sometimes accompanied him to medical consultations, but did not mediate the communication. Hamish always communicates with his Japanese doctor by himself, even though he occasionally misses information. He never expects his wife to act as an interpreter.

I think I had three or four operations in a hospital here, and also in Tokyo. I have a hand problem. I have to have operations, sometimes. I had one two... about six or seven, I suppose. But they are usually day surgery. I had a couple of hernia operations. None of them were terribly serious. However, I had to stay in hospital. I had one operation in this prefecture. Explanation was usually quite long and detailed. They used quite a lot of medical terms. I mostly understood them. If I have an operation, my wife usually comes with me to the hospital. If necessary, she comes with me to the explanations because we are a couple. She has to understand, I have to understand. We have to understand together.

I asked Hamish whether his wife explained the doctor's explanation to him. He replied, "Not really, sometimes I explain to her [laughs]". I also asked him whether he thinks having a Japanese person in a consultation with a Japanese doctor would change the atmosphere of the encounter. He indicated that the presence of his Japanese wife had no impact on the communication. These responses were completely opposite to those given by Japanese-speaking women.

Japanese-speaking women drew a social boundary to segregate family from strangers to maintain social and relational coherence. The boundary Hamish established worked in another way, in which he did not allow his wife to mediate the communication. His account suggested that he drew a boundary to maintain his agency. Unlike Japanese-speaking patients, I did not observe in Hamish's account that he was concerned about the relational positioning of participants centring on the concept of *uchi/soto*.

Hamish's account provided me with an alternative interpretation of boundaries drawn by the patient in a cross-linguistic medical encounter. Hamish's exclusion of his wife may not be solely by his own choice, but also reflected his wife's preference. Given the gendered role of Japanese women, it might be the case that his wife, performing the role of a good

Japanese wife, chose to be subordinate to her husband. Hamish's understanding of the position of his Japanese wife in medical encounters was different from Japanese-speaking women's understanding of the position of their English-speaking husbands. These Japanese women emphasised that it was important for them to share contextual knowledge and a stance toward health with the communication mediators. On the other hand, Hamish did not seem to find it necessary for him to share such aspects or take a collective approach with a potential communication mediator, though he did feel his wife should be with him so that two of them understood the outcomes of the consultation "as a couple".

Hamish occasionally missed information given by his Japanese doctor because he did not receive any communication support. He said that it was his responsibility to ask them for clarification.

They always ask you to sign [an informed consent form prior to surgery]. "Did you listen to the explanations and did you understand it?" I signed it. However, I probably didn't fully understand. Since it involved no cutting, I thought it was good. However, it might have been better if I had got more information on it. But it's not the *sensei's* (doctor's) fault. It's my fault, although they used lots of technical terms. When I did not understand them, I asked questions to the doctor, "*Sensei, koko wa yōgo dewa nakute setsumei shite kudasai* (Doctor, could you please explain this to me, not just in technical terms?)".

Matt, Ray and Adam indicated a similar attitude to that of Hamish. These English-speaking informants are also married to Japanese women. As in the case of Hamish, Matt and Ray were accompanied by their wives to medical consultations in Japan. The wives of Matt and Ray provided some basic communication support, but did not mediate the conversations to an extent indicated by Japanese women describing communication mediation by their English-speaking partners. Adam has never taken his Japanese wife with him to his doctor appointments in Japan.

All these English-speaking informants did not actively avoid communication intervention support to talk to Japanese clinicians. They accepted in the abstract that they might need it

if they found it necessary. They were not as selective about the type of communication mediator as Japanese-speaking women were. Ray's comment summarised the overall attitude indicated by other English-speaking informants.

Sure, why not. I would have to accept [any kind of communication support]. I would have to accept it for what I can't do by myself. They wouldn't have a choice of interpreters [laughs].

In general, however, they did not seek communication support because they were confident of their Japanese language skills. All four English-speaking informants have medium to high levels of Japanese proficiency. All Japanese-speaking informants, except for Yuta, also have medium to high levels of English proficiency. Japanese women were not as confident in speaking to English-speaking clinicians as these English-speaking informants were in speaking to Japanese-speaking clinicians. Language in a technical sense may not be the reason why a patient, particularly a Japanese patient who is relatively fluent in English, may need a communication mediator. More importantly, the decision and behaviour of English-speaking men and their Japanese wives in this thesis reflects the gendered notion of behaviours in marriage by Japanese women.

3.5 When a spouse cannot provide cross-linguistic support

My analysis so far has been focused on the tendency for Japanese-speaking patients to rely on their partners, particularly Japanese women partnered to native English speakers. I now turn to two cases that offer contrasting experiences, of Japanese speakers who welcomed professional health care interpreters. They are the accounts of a single Japanese woman in her thirties and a Japanese man in his sixties married to a Japanese woman.

“I prefer a professional interpreter to my family member”: the case of a single Japanese woman

Yoko is an independent woman. She has worked in a few Japanese companies straight after obtaining a bachelor’s degree from a Japanese university. She owns a residential unit in the central Tokyo area, and enjoys overseas holidays several times a year. She enjoys her current status of being single. She is not keen on talking about marriage and relationships.

Yoko studied English in secondary and tertiary education in Japan. She can communicate basic ideas in English, but has difficulty exchanging complex information in English, including health information. She told me about her experiences of Japanese-English medical encounters in India and the Philippines. In India, she suffered from food poisoning; and in the Philippines, she suffered from tonsillitis. In both situations, Yoko did not have access to sufficient language support.

I travelled in India with a local guide. One evening, I went out for dinner by myself. I had what the local people called ‘continental dinner’ at a restaurant. In the evening, I felt sick and had strange sweating and a fever. I went down to the reception of the hotel where I was staying, and collapsed there. Indian guys came up to me asking, “Are you OK?”. They were the staff members of the hotel. They called a doctor for me. When the doctor came, the interpreter, I mean, my guide, wasn’t there. So, I could hardly explain my symptoms. I mostly did by gesture. The doctor said that my symptoms were typical of patients suffering from food poisoning. He gave me an injection without asking me anything. I was scared of having an injection overseas. I didn’t know what was in it, and whether the equipment had been sterilised.

Yoko continued on to tell me about another experience of Japanese-English medical encounter in the Philippines.

I went to see a doctor when I was suffering from pretty bad tonsillitis. I knew that I wouldn’t get any better if I couldn’t get antibiotics. I looked up an English dictionary, but couldn’t explain my symptoms and the medication I needed to the doctor. It turned out that the clinic didn’t have antibiotics. The place was like a really small local clinic. I was wondering whether the doctor was really reliable. I put up with the symptoms till I went back to Japan. I had fevers about three times in the week until I left. My body temperature was about 39 °C.

In both cases, Yoko simply indicated that she would have appreciated any kind of language support, including a professional interpreter. I asked Yoko whether she would prefer an interpreter who was originally from Japan to those who were not, but could speak Japanese:

I would prefer a local person, I just feel so. I would like the person to fluently speak the local language. I prefer a person who can make what I am saying understood by the doctor in their local language.

As with the other Japanese-speaking patients, Yoko did not consider that the main role of a health care interpreter is necessarily accurate language rendition. Her account suggested that she considered that it is more important that the interpreter and the health professional have a smooth conversation than that the interpreter makes Japanese cultural concepts understood by the health professional. Yoko was very open to the foreign culture, and was ready to accept its communication norms. Her account did not suggest the order/disorder boundary or the image of a good Japanese woman.

Yoko also said that she would prefer a professional interpreter to family members.

I might feel easier to be with an external, professional interpreter because I can explain to them my situation in an objective way. The interpreter would also explain to the doctor in an objective manner. If I was with my family, I would be more emotional. I would say things emotionally like, "It hurts! You know, it hurts!" [laughs]. So, I think, in my case, communication would work better if it would be dealt with in a more business-like manner.

Yoko's comment indicated an opposing view to that of other Japanese-speaking women.

Unlike those partnered to English-speaking men, Yoko did not mention the feeling of peace of mind; rather, she suggested that having a family member in the consultation may increase her expression of emotional distress, perhaps interfering with social cohesion.

“I appreciate both my son-in-law and the professional interpreter”: the case of an older Japanese man

Yuta’s view on health care interpreters was similar to that suggested by Yoko. Both Yuta and Yoko were willing to receive communication intervention whenever available. The difference between Yoko and Yuta included gender, age and the severity of condition.

Yuta is a Japanese male in his seventies. He suffered from serious acute gastric symptoms, and was hospitalised in an Australian local hospital as an emergency case. This event occurred while he was visiting his daughter from Japan. His daughter is married to an Australian man and lives in Australia. Yuta has limited English proficiency, and he has never undergone formal English training. He said that schools barely taught English when he was a school student in the 1940s and 1950s. Yuta needed language support when he fell sick and needed to see a doctor in Australia. When Yuta saw a GP prior to admission to a hospital, his English-speaking son-in-law, who is also fluent in Japanese, accompanied him. Yuta said that he also spoke through a professional interpreter on the phone during his stay at the hospital.

Yuta was one of the only two male Japanese-speaking patients in this study, and one of the few who provided an account of an emergency consultation for himself.

It was twelve years ago. I visited my daughter. She lives in Australia. I spent about one month at her place. Two days before my scheduled return day to Japan, I felt very tired when I woke up in the morning. I could not get up. I was very worried because I did not know what was happening to me. I had to see a doctor. I was told that I had to see a GP first, so I asked my son-in-law to take me there. He speaks very good Japanese. My son-in-law explained my symptoms to the GP. I assume that it would be difficult for a person who only speaks an intermediate level of English to do this. I wouldn’t be able to get my symptoms understood by the doctor if I had not had my son-in-law with me.

I received an explanation on my symptoms and a referral letter to a hospital. Thereafter, we went to a local public hospital straight away. They quickly diagnosed me and decided to admit me. They diagnosed me with reflux oesophagitis, which damaged the junction of my oesophagus and stomach, caused bleeding and anaemia.

They arranged an interpreter on the phone. With the help of the interpreter, I was also able to tell my needs to my doctor. What I clearly remember is that I needed to have a lot of blood transfusion, and that they were urgently trying to find a blood transfusion specialist. It goes without saying that an interpreter is extremely important in serious cases like mine. I am certain that both my son-in-law and the interpreter on the phone were absolutely necessary for me because my symptoms were life-threatening.

Yuta mentioned that he was certain that effective communication is vital in treating a patient who is suffering from severe symptoms and who does not share language with their doctor. For him, “effective communication”, embraces both linguistic accuracy and cultural sensitivity. Yuta equally appreciated communication intervention by his son-in-law and professional telephone interpreters. He did not draw the order/disorder boundary nor was he subject to a particular gendered notion of reticent behaviour expressed by some of the Japanese-speaking women. As with Yoko, he was open to any kinds of language support. As in the cases of other Japanese-speaking patients, Yuta’s son-in-law did not only perform interpreting but also advocacy for Yuta. His son-in-law explained his symptoms on his behalf. He also arranged the visit to the GP for Yuta, and escorted him there.

Yuta appreciated both types of communication mediation primarily because his symptoms were life-threatening. However, Saki’s account of the time when her daughter was having a serious asthma attack suggests that even when a condition is serious, there may be a preference not to use a professional interpreter. In her case, the emergency context seems to have exacerbated Saki’s desire to establish a familiar social boundary around family which excluded the interpreter.

Garrett and her colleagues (2008) analysed the correlation between the level of complexity of the patient communication needs and the likelihood of the use of a professional interpreter in New South Wales, Australia. The researchers recruited participants through convenience sampling based on hospital records which showed the patients’ preferred

languages being other than English. The participants consisted of the speakers of Arabic, Spanish, Italian, Greek, Cambodian, Vietnamese, Chinese, Croatian or Serbian.

While the researchers found that there was a tendency for a professional interpreter to be used when the level of complexity of the patient's communication needs was high, they also found many exceptions, suggesting that there were other factors determining the use of a professional interpreter. The researchers also found that a professional interpreter was likely to be used when the patient's family member was present.

Interestingly, the regression analysis showed that patients were 11 times more likely to have a professional interpreter when family and bilingual staff were used to interpret and that patients whose family visited them in hospital were three times more likely to have a professional interpreter (Garrett et al. 2008: 214).

This is a rather counter-intuitive finding; patients who have one form of communication support are more likely to be given another. All these patients had been admitted to hospital, so they had a certain level of acuity. In hospitals in Australia, the decision about using an interpreter is made by the health care staff, not the patient. Patients who do request interpreters often find that their requests to use interpreters are not followed through for a range of reasons from logistics to lack of knowledge by the doctors.

While Garrett and her colleagues did not provide an analysis of the relationship between the presence of a patient's family member and the use of a health care interpreter, it is possible that the presence of a patient's family member or a hospital staff member may change the dynamics of the patient's perceived social position. It may be that requests by patients' families for interpreters are more likely to be followed through. Alternatively, doctors may wish to use interpreters to clarify a message being refracted in different ways by family members.

3.6 Communicating through family members: a risky option?

The tendency among Japanese-speaking patients is contrary to what much of the literature on interpreter-mediated communication, discussed in Chapter 1, suggests. The literature encourages minimising the use of an interpreter who has not undergone formal training or obtained a professional qualification (Brough 2006; Elderkin-Thompson, Cohen & Waitzkin 2001; Flores 2005; Flores et al. 2003; Karliner et al. 2007; Youdelman 2013).

In particular, interpreting by a patient's family member is often the subject of criticism. Youdelman states that "[t]he use of untrained family members and friends to interpret for non-English-speaking patients has been associated with omissions, additions, substitutions, volunteered opinions, and semantic errors" (Youdelman 2013:115). She referred to Quan's report (2010) as the basis of her statement. Quan's report (*ibid.*) showcased serious and fatal consequences which he considered to have been caused by the use of a patient family member as an interpreter. However, a number of uncontrolled variables which go beyond the interpreting skills of the patient family members appear to have contributed to the tragic consequences.

In addition to the cases quoted from Quan's report (*ibid.*) in Chapter 1, his report includes cases in which: a 17-year-old female patient was made to interpret the conversation between her family and doctor while she was suffering from a fever after being hit in the head with a tennis racquet, and she continued interpreting until she fell into respiratory arrest; the father of a 7-year-old boy who was suffering from arterial inflammation interpreted the conversation although the father had little formal education and spoke limited English; and the husband of a 90-year-old patient who was suffering from dementia served as an interpreter even though he was almost deaf.

The critical cause of tragic consequences in these cases is that no competent interpreter was used, rather than the fact that the interpreter relied upon was the family member. These

cases do not necessarily prove that patient family members are incompetent interpreters. Attributing the errors to the membership of the patient's family, rather than to their linguistic or physical inability to communicate, apportions some contributory blame to the family member, when the fundamental problem was the failure of the clinician to select a competent language mediator.

In a report on strengthening health care interpreter use in primary care in Canada, Hoen, Nielsen and Sasso (2006) argued that it is not desirable to use a patient's family and friends as interpreters, though they are often the preferred option by patients and clinicians.

[P]ractitioners rely on family and friends to provide interpreting, in part because they believe that patients may prefer and feel more comfortable involving someone known to them. Many do not appear to be aware of the limitations of interpreting by family and friends. (Hoen, Nielsen & Sasso 2006: 18-19).

The evidence cited in this report relating to family use cites research evidence of linguistic errors, and the risks of partial communication from family members. This chapter suggests that Japanese patients may not view family members as risky, but rather as risk-mitigators, in cross-linguistic medical encounters. Findings from a study by Gray, Hilder and Donaldson (2011) referred to in Chapter 1 strongly support findings in this chapter.

3.7 Summary

In this chapter, I analysed the accounts of patients about their experiences of Japanese-English medical encounters, in order to shed light on their understanding of health care interpreters. There was a significant gender imbalance in Japanese-speaking patients – women outnumbered men in the Japanese-speaking patient group. The culturally constructed moral image of good Japanese women may be perceived as a constraint by Japanese women, but even those who marry outside of Japanese culture tend to prefer their husbands to mediate for them in cross-linguistic cultures.

I drew on a number of concepts related to social boundaries which people may draw in interactions with others: the concepts of inside/outside, pure/contamination, and order/disorder. Firstly, a patient may draw a boundary around participants in a cross-linguistic medical encounter, in order to maintain social and relational coherence in the context. The understanding of such coherence varied between patients, and may or may not include professional interpreters. Secondly, the reason why a patient may need a health care interpreter is not necessarily related to linguistic proficiency. There are significant gender and cultural implications underlying the patient's choice of the communication mediator. Thirdly, strong preference for partners over professional interpreters was a tendency found exclusively among Japanese-speaking women partnered to English-speaking men. Fourthly, the severity of condition, rather than the level of language proficiency may be a more significant determinant for a patient to use a professional interpreter.

The understanding of the role of a health care interpreter varied between patients, depending on their gender, and social and cultural backgrounds. The analysis clearly indicated that the perceived role of mediators providing good communication support in Japanese-English medical encounters was unlikely to be limited to accurate and neutral language rendition. A patient's refusal of a professional interpreter does not necessarily mean that the patient, or their chosen communication support, has proficiency in two languages. In the next chapter, I analyse Japanese-speaking patients' perceptions of the English language, and the implications for these patients' views on receiving language support in Japanese-English medical encounters.

Chapter 4 Being embarrassed by professional interpreters: English as symbolic capital

This chapter examines the socially and politically constructed perception of the English language among Japanese people. I investigate its implications on Japanese-speaking patients' views on receiving English language support in Japanese-English medical encounters. This chapter takes into account relational factors found in the preceding chapter. I compare the views of Japanese-speaking patients on proficiency in the English language to those held by English-speaking patients on the Japanese language and receiving Japanese language support.

In this thesis, the proportion of Japanese-speaking patients who have undergone formal English training was significantly greater than that of English-speaking patients who have undergone formal Japanese language training. Out of a total of sixteen Japanese-speaking patients, fifteen have undergone formal English training. On the other hand, out of a total of fifteen English-speaking patients, five have undergone formal Japanese language training.

Another noteworthy difference between these patient groups was the environment in which they underwent training for the respective language. All Japanese-speaking patients who have undergone formal English training started to regularly study the language in secondary school. The environment of learning the Japanese language varied among English-speaking patients. Two (Sharon and Cathy) started studying the language in secondary school. One (Adam) learned it from a private tutor as a little child. Two (Audrey and Hamish) learned the Japanese language in university. The remaining informants have never undergone formal Japanese language training, including those married to Japanese women and living in Japan (Matt, Nick and Ray).

The degree of interest in the relevant language also varied among patients. All Japanese-speaking patients suggested that they started studying the English language regardless of

their interest. Their exposure to the English language was not because they were interested in it but because they had to study it as a compulsory school subject. All English-speaking patients indicated that they studied the Japanese language because they had been interested in Japan. Out of sixteen Japanese-speaking patients, the only one to express any interest in English for its own sake was Haruka, who studied the English language in tertiary education because she was interested in American culture. A few others (Chie and Yumi) mentioned the instrumental aspects of the English language, such as increasing the learner's competitiveness in the job market both within and outside Japan.

4.1 The shaping of English as symbolic capital

The experience of exposure to English among Japanese-speaking patients, particularly at initial stages, was homogenous overall. It was mostly limited to be within a school environment. Bourdieu (1994) pointed to the role of school education on the shaping of politically manipulated concept of the object of teaching. Bourdieu argued that school education is a medium of state control and the formation of *doxa* – an unquestioned concept within structural control. According to Bourdieu, school education “produce[s] and impose[s] categories of thought that we spontaneously apply to all things of the social world” (1994: 1). It also “molds *mental structures* and imposes common principles of vision and division” (*ibid.*: 7 – original emphasis).

Bourdieu argued that school is a field of exercising *symbolic power* to generate *doxa*.

According to Bourdieu, symbolic power has an effect when the members of society believe in the legitimacy of values presented by those who use the power.

Symbolic power – power to constitute the given by stating it, to show forth and gain credence, to confirm or transform the world view and, through it, action on the world, and hence the world itself, quasi-magical power which makes it possible to obtain the equivalent of what is obtained by (physical or economic) force, thanks to its specific mobilization effect – is only exerted insofar as it is recognized (i.e. insofar as its arbitrariness is misrecognized) (Bourdieu 1979: 83).

Bourdieu also explained that the state wields symbolic power to make its people associate prescribed value with *symbolic capital*.

[S]ymbolic capital is the form taken by any species of capital whenever it is perceived through categories of perception that are the product of the embodiment of divisions or of oppositions inscribed in the structure of the distribution of this species of capital. It follows that the state, which possesses the means of imposition and inculcation of the durable principles of vision and division that conform to its own structure, is the site par excellence of the concentration and exercise of symbolic power (Bourdieu 1994: 9).

Phillipson (1992) described how the English language functions as a vehicle of spreading politically prescribed values, a process he termed *linguistic imperialism*. He argued that the unequal distribution of power occurs through linguicism, which legitimises a specific language in a political discourse.

English has, in the twentieth century, become the international language *par excellence*. English has a dominant position in science, technology, medicine, and computers... in education systems, as the most widely learned foreign language (Phillipson 1992: 6).

School education is also a medium of transmission of social values through English.

English is not merely an instrument for communication, it is a value one identifies with for the social functions the language is seen as serving, its utility in the linguistic market. Its use is spreading worldwide. (Phillipson 2008:7)

In Phillipson's view, the English language functions as "[l]inguistic capital, [and] its acquisition and investment, is a prime example of symbolic power in use. (2008: 29). Non-native English speakers absorb politically created social values attached to the language through state education which the governments of non-English-speaking countries provide to their people, through complicity with English-speaking countries. Pennycook (2007) argued that the English language is often used in collusion with a globalisation agenda as an epistemological figure. He criticised the appropriation of the English language in this way for creating myths about this language throughout the world.

Particularly salient today are claims that English is merely a 'language of international communication' rather than a language embedded in processes of globalisation; that English holds out promise of social and economic development to all those who learn it (rather than a language tied to very particular class positions and possibilities of development); and that English is a language of equal opportunity (rather than a language that creates barriers as much as it presents possibilities) (Pennycook 2007: 100-101).

Conceptual domination through symbolic power gives rise to a spiral in which power reproduces the relationship of domination, and the dominated unconsciously adopt it as the status quo (Bourgois 2009).

Grammar-oriented, English-centred foreign language education in the Japanese education system

The English language has dominated foreign language education in Japan since the 19th century (Stanlaw 1992). Particularly after the end of the World War II, the Japanese school curriculum has been exclusively focused on English (Liddicoat 2007). The latest Japanese secondary school curriculum (Ministry of Education, Culture, Sports, Science and Technology 2008), for example, has a section dedicated to foreign languages. This section, entitled "*Gaikokugo* (foreign languages)" consists of six pages. It starts with the objectives which are supposed to generally cover languages other than Japanese.

To deepen learners' understanding of language and culture, foster in them a positive attitude toward communication, and develop their basic communication skills such as listening, speaking, reading and writing. (Ministry of Education, Culture, Sports, Science and Technology 2008: 92 – translated by the author)

The section devotes five and a half pages to instructions on teaching the English language. It mentions other languages in one line toward its end.

Instructions for other languages should be provided in accordance with the objectives and contents for the English language. (*ibid.*: 98 – translated by the author)

The section concludes by stating that “[i]n principle, English should be selected for the foreign language subject” (*ibid.*: 98 – translated by the author).

It is common among Japanese people to think that it is impossible to learn non-Japanese languages other than English. Haruka and Yumi, Japanese-speaking informants, also considered that English was the only non-Japanese language they could acquire.

Haruka: I wanted to understand English films without subtitles - only in English [laughs]. It is impossible for me to learn the French language and other languages.

Yumi: I studied English at school. English is the language which I am most familiar with. I went to a French language school, but gave up because the language was too difficult. When I was studying to become a Japanese language teacher, I also had to study Chinese or Korean. I chose Korean because I'd heard that it's easy for Japanese people to learn it. However, it turned out that it was more difficult than English.

The perception expressed by Haruka and Yumi of the difficulty of learning languages other than English resulted from limited opportunities to expose themselves to languages other than English while they were young students. Yumi reached this conclusion after she studied the French and Korean languages for much shorter periods of time after she turned twenty-five, compared to her formal education in the English language from the age of thirteen years in school and university in Japan.

In my own school experience in Japan as a typical middle-class Japanese student, students had almost no opportunities at school to learn second languages other than English. I had a few opportunities to learn French in university for the first time in my life. Until then, I had never thought of studying languages other than English. I took a French language course because I knew that my knowledge of English grammar would help me understand basic French grammar. Japanese people, including myself at that time, tend to perceive languages other than English within a framework determined by their experience of the English language as the normative second language.

I studied the English language in school because it was one of the compulsory subjects of the Japanese national school curriculum, and because it was one of the subjects for senior high school and university entrance examinations which I was going to sit. By the time I started my undergraduate degree, I had unconsciously convinced myself that I needed to have a high level of English proficiency. Until I physically relocated myself to the UK in my second year of my undergraduate study, I had never used the language as a means of communication, although I knew that people communicate in English in many parts of the world outside Japan. It had never been necessary for me to communicate in English in my entire life in Japan.

While students have almost no opportunity to use English in real communication, their English knowledge, mostly of grammar, is tested at every important milestone, such as high school and university entrance examinations and regular examinations during school years and university semesters. The results of a survey by Kobayashi (2001) of sixty-six Japanese high-school students indicated that Japanese secondary-school students were devoted to learning exam-oriented, grammar-focused English in order to enter reputable universities. Loveday described English education in Japan as “concentrated exclusively on university entrance tests which require the ability to translate written English into Japanese” (Loveday 1986: 28).

Difference in the phonological system of the Japanese and English languages may partly contribute to excessive focus on grammar in English language education in Japan. In a comparative analysis of the phonetic systems of the Japanese and English languages, Ingvalson, McClelland and Holt argued that native Japanese speakers fail to perceive and produce the English [l] and [r] sounds as reliably as native English speakers do (McClelland & Holt 2011: 572). A study by Miyawaki and her colleagues (1975) found that native Japanese-speakers could not differentiate the English [l] and [r] sounds. The study subjects could not even distinguish these sounds by listening to the recording of their own pronunciation. A

study exploring the attitude of Japanese women in Australia toward contraceptive methods (Inoue et al. 2016) also pointed to difficulty in English pronunciation faced by native Japanese speakers.

While a number of private schools offer classes on languages other than English, most students do not take up such opportunities because they prioritise the English language – particularly English grammar – over other languages. In an exploration of the unsuccessful outcome of a government-led special English education plan in 2013 which aimed to improve students' English communication skills, Matsumoto (2015) pointed to the gap between the ideal goal proposed in the plan and the grammar-focused English tests in Japanese university entrance exams. Matsumoto argued that while teachers in schools in Japan are aware of the necessity for improving the communicative aspect of English in students, they could not shift the weight from grammar because the primary objective for students of studying English is to become more competitive in grammar-focused English tests in school and university entrance examinations.

Oomi (2010) criticised English education in Japan for lacking clear objectives, leaving students at a loss to understand the direction of study. Ivy (1995) argued that the Japanese government deliberately created this ambiguity by “carefully circumscribing the problem of identity and difference” (Ivy 1995: 3). Ivy explained that the concept of *kokusaika*, which is often translated as internationalisation, is not equivalent to the concept of internationalisation in the English language.

[K]okusaika is a conservative policy that reflects the other side of a renewed sense of Japanese national pride, if not nationalism. It has been remarked that instead of opening up Japan to the struggle of different nationalities and ethnicities, the policy of internationalization implies the opposite: the thorough domestication of the foreign and the dissemination of Japanese culture throughout the world (Ivy 1995: 3)

Liddicoat (2007: 37) also argued that the Japanese government adopted English in its national education system only to reinforce Japanese identity both among Japanese people and non-Japanese people.

The attitude toward the English language and *kokusaika* of the Japanese government implies Douglas's concept of purity and danger (1969). I drew on this concept in the preceding chapter to explain the boundaries which some Japanese-speaking patients drew to exclude professional interpreters. In these boundaries, Japanese-speaking patients recognised external, professional interpreters as the cause of disturbance to social and relational coherence. Kelsky's description of resistance from some 'internationalist' Japanese women against Japan's conservative, insular policy may also suggest that grammar-oriented, exam-focused English education is by no means a 'failure' in developing learners' communication skills, but rather an intended result by the Japanese government.

[W]hereas the encroachment of Western modernity has often been viewed in Japan as a traumatic event of the first order... for some women, internationalist modernity is seen as offering them (and potentially Japanese men too) their very first chance at unfettered freedom (Kelsky 2001: 4).

It may be the natural consequence of state control that Japanese students study the English language only as an aggregation of grammatical components instead of a medium of communication. Within the context of school education in Japan, proficiency in the English language – predominantly its grammar – is symbolic capital associated with success in academic competitions.

Nakamura (2003) pointed to the great social importance which Japanese people attach to success in academic competition, particularly in university entrance examinations.

Junior high school students... consider the results of numerous tests and mock entrance examinations taken at *juku* - the private cram schools that many of them attend outside regular school hours... Academic senior high schools that send nearly all their students on to university are located at the summit of the hierarchy, while vocational senior high schools whose students do not generally go on to university

(or at any rate not to prestigious universities) are positioned at the bottom (Nakamura 2003: 204)

It appears that for most Japanese people, studying the English language means little more than gaining strategic knowledge which is supposed to make them more competitive in university entrance examinations in Japan. Lareau and Weininger (2003) argued that in a state education system, students who demonstrate competencies in certain skills enjoy favourable treatment in accordance with normalised criteria set out by the state. Privilege associated with certain competencies stratifies people into social classes as per “the institutionalized *répertoire* of high status cultural signals” (Lamont & Lareau 1988: 164). The mastery of English grammar is one such competency which stratifies Japanese people into a social hierarchy in Japan.

Interestingly, Japanese people’s pursuit of the mastery of the English language still continues after they complete school education. In an exploration of Japanese people’s experiences of learning the English language after completing formal school education, Kubota argued that there is the discourse of linguistic instrumentalism in Japan which “assumes a connection between English skills and national and individual economic benefits” (Kubota 2011b: 251). Interviews with eight adult Japanese learners of the language at private English conversation schools by Kubota (*ibid.*) found that English proficiency had a limited impact on success in career. Kubota’s study suggested that gender and class-related factors may be more significant.

[L]inguistic instrumentalism creates a cycle of assumptions that privilege English skills, English language teaching and learning, and communicating with native speakers of English, which turned out to be illusive in this study (*ibid.*: 257).

It appears that Japanese people’s aspirations for mastering the English language are not limited to the context of school education. Kubota’s study provided an important finding

that Japanese people are subject to the symbolic power of the English language for a considerable part of their lives.

Modernisation and English language as symbolic capital in Japan

In Japanese society, the English language carries a different kind of symbolic capital outside the domain of education. While Japanese state schools teach students the language almost exclusively as an instrument for winning academic competition within Japan, Japanese industries use the language as a marketing strategy (Takashi 1990). Regardless of the degree of practical demand for the English language, the language is widely used in signs at train stations and bus stops (Figure 2) as well as in product names and advertisements (Figure 3).



(Photos taken by the author)

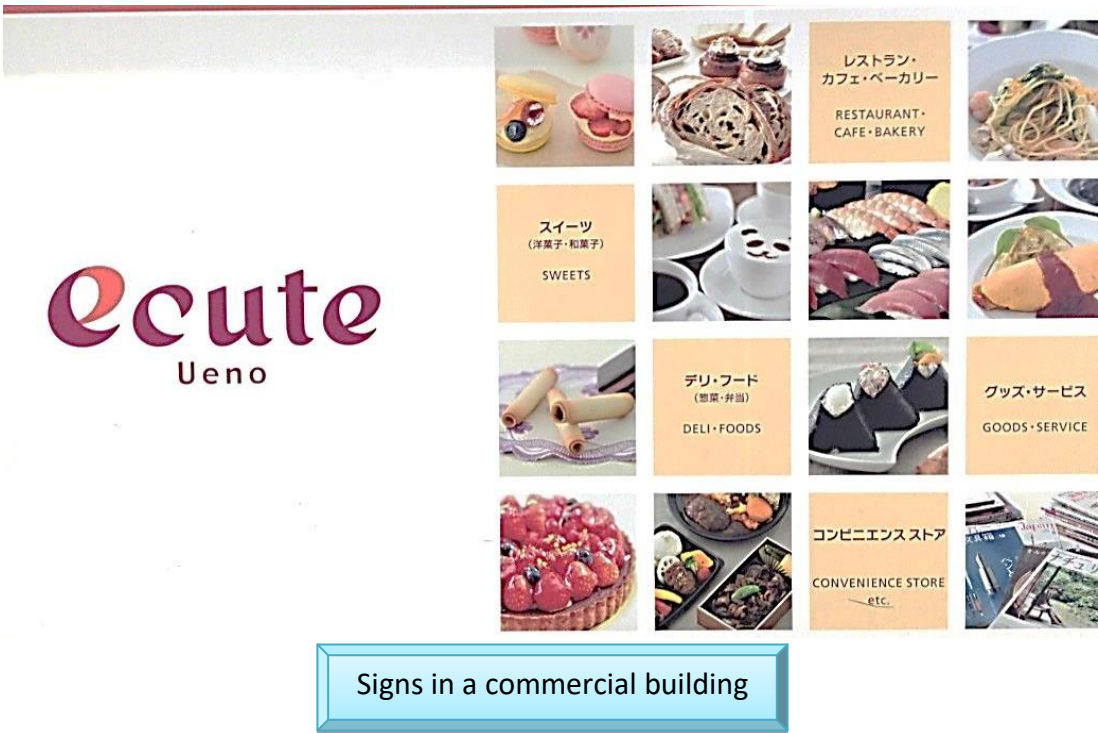
Figure 2: English signs at a train station in Tokyo



Fabric softener



Signs in a commercial building



Signs in a commercial building

(Photos taken by the author)

Figure 3: English in Japanese products and services

Takashi (1990) argued that the use of the English language in product names and descriptions – even if in most cases it is only with short phrases or a few words – has the effect of making the products look sophisticated and modern. From the perspective of Japanese readers, who have learned the English language as a set of grammar-focused rules at school, the language carries symbolic capital as an index of academic achievement. Many Japanese people also recognise the English language as an embodiment of modernisation and sophistication related to their exposure to global culture.

Japanese growing bilingualism in English, internal social desires concerning image and levels of sophistication that seem to be satisfied through an appeal to English linguistic resources and the exploitation of these feelings by advertising and mass media, both of which play a decisive and innovative role in Japanese society (Loveday 1986: 27 – 28)

In Japan, the English language as a symbol of modernisation is not always used in its correct form. Japanese companies often blend the Japanese and English languages to communicate the sophisticated image of their products in a form which is comprehensible to Japanese consumers in the Japanese context.

The exploitation of English for whimsical corporate and product slogans can also be seen in Kanebo's ridiculed *For Beautiful Human Life*, Shiseido's *hito o irodoru saiensu* 'the science of make-up', and Mitsubishi's *creating together*. The Daiwa Bank included the slogan *hāto no ginkō* 'the bank with heart' as part of its marketing image, and went so far as to adorn bank books and other products with little red hearts. (Miller 1997: 131)

The English language in Japanese society is often used as a commodity which can be “useful as added value for niche markets and for distinguishing among standardized products that have saturated markets” Heller (2010: 102-103).

[A]s we wander around the Japanese cities, we hear little English but might see what look like English words used in shop names or on commercial items... The English there is for decorative rather than communicative purposes (Tan & Rubdy 2008: 2).

Nick, one of the English-speaking informants in this thesis, said, “I can see many English words in Tokyo, like train stations and shops. I see English everywhere”. For Japanese people, proficiency in the English language carries two different kinds of symbolic capital, depending on the context in which they encounter the language. One is related to living in a modern, liberal society; and the other is to academic and career success. Haruka wanted to enjoy English films while living in Japan. Her motivation for studying the English language was separated from the image of the language in the Japanese school education context. Her motivation was instead a desire to immerse herself in the modern West.

Advancing oneself through English

English language tests are one of the major forms of language consumption in Japan (Kubota 2011b). Japanese people consume the English language not only in the form of tests, but also purchase products and services to help them achieve high scores in English tests. These products and services include books and private classes and tutoring. When I searched Amazon.co.jp in November 2015 for books on English tests, I found 3,072 titles with the keyword of TOEFL (Test of English as a Foreign Language), 4,490 with TOEIC (Test of English for International Communication) and 156 with IELTS (International English Language Testing System).

Japanese companies enthusiastically encourage their employees to sit commercially available English tests (Chapman 2003). Some Japanese companies have the extreme opinion that it is a hindrance to the growth of their business if their Japanese employees use Japanese in operations (Norisada 2012). In recent years, a number of Japanese companies have started adopting English as their official language, even though the majority of their employees are Japanese. Rakuten, Nissan and UNIQLO are major examples (Takakuwa 2015). My former employer in Japan, a Japanese pharmaceutical company, ordered me to sit a

commercially available English test, and the company paid for the test. I sat the test despite the fact that all my clients were native Japanese speakers.

Chie is a Japanese-speaking informant in her forties who has lived in Australia for over a decade. She studied the English language anticipating that mastery of the language would expand her career opportunities.

I used to go to an *eikaiwa* [English conversation] school very often, even before I met my husband. I met him through a friend whom I met at the *eikaiwa* school. Since I like travelling overseas, I thought it would be helpful if I could use English. I also thought that it would be useful for my career. You know, in some large Japanese companies, employees must communicate only in English. I thought that it would be better if I would improve my English. I studied English for the purposes of both work and holidays.

Yumi gave a similar account to that of Chie, stating that mastering English opens the door to more career opportunities.

I studied in Scotland and London. I stayed there for about one year. I was in Australia for six months before I went to the UK. I went to Australia to study to become a Japanese teacher. I didn't have a qualification to be a Japanese teacher but worked there as an assistant teacher for six months. I did home stay in Australia. It was a volunteer job which didn't require any professional experience. I wanted to develop my career by using English, so I chose this opportunity as a step towards my goal. If you can use English, your possibilities expand.

According to Bailey (2006) and Kubota (2011a; 2011b), many Japanese people consume the English language through *eikaiwa* (English conversation) lessons. Kubota (2011b) argued that since the consumption of *eikaiwa* occurs outside Japan's formal education system, it reflects participants' real life and career trajectories.

Kubota (*ibid.*) noted that women generally outnumbered men in *eikaiwa* schools. Bailey (2006) argued that there are three reasons for Japanese women to consume *eikaiwa* lessons. The first reason is "to enhance their career prospects" (*ibid.*: 105), the second reason is "to engage in travel, either for vacation purposes or for ryugaku (studying overseas)" (*ibid.*: 106), and the third one is "to actualize... eroticized discourses of new selfhood... by realizing

romantic and/or sexual desires with Western males” (*ibid.*: 106). Kubota (2011a) argued that those who go to *eikaiwa* schools seek joy and fantasy derived from yearning for white native English speakers, and that purchasing *eikaiwa* is “more related to the notion of consumption than investment” (*ibid.*: 487).

The university in Japan I went to for my undergraduate study had a relatively large number of international students, predominantly from the USA. One day I heard from one of the international students that his application for an *eikaiwa* teacher position was rejected. The school was one of the major *eikaiwa* franchise groups in Japan. The international student is American-Chinese. I knew that he was well-educated, and from an upper-middle or upper-class family. The reason for his unsuccessful application was because of his appearance. He said that the school wanted Caucasian men with blue or green eyes, instead of Asian-looking teachers, and that the school was not deeply interested in the applicants’ educational backgrounds.

Kubota’s study (2011b) suggests that the general purpose of consuming *eikaiwa* lessons among Japanese men is expanding career opportunities. In contrast, Kubota (2011a) and Bailey (2006) suggested that the purpose may vary among Japanese women. The difference in motivation among Japanese learners of the English language suggests that the language has deeply taken root in Japanese culture through pluralistic perceptions held by Japanese people.

4.2 The pressure of gaining symbolic capital: views of Japanese-speaking patients on their English proficiency

An analysis of the accounts of Japanese-speaking patients about their perceptions of English proficiency found that most of them considered their English proficiency as a personal attribute. Overall, their self-evaluation of their English proficiency was very low. This finding is consistent with a finding from a survey by Oomi (2010) of 153 Japanese university

students who were taking English classes. Participants perceived their English proficiency negatively. On a scale from 0 to 6 with 0 indicating poor and 6 high, the average score given by participating students for the self-evaluation of their own English proficiency was 2.06.

Some Japanese-speaking informants in this thesis associated their limited English and cultural proficiency with their unfavourable experiences in Japanese-English encounters in general.

Kaori: [Communicating in English] was hard at the beginning. The first difficulty that I faced was when I went to Shop A [a major retail chain store in Australia]. The shop staff said, "Flybuys? [an Australian shopping loyalty programme]". I didn't understand what I was being asked about. I asked them back what it was, and they said, "No, that's fine" [in a blunt way].

Saki: The most difficult times are when I have to explain situations [in English]. For example, when I go to school and give some explanations, go to a health care facility and give some explanations, listen to the landlord of our rental property and communicate with the parents of our children's friends. At such times, I get very nervous. Also, I'm not good at speaking English on the phone. I still can't pick up calls due to fear of speaking English.

In contrast, English-speaking patients generally described their Japanese and cultural proficiency in less emotional language. They described their limited Japanese language and cultural proficiency with more neutral expressions, and sometimes together with favourable experiences of cross-linguistic encounters.

Kate: I think it's worth learning it, but I found it really hard [to learn Japanese] because of school work on other stuff. I wish if I could learn Japanese in school or university. But when I went to Japan, it helped when I smiled. You have basic kind of gestures, like this one - showing "this is too big" [showing a gesture], and "OK" [showing a gesture]. If you want a smaller one, you say "*chīsai* (small)". If you want a large bowl of noodles, you can say "*ōkī* (large)", with motion. This works.

Andrew: The language itself is relatively easy compared to other things about Japan. Self-studying the language is relatively easy but still hard. Very often, [Japanese people] expect you to not speak any Japanese at all, which is probably fair enough. I was reasonable [in my proficiency in Japanese]. I liked to think in Japanese at certain points, certainly after working in Japan for over half a year.

There was a tendency for Japanese-speaking patients to use negative, personal words and expressions when they described their English proficiency. Many Japanese-speaking patients were apologetic when they mentioned their perceived limited English proficiency. They considered that it caused them to have feelings such as “feeling down” (Aki, Emi, and Chie), “feeling nervous” (Saki and Sanae), “bothering Australian doctors” (Kaori) and “being a burden to Australia” (Miho). Nevertheless, most of them indicated that they would not like to use a professional interpreter. Since they blamed themselves for their poor English proficiency, they felt that they should not be seeking help from an external source to overcome language barriers.

English grammar as the determinant of overall English proficiency

Emi, a Japanese woman who moved to Australia following her marriage to an Australian man, emphasised grammar when she talked about difficulties she faced in communicating in English. She had never lived or worked in an environment which would require her to use the English language before she came to Australia following her marriage to an Australian man.

When I went to a language school [in Australia], I told the teacher, "I came here because my English grammar is terrible, so I would like to correct it". The teacher said, "Don't worry. All Australians speak English with broken grammar, so don't worry about it". They didn't correct my grammar. I think that they did not want to correct my mistakes because I was making numerous grammatical errors. I would never know what's wrong with my English unless someone would point out errors that I am making. My English will never improve unless I get someone to point out what's wrong with my English. I am aware that I'm not using English grammar correctly. I want someone to point out the errors I'm making, but no one does this for me.

Emi focused on correcting her English grammar more than improving the overall communicative aspects of her English. Her account suggested the implications of grammar-focused English training in the Japanese education system on her perception of proficiency in the language. Emi's perception of the English language is typical for Japanese people.

Japanese students learn this language through the repeated training of memorising numerous grammatical rules and applying them to translate between the Japanese language and the English language. Therefore, Japanese learners of the English language tend to focus on whether their grammar is correct or not more than whether the listener or the reader of their English understands their intention. A survey of Japanese university students by Oomi (2010) found that over 50% of respondents prioritised improving English grammar over other aspects of the language.

Values Japanese people attach to the English language vary depending on the context. One of these values is related to the instrumental aspect of the language which is supposed to increase the learners' possibility of winning higher social status. Another value is related to yearning for the West. While the interest of participating students in Oomi's study (*ibid.*) in English education was concentrated on grammar, they held negative views of the Japanese accent. In contrast to the common perception of English grammar as strategic knowledge to increase the learner's possibility to pass the entrance examinations of reputable universities (Kobayashi 2001; Loveday 1986; Matsumoto 2015), the perception of English pronunciation by respondents in Oomi's study (2010) did not indicate the relationship between the language and academic success. The most common perception of native English pronunciation among participating students in Oomi's study was "cool and beautiful" (*ibid.*: 74). This suggests that English grammar and pronunciation carry different kinds of symbolic capital for Japanese people.

Emi's exclusive focus on English grammar was related to gaining symbolic capital as an instrument of achieving academic and career success. This does not mean that Emi is free from the other type of symbolic capital associated with an image of the West as an icon of modernisation. As indicated in Chapter 3, her preference for her white, English-speaking husband over a professional interpreter in Japanese-English medical encounters suggested that she may have found this kind of symbolic capital in her status as a Japanese woman

married to a white, English-speaking man, rather than through the mastery of the language as a medium of communicating with native English speakers.

Limited English proficiency perceived as a failure in life

Aki is a Japanese woman in her early thirties who has been in Australia for over eight years. She explained to me her psychological strain when she uses the English language, particularly in the presence of other Japanese people.

Everyone judges a person based on their English skills. They even judge their personality based on how well they speak English. Japanese people who have lived overseas and are interested in overseas cultures definitely check how well other Japanese people speak English. I feel jealous when I see someone who is good at English. Their good English just reminds me of my poor English. When a person who is good at English is around me, I continue to feel down. I will not be able to say even simple things. I do not know why.

Both Aki and Emi indicated that making 'errors' in the English language in the presence of Japanese people results in a deterioration in their self-esteem. They do not feel this level of pressure in the presence of English speakers or when they are in an environment in which the dominant language is not English. Their accounts suggested that the shared perception of the English language among Japanese people creates special symbolic power which is deployed in interactions between Japanese people. Emi mentioned how she would feel about her language proficiency if she was not in a predominantly English-speaking country.

[If I was in Italian- or French speaking countries] I wouldn't feel this level of pressure because almost no Japanese people are fluent in French or Italian. Japanese people would not notice when I get the grammar of these languages wrong [laughs]. This is why I avoid speaking English in front of Japanese people as much as possible. I don't want them to notice every single mistake I make.

The pressure which Aki and Emi indicated was not related to the effectiveness of the communication in the language. Their accounts instead suggested that the presence of other Japanese people make them unconsciously compete against other Japanese people over the English language as symbolic capital for academic and personal success.

Sanae, a Japanese woman in her forties, is self-conscious about her English proficiency regardless of who is present. She mentioned how nervous she became when she spoke English at work in Australia. Sanae was conscious of what people including non-Japanese people would think of her English proficiency.

I don't want to be off the point. I'm an assistant, so I can do no more than just getting information. I might propose to improve something only when I am directly talking with my boss. Otherwise, I only listen to other people at large meetings. I can do no more than simply keeping up with what they discuss. When the conversation is in English, I always only listen. At work, people discuss everything in English. I don't feel comfortable in work meetings.

By stating that she did not want to be “off the point”, Sanae meant that she did not want people around her to notice that she was not always keeping up with English conversations. Given that she obtained a master's degree in one of the top universities in Australia, it is probably not the case that she had difficulties understanding the context of her work as an assistant office administrator. Sanae did not want other people to think that her English proficiency is poor. Sanae's account suggested that she recognised native English speakers as the holders of symbolic capital linked to academic and career success. While Aki's account suggested the competitive aspect of the mastery of the language among Japanese people, Sanae's account suggested fears of receiving negative evaluations from perceived authoritative figures.

Seeing limited English proficiency as a burden to Australia

Miho is a Japanese woman in her forties. She also moved to Australia following her marriage to an Australian man. Miho had used a professional interpreting service several times when she saw English-speaking doctors in Australia. Miho said that she felt guilty about using professional interpreting services because she considered that her limited English proficiency caused additional expenditure of taxpayers' money.

I feel bad about using a professional interpreter. I had a sense of guilt when the hospital called an interpreter. They had to spend state money due to my poor English. My English is still not good even though I have spent several years in Australia. I feel really bad about this.

Miho was very apologetic when she mentioned this. Miho considered that her limited English proficiency prevented her from being an equal participant in Australian society.

Miho's thought may be rooted in the patronising attitudes held by Japanese people toward non-Japanese residents in Japan. In a review of the Japanese concept of multiculturalism, Shiobara (2011) argued that community services in Japan for non-Japanese-speaking residents give rise to a patronising attitude among Japanese people toward these residents.

Shiobara pointed to the victimisation and stereotyping of non-Japanese residents by Japanese people, disregarding their length of lived experience in Japan. One consequence of this attitude may be that it licences expression of dissatisfaction among poorer Japanese communities with current social services, which may be mischaracterised as unfairly prioritising the needs of non-Japanese residents over the needs of Japanese residents. Thus, Shiobara argues, Japanese people who are socially or financially marginalised in Japan may consider that non-Japanese residents are a burden to Japanese society.

In an ethnography of senior Japanese citizens in west Japan, Kavedžija (2015) pointed to Japanese moral values about 'good' members of Japanese society. Kavedžija argued that these values might cause senior Japanese people to contemplate whether they were a burden to their family and other social units with which they had connection; this sense of being a burden inflicted great stress on her study participants.

Miho's account also suggested that she has created a moral image of a good Australian resident, one of the criteria for which is a high level of English proficiency. Miho blamed herself for the lack of English proficiency. Miho might also have seen her limited English proficiency as an index of her academic failure which was attributable to her lack of effort and abilities.

Needing a professional interpreter highlights one's lack of symbolic capital

While Aki had never used, and is not interested in using, a health care interpreting service, she told me her thoughts about how a Japanese-speaking patient would feel if they found a health care interpreter arranged for them.

[If a Japanese patient found an interpreter arranged for them] they might think, "Why did they call an interpreter? I have been living in Australia with no problem".

[If I would find a professional interpreter when I see a doctor,] I would feel embarrassed.

Chie also suggested that being aware of her limited English proficiency is 'embarrassing'.

[If I find myself not being able to communicate well in English,] I feel embarrassed. Although I just smile and let it go, I feel very down. I feel like walking off when I cannot communicate well in English.

Aki's account suggested that the presence of a professional interpreter might unnecessarily remind the Japanese-speaking patient of their limited English proficiency. It would be an index of their lack of symbolic capital – an idea which many Japanese people would probably like to avoid confronting. Aki's account suggested that it may be more important for some Japanese-speaking patients to avoid acknowledging their lack of symbolic capital than to overcome language barriers with a help of a professional interpreter. I have been turned down by Japanese-speaking patients a number of times when I went to health care facilities as an interpreter. Their reason for refusal might have included this reason.

The accounts of other Japanese-speaking patients partnered to English-speaking men indicated that they did not have negative feelings about their limited English proficiency when their partners acted as interpreters. Since the prescribed role of a professional interpreter in Australia is accurate and neutral language rendition, the Japanese patient may recognise the health care interpreter only as an individual who has better proficiency in English than they do.

A common finding from the accounts of Emi, Aki and Sanae, Chie and Miho was that they could not help being self-conscious about their English proficiency. Given their academic backgrounds and the narratives of their lives in Australia, I did not consider that their English proficiency was actually as limited as they described it. Except for Miho, all of them were not keen on using a professional interpreter in Japanese-English medical encounters.

Except for Saki, informants who negatively described their English proficiency in my study were all Japanese women partnered to English-speaking Australian men. Saki was married to a Japanese man. Her position was different from these Japanese women because she moved to Australia, accompanying her Japanese husband. Martin's study (2007) of Japanese housewives accompanying their Japanese husbands to the UK suggested that temporary physical displacement to Western countries had little impact on their gendered perception of the role of Japanese housewives. Saki's account also did not indicate aspiration for the West in connection to her relationships with her husband.

Yoko, a single Japanese-speaking woman, Yuta and Ryo, Japanese-speaking men, noted that they had limited English proficiency. In contrast to Japanese-speaking women who negatively perceived their English proficiency, their descriptions of their English proficiency carried no negative connotations. All three informants were willing to use professional interpreting services, whereas Japanese-speaking women partnered to English-speaking men were generally reluctant to use them.

In contrast to findings from an analysis of the accounts of Japanese-speaking informants, particularly those of Japanese women partnered to English-speaking men, English-speaking informants did not describe their Japanese proficiency negatively. Many of them were rather confident about their Japanese language skills regardless of their actual levels of Japanese proficiency.

While Sharon and Adam were more critical of their Japanese proficiency than other English-speaking informants, their accounts still implied no negative feelings. Sharon is an Australian woman in her forties. She started studying the Japanese language when she was in Year 11 or 12 in Australia. She was so interested in the Japanese language and culture that she continued to study the language in university. She is married to a Japanese man.

I'm quite hard on myself when it comes to Japanese. I prefer to speak in Japanese. When I'm in Japan, I would speak in English with my [Japanese] husband to translate what I don't know how to say in Japanese. Otherwise I would prefer to speak in Japanese. I mean, it depends on the limits of your linguistic ability. If you can't say in the language, you have to use your own language, you don't have any choice. Of course, for me, I prefer to speak, if I can, the country's language. But like my sister, she never tried to learn Japanese when we were in Japan. She just talked to everyone in English. She didn't even try.

Adam learned the Japanese language from a private tutor, and had continued studying it.

Both Sharon and Adam spent a year in Japan with a working holiday visa before going to university. As with Sharon, Adam's description of his Japanese proficiency was more objective and included less personal feelings compared to the accounts of Japanese-speaking informants.

I had pretty good Japanese, wasn't fluent, but I had basic grammar well in place. I knew quite a decent range of vocabulary. I couldn't read newspaper but I could read children's books or something like that. And I probably knew 1,000 kanji, so it was not too bad. I had a lot of work at university, and after that I got to my current reading level. I didn't want English everywhere to support me [when I was in Japan]. I wanted Japanese everywhere so that it would support my mastery of Japanese.

The pressure described by the Japanese informants suggested the complex mixture of feelings deriving from an imbalance of different kinds of symbolic capital which the English language carries in the politically-formed social, education and gender contexts. On the other hand, the accounts of Sharon and Adam indicated that their perceptions, including self-criticism, were more straightforward, and based on their personal goals and commitment. Their accounts suggested that they recognised the Japanese language as personal capital which would satisfy their intellectual and personal curiosity, rather than

symbolic capital to legitimise their position in society. Unlike Japanese-speaking informants, neither Sharon nor Adam was concerned about the correctness of grammar. Nor were they concerned about what people around them would think of their Japanese proficiency.

4.3 English language as symbolic capital and the experiences of English-speaking patients in Japan

In contrast to Japanese informants, the experiences of Japanese-English medical encounters described by English-speaking informants were overall positive. None of them mentioned negative feelings about their Japanese proficiency. While Chapter 3 found that a few English-speaking patients who are partnered to Japanese wives avoided language support either from their wives or any other sources, the majority of English-speaking informants were positive about receiving any kind of language interventions. The accounts of some of them also indicated that they attracted extra attention and care from Japanese-speaking clinicians, nurses and other Japanese people because of their linguistic identity as native English speakers.

A 'very important patient' in a Japanese hospital

George is an English-speaking Australian in his thirties. He sprained his knee while he was snowboarding in rural Japan, and went to a local hospital to get the injury treated. George told me about his experience of the medical encounter.

I walked in the front doors to the reception. It was clear that I was injured even without a language barrier. Nurses there laughed [laughs] in a very friendly way. They tried to give me some slippers, which didn't fit. They thought that was hilarious. They gave me a hospital gown, and it didn't fit either, and they thought that was very funny. I pointed to my knee [laughs], and they pointed to a chair, so I sat and waited. They tried to ask me some questions, which I didn't really understand. They tried to speak [in English] a little. At the reception, the nurses didn't know any English. The doctor spoke a little bit of English.

George's account suggested that his limited Japanese proficiency and his linguistic identity as a native English speaker made Japanese health professionals give special attention to

George. Japanese patients in Japan usually would not be treated in this way. While George was relaxed during the entire encounter, this does not necessarily mean that the nurses and the clinician were also relaxed.

Ekman and his colleagues (1987) analysed facial expressions of people from ten different countries, namely Estonia, Germany, Greece, Hong Kong, Italy, Japan, Scotland, Sumatra, Turkey, and the USA. The researchers found that Asian participants including Japanese ones tended to express emotion slightly less obviously than the non-Asian counterparts did. The researchers also noted that it may be difficult to correctly read the facial expressions of those who were from foreign cultures and who were of different races. With reference to his prior study with Friesen (1969), Ekman noted that Japanese people “conceal negative emotional expressions in the presence of an authority figure, using a masking smile” (Ekman 1997: 338). It was possible that the Japanese clinician and nurses recognised George as an embodiment of symbolic capital.

George mentioned that while the Japanese clinician and nurses had limited English proficiency, all of them put effort in communicating with him in English as much as possible, even though this encounter was occurring in Japan. George said that he used a Japanese-English translation application on his smartphone to assist the conversation. While George had almost no knowledge of the Japanese language, his account suggested that this did not cause him to consider his Japanese proficiency negatively.

Yes, at least a little bit, well, maybe not fluently. [I should speak Japanese] at least a little bit. No, [I did not feel pressure of speaking good Japanese at the hospital]. They were all very helpful.

George’s perceptions of Japanese proficiency were completely different from those of Japanese-speaking informants who indicated that they were ‘stressed’, ‘nervous’ or felt ‘embarrassed’ when they mentioned their English proficiency, even though their English proficiency was not as poor as they thought it was.

George also said that “[i]t was very good and easy most of the time. In Tokyo especially, there were enough things in English - things like train stations”. This comment by George and his description of the Japanese-English medical encounter, together with Nick’s description earlier in this chapter of the ubiquitousness of the English language in Tokyo, suggested that Japanese people often prioritise the English language over the Japanese language in Japanese-English encounters. This is likely to be the case even if the encounter occurs within Japan.

Overall, Japanese-speaking informants in Australia, particularly women, attributed communication difficulties in Japanese-English encounters to their limited English proficiency. Unlike George, their experiences of Japanese-English language barriers have little positive affect on their motivation to improve English proficiency. It rather appeared to have created more reasons for them to blame themselves for their limited English proficiency. In contrast, George started learning the Japanese language after he returned to Australia. His attitude to the Japanese language was very positive compared to that indicated by Japanese-speaking informants.

Japan is a beautiful country, I love it. That’s why I’m trying to learn [the Japanese language]. I have been back a couple of times since then. The more Japanese I know, the easier it is to just travel and to meet people, and everything.

The attitude toward the English language of Japanese people in George’s account and that of the Japanese-speaking informants together suggested that Japanese people are often subject to the symbolic power of the English language, and the image of the modern West with which they associate the language.

‘Privileged’ native English speakers in Japanese society

Matt is an English-speaking British man in his forties. In the interview, he used the word, “privilege” in describing how native English speakers are treated in Japan. He also observed

that Japanese people treated English speakers differently from the speakers of other languages. Matt has been working in Japan as an English teacher for seventeen years. He is married to a Japanese woman. Matt told me about his Columbian friend, who had an unpleasant experience in a Japanese-Spanish encounter with a Japanese-speaking clinician.

Definitely, definitely, 100%. I think they show more respect to us [English speakers]. I think sometimes we're quite privileged, sometimes. I don't think so many Japanese women get the same response from their Japanese doctor. I think we're quite lucky [in a slightly sarcastic manner]. I've heard a story from one of my friends from Columbia. He basically said that he found one Japanese doctor very rude. I think it's mainly because the doctor didn't have any knowledge of Spanish. I think a lot of Japanese doctors understand English. The Columbian friend was really upset. I've got lots of good experiences with Japanese doctors. It's quite different. Yes, I think this depends on the foreigner, whether they speak English or not.

As in George's case, Matt indicated that he felt no pressure to speak the Japanese language in Japan.

I feel quite relaxed, surprisingly. I think English speakers are lazy with languages anyway. I think even if somebody speaks a little bit of English in Japan, you have to respect that, a lot of respect, actually. I have never really felt such pressure.

Kate, an English-speaking Australian woman in her twenties, also had pleasant experiences of Japanese-English medical encounters. Her limited Japanese proficiency as a native English speaker had rather a positive effect on her experiences. She described Japanese people as very welcoming.

Everyone is very responsible and knows their roles. Everyone was like a police officer. They said to me, "If you have a problem, then come to me." They had that kind of attitude.

Kate also gave a critique on how differently Japanese people treated her and her family members, who were all English-speakers, from non-English-speaking international students. Kate considered that the occupation of her father as a professor also affected the attitude of Japanese people.

People said “*sensei*³”. When I said “that’s my dad”, people said, “Wow, you are his daughter!” I think so far we have had more positive experiences, but mainly because of saying my dad’s job. This touches on social and cultural issues as well as on [those related to] migrants from other countries like Vietnam. They speak Japanese very well. I could see that those people were not treated as nicely [as I was], even though they could speak Japanese much better [than I did]. I saw that kind of stuff a few times as well. I felt sad because they were sick. They were just getting health care. That was definitely one thing I saw. That wasn’t directed to me, but I felt bad for them.

An analysis of survey data collected by a Japanese local council and interviews with five Japanese adults by Kubota and McKay (2009) suggested that the socially constructed perception of the English language among Japanese people may be the cause of racial stratification in the country. A comment from Brazilian residents in Japan quoted in their study said that they observed that “[i]deal foreigners for Japanese people are Americans” (2009: 613).

One of the Japanese adults who participated in the study by Kubota and McKay (2009) stated that non-English-speaking migrants were a burden to Japan. While the interviewee said that her child “could benefit from learning *eikaiwa* from foreign students”, she complained about non-English-speaking students because “the teacher has to interrupt instruction to help foreign students who cannot speak Japanese” (*ibid.*: 601). This account indicates that foreigners welcomed in Japan are often native English speakers.

A belief in the power of English champions Japanese people's bilingualism in English and Japanese while alienating non-English-speaking newcomers from imagined international communication in English and assimilating them into Japanese monolingualism (*ibid.*: 613).

The symbolic capital which Japanese people associate with the English language has strong implications on their attitude to people from outside Japan. Kubota and McKay (*ibid.*) also argued that the linguistic identity of non-Japanese residents in the country is now a social class factor in the country. The researchers pointed to the connection which Japanese

³ *Sensei* is a Japanese term referring to an individual with authority who has expertise in a certain field and who gives advice and directions to people. It is commonly used for teachers, clinicians, politicians and lawyers.

people assume between English-speaking and middle- or upper-class. A friend of mine who is partnered to a man whose cultural background is Pacific Islander once told me that he was stopped by the police in Tokyo while he was riding his own bicycle because they suspected that he was a bicycle thief, simply because he appeared to be a non-English-speaking foreigner.

English speaking informants in this thesis described the attitude of Japanese people they met as caring and respectful. Such attitudes may be derived from their views on the symbolic capital attributed to English language proficiency, rather than respect for cultural and linguistic diversity. The discriminatory attitude shown by some Japanese people in the accounts of Matt and Kate toward non-Japanese people who do not speak English may support this finding.

4.4 Summary

This chapter explored the perception of the English language held by Japanese people, and its implications on their views on receiving language support in Japanese-English encounters.

This chapter began with a reflection on the concept of *symbolic capital*. I pointed to two kinds of symbolic capital which Japanese people may associate with the English language.

One is related to academic and career success. Many Japanese people pursue this kind of symbolic capital through grammar-oriented school education with an ultimate goal of winning competition in entrance examinations for reputable universities. The other kind is related to the social construction of modern Western culture as object of fantasy and ideal of economic advancement, symbolised by English language proficiency. This kind of symbolic capital is closely related to gender issues in Japanese society, which I also discussed in Chapter 3.

An analysis of interview data suggested that the Japanese-speaking patients were subject to the symbolic power of the English language in both of the above aspects. A tendency among

them to be highly self-conscious about their English proficiency, particularly in the presence of other Japanese people, indicated that they were situating themselves in the context of academic and class competition in Japan.

The negative self-evaluation by Japanese-speaking patients about their English proficiency was not based on objective measurement but rather reflected their fear of other people seeing that they lack symbolic capital. None of the Japanese-speaking patients was certain about why they were extraordinarily critical about their English. Their perception of English proficiency affected their self-esteem. They were constantly under pressure to use good English in accordance with abstract, unrealistic criteria which make them feel that they should speak the English language in the same way as Western native English speakers do.

The analysis suggested that the presence of a professional interpreter could further undermine their self-esteem. I observed this tendency almost exclusively among Japanese women partnered to English-speaking men. I did not observe this kind of tendency among other Japanese-speaking informants, who did not have the option of using an English-speaking spouse, or English-speaking informants.

None of the English-speaking informants stated that they feel pressure to speak the Japanese language in Japan. Although two of them were slightly critical about their own Japanese proficiency, this appeared to be because of their personal interest in the Japanese language and culture.

Language barriers *per se* were not the direct cause of negative experiences of Japanese-English encounters for Japanese-speaking informants. Nor do they appear to have caused a major hindrance for either English-speaking informants or Japanese-speaking informants to access health services. In the cases of Japanese-speaking informants, their subjectivities related to the English language, rather than their English skills in a technical sense, were the cause of barriers to using health services and professional interpreting services. In the following chapter, I will examine the in-betweenness of interpreters in cross-linguistic

encounters. I will examine the agency of the interpreter, and explore how it affects patients' satisfaction with the interpreter-mediated medical encounter.

Chapter 5 Language and liminal agency in cross-linguistic medical encounters

This chapter explores the agency of communication mediators in cross-linguistic medical encounters. I draw on the accounts of informants who have experienced Japanese-English medical encounters with the help of communication mediators. All informants in this thesis who have spoken as patients through communication mediators mentioned the plurality of the mediators' cultural and social identities.

I begin this chapter by setting the premises of argument by reviewing existing literature on the malleable agency of interpreters in wider contexts. The ideal model of health care interpreters widely accepted in Western countries is an invisible, neutral language conduit. I present studies which argue that what this model can offer may not be consistent with the preference of speakers in cross-linguistic encounters, particularly from the perspective of those from non-Western backgrounds. These studies point to the in-between agency of the communication mediator in cross-linguistic encounters.

I then analyse exemplary cases of effective cross-linguistic mediation described by Japanese-speaking and English-speaking patients. Their accounts show how their mediators flexibly take into account different cultural and social identities to accommodate the versatile needs and expectations of speakers with different cultural, social, and linguistic identities.

5.1 The intercultural and interstructural agency of communication mediators

Neutral, accurate language rendition is often not the only skill required for a communication mediator to provide effective cross-linguistic mediation. Laster and Taylor (1995) and Angelelli (2004) criticised interpreting services which only provide neutral language conversion for being mechanical and ignoring the social aspect of communication. A survey and interviews with 467 Spanish-speaking patients who used emergency services at a public

hospital in Los Angeles found that patients who spoke through an interpreter perceived the clinicians as “less friendly, less respectful, and less concerned for them as a person” (Baker, Hayes & Fortier 1998: 1465), compared to the perceptions of clinicians held by patients who had not used an interpreter. The study indicated that interpreter-mediated cross-linguistic health communication involves complex social factors which affect the relationship between the speakers.

A comparative discourse analysis of monolingual and interpreter-mediated bilingual conversations suggested that in successful interpreter-mediated medical encounters, the interpreters were collaborative participants in the conversation (Davidson 2002).

Interpreters are speaking agents who are critically engaged in the process of making meaningful utterances that elicit the intended response from, or have the intended effect upon, the hearer, not a simple or thoughtless task. (*ibid.*: 1275)

In a paper presented at the Forum on Language Barriers to Care in September 1995, sponsored by the Henry J. Kaiser Family Foundation, Chang and Fortier (1998) argued that the role of health care interpreters is not limited to neutral language rendition.

Interpreters are often called on to take different roles, including those of cultural mediator and advocate. These labels describe different types of interpretation and different roles for interpreters; in practice, both types and roles are often mixed. (1998: S7)

Professional interpreters are alive to challenges of these role expectations. In Australia, Butow and her colleagues (2012) conducted focus groups in Victoria and NSW with thirty professional interpreters working with cancer patients who spoke Mandarin, Cantonese, Greek or Arabic.

Participants were... very clear about the role they were supposed to take in the consultation, which they saw principally as conveying information, ensuring understanding and being accurate, confidential and impartial... However, despite their role clarity, the interpreters described three broad dilemmas which faced them daily: (a) being accurate but also ensuring understanding; (b) translating only versus

cultural advocacy and sensitivity; (c) maintaining a professional distance versus providing support (*ibid.*: 237).

Dysart-Gale (2005) interviewed seventeen experienced interpreters in Spanish, Arabic, Russian, Serbian, Italian, Burmese and Turkish who work in two major cities in the central United States. The interviews explored work challenges faced by participating interpreters. The interpreters described the difficulties of navigating between their prescribed role as a neutral language conduit and responding to the actual communication needs of the patients and hospital staff (*ibid.*).

Frequently, interpreters interviewed at the hospital complained about being constrained by the conduit model from verbalizing questions that patients do not pose themselves, possibly because of culturally determined reluctance to question physicians (*ibid.*: 97-98)

Reviewing the implementation of codes of ethics for interpreters in the USA and interpreters' real-life experiences, Nicholson (1994) found that professional tenets in the codes were often incompatible with real-life situations. Nicholson argued that compared to the neutral conduit model, the 'facilitator' model proposed by Ashworth (1990), with reference to the cases of Japanese-English communication, may "increase the likelihood of mutual understanding" (*ibid.*: 83) because a facilitator "allows both sides to talk **with** each other (as opposed to **at** each other)" (original emphasis - *ibid.*: 83). Nicholson explained that the facilitator's role is different from the traditional interpreter's role in that it involves the processes of reflection and clarification.

[T]he facilitator employs (1) "reflection," during which he/she "reinterprets statements made by the American staff using a variety of English that is more likely comprehended by the Japanese staff" and (2) "clarification," which is "similar to reflection" and involves elucidation (*ibid.*: 38).

The same dilemmas of navigating between the conduit role and recognising the contexts and needs of speakers or writers of language are also described by translators. Kuhiwczak (2007) reflected on this point in an analysis of 'Holocaust testimonies', noting the

disproportionate number that are written primarily in English or disseminated through English translations – not the first language of the victims or the perpetrators of this historical event. Kuhiwczak argued that the fact that survivors' accounts are often represented in their second or third language obscures or simplifies their true stories.

Considering the fact that a majority of the victims came from Europe and that English was not for them their first language, it is surprising to see that in a huge body of writing devoted to trauma and witnessing, there is little attention paid to the question whether bilingualism, or often multilingualism plays any role in accounts given of the past... [The survivors' lives are] acknowledged only as a backdrop, an unusual accent superimposed on the English phonetic pattern (2007: 67)

Kuhiwczak suggests that translation which is based on a one-sided cultural perspective is often insufficient to express the sentiment conveyed in the original language.

[Translators can make literature on the Holocaust compelling] by retaining often crucial Polish, Yiddish or German words to show the communication gaps and the function of language as an instrument of coercion, or by careful characterization in order to make sure that the victims belong to a *shtetl* and not to a small market town in southern England (*ibid.*: 71)

Cross-linguistic communication mediation involves the complex negotiation of subjectivities derived from different cultures, symbolic positions, and social structures. Greenhalgh, Robb and Scambler found that interpreting which does not go beyond neutral, grammatically faithful language rendition failed to “acknowledge the linguistic impossibility of direct translation from one language into another, and it ignored or marginalised critical humanistic inputs such as intersubjectivity, support, and system navigation” (2006: 1182). Davidson also questioned the traditional conduit role by pointing to the independent agency of an interpreter in a cross-linguistic encounter.

[L]inguistic systems are not 'the same' in how [interpreters] convey information contextually... [interpreters] are themselves social agents and participants... in the discourse” (2000: 401).

A health care interpreter may also act as an institutional gatekeeper “who keep[s] the interview ‘on track’ and the physician on schedule” (Davidson 2000: 400). Their role may also involve being a “cultural broker” (Kaufert & Koolage 1984: 283).

In an analysis of the professionalisation of the occupation of interpreting, Rudvin (2007) pointed to the impacts of culture on the professional and social identities of the interpreter and the communication strategies which they adopt according to the context.

If [the interpreter’s] identity is primarily governed by the group rather than on an individual basis, his/her loyalty and impartiality will be determined by the group bond (*ibid.*: 61).

Rudvin argued that this is particularly applicable to Japanese culture (*ibid.*: 61). I have noted elsewhere in this thesis the collective *self* of Japanese people and its impact on their group-focused social identity (see Lebra 2004, Peak 1989). I referred to this notion in the introduction of this thesis to explain the tendency for Japanese people to be highly conscious about whether their behaviour meets commonly held social expectations in the community. Rudvin also pointed to the gap in the general understanding of the role of an interpreter between Western culture and non-Western culture.

In a typically Western achievement-oriented, individualist culture the interpreter feels more comfortable in an ‘independent and neutral’ role, where the only aim of interpreting is to give an accurate account of the interlocutors’ utterances, and the interpreter does not serve the interests of either party (*ibid.*: 62)

Rudvin’s analysis suggested that there is a thin line between professionalism and essentialism. It is possible to see interpreters’ professionalism based on this prescribed role as a legitimating excuse for essentialising cross-linguistic communication to the mechanical exchange of utterances composed in accordance with different grammatical rules.

Bahadır, an academic who is both a Turkish-English interpreter and an anthropologist, pointed to the in-between agency of communication mediators in cross-linguistic

communication. She argued that it is important for the mediator to have “the awareness of the multitude of different layers of identities and roles” (2004: 812).

[An interpreter] should be trained as an intercultural communication expert whose profession evolves around cultures and communication between persons belonging to these cultures (*ibid.*: 811)

Bahadır rejected the universality of the impartial, detached ideal of interpreters, which is often codified through codes of ethics. She argued that interpreters have a unique identity as in-between cultural mediators.

Interpreting in the sense of professional intercultural communication can also be seen as a ‘staging’ of both cultures plus a third one. Interpreters, too, are engaged in a borderline activity, producing other cultures against the background of their own cultures, and creating a new space, a third culture (*ibid.*: 816)

Arnold Van Gennep (1960) coined the term liminality to describe the ambiguous central moment of a ritual, where participants are ‘standing at the threshold’ of the reframing and restructuring of identity which the ritual fosters. The ritual as rite of passage comprises preliminal rites (rites of passage), liminal rites (rites of transition) and postliminal rites (rites of incorporation).

Moore (2015) used the notion of liminality in an observational study of a Korean-English interpreter who was mediating business negotiations in London. Moore drew on this concept to explain the position of an interpreter being “neither one thing nor the other; a mix of different, normally separate categories” (Moore 2015: 87). She noted that the interpreter gained power to negotiate between two social and cultural groups by maintaining a liminal position between Korean communities and British corporations in London. The liminal interpreter also had power to control the impression the speakers formed of each other (*ibid.*: 98-99). In other words, the interpreter was engaged in a liminal rite of transitioning the other speakers to a new way of understanding their interconnected selves in the communication.

The concept of liminality which Moore applied in her study (2015) may be closer to an extended notion used by Victor Turner (1967; 1969) than to Van Gennep's original concept. Turner extended the application of Van Gennep's original concept of liminality as a stage of transition in magico-religious ceremonies to an instrument of inquiry into broader social contexts.

Turner redefined liminality as "any type of stable or recurrent condition that is culturally recognized" (1969: 94), in which an entity is "betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial" (1969: 95). According to Turner (1969), society comprises the structures of different symbolic positions. A liminal subject is free from a "'structural' type" (1969: 95) in which the subject is "expected to behave in accordance with certain customary norms and ethical standards binding on incumbents of social position in a system of such positions" (*ibid.*: 95).

Turner argued that since "the attributes of liminality... are necessarily ambiguous", they are "expressed by a rich variety of symbols in the many societies that ritualize social and cultural transitions" (*ibid.*: 95). Using the example of hippies in modern Western society, Turner explained power which people who opt out of structure wield to manipulate values in society (*ibid.*: 112-113).

5.2 Liminality and the sharing of cultural and social identities

In this section, I investigate how patients understand the position of the communication mediators through or with whom they communicate in Japanese-English medical encounters. I show the dynamics of the mediators' cultural and social identities in the informants' eyes. I then analyse how such dynamics are relevant to the informants' satisfaction with the mediated cross-linguistic communication.

Yuri is a Japanese woman in her thirties. She has seen a doctor several times in Australia. She has communicated with her English-speaking clinicians with the help of her English-speaking husband and professional interpreters. All professional interpreters whom Yuri met are native Japanese-speakers who grew up in Japan.⁴

Yuri told me her understanding of the significance of the common cultural and social identities which Yuri found in the professional interpreters and her husband.

I relied on the Japanese interpreters who came for me. It was particularly important for me that both of them were women. They had been living in Australia, so we were able to share many experiences as Japanese women who migrated to Australia. On the other hand, I relied on my husband because we share a life.

Yuri noted that professional interpreters and her husband were helpful for different reasons. Yuri's account suggested that the shared socio-cultural knowledge which she found in the professional interpreters was different from the shared socio-cultural knowledge established when her English-speaking Australian husband acted as an interpreter. Yuri's account highlighted that an interpreter can have juxtaposed multiple identities imposed upon them by others in the communication. Yuri also mentioned the difference she would find between a professional interpreter who was born and grew up in Japan and one who was not.

I would prefer a professional interpreter who is originally from Japan. I have never thought about using a professional interpreter who has an Australian background. I prefer an interpreter who is originally from Japan because they give me peace of mind. I feel more familiar with them. I can trust them. Around the time when I used professional interpreting services, I always wanted to go back to Japan. I was clinging to everything that could remind me of Japan [laughs]. I think I was missing Japan a lot.

⁴ Professional interpreters in Australia include those who were: born and grew up in Australia; born overseas and grew up in Australia; or born and grew up outside Australia. I assumed that the professional interpreters Yuri mentioned migrated to Australia as adults, based on her description of their behaviour and the ways of communication.

Yuri said that she would prefer an interpreter with whom she could share her cultural and gender identity as a Japanese woman.

I felt that I was familiar with both of the professional interpreters because they were Japanese. When I see Japanese people in the city, I would like to become friends with them. Becoming friends with Australians is different from doing so with Japanese. Even if an Australian friend knows about Japan well, and even if we understand each other well, I can't talk much in detail when we have a chat. At the end of the day, an Australian friend is still Australian. While I have lived in Australia for this long, I haven't met an Australian friend whom I could get really close with. We somehow engage in a conversation. However, I still prefer speaking with Japanese people.

While Yuri has lived in Australia over ten years, she still faces cultural barriers when she tries to become friends with local Australians. This is not uncommon among Japanese residents in Australia. Her account suggested that a migrant patient may seek a cultural tie regardless of the situation which could give them a sense of togetherness with the members of their home culture.

A sense of togetherness with the interpreter as the member of the same ethnic community helped Yuri to be more relaxed and engage in the medical procedure. Yuri's account showed the implications of assumptions of shared common cultural and social identities on the quality of the interpreted cross-linguistic communication. This finding is consistent with an observation of British asylum appeals by Gill and his colleagues (2016). The researchers found that the appellant was less stressed when an interpreter with the same cultural background as theirs was present than otherwise.

In an exploration of the effect of background sounds in remote telephone interpreting in health care services for refugee patients in Australia, Phillips (2013) found that the patient's perception of the social and cultural identity of the interpreter has a significant impact on the rapport between the patient and the interpreter and between the patient and the clinician. In Phillips' study, refugee patients created an image of the interpreters by listening to the background sounds over the telephone. This image made them recognise the

interpreters as the embodiment of successful resettlement, and thus had a positive impact on the interpreter-mediated consultations.

The interpreter can thus be located within an imagined world which overlaps with the world as the refugee experiences it. The interpreter has an established life, demonstrated through the subtle soundscapes of domestic and working life, and can adopt an authoritative communicative stance in the consultation. They represent the establishment of selfhood and authority after resettlement (Phillips 2013: 518).

Miho, another Japanese-speaking informant also indicated that she prefers a professional interpreter who has the same cultural, linguistic and ethnic identity as hers.

I feel peace of mind when an interpreter who is originally from Japan comes. Japanese expressions are different from English ones... Even if an interpreter who is not originally from Japan loves Japan and even if they have been studying about Japan, I think that they still have different views from those which Japanese people intuitively have. I think that an interpreter who is fluent in Japanese as a second language is clearly different from one who is a native Japanese speaker.

Yuri appreciated support by the professional interpreter who went beyond neutral language rendition. Her account implied the importance of cultural knowledge which the patient believes they share with the communication mediator.

[The interpreter] explained to me about the informed consent form for spinal anaesthesia... [My husband] was with me there all the time. He held me on the delivery table together with the interpreter. The interpreter was there, too, holding me on there.

Whether the interpreter intuitively provides this kind of help or not depends on their cultural knowledge of the general attitude toward care in the patient's home country. Yuri understood that the interpreter provided physical support as well as language support because of a culturally shared attitude toward care for the patient. Professional interpreters in Australia are not allowed to be involved in any procedures other than language rendition (AUSIT 2012). The action of the professional interpreter in Yuri's case would have been natural if this event occurred in Japan.

In Japan, it is not unusual for those who are present at a medical encounter to provide extra small support to the patient. Such an act is supposed to show that they care about the patient. While findings in Chapter 4 suggested that the friendly and playful attitude of nurses in George's account may have largely reflected their subjectivities toward him as a holder of symbolic capital, it may partly have come from this Japanese cultural attitude toward the sufferer and weak. Kate, an English-speaking informant, also received this kind of support from a nurse in a clinic in Japan.

I went to a clinic. That's when the nurse patted me. There was no interpreter. My dad and I were using a dictionary to communicate [with the clinician and the nurse]. The nurse was standing and patted my back. It was very helpful especially because I did not know the language well.

Kate indicated that the action of this nurse alleviated her anxiety caused by the language barrier. The accounts of Yuri, George and Kate suggest that Japanese people's understanding of communication support is not always limited to language rendition. An observation of Japanese and American communication strategies by Yamada (1997) to explore different values attached to relationships in interactions suggested that Japanese communication strategies are centred on "anticipatory guess work" (Yamada 1997: 81). According to Yamada, a listener who understands the speaker's unstated intention and who shows empathy is highly valued in Japanese society.

Being able to guess at what others are going to say is central to the Japanese expectation of unspoken interdependence... a sentence in Japanese is only part of the larger interaction, and consequently often gets completed *across* communications rather than by a single individual on her own (original emphasis - *ibid.*: 81)

The nurses in the accounts of George and Kate as well as the interpreter in Yuri's account may have been performing the role of a skilful listener to fill the blank in the communication.

The account of Yuri suggested that the shared understanding of an attitude toward care between the patient and the interpreter made the interpreter slightly deviate from their

prescribed role as a neutral language mediator. This allowed the interpreter to serve as a culturally proficient communication mediator. This subtle behavioural change had significant implications on Yuri's overall impression of the medical encounter.

Unlike other Japanese-speaking informants who are partnered to English-speaking husbands, Yuri and Miho gave positive accounts about professional interpreters. Both Yuri and Miho found common cultural, linguistic, gender and ethnic identities in the interpreters they met. Yuri and Miho were reluctant to use professional interpreters with whom they would find little shared socio-cultural knowledge. Their accounts suggested that while Japanese-speaking women who are partnered to English-speaking men tend to rely on their partners in Japanese-English medical encounters, some of them may be willing to use a professional interpreter if they find common cultural, linguistic, gender and ethnic identities in the interpreter.

When Yuri explained why she appreciated communication support by her English-speaking husband, she indicated that a sense of belonging to the same social unit as her husband made it easy for her to communicate with her English-speaking clinician. Yuri's husband has a limited level of Japanese proficiency. Therefore, his communication mediation was mostly through monolingual paraphrasing in English. His social identity as Yuri's husband, and his cultural identity as an Australian helped him effectively communicate with Yuri's Australian doctor in a culturally and socially appropriate fashion for both Yuri and her clinician.

This suggests that a non-professional interpreter and a professional interpreter are not extreme alternatives. In Yuri's case, the professional interpreters and her husband performed complementary functions. Yuri appreciated that the interpreters and her husband provided communication support which helped her engage in the treatment procedure in the Australian health care system, based on their understanding of Japanese and Australian cultures and Yuri's personality. The mediator's intersubjectivity which let

them move between different statuses and positions may be an important factor for a successful mediated Japanese-English health communication.

A Japanese-speaking patient may be open to an interpreter when the patient finds that they can share cultural and social identities with the interpreter. This does not mean that every Japanese patient looks for an interpreter with whom they find common identity. A survey of 193 individuals of various nationalities who work outside their home countries found that compared to those who were assigned by their employers, those who voluntarily moved overseas tended to have negative views of their home countries (Andersen, Biemann & Pattie 2015). The researchers (*ibid.*) also argued that the stronger tendency for women than for men to voluntarily move overseas for career opportunities may be due to gender inequality in their home countries. Japanese migrants who have had unpleasant experiences in Japan and who have negative feelings about Japanese culture may prefer an interpreter who does not have many characteristics which remind them of Japan. Japanese women partnered to English-speaking men, discussed in Chapter 3, may also be examples of such voluntary expatriates.

Miwa is a Japanese woman in her forties who is married to Brian, an English-speaking Canadian man. Miwa lives with Brian and their children in Japan. During a visit to Brian's family in Canada, Miwa used local health services several times. All visits were for their daughters. Brian acted as a communication mediator between her and English-speaking Canadian health staff. The place Miwa visited was an Anglophone province where no government-funded health care interpreting services were available.

Brian's familiarity with both Japanese and Canadian cultures placed him in a liminal zone, in that it helped him to understand what could cause Japanese people to be anxious. He was also aware of Japanese ways of thinking which Canadian people might not fully understand. Brian has spent over two decades in Japan, works in a Japanese education institution, and

has a strong command of Japanese. In order to maintain the English proficiency of their daughters while they are living in Japan, Miwa and Brian speak to their children in English.

Miwa started with a description of the first Japanese-English medical encounter, which was for her second daughter.

We went a long way by car when [my daughter] was five months old. Her skin was sensitive, so she had severe nappy rash. It was so bad that we took her to a clinic. Brian deals with everything once we go outside Japan. I sometimes directly talked to the doctor, but my reply was always through Brian. I don't know English medical terms. We went there because we were in trouble, but I wasn't very worried or anxious. I assume that those who can't get support from their husbands would be more worried and anxious than I was.

The second case Miwa talked about was more serious than the first one. Her elder daughter suffered from severe burn and required emergency treatment.

I spilt tea by accident. I spilt it on her thigh. It was boiling water. We called an ambulance, and went to a hospital emergency unit. From the following day, we took her to the hospital every day. We went there for about 10 days. We were lucky because the hospital had a burns management specialist. Both my husband and I went into the ambulance when she was taken to the hospital. I was mainly cheering her up. Brian was explaining to the emergency staff how the injury occurred. He was also discussing treatment procedures with them. Since I had issues with English, Brian came with me for every subsequent follow-up appointment. I didn't know the way to the hospital. Brian drove us there.

Miwa's account suggested that communication intervention by Brian was a continued act throughout the medical episodes. Brian's support was effective because he understood the situations, Miwa's personality and what Japanese people and Canadian people would normally expect in interactions.

While Miwa said that she was not confident about her English skills, as I mentioned in Chapter 3, Japanese-speaking women tend to assess their English proficiency as being worse than it actually is. Brian described Miwa's English to me thus: "She has pretty good English, so she was able to communicate basically with the doctors. But things like cultural understanding were quite different".

Brian's proficiency in both Japanese and Canadian cultures was the most significant factor for effective health communication in their daughters' cases. Miwa was present when the accident with her elder daughter occurred, and therefore knew more than Brian about the situation. However, she did not have to give explanations in her words. Brian communicated his interpretation of her needs, both stated and unstated.

Since Miwa was also in the consultation room, Brian occasionally came back to her to confirm information she had given. Miwa waited for him to bring information back to her from the doctor. All explanations by Brian were based on his subjective understanding of Miwa and Japanese and Canadian cultures. He also explained to a member of administration staff at the hospital how to complete documents for claiming an insurance payment from a Japanese insurance company. Miwa also entrusted all explanations to him on this topic.

The liminality of Brian let him make decisions in cultural negotiations without completely belonging to either side. Miwa's approving statement of the psychological proximity to Brian echoes Yuri's description of how she relies on her husband. For both Yuri and Miwa, their perception that they and the communication mediators belonged to common cultural and social units and that the mediators had liminal agency which allowed them to travel through language barriers was crucial for the successful mediated Japanese-English health communication.

5.3 "Our friend is an interpreter at the hospital": liminal agency between a hospital employee and a friend of the patient

The role of a professional interpreter is not clearly defined in Japan. In Japanese culture, ambiguity is often vital for effective communication because, according to Ohnuki-Tierney (1990), the relationship of the speakers is redefined in every encounter. Ohnuki-Tierney explained that the Japanese perception of self in interactions is ambivalent, redefined

depending on “the difference or the sameness of the social status of the speaker and the addressee as dialogically defined in the context of the discourse” (*ibid.*: 207).

Ohnuki-Tierney argued that Japanese people identify and take up given roles which are contingent on their discourse. The ambivalent self (*ibid.*: 198) of Japanese people is never based on “a single level of language that forms the locus patterning and regularity” (Shibamoto 1987: 272). This ambivalence is also part of the role of the communication mediator in a Japanese-English medical encounter.

Cathy and Will came from Australia to northern Japan to work as English teachers. Their friend Kei is a Japanese-English interpreter at a local hospital where she is employed to undertake clerical tasks at the reception and also to interpret when needed. According to Cathy and Will, Kei is the only interpreter in the hospital. Demand for an English-Japanese interpreter is relatively high at this particular hospital compared to other parts of the area because a university close to the hospital employs a large number of non-Japanese researchers and teaching staff compared to other education institutions in Japan.

She is a hospital staff member. Because she’s got a high level of English, they use her as an interpreter. She usually works at the reception of the emergency department. She’s usually a receptionist of the emergency department. But if they have an English-speaking patient somewhere else, she is called to that area.

A clerical worker doubling as an interpreter runs contrary to the recommendation by a body of literature from the USA that a bilingual staff member should not be used as an interpreter (Elderkin-Thompson, Cohen & Waitzkin 2001; Flores 2005).

Cathy studied Japanese through secondary and tertiary education in Australia. Will came to Japan because Cathy had work in an English teaching programme; he had not undergone formal Japanese language training. Cathy and Will were less self-critical about their level of Japanese proficiency compared to the way in which a number of Japanese-speaking informants described their English proficiency. These Japanese-speaking informants used

negative expressions such as “embarrassing” (Chie), “nervous” (Sanae) and “depressing” (Aki). While Cathy faces no difficulties in everyday conversations in Japanese, Will has little Japanese, but feels his knowledge of technical terms is helpful in medical consultations.

Cathy: I think general conversation is fine for me. But when it comes to medical things, I don't know so many words in Japanese.

Will: I understand more Japanese than I can speak. Generally I figure out what people are talking about while I don't necessarily give response. But when it comes to technical things, like medical and technology, I'm actually better than Cathy because I've got a technical background. My sister is an emergency nurse. We have medical professionals in our family for a while, so I understand more medical stuff. When they talk about a particular illness, I don't necessarily need to understand what's in the language because I know the technical stuff.

Cathy and Will told me how they met and befriended Kei.

We have been friends [with Kei] since we met her at the hospital. At first, we met her as a translator [*sic*], and Kei became our friends. She said if we needed to make an appointment, just let her know, and she would be able to arrange our visit.

The accounts of Cathy and Will indicated that Kei occupied a liminal position between a friend and a professional interpreter and between an administrative worker and a language worker. Interpreters often hold multiple positions such as nurse, clinician (Baker, Hayes & Fortier 1998; Elderkin-Thompson, Cohen & Waitzkin 2001), family member and acquaintance (Free et al. 2003).

Kei did not perform word-to-word interpreting. She instead offered to escort Cathy and Will to the hospital, and negotiated the cultural and social meanings of both verbal and non-verbal messages.

Will: Japanese hospitals ask you which department you want to go. In Australia, if you need to go to a hospital or if you need to see a doctor, you go to a general practitioner [first]. He'll be able to diagnose a wide variety of illnesses and conditions. And then, if you need to see a specialist, the GP would refer you to the specialist. Whereas in Japan, it's up to the patient to know what specialist they go to in the first place. If you choose a wrong specialist, [you will need to try a different one].

Cathy: That's what Kei helps us with.

Will: Yes. She can tell the best place we should go.

Cathy: We often contact Kei first, and say, "This is the problem. Which doctor do we need to see?" She offers that she'll make an appointment for us. Last winter, for example, I got influenza, but I didn't know which doctor to see. I contacted Kei, and said, "Should I just go to the emergency department, or should I make an appointment with another doctor?" She contacted the right department for me, and found out when they had appointments available. She then contacted me again, and told me when I could go and see them.

As their friend, Kei made it easy for Cathy and Will to ask her for help. Her liminality between a friend and a hospital employee helped Cathy and Will communicate with people in Japanese health care services. Kei also helped Cathy and Will make a payment at the hospital reception and buy prescribed drugs at a pharmacy outside the hospital. Kei facilitated the entire hospital visit for Cathy and Will on the basis of her triage of their symptoms and her prior knowledge of Cathy and Will as friends, as well as Japanese health care culture. Cathy described how Kei helped her at the hospital.

I didn't know anything about the Japanese hospital system, so Kei helped me with filling in forms for new patients, and showed me where to go and how to communicate with the health staff, like what papers you have to give to which people, how to pay the money at the end, and where to pay. She came in to a doctor with me as well, and afterwards, went across the road [with me] to go to the pharmacy to get my medication.

Kei acted as a "health counselor-interpreter" (Kinzie 1985: 120) and a "cultural consultant" (Ishisaka, Nguyen & Okimoto 1985: 44). Cathy and Will did not need to be the main participants of the communication. Kei did everything on their behalf.

The positioning of Kei in navigating communication in an unfamiliar health system which uses a different language is similar to the positions adopted by the English-speaking husbands of Japanese-speaking informants analysed in Chapter 3. In all cases, the communication mediators did not always engage in precise language rendition. Their

mediation was instead centred on explanations based on their social, cultural and linguistic knowledge which they gained through their plural identities.

Effective mediation in cross-linguistic medical encounters often goes beyond simple language conversion. Interviews by Morris and her colleagues (2009) with medical practitioners, employees of refugee support organisations and recent refugee arrivals in San Diego, USA found that while it is expected that refugees in a post-resettlement stage have improved access to health care, their culturally specific expectations of care were an obstacle to accessing adequate health care services.

Barriers relating to language, the acculturation process, and cultural beliefs regarding health care all contributed to a decreased ability or willingness to obtain care. Many of these barriers are inter-related and jointly contribute to a larger access to care problem among the refugee population. (*ibid.*: 536).

Free (2005), a practicing GP, also pointed to the gap in expectations of care between the clinician and the patient who do not share the same cultural background.

A GP who is a good communicator will draw on such tacit cultural knowledge to frame responses and advice in a way that is both acceptable and understandable to the patient... Such a process becomes more complex when patients are from a different cultural or sub-cultural group to the doctor. Patients from a different ethnic group to the doctor may hold health beliefs that are not familiar to the doctor (*ibid.*: 339)

Differences in the expectations of the structure and function of a good therapeutic patient-doctor relationship may pose an obstacle to Japanese-English medical encounters. Unlike Western countries, medical practitioners and health care organisations in Japan have great authority (Ohnuki-Tierney 1984; Slingsby 2004). Cathy and Will commented that:

Japanese medical professionals are very different from Australian medical professionals. You are supposed to never question what Japanese doctors say, whereas in Australia, medical consultation is a very collaborative process. The doctor will ask you how you're feeling and what the symptoms are. But in Japan, they just assume the knowledge because they're doctors, and therefore you must accept this without ever asking any questions. There are not many opportunities for patients to ask questions, either.

A Japanese medical practitioner seeing a non-Japanese patient may be taken aback by the proactiveness of the patient who asks endless questions (Multilanguage Center FACIL 2012).

Emma, another English-speaking informant, described how she 'overwhelmed' a Japanese-speaking obstetrician in Japan.

I kept asking questions to the doctor. I had a list of questions. It was probably annoying [laughs]. The doctor probably wasn't really familiar with being asked so many questions by her patient. The doctor at the beginning was a little bit surprised. She ended up being very nice. I guess asking too many minor things is not really anticipated [in health care in Japan].

Kei expressed Cathy's questions in a culturally appropriate manner and using the right conversational timing to the Japanese clinician so that the questions were addressed without causing awkwardness or misunderstandings.

I knew that I wanted to ask questions, so I asked Kei to come with me and explained to her what I wanted to ask. So, before we left the room, she was able to tell the doctor that I had questions to ask.

The accounts of several English-speaking informants including Cathy and Will indicated that it is often difficult for non-Japanese patients to ask Japanese-speaking clinicians questions firstly because of the culturally accepted inferior social status of patients relative to medical practitioners and secondly a relatively shorter consultation time compared to those in Western countries. Wooldridge and his colleagues (2010) conducted an eight-day analysis of the duration of 263 consultations in a private clinic in Japan to verify the Japanese saying, "*sanjikan machi, sanpun shinsatsu* (three hour wait, three minute visit)". The researcher found that the mean duration of each consultation was 6.12 minutes. While it was longer than three minutes, it was still much shorter than the average consultation length of 16.3 minutes in the USA.

Audrey's description of her experience of a medical consultation in Japan includes reflection on the difficulties of asking a clinician a question in Japan.

I was quite surprised first by probably the amount of medicine. You know how you get many little packs of many different types of medicine, like powder medicine. Usually you just get here [Australia] just one, maybe two. But there I got a full kind of little plastic bags, full of different sorts of medicine [laughs]. The doctor just said, "I'm going to give you some medicine", "Have rest". He didn't really explain about the medicine. He just said, "*kazegusuri* (cold relief)" in Japanese.

In addition to bridging different cultural expectations of the patient and the clinician, the liminal agency of the communication mediator is an important influence on the impressions held by the patient and the clinician about each other. Modifying expressions, regardless of whether they are verbal or non-verbal, help the speakers control the formation of impressions (Goffman 1967). When the speakers do not share certain cultural expectations and understandings, their intentions are not always mutually understood. This may compromise trust formation between clinician and patient. Kei helped Cathy and her Japanese-speaking clinician not to form negative impressions of each other by communicating Cathy's questions to the clinician in a culturally appropriate manner. The Korean-English interpreter in Moore's observation (2015) also influenced impression formation for the parties involved in the communication.

Kei's versatility is taken for granted at hospitals in Japan. Part of the reason is because, unlike Western countries, liability for miscommunication and mistreatment in health care in Japan is not clearly incorporated into the legal system.

Echigo's analysis (2014) of 836 medical litigation cases in Japan found that in many cases the defendants retained no or insufficient records of explanations given to the patients. A study of 366 medical malpractice cases in Japan in which the physicians' duty of providing the patients with sufficient explanations was the main point of conflict also suggested the vague responsibilities of physicians for giving clear information to the patients.

Interestingly, written consent by the patient or family showed no relationship to the physician's legal liability... The result suggests that the patient's actual consent is more important than a particular written consent form. (Hamasaki & Hagihara 2011: 8)

The researchers did not clarify what “the patient’s actual consent” means, although they distinguish it from written informed consent using a pro forma. The equivocal significance of informed consent from patients suggests that in Japan, written consent is a ritual, a borrowed concept from the West, and rarely carries substantial legal significance. When I was hospitalised in a university hospital in Japan for an acute illness, I underwent a CT scan without being provided with any explanations. On the following day, the doctor asked me to sign a back-dated informed consent form which stated (incorrectly) that I had agreed to receive an injection of contrast agent after having received an explanation of the risk of anaphylactic shock which the agent could cause.

The following statement by Hamasaki and Hagihara (*ibid.*) implies that in Japan, patients are given insufficient time to consider treatment options.

Since, in many cases, the patient has little medical knowledge and may be mentally or physically unstable, it is difficult for the patient to decide on a treatment option adequately in a short period time. Therefore, where possible, the physician should avoid performing medical treatment or surgery on the day of providing explanations to the patient (*ibid.*: 8)

Although it may not be possible or realistic to give the patient time to consider treatment options in emergency cases, the above statement still suggests that the significance of patient-doctor communication may often be underestimated in Japan. This Japanese custom makes it difficult for an interpreter to draw a clear role boundary between language rendition and all other tasks because the latter is potentially crucial for the patient’s understanding of the health service and possible consequences. The way in which Kei provided support to Cathy and Will was novel to them because she went far beyond their perceived role of an interpreter from a Western point of view. Kei played an important role in closing the gap in Cathy and Will’s understanding of the Japanese health system.

Health care interpreters in Japan are expected to contribute to the patients’ overall satisfaction with health care services. Accurate language rendition is not as central to the

objectives of health care interpreting service as it is in Australia. The role of health care interpreters in Japan is versatile, and changes depending on the situation (Committee to Review Standards for Medical Interpreters 2010).

Kei's role may be closer to the role of a 'bicultural worker' in Australia. Bicultural workers are often employed by organisations which provide support for refugees and migrants with ethnic minority backgrounds to settle in Australian society. The Centre for Multicultural Youth in Melbourne provides the following definition of a bicultural worker to distinguish them from an interpreter.

Bicultural worker: A person employed to work specifically with people or communities with whom they share similar cultural experiences and understandings, and who is employed to use their cultural skills and knowledge to negotiate and communicate between communities and their employing agency (2011: 3)

In contrast to Australia where the linguistic and cultural elements of communication are often separated from each other, these two elements are integrated into one single role in Japan.

The shared language and cultural identities of the communication mediator and the clinician

Emi, another Japanese-speaking informant, described the positive impact of the shared cultural and linguistic identities of the communication mediator and the clinician.

No, [my husband cannot speak Japanese] at all... I'm terrible in English, but he understands most of what I say. Since he is a native English speaker, he can use professional medical terms [*sic*] and give explanations [to the doctor]... He understands my symptoms, so he can explain them in detail. It's like a mother can explain well about her own child. This often works better [than using a professional interpreter].

Emi and her husband rely on various non-language clues when communicating with each other. In medical consultations, Emi's husband explained her symptoms and concerns on

her behalf. Emi said that her clinician understood her husband's explanations because her clinician and her husband shared the same language and cultural understanding.

Emi has previously had an unpleasant experience of using a professional interpreter (see Chapter 3). She had difficulties in expressing what she really wanted to say when she spoke through a professional interpreter because the interpreter rendered only the literal meanings of her words. In contrast, when Emi told her husband her symptoms and needs with her limited English, he understood her intent, and communicated it in a culturally appropriate manner.

Drawing on interviews with twenty-four bilingual adults who speak English as their second language, and the autobiographies of bilingual novelists, Burck (2004) suggested the impact of one's first language and home culture on communication.

A first language could engender a sense of belonging and a sense of authenticity. These meanings given to first languages were also constitutive of the speaker... A first language could also carry a symbolic meaning, of national identity, and could therefore be used to make political claims (Burck 2004: 321).

Given the findings from Burck's study and the accounts of Emi, it may be as important for the clinician and communication mediator to share language and cultural identities as it is for the patient and the mediator. This suggests that the liminal agency of the mediator between different identities is crucial for effective cross-linguistic medical encounters.

5.4 Communicating Japanese 'roundabout' expressions in Australian contexts

Ryo is a native Japanese speaker in his forties. He grew up in Japan, and moved to Australia approximately ten years ago when he found a job as a legal professional in a major Australian city. He has experienced Japanese-English medical encounters in Australia, and also served as an interpreter at his current site of employment. Ryo explained to me what

he thinks a good communication mediator is, by reflecting on his own experiences of being a communication mediator and a patient in Australia.⁵

The Japanese language has its own unique ways of expression. In many cases, if an interpreter accurately reproduces all Japanese speech in English, the conversation gets screwed. Japanese metaphors often make no sense to Australian people. I often see this happening between our Japanese clients and my Australian colleagues. So I think it would be good if an interpreter could identify what the speaker really wants to say, rather than literally interpreting their words. When a Japanese patient uses an interpreter, it is likely that they start talking in detail about how people deal with things in Japan. If an interpreter fully tells such details to the Australian doctor, the doctor would probably only think, "So what?"

Ryo mentioned that Japanese people tend to add extra narratives when they give explanations, instead of stating the key point in short sentences. Ryo noted that this is because Japanese people tend to consider that cutting to the chase is rude.

Japanese people tend to include information which is totally unnecessary for communication with Australians. Such information, if it is mentioned, would make the Australian counterparty confused. If we use an interpreter, we want them to give us more comprehensive assistance. An interpreter does not have to interpret every single word which the Japanese client says. It would be good if the interpreter would tell the Australian counterparty only a summary of what the Japanese client is saying.

Ryo's account suggests that Japanese speakers and Australian English speakers may consider the relevance of information to the topic differently. While those who are familiar with the Japanese way of communication search for the intention of the speaker behind their usually lengthy, roundabout statements, this is not necessarily a communication strategy used by those who are not familiar with Japanese culture. Japanese roundabout expressions often do not effectively convey the Japanese speakers' intentions to the English-speaking listeners. Ryo gave an example by referring to his own experience in his current office in Australia.

Emails from typical Japanese companies are extremely long. Over half of the text is the explanation of the background. They finally ask a question in the very last line of

⁵ While Ryo is a Japanese-English bilingual, our interview was all in Japanese.

the message [laughs]. I've received emails which I would've understood quicker if I had read them from the end. The [Australian] recipient of the email doesn't have to know most of what's happening internally within the [Japanese] sender's company. Knowing such information doesn't really affect the reply from the Australian recipient.

A cross-cultural survey of fifty Japanese and sixty Anglo-Australian individuals on their understanding of the traits of a good person found that 70% of Japanese respondents used the word *omoiyari* (the closest English equivalence is 'empathy') whereas Anglo-Australian respondents cited 'honesty' (70%) and 'intelligence' (50%) (Travis 1998).

Omoiyari can be broken down into two main components... The first refers to "intuitive" understanding, and the second to actually performing some action on the basis of this understanding (1998: 58).

Based on her analysis of Japanese conversations, Travis argued that in Japanese society, the concept of *omoiyari* is "essential for the maintaining of harmonious relations in day-to-day interaction" (*ibid.*: 70). This conforms to the statement by Yamada (1997) I referred to earlier in this chapter on the role of 'anticipatory guess work' in Japanese society. According to Travis, the English term 'empathy' does not have the same social implications as the Japanese *omoiyari*.

[I]n Japanese society, acting on the basis of one's understanding of others is not only highly valued; it is essential if their desires and feelings go unexpressed. In Anglo culture, on the other hand, we are brought up to understand that people will communicate their needs and wants to us and so acting on the basis of one's own "intuitive" understanding is not as highly valued (*ibid.*: 66).

Both Travis and Ryo mentioned that English speakers usually prefer concise explanations. Ryo pointed out that Australian people may find Japanese roundabout expressions are off the point. Yamada (1997) also pointed to this difference in communication strategy between Japanese and Americans as the cause of misunderstanding. Redundancy and vagueness are the most important strategy for a Japanese speaker to show their respect to the listener, by avoiding directness.

I have served as a professional interpreter in conversations similar to those described by Ryo. I have seen a Japanese patient giving a long narrative about their symptoms and life circumstances in response to a simple question from their doctor such as, “How can I help you?” or “Would you like me to write a referral letter for you?” Given Ryo’s account and the analyses by Travis (1998) and Yamada (1997), such responses from a Japanese patient may be a communication strategy to prompt the clinician’s action based on their ‘intuitive’ understanding of the patient’s issues which include not only biomedical symptoms but also psychosomatic factors.

When this Japanese-style communication occurred in a Japanese-English medical encounter in Australia, I usually saw the doctor stop and redirect the conversation. Otherwise, I stopped the patient, and explained to the doctor that the patient was giving a long narrative and was yet to answer their question. I usually briefly explained to the doctor that this is how Japanese people communicate. I also explained to the patient that their doctor wanted them to give an answer to the specific question. Without such an explanation, it would be difficult for a Japanese patient and their Australian doctor to understand each other’s intention. Giving extra explanations often made the conversation longer and more complex because it increased the volume of information exchanged.

Japanese patients tend to refrain from asking questions or making clear requests to their doctor (Ohnuki-Tierney 1984; Slingsby 2004). Instead, a Japanese patient gives their doctor a large amount of peripheral information, such as life circumstances and family situations, in addition to the description of their symptoms. A patient waits for their doctor to identify their unstated needs and navigate the conversation based on their understanding of such needs. They also leave a treatment decision to their doctor. Slingsby explained why Japanese people adopt this entrusting model because “the patient respects the doctor as the ‘expert’ in the situation” (2004: 86). A Japanese patient may be wary of making their

doctor feel that they do not trust their doctor's capabilities, by asking questions or making requests.

Japanese people adopt the same communication style when they communicate with people with authority in other areas. In a school classroom in Japan, for example, it is rare to see students asking questions or making requests to their teacher. As Travis (1998), pointed out, the focus of communication in Japanese culture is to maintain harmony in the interpersonal relationship.

Japanese people often consider that asking questions and making requests disturb harmony in the relationship. A comparative analysis of responses to tutors by Japanese and English-speaking British students (Turner and Hiraga 1996) found that Japanese students were less elaborative (that is, focused on specificities and relevant detail) and more informative and conciliatory than British students. The researchers also found that Japanese students who have spent more time in an Anglophone country were more elaborative, suggesting that the reticence observed in Japanese students was largely due to the culturally constructed image of an ideal student in Japan.

The informative strategy was used by the Japanese groups in four out of five situations. This appears to be operating against the background sociopragmatic assumption that what is required is the display of knowledge. The conciliatory strategy has two rhetorical effects, namely keeping the peace and complying with what the tutor seems to want (Turner & Hiraga 1996: 138-139).

While most Japanese patients face little difficulty in finding the right time to give subtle clues for questions to their doctor, it is often challenging for a non-Japanese patient to do so. English-speaking informants expressed multiple interpretations of this preference for not questioning clinicians. Will surmised that this represented a cultural style of communication:

Japanese doctors are very uncomfortable being asked questions because it's not the Japanese way of asking questions.

Matt also saw this as a cultural practice, though he wondered if this deference reinforced the high status of professionals.

I think you may get over-proud doctors, but I think it's just a cultural thing. I don't think that they are conscious that they're doing it. It's just you never ask questions to your Japanese doctor.

Cathy noted that one of the consequences of the cultural proscription on questioning doctors was that it became structurally reinforced through institutional practices - in this case, very short consultations.

The doctor I see now is a bit older. He's more traditional. He only speaks Japanese. He goes through things very quickly. I go into the room and stay there maybe for two to three minutes. He says, "This is the blood test results, this was good, this was good, this was good. Okay, I'll give you medication. Bye" [laughs]. With this doctor, I don't have much chance to ask questions.

Ryo also said that since a Japanese speaker tends to make roundabout statements as a cultural practice, a Japanese-English interpreter needs to be capable of effectively summarising messages from a Japanese speaker. Ryo pointed to the trust relationship between the patient and the interpreter when the interpreter summarises the patient's statement.

It's not good if the patient thinks that the interpreter isn't telling what they are saying to their doctor. If there is a trust relationship between the patient and the interpreter, the interpreter will not have to interpret every single word which the patient says.

The ideal model of interpreter-mediated Japanese-English communication described by Ryo is contrary to the traditional view on the professional practice of interpreters, which is also reflected in the Australian Code of Ethics.

[I]t has been the traditional and persistent view that interpreters should be transparent, invisible, passive, neutral, and detached. They should do no more than make a faithful and accurate language switch and are not entitled to intervene in the communication process... an ideal interpreter should not make people feel his/her presence. Along with the professionalization of interpreting, this view has

been reiterated and reinforced in interpreters' codes of conduct as prescribed by many national and international professional translation and interpreting organizations. (Mason & Ren 2014: 117)

In the next chapter, I address the mismatch between the Australian model of professional practice of interpreters and the Japanese notion that good communication may require stepping outside direct matching of words across different languages.

Ryo mentioned that a trust relationship between the communication mediator and the Japanese speaker makes it easy for the mediator to avoid causing doubt in the speaker about the capabilities of the mediator. His account suggested that the cultural and contextual proficiency of the communication mediator is important in identifying the intention of the speaker. The liminality of a communication mediator between different cultures and between different symbolic and social positions allows them to identify the intention of each speaker and render it in a culturally understandable manner for each speaker.

5.5 Summary

In this chapter, I explored the liminality of communication mediators in Japanese-English medical encounters. I showed the implications of the patients' perceptions of the liminal agency of the communication mediators on the patients' experiences of the mediated communication. The accounts of informants suggested that successful cross-linguistic communication mediation involved the negotiations of tacit, culturally and socially nuanced meanings between different perspectives. The communication mediators had plural cultural and social identities and constantly moved between them. The liminality of the communication mediator allows them to apply their cultural knowledge to mediating the conversation in a cross-linguistic encounter.

This chapter also suggested that the trust relationship between the communication mediator and the patient was important for the communication mediator to maintain their liminal agency. This finding was contrary to Australian guidelines of using interpreters which warn that the personal relationship between the interpreter and the patient has a negative impact on the quality of interpreting (Victorian Government Department of Human Services 2005; Western Sydney Local Health District *n.d.a*). None of the cases drawn on in this chapter showed that the close relationship between the interpreter and the patient resulted in a failed communication. It instead had a positive impact on the quality of communication.

Japanese communication strategies often avoid the explicit expressions of needs and concerns. The liminality of the communication mediator is thus essential to effective communication between a Japanese speaker and an English speaker. Findings in this chapter suggested that modifications to messages by the communication mediator in line with the context and situation are sometimes necessary for effective Japanese-English health communication.

In the next chapter, I explore the implications of the professionalisation of the occupation of interpreting in Australia on Japanese patients' experiences of interpreter-mediated medical encounters in the country. I analyse the relevance of the interests of interpreters to those of patients, by drawing on a number of theories which explain the societal functions of professions in society, and by reviewing the AUSIT Code of Ethics, a compilation of professional tenets for interpreters and translators in Australia.

Chapter 6 The impact of the professionalisation of interpreting on the role of health care interpreters in Australia

In this chapter, I examine the impact of the Australian model of professionalisation of interpreting on the relationship between the patient, the interpreter and the clinician. This chapter begins with an exploration of the impact of the professionalisation of an occupation on the social status of its practitioners. The Australian professional model of interpreting encompasses a set of assumptions about best practice. This is enshrined in the AUSIT Code of Ethics, which emphasises the accuracy of language rendition, the impartiality of the interpreter and the speaker's confidentiality. The Code explicitly prohibits patient-centred practices such as advocacy or prioritisation of communication needs. In other words, the interpreter is not supposed to prompt the patient even if they are aware that the patient does not know how to clearly state their needs in a culturally appropriate manner. Institutional practices such as surveillance and monitoring of interpreters determine and confine the relationship between interpreter, patient and doctor. I trace the interrelationship of the interests of interpreters and those of the users of interpreting services with a particular focus on the Australian context, arguing that experienced doctors often subvert the Code of Ethics to engage patients and interpreters in communication suited to the patients' interests and the context of the consultation.

6.1 The profession of interpreting in modern society

The two broad sociological approaches to professionalisation are articulated in the work of Talcott Parsons (1939) and Eliot Freidson (1970), who were influenced by the Harvard School and the Chicago School respectively. The functionalist Harvard School approach posits a profession as:

an "analytically and empirically distinct type of occupation", characterized by the complex technical knowledge possessed by its practitioners, the extensive

education required to obtain it, the social importance of their work (in its relation to urgent individual needs), and the high degree of uncertainty, responsibility, and consequent stress that accompanies practice (Newton 1982: 33).

On the other hand, the Chicago School focuses on the social statuses of the members of professions rather than the societal needs of and for the profession.

The Chicago school begins with the assumption that “the category of professional is a semi-mythic construct,” fashioned by members of an occupation for the purpose of obtaining social and economic advantages, who then successfully persuade the rest of the society to accept their construct and honor their claim for special protection and privileges. (*ibid.*: 33-34).

Parsons (1939) argued that “profession” is a highly institutional concept because professionals are important intermediaries in the smooth operation of society. According to Parsons, professions are not simply labels which endorse the special skills of an occupational group but are part of a social structure. The members of a profession gain recognition in the society that their skills help satisfy the shared needs of the public (*ibid.*: 467).

This approach enables the comprehensive understanding of modern occupations as being primarily defined through their connection to the society. It concisely justifies technical monopoly by professionals. Parsons argued that “[t]he professional type is the institutional framework in which many of our most important social functions are carried on, notably the pursuit of science and liberal learning and its practical application in medicine, technology, law and teaching” (*ibid.*: 467).

In an analysis of the relevance of professional codes of ethics for sign language interpreters and translators to their current practice in the US, Cokely (2000) explained that the members of traditional professions, such as those which Parsons referred to, are recognised as professionals in society because they practice in accordance with publically proclaimed role boundaries and because they follow guidelines for which implicit or explicit agreements have been made between the professional group and the public.

Cokely (*ibid.*) argued that while newer occupations such as technicians and athletes may lay claim to being professionals, their functions in society are different from those of traditional professions.

We do not perceive that the same type of collective agreement (explicit or implicit) or public proclamation of boundaries or guidelines exists within [the newly claimed professions]. Rather, we perceive that the boundaries within which individual practitioners within these groups approach their work vary greatly, or perhaps that there are no clear boundaries or guidelines for individuals of such groups (*ibid.*: 29).

While Parsons' approach elucidates one of the aspects of the relationship between professions and society, according to Cokely, not every profession in modern society can claim societal importance as its defining characteristics.

According to Freidson (1970; 1989), satisfying a common societal needs is only one aspect of a profession. Building on his formative work on the profession of medicine, Freidson argued that an analysis of what constitutes a profession should be "a systematically interrelated set of comprehensive even if not exhaustive criteria by which we can distinguish among occupations in consequential ways" (1989: 424).

[I]t is almost meaningless to invoke serving the common good rather than personal interest without at the same time specifying the conditions (such as a reasonably secure income) that support the very possibility of doing so (*ibid.*: 424).

While noting that criteria for distinguishing a profession from other occupations are varied and arbitrary, Freidson pointed to the power which members of a profession exercise to determine how their work should be performed and evaluated (*ibid.*: 425).

Such power can operate in conflicts immanent in a profession to which different interests of various parties are linked. Wilensky (1964) pointed to increasing complexity in emerging occupational structures which involve conflicts in the requirements and expectations of practitioners, organisations and the general public.

Wilensky (1964) argued that the application of “exclusive technical competence and adherence to the service ideal” (*ibid.*: 156) to all occupations which are undergoing professionalisation is no longer an effective approach to understanding how the public in modern society perceive professions. The members of a profession can no longer be distinguished from lay people simply on the basis of an esoteric monopoly which is supposed to reflect societal needs for their special skills and knowledge. Wilensky argued that it is possible to see newly emerging professions as an analytic window through which one can investigate the intricate relationships and conflicts of interests between the members of such professions and the society.

Interpreting is an example of these newly emerging professions whose position in society cannot be fully analysed through Parsons’ conceptual framework. Firstly, societal needs for professional interpreting are not as clear as those for professional medical and legal services. This may be partly because it is possible for an individual who is proficient in two cultures or languages to perform an interpreting task to an extent which allows the speakers to manage to communicate with each other, even though scholars in interpreting studies (who are often themselves professional interpreters) argue that this practice is problematic (Gentile 1997: 117; Hale 2007: 70). Secondly, interpreting is almost always performed in conjunction with another profession. When an interpreter works in a clinic or courtroom, for example, their performance needs to align with that of other medical or legal professionals. The need for inter-professional work with interpreters spans various fields from health care, legal and education. Freidson’s work – particularly his focus on the labour market that frames a profession – offers a useful insight into the ways the profession of interpreting functions in the labour market. In the next section I examine how codes of ethics function as tools for forging a place in the labour market for interpreters.

The profession of interpreting and codes of ethics

Codes of ethics are central to the professionalisation of the occupation of interpreting (Angelelli et al. 2007; Bancroft et al. 2015; Herndon & Joyce 2004; Mikkelsen 2004).

Freidson (1989) argued that this is a common strategy which many professions adopt when recruiting members.

Lately the stress has been on selection by universalistic criteria of competence, which itself seems to require placing less emphasis on character and more on the content of the training of recruits, and most particularly on training in ethics and professional conduct (Freidson 1989: 428)

Cokely explained the significance of codes of ethics for the members of proclaimed professions in establishing their social statuses.

Among the factors that separate a profession from an occupation is that a profession, through organizations composed of practitioners, consciously adopts a code of ethics. These practitioners, acting in concert, publicly affirm that as a group they pledge to uphold a set of agreed-upon values and principles that will guide their work (Cokely 2000: 29).

The special skills which the members of a profession utilise in delivering their services are in many cases endorsed by publically recognisable tangible means including codes of ethics, and credentials and certifications issued by publically recognised organisations (Cokely 2000).

Bryan Turner (1995) described the professionalisation of an occupation through such an instrumental approach as a monopolistic strategy.

[P]rofessionalization is now regarded as an occupational strategy in which social groups attempt to control their place within the market... these market strategies also depend upon the acquisition of an esoteric body of knowledge via the university system under the general regulation of the state" (Turner 1995: 138).

A body of research in the field of interpreting studies emphasises the importance of codes of ethics for health care interpreters (Janzen & Korpiniski 2005; Mizuno 2005; Nicholson 1994; Niska 2002).

Making ethical choices is important for the interpreter because these decisions greatly affect the consumers' understanding of what has transpired during their interaction both with each other and between the consumer and the interpreter herself. Our assumption is that an interpreter needs to adopt a philosophy of proactive ethical behaviour at the onset of her training, and this approach must continue throughout her career. (Janzen & Korpiniski 2005: 165)

In an analysis of the AUSIT Code of Ethics in Australia and other codes for professional interpreters in the USA, Mizuno (2005) posited codes of ethics were a prerequisite for the occupation of interpreting to be recognised by the public as a profession. Mizuno argued that tenets in codes of ethics clarify the role boundaries of the interpreter, and that compliance with such codes by interpreters is therefore likely to increase the quality of their services (2005: 170).

Nicholson's argument (1994) that codes of ethics for professional interpreters should be reviewed as they often do not provide guidance for real-life working situations is premised on the assumption that codes of ethics are indispensable to the existence of the profession. The same applies to a statement by Niska (2002) writing on training for interpreters in the areas of community services.

Among the many variables to which the community interpreter must be sensitive are the setting in which interpreting is provided, its purpose, the status of participants, societal norms regarding interpreter behaviour, and professional ethics (Niska 2002: 133)

The purpose of codes of ethics is to regulate the behaviour of the members of the profession so that they can provide 'ethical' services which are supposed to meet the societal needs of the public. In a philosophical exploration of the existential significance of codes of ethics for professions, Lichtenberg (1996) argued that the instrumental aspect of codes is derived from the self-interest of the members of the profession. An excessive focus

on instrumental means is a strategy which many modern professions employ for the purpose of “increasing the influence of the man of applied knowledge at the expense of the freedom of others” (Freidson 1970: xii).

Hsieh (2002) gave another insight into interpreters’ role definitions and their work. She described the role of professional interpreters with reference to Erving Goffman’s (1959) concept of non-person in interactions in everyday lives. Hsieh argued that interpreters take up the non-person role by emphasising accuracy and neutrality as a defence strategy. According to Hsieh, interpreters maintain the inviolable boundaries of this space, by defining certain tenets and skills which are exclusive to this non-person profession.

Associations representing and regulating interpreters, mainly those in the United States, Canada and Australia, have set up codes of ethics (Bancroft et al. 2015; The Healthcare Interpretation Network 2007; AUSIT 2012) and special guidelines dedicated to health care interpreters (California Healthcare Interpreters Association 2002; NSW Health Care Interpreter Services 2014; Queensland Health 2007; The National Council on Interpreting in Health Care 2004).

In Australia, the AUSIT Code of Ethics functions as the unified national standard. It is closely linked to the professional credentials issued by NAATI (introduced in Chapters 1 and 2). By contrast, in the USA, Canada and the UK, there is no national code of ethics which is linked with the obtaining and awarding of professional credentials for interpreters in the same way as in Australia.

Codes in the USA and Canada are segmented into different fields such as health care and law, and most of them are created and implemented at the state and provincial level.

Examples are the California Standards for Healthcare Interpreters (California Healthcare Interpreters Association 2002) in the USA, and the Code of Ethics of the Society of Translators and Interpreters of British Columbia (Society of Translators and Interpreters of

British Columbia 2015) in Canada. While there is the National Standard Guide for Community Interpreting Services (Healthcare Interpretation Network 2007) in Canada, it is not as institutionalised as the AUSIT Code of Ethics in that health care interpreters in Canada are not obliged to comply with this standard for the purpose of maintaining interpreter credentials. Codes and credentials in the UK have not been as systematically implemented as they are in Australia, the USA and Canada.

The AUSIT Code of Ethics defines the ideal model of professional interpreting (AUSIT 2012). The model is centred on accuracy, impartiality and confidentiality. Tenets set out in the Code apply to all interpreters who have NAATI credentials regardless of their specialist field (*ibid.*).

Within Australia, a large number of agencies, institutions, language service providers and purchasers of interpreting and translating services now require practitioners who work with them – whether AUSIT members or not – to adhere to this Code of Ethics. It is recognised as setting a general standard for interpreting and translating. (AUSIT 2012: 3)

In the final four lines of the fifteen-page document, the Code mentions that when an interpreter works in a health care institution, their behaviour needs to meet the regulatory requirements of the institution.

In specific institutional settings where duty of care or security rules regulate the behaviour of all participants, such as in health care or high security settings, interpreters follow the relevant policies and procedures combining them with their interpreting code of ethics. (*ibid.*: 15).

In its main section, the Code stipulates that an interpreter should draw a clear role boundary which separates professional communication from personal communication.

Interpreters and translators do not, in the course of their interpreting or translation duties, assume other roles such as offering advocacy, guidance or advice. Even where such other tasks are mandated (e.g. by specific institutional requirements for employees), practitioners insist that a clear demarcation is agreed on by all parties between interpreting and translating and other tasks. (*ibid.*: 9)

This demarcation may not be effective in cross-linguistic communication. The role distinctions of 'interpreter' (defined by the profession) and 'advocate/guide' (required by some workplaces) may be confusing for interpreters and patients.

The ultimate purpose of setting up professional credentials and codes of ethics for health care interpreters is to effectively respond to the needs of patients who do not speak the country's dominant language. Arocha and Joyce (2013) reviewed the process of developing a national certification programme for health care interpreters by the National Board of Certification for Medical Interpreters in the USA. In explaining the rationale for setting up the certification programme, the researchers gave an example of misdiagnosis due to communication failure in a consultation which involved the patient's family member.

Interpretation errors have even led to serious harm, as in the 1980 case of, eighteen-year-old Willie Ramirez. Due to an error of interpretation, doctors misunderstood the Cuban Spanish word *intoxicado* to mean that Ramirez had intentionally overdosed on drugs, rather than that his family thought he had eaten a spoiled hamburger and was "intoxicated" as a result. As a result of this misunderstanding, doctors failed to detect an intracranial hemorrhage for two days and Ramirez was left a quadriplegic (Arocha & Joyce 2013: 128)

On the other hand, certifications and codes of ethics which are applied to interpreters regardless of the context restrict the agency of interpreters. In health care contexts, norm-based practice may fail to achieve successful interpreter-mediated communication. Drawing on interviews with seventeen interpreters from seven different countries, Dysart-Gale (2005) observed that a large number of codes of ethics for interpreters, predominantly in Western countries, overlook the social aspect of communication. The interviews indicated that codes which reflect the Western style, individual-focused communication model focus excessively on the mechanical transmission of utterances. One of the interviewed interpreters stated that they felt uncomfortable when they were supposed to refrain from expressing condolence to a mother after she had miscarried her baby. In another study by Angelelli (2004), one of the Spanish-English interpreters stated that he controls the power

balance between the patient and the clinician, by aligning himself with one of them depending on the extent to which the patient can describe their issues and the degree of the clinician's understanding of cultural difference (Angelelli 2004: 115).

Mechanical interpreting as best practice for interpreters in Australia

Professional interpreters in Australia uphold the notion that “[i]nterpreters and translators are not responsible for what the parties communicate, only for complete and accurate transfer of the message” (AUSIT 2012: 5). This statement overlooks the possibility that a patient may withhold statements depending on who mediates the conversation.

Interpreter-mediated health communication should not be considered in isolation from its cultural and socio-political context (Gray, Hilder & Donaldson 2011; Greenhalgh, Robb & Scambler 2006). A body of literature suggests that the experiences of illness vary between patients depending on the environment and the patient's circumstances. Kleinman and Gale (1982) argued that the shaping of illness and the behaviour of patients vary between cultures. Taussig (1980) criticised the masking of illness as subjective experience by positivist biomedical knowledge. Sontag (1983) pointed to images which people create in connection to illness and society. Ethnographic studies have found that a patient's illness experience alters and reshapes the multiple dimensions of their lives, such as family ties and their political and social identities (Biehl & Moran-Thomas 2009; Gammeltoft 2006).

The professional practice of health care interpreters and the language service system in Australia treat language barriers in the same way as that in which governments in modern society treat diseases and bodies as biomedical objects. They reify language barriers in health care as if they were a stand-alone object which can be resolved when the interpreter, the patient and the clinician follow a prescribed mechanical process.

The words of a patient are not the mere production of sounds which can only be used to render biomedical information. Illness and language are an embodiment of the patient's lived experience (Biehl 2005). The ideal model of professional interpreting in Australia may impose a rigid set of communication rules not only on interpreters but also on patients and clinicians, by regarding language as a functional object. This may be analogous to the medicalisation of illness, which controls and elides the subjectivity of the sufferer (Biehl & Moran-Thomas 2009).

Rigid compliance with the AUSIT Code of Ethics undervalues relationship-based communication, by fading the line between human and machine interpreting. In an analysis of the quality of machine translation and human translation based on a survey with 300 professional Chinese-English translators, Huang (2011) argued that both human and machine translation produce text which carries distinctly different meanings from those intended in the original text. Noting that neither human translators nor translation machines can produce perfect translation (Huang 2011: 2), Huang concluded that human and machine translation are the same kind of language transferring systems.

... both human translation (literary or nonliterary) and machine translation (fully automated or human assisted) are twins that transfer not only language, information, and knowledge including culture, history, politics, religions, as well as science and technology (Huang 2011: 10).

Huang's view on machine translation, which may essentialise cross-linguistic communication, seems to be increasingly dominant among interpreters, the government and the language service industry in Australia. When an interpreter who is detached from the patient provides a mechanical interpreting service (ie. one analogous to that provided by a machine), the onus of success in communication is likely to be on the patient, regardless of whether they are aware of this mechanism, and whether they are adept at adjusting to this artificial communication model.

Findings from participant observations and interviews with patients in the UK suggested that even in a monolingual environment, patients tend not to articulate their needs and concerns to those with whom they do not share common views about health and the behaviour of patients (Webb & Stimson 1976). Webb and Stimson (1976) studied how patients reconstructed their experiences of medical encounters, and found that patients frequently avoided directly confronting or questioning their doctors about services which they received even if they had concerns. Their study (*ibid.*) also found that the patients usually suppressed dramatic and emotional accounts during the consultation. Such accounts only emerged in the form of 'atrocious tales' when they told the stories to people with whom they believed they shared common standpoints, such as family, friends, and possibly interviewers. In a recent study from the UK, Morriss (2015) interviewed 17 mental health social workers in different areas individually or in groups. This study found that atrocious stories were told in a group interview because the participants share an understanding that they belong to the same professional community, and that such stories were told in an individual interview because the researcher and the informant shared the same professional identity as social workers (Morriss 2015: 1082-1083).

6.2 Is compliance with a code of ethics by the interpreter always in the patient's best interest?

In Australia, interpreters who work with health care providers are required to abide by the AUSIT Code of Ethics. Most health care interpreters hold NAATI credentials unless NAATI does not offer accreditation or recognition (see chapter 2) for the languages which they are practising in. Compliance with the Code is one of the conditions for NAATI-credentialed interpreters to maintain their credentials. Although language service agencies also pool and dispatch interpreters who do not have NAATI credentials, they nevertheless require, as a contractual responsibility, that such interpreters also abide by the Code.

Interpreters, policy makers and governments in Australia adopt the AUSIT Code of Ethics as an instrument for distinguishing professional interpreters from non-professional interpreters. Although the Code is not designed specifically for interpreters working in the health care context, all NAATI-credentialed interpreters, regardless of the area in which they work, are obliged to comply with it. The Code barely considers context-specific circumstances, such as complexity unique to patient-doctor communication. A booklet produced by NAATI on their accreditation testing system states:

NAATI adopted both the AUSIT Code and the ASLIA⁶ Code as important elements in the accreditation testing process and several government and private interpreting and translating services and agencies have implemented them as an integral part of the contract that practitioners must sign before joining their service and adhere to while performing their assignments. These services and agencies include:

- TIS (Translating and Interpreting Service, the Department of Immigration's official language services division)
- Centrelink⁷
- Refugee Review Tribunal
- Federal Attorney General's Department
- NSW Law Society
- NSW Health Care Interpreter Service
- Other major private suppliers of interpreters and translators (NAATI 2013: 1).

The AUSIT Code of Ethics is incorporated into degree programmes in universities and vocational training institutions throughout the country. Hale (2007) criticised this trend.

A code of ethics by itself cannot provide interpreters with a thorough understanding of their role, the interpreting process, the difficulties of achieving accuracy and the many other complex issues surrounding their work. Codes of ethics for other professions do not attempt to outline how to perform each of their required tasks. Expecting a code of ethics to do so would naively assume that it is capable of doing

⁶ Australian Sign Language Interpreters Association

⁷ Centrelink is a government authority responsible for providing human services such as disbursement of social securities payments, benefits and pensions as well as assistance for finding jobs.

so. It would also be oversimplifying what is in fact an extremely complex matter (2007: 114).

Major guidelines for using interpreters in Australian health care services refer to the AUSIT Code of Ethics, implying that compliance with it is indispensable to achieving optimal interpreter-mediated communication (NSW Health Care Interpreter Services 2014; Queensland Health 2007; Victorian Government Department of Human Services 2005). This logic may give rise to speculation that non-professional interpreters are likely to violate patient rights such as confidentiality whereas professional ones are not (see NSW Health Care Interpreter Services 2014; Queensland Health 2007; Victorian Government Department of Human Services 2005).

The AUSIT Code of Ethics states that “[i]nterpreters and translators are not responsible for what the parties communicate, only for complete and accurate transfer of the message” (AUSIT2012: 5). It also prohibits interpreters from engaging in tasks other than message transfer, by stating that, “[p]ractitioners do not, in the course of their interpreting or translation duties, engage in other tasks such as advocacy, guidance or advice” (*ibid.*: 6). The Code is in contrast with a US version for health care interpreters, in that the latter leaves the ultimate decision on whether to engage in patient advocacy to the interpreter.

In undertaking patient advocacy, interpreters must carefully balance the ethics of patient autonomy and impartiality with the need for supporting patient well-being... Due to the complexity of patient advocate interventions and potential risk to patients, [the California Healthcare Interpreters Association] suggests that such interventions remain an option to interpreters for pursue after considering their advocacy skills and potential risks and benefits. (California Healthcare Interpreters Association 2002: 46)

This (mis)appropriation of the Code as an instrument for drawing a line between credentialed interpreters and non-credentialed interpreters can be seen in several guidelines and standards for using health care interpreters throughout Australia.

Family members, relatives and friends... tend to filter the information. Their language skills are not tested and they are not trained in medical terminology. Most importantly, they are not bound by the Code of Ethics and there is no guarantee of confidentiality, impartiality or professional conduct (Western Sydney Local Health District *n.d.a*: 2).

Queensland Health (2007; 2012a) gives a similar justification based on a dichotomy between credentialed interpreters and non-credentialed interpreters, implying that the latter group are likely to be the cause of subsequent litigations against the health care providers.

Queensland Health requires that all interpreters engaged by the Queensland Health Interpreter Service abide by the Australian Institute of Interpreters and Translators code of ethics (Queensland Health 2012a: 1).

Working with accredited interpreters ensures that you communicate through a trained, bilingual person, who is guided by a code of ethics... Health services must consider the potential legal consequences of adverse outcomes when using unaccredited people to 'interpret' (Queensland Health 2007: 6).

The ACT Government (2015) also emphasises compliance with the Code by credentialed interpreters as a rationale for prioritising credentialed interpreters over non-credentialed interpreters.

Professional, accredited interpreters must be used wherever possible, due to the risks involved in using non-professional interpreters. Interpreting is a professional skill and professional interpreters are trained, insured, and bound by a code of ethics (ACT Government 2015: 10 – original emphasis).

None of these guidelines provided evidence that credentialed interpreters always comply with the Code. Nor did they mention the relationship between compliance with the AUSIT Code of Ethics and patients' interests. Apparently, they are more focused on the group of patients for whom the health care organisation cannot provide the evidence of their fulfilment of duty of care. While the wish to avoid legal consequences associated with not using an interpreter is natural and understandable, the question remains as to the relationship between compliance with the Code and patients' satisfaction with health services.

A survey of 152 internal medicine and 42 psychiatric care facilities in Switzerland on the use of health care interpreters found that patients' family members and bilingual clinicians and nurses are often relied on (Bischoff et al. 1999). In explaining the reason why professional interpreters should be used, the researchers pointed to aspects which cannot be addressed through neutral language rendition.

The problem with [using non-professional interpreters] is that they rely on their own linguistic skills which they can hardly evaluate themselves. Neither can they ensure that patient and provider have understood each other, especially when culturally sensitive issues are addressed which would need cross-cultural mediation (Bischoff et al. 1999: 253).

While the study indicated that effective cross-linguistic health communication require both accurate language rendition and cultural mediation, satisfying both may contradict the role of interpreters defined in the Code.

Communication failure caused by factors other than accuracy

The account of Saki, a Japanese-speaking woman married to a Japanese speaking man, suggested that communication failure is not always attributable to the inadequate skills of the non-credentialed communication mediator.

I had a stomach ache. Although it really hurt, I waited till the morning. In the morning, I went to a facility like an out-of-hours GP practice [walk-in nurse-led primary care clinic], which was next to the emergency department of a local hospital. They told me to go to the emergency department, so I went there. After waiting for a long time, the doctor in charge came in, and asked me to explain what happened. He reacted like, "Ah, you can't speak English [in a scornful way]". He then asked my husband, who was next to me, to interpret the conversation. I said, "No, I can explain to you", and my husband also said, "She's fine. She can explain to you. Her English is not perfect, but she can say what she wants to say". But the doctor said, "That's fine. I know". He was like talking down on us, and didn't listen to us. He was so rude that even my husband said to me in Japanese that he was rude. I know that it was our fault that my husband couldn't explain well and that neither of us could explain, but we were in such a tough situation.

Communication mediation by Saki's husband was not successful. This unsuccessful mediation was not solely attributable to his English skills. Saki found no issues with

communicating in English with nurses and another doctor whom she saw following this doctor. It is difficult to imagine that their English was so limited that it was impossible for them to communicate with the doctor because this couple had lived in the United States and Australia for over ten years, and because the husband always uses English at work.

Saki's account suggested that the ultimate cause of communication failure was the clinician's disrespectful attitude towards Saki and her husband. It is questionable whether neutral, impartial language rendition would have resolved this situation. If it had, it would mean that the clinician was discriminating against Saki and her husband based on their language identity. The clinician called another clinician, and he treated Saki.

They didn't ask us if we wanted to use a professional interpreter. After asking us several questions, the doctor went out of the room. Thereafter, an Asian doctor, who was his subordinate, came in instead. The doctor was a little friendly and said to us that he had been to Japan. This Asian doctor checked me in a very nice way, so we overcame frustration with the last doctor, but my stress level went up very high while I was seeing the last one.

Possibly making some assumptions about cultural similarities, the first clinician anticipated that an Asian clinician, irrespective of the language they spoke, would be able to communicate with a Japanese patient better than he did. This Asian doctor was not Japanese, and the communication was still in English. Nonetheless, Saki had no difficulties in communicating with this Asian clinician.

According to the AUSIT Code of Ethics, “[a]ccuracy for the purpose of this Code means optimal and complete message transfer into the target language preserving the content and intent of the source message or text without omission or distortion” (AUSIT 2012: 5).

Although the transfer of the intent of the source message may not necessarily be equivalent to word-to-word interpreting, users of an interpreting service may consider modifying the original message as distortion, even if it was for the purpose of transferring the content and intent of the source message. The quality assurance mechanism of TIS National tends to

focus more on word-to-word accuracy than communication of intent – something which would be difficult to assess through their chosen mechanism of third-person monitoring of randomly-selected telephone interpreted communication. From my own experience as a professional interpreter, in order to avoid potential accusation for distorting the message, interpreters are likely to stick to word-to-word interpreting. Saki's account illustrates the point that aiming for complete accuracy does not ensure an optimal communication outcome. Saki's account suggests that it is unlikely that a communication intervention will be successful if the interpreter and the doctor disregard non-verbal elements. Phillipson (1992) argued that many language experts have failed to link language, culture and structure.

6.3 Discrepancies between the stated benefits of professional interpreters and patients' experiences

The issue with relying on codes of ethics to distinguish professional interpreters from non-professional interpreters lies in the instrumental appropriation of these codes. In particular, the tenets of accuracy and impartiality are mutually complementary to reinforce the belief that mechanical language rendition is the best option to overcome language barriers.

Dysart-Gale (2005) criticised the code of ethics for medical interpreters issued by the Cross Cultural Health Care Program. It is a compilation of the codes of the Boston City Hospital, the Hospital Interpretation Program in Seattle, and the American Medical Interpreters.

Dysart-Gale (*ibid.*) argued that the code overemphasises accuracy, and reaffirms the impartial position of interpreters.

Dysart-Gale (2005) found that health care interpreters are often bound by the neutral conduit role. The accounts of interviewed interpreters indicated that they were instructed to stick to this role through training which presented scenarios of malpractice committed by interpreters who disobeyed the conduit role.

[I]nterpreters are trained to spend most of their time in the conduit role. The interpreters interviewed each affirmed the primacy of their role as a neutral conduit in the transmission of spoken messages... Strict adherence to the conduit role was generally identified as necessary to prevent egregious instances of interpreter malpractice (Dysart-Gale 2005: 95-96).

Interviews and focus groups with 39 clinicians and nurses in the southern United States found that participating health care providers tend to see an interpreter who sticks to the conduit role as emotionless and uncaring (Hsieh & Hong 2010).

Providers' and interpreters' emotional support are intertwined and may be difficult to separate. Although providers in our study believed interpreters should not interact with patients in such a way that the providers' and interpreters' voices blend together, they also viewed interpreters' emotional support as the reproduction of their emotional support for patients... [A] more realistic and effective way of conceptualizing emotional support in bilingual health care is to consider providers and interpreters as allies, complementing each other to support the patients' emotional needs and acting as joined forces to reinforce and complement each other. (*ibid.*: 196)

Jacobs, Diamond and Stevak (2010) created and implemented a training programme for medical students in the United States on using interpreters for cross-linguistic consultations. Participating medical students discussed the importance of using a professional interpreter and the risk of using a non-professional interpreter. The students also participated in simulations of interpreter-mediated medical consultations. The students participated in the discussion and simulations immediately after they watched a video which emphasised negative outcomes associated with using a non-professional interpreter.

In order to engage students to think about and discuss what can go wrong when an encounter is badly interpreted or an inappropriate interpreter is used... a 5-min teaching tape was shown in which a Muslim woman's sister-in-law is interpreting for her when she comes to the doctor to discuss the fact that she has been bleeding after sex... Clearly the patient and sister-in-law are uncomfortable in the situation and the sister-in-law violates all principles of interpreting (Jacobs, Diamond & Stevak 2010: 150).

While the researchers emphasised the breach of “principles of interpreting” by the family interpreter, they did not specify those principles. Nonetheless, the study concluded that the training programme increased the participants’ knowledge of professional interpreters.

[Participating medical students] were more likely to say that they would seek out a professional interpreter, ask patients to repeat back instructions, and take culture into account when taking care of LEP patients (*ibid.*: 151).

Training scenarios for interpreters and the users of interpreting services tend to provide extremely poor representations of the practice of non-credentialed interpreters. One of the interviewees in Dysart-Gale’s study (2005) described a scenario prepared for health care interpreter training. In this scenario, the interviewee observed that a non-credentialed interpreter behaves in an irresponsible manner, adding their own judgement to the clinician’s statement.

The doctor was telling a pregnant girl that she needed a test—an amniocentesis... the interpreter said “oh, she’s telling you [to] get this test, but it’s not a good one and you don’t need it, so forget it” (Dysart-Gale 2005: 96).

It is questionable whether the lack of formal interpreting training is the main cause of miscommunication, given the accounts of patients in the preceding chapters of this thesis. None of the patients indicated that communication mediators who had not undergone formal interpreting training acted in a way such that the patients experienced negative communication outcomes. Some Japanese-speaking patients associated professional interpreters with negative communication outcomes.

While the curriculum implemented by Jacobs, Diamond and Stevak (2010) increased participating students’ knowledge of professional interpreters, it did not increase their knowledge of why and when a patient may prefer a family interpreter, and may safely have this arranged. Interviews with GPs, patients and interpreters in Assyrian, Sujarati, Khmer, Mandarin, Samoan, Somali, Tigrinya, Arabic and Tongan in New Zealand suggested that the

use of a family interpreter may be both effective and efficient as long as it is a decision carefully made by the clinician after considering the likelihood of success (Hilder et al. 2016). While the study by Jacobs, Diamond and Stevak (2010) claimed a similar point, the researchers concluded that a professional interpreter helps the clinician consider cultural barriers. In effect, the researchers discarded the neutral conduit model as best practice. Instead, they suggested that a competent interpreter steps beyond this model.

[C]linicians need to learn to respect and be open to hearing interpreters' insights into patient cultural norms and political experiences which, when missed by physicians, have important consequences on the development of the therapeutic relationship (*ibid.*: 152).

A recent study conducted in Sweden (Krupic et al. 2016) which explored patients' accounts of negative experiences of using professional interpreters found that professional interpreters do not always demonstrate better performance. In the study by Krupic and his colleagues, the accounts of informants indicated that professional interpreters were often found to be lacking in professionalism. Study participants reported that interpreters were often "delayed, not arriving at the scheduled time, misinterpreting information, exhibiting a lack of professionalism and even being arrogant" (*ibid.*: 1724).

According to the participants in the present study, interpreters often cancelled or did not appear at the scheduled time. This issue was mentioned as a major problem by the participants, which often led to the interpretation being performed by health care staff. This solution is frequently suboptimal because staff usually lacks an interpreter's professionalism... and is usually not trained to act as interpreters (Krupic et al. 2016: 1726).

This study found that professional interpreters may cause issues which many scholars argue to be caused only by non-professional interpreters. The extent to which this reflected inadequate oversighting and governance, or lack of existence of a code of ethics to act as a guideline, was not stated, but the study does indicate that being a designated professional interpreter may be no guarantor of good performance. The researchers emphasised the importance of several competencies for interpreters.

[I]nterpreters should be linguistically, culturally and socially competent, as these factors may have a substantial impact on consultation outcomes (*ibid.*: 1727).

Although this study uses this finding to claim that professional interpreters need to have such competencies, at present professional credentials provide no guarantee that interpreters always demonstrate such competencies.

In a proposal by the Association of Professional Engineers, Scientists and Managers, Australia for revising the AUSIT Code of Ethics, Rickard (*n.d.*) argued that revising the Code would reduce the number of occasions in which interpreters need to explain the Code to their clients. In this proposal, Rickard implied that compliance with the Code guarantees that the interpreter will demonstrate competencies set out in the Code.

Confidentiality is one of the most critical tenets relevant to both interpreting and health care. Australian health care policy frequently refers to the use of a professional interpreter as a way of ensuring confidentiality, compared to a non-professional interpreter:

The use of relatives to interpret is also breaching confidentiality for the patient/client, and there is no guarantee of impartiality or professional conduct (Western Sydney Local Health District *n.d.b*: 1).

Haruka, a Japanese-speaking woman who has been living in Australia for two decades, described the story of her acquaintance Maki who thought that a professional interpreter violated her confidentiality.

Maki was very new to Australia. She married an Australian man, and moved to Australia. She couldn't speak English at all when she met her husband. She still couldn't when she came here. She then had a baby. The hospital called an interpreter. The interpreter was with Maki for quite a long time in the treatment room [*sic.*], and ended up talking with her privately. The interpreter was very nosy, asking everything about Maki's life. The interpreter spread a rumour outside the hospital after hearing everything about Maki's situation - a rumour that Maki was forced to come to Australia.

Haruka's story does not constitute evidence that the health care interpreter violated Maki's confidentiality. Regardless of whether the interpreter actually committed a breach of

patient confidentiality or not, Haruka had no trouble believing Maki's story. Haruka's account is an atrocity story (Webb & Stimson 1976), providing a moral lesson that a patient should not easily trust a professional interpreter because they are a stranger.

Haruka's atrocity story reflects the Japanese understanding of purity and contamination in interactions (Ohnuki-Tierney 1984; Martin 2007). The Japanese concept of *ie* (a social concept of Japanese domestic units) which Lebra (2007) pointed to in an analysis of the Japanese concept of nobility and child adoption in Japan explains the relationship between Haruka's moral lesson and the Japanese concept of purity and contamination. Lebra explained that the Japanese *ie* is "more than just family and as not amenable to the framework of kinship or descent" (Lebra 2007: 286).

[*ie*] is a structural unit consisting of roles or positions, rather than a group of persons as implied in 'family.' Such structural elements as roles or positions are defined in reference to the *ie* as a corporate body with its own status, assets, career, and goal (Lebra 2007: 286).

Lebra argued that the social status of the members of an *ie* is inseparable from that of the *ie*. Children to be adopted were therefore carefully chosen so as not to 'contaminate' the pure profiles of the *ie*. Although Haruka did not clearly define the interpreter as a stranger, she stated that she "did not know why [Maki] needed to use an interpreter because I did not think that I needed one when I was pregnant", in a slightly critical tone. Haruka's account suggests that Maki misinterpreted the personal questions from the interpreter as indicating that the interpreter was trying to build a personal connection with Maki. While Haruka did not deny the benefit of using a professional interpreter, her account suggests that a patient should be careful not to assume a close personal relationship with an outsider based on their apparently friendly attitude. This analysis can be supported by Yuri's account in Chapter 5 that she wants to become friends with Japanese people whom she sees in Australia.

General conversation between the interpreter and the patient is likely to occur when they are together for a long period, particularly in waiting rooms. In order to prevent such conversation from happening, NSW Health Care Interpreter Services has set up guidelines.

Many outpatient units have separate waiting areas that can be utilised by the interpreter. It is recommended that interpreters take advantage of these whenever possible and avoid sitting with patients in the waiting area prior to the medical interview. In inpatient wards, interpreters wait in the nurses' station until the healthcare provider arrives. Offers to sit with the patient by their bedside to 'get to know them' are best politely declined (NSW Health Care Interpreter Services 2014: 16)

The aim of these guidelines is to ensure ethical conduct by a professional interpreter.

Restricting contact between the patients and the interpreter in this way paradoxically implies that a professional interpreter needs such a provision to maintain their professional integrity.

AUSIT (AUSIT 2007) may face a contradiction which derives from the ambiguity of the definition of a professional interpreter's role which is set out in its own Code. Contrary to the above guidelines by the NSW Health Care Interpreter Services, AUSIT (*ibid.*) acknowledges the positive effect of a casual conversation between the patient and the interpreter, in its booklet which is designed to be read by health professionals.

If the interpreter and the patient meet before [the doctor] arrive, this brief contact can help the interpreter establish a positive rapport with the patient, which may contribute to better communication. A well-briefed and competent interpreter can be relied on to exercise initiative and discretion. (AUSIT 2007: 4)

AUSIT stated that this ideal situation may not be realised because "interpreters may choose to avoid being alone with patients, or being seated with them during waiting-time... some interpreters feel uncomfortable about this proximity to patients" (*ibid.*: 9). AUSIT attributes this to the interpreter's preference. In fact, this is not necessarily the interpreter's preference but rather the practice which they are required to follow as per the Code.

Interpreters are also encouraged to maintain a detached stance through the surveillance system which I will discuss in more detail in Chapter 7.

AUSIT gave this explanation to health professionals who work with professional interpreters. It did not mention the requirement which AUSIT and NAATI place on professional interpreters to be detached from their clients and focus only on accurate language rendition. Instead, AUSIT attributes the desire for detachment to interpreter preference. The ambiguous definition of interpreters' professional detachment requires clarification.

An analysis of interview data in the following section explores the adequacy of the universal imposition of the Code on interpreters. I examine the effect of compliance with the Code by interpreters on successful interpreter-mediated communication in the eyes of the users of interpreting services.

6.4 Codes of ethics as an endorsement of the quality of interpreting services

In this section, I analyse the accounts of experienced Australian medical practitioners who are familiar with interpreter-mediated medical encounters, as well as those of Japanese-speaking and English-speaking patients who have experienced Japanese-English medical encounters in Australia and Japan. The analysis explores how professional tenets in the AUSIT Code of Ethics may or may not serve patients' best interests. I examine a number of specific tenets, namely accuracy, impartiality and confidentiality, which the AUSIT Code of Ethics holds as essential elements of successful interpreter-mediated communication.

Speaking with interpreters, not through them

Doctor J is an Australian medical practitioner. He has undergone medical training in a university in Sydney and has been practicing for over fifteen years in the Sydney area.

Doctor J specialises in infectious diseases. At the time of the interview, he was working in a large hospital in the central Sydney area. Doctor J stated that he uses professional

interpreting services for inpatients more frequently than for outpatients. In the interview, Doctor J explained how he uses professional interpreters in order to meet the communication needs of patients with diverse cultural backgrounds.

[Using an interpreter] makes it easier to communicate. Sometimes an interpreter doesn't explain things completely either. But overall, they are pretty good. If I think they haven't given all information, I'll ask them to double-check if they did that. I think they are good, very professional. They are very well trained.

If a patient is with just a family member, the patient seems to get more passive. The family member deals with all the talking. An interpreter is a stranger to the patient. In this case, the patient is a little more engaged. Also, a good thing about having an interpreter is that if a family member is there, the interpreter could talk to the family member as well. You know, ideally, an interpreter is there at the right time, with a reliable family member.

Doctor J said that he lets the patient, their family member and the interpreter discuss with each other. His re-arrangement to the communication helps the patient to be more proactive, allowing them to state what they really want to say. Doctor J indicated that he knew that interpreters who were present at the consultations had NAATI credentials. He did not know about the Code. The communication strategy adopted by Doctor J did not anticipate the interpreter being strictly neutral and accurate in word-to-word communication, but effectively helped the speakers effectively communicate with each other.

While Doctor J mentioned that using a professional interpreter may help the patient maintain their agency, he was aware of the possibility that the patient's statement can differ depending on who is providing the communication support. Findings from preceding chapters indicated that the degree of openness of the patient to the clinician, particularly a Japanese female patient partnered to an English-speaking man, may change depending on who is present at the consultation as a communication mediator. The Japanese informants' accounts of their own views of the consultation presented in Chapter 3 suggested that in some cases, the increase in speaking by a patient with a professional interpreter may be

reflective of a *loss* of agency in this situation which they did not feel as much with a family member interpreting.

In a review of the use of paraprofessional bilingual, bicultural workers in mental health care for refugees in the United States, Musser-Granski and Carrillo (1997) suggested that “[a]side from the linguistic and cultural barriers, the additional relationships in the clinical setting create different dynamics (Musser-Granski & Carrillo 1997: 58). The researchers perceived such dynamics negatively, arguing that a close relationship between the interpreter and the patient may undermine the trust relationship between the clinician and the patient as it makes the clinician feel that they are left out.

The account of Doctor J suggested otherwise. The involvement of both the patient’s family member and the professional interpreter in Doctor J’s account had a positive effect on the cross-linguistic medical encounter. Doctor J suggested that a patient’s family member and a professional interpreter have different kinds of effects. Success in a medical encounter which involves the patient’s family member and the interpreter depends on the communication skills of the clinician and their capabilities of making flexible arrangements to the communication style. Doctor J’s account suggested that incorporating a wider variety of approaches to interpreter-mediated medical encounters may improve the quality of communication.

Professional interpreters in Australia are prohibited from going beyond their defined role of accurate and impartial message transfer. The strategy which Doctor J employs works as long as the interpreter agrees to go beyond their defined professional role. If the professional interpreter agrees to do so, they undermine the justification for using a professional interpreter given in their own standards and guidelines.

Doctor P, another Australian clinician, explained how she prompts an immigrant patient to state what they want to say when she speaks with them through an interpreter. Doctor P is

an experienced GP who has worked with patients from various different ethnic groups and refugee backgrounds. Over many years of practice, Doctor P now prefers to use telephone interpreters rather than on-site ones. Her account suggested that interpreting which is faithful to the Code may be effective only when the clinician is aware that not every immigrant patient is as assertive as they are expected to be in the Australian health care context.

There is a huge difference in the degree of patients' engagement in communication, depending on the ethnic group. I commonly ask, "Is there something else?" and, "Do you understand what things are?". However, certainly some patients are less proactive. I've learned that people from [Ethnic Group A] often aren't proactive in asking questions. Only if I ask if there is anything else, they start finding out that they actually needed to get something sorted.

Doctor P clarifies with her patient if they have said what they really wanted to say. The account of Doctor P also suggests that the clinician's capabilities of navigating the conversation is an important factor given that professional interpreters in Australia are not supposed to go beyond the role of neutral conduit.

While Doctor P indicated that she was aware that a professional interpreter is supposed to render only what is actually stated, she still sometimes re-arranges interpreter-mediated communication depending on the relationship between the patient and their family member. Doctor P indicated that she was aware that some patients are not comfortable to involve a stranger in their private conversation. Doctor P said that involving an on-site interpreter may "make the conversation artificial and stilted".

If the patient comes in with their family member who has quite good English, and they'll tell me, "No [I don't need to call an interpreter]". They want this family member to interpret for them. They are quite clear about that because I think they trust that person. Also, they don't want anyone outside to know their business. They may feel more comfortable with their family member. So I guess it depends partly on how new they are to the country. If they've got a family member who's been here for a long time, and they trust that the family member can speak English, there would be an advantage of using the family member.

Doctor P uses both the patient's family member and a professional interpreter, depending on how the patient wants to communicate with her. In her strategy, the interpreter does not have to go beyond the role of a neutral language conduit. The account of Doctor P suggested that the success of interpreter-mediated communication largely depends on the clinician's communication skills and awareness of norms in the patient's home culture.

I usually say to the interpreter, "Look, this person's English isn't actually too bad, but there might be some complicated bits. Do you mind if we would continue the consultation, then I'll tell you the bits we might need you to interpret?". The patient does not have to rely on the interpreter all the time. When I think the patient's English is pretty good, I'll say, "You actually understood everything I said, didn't you?". If they admit that they did, it's time to, maybe for simple things, stop the interpreter.

The accounts of Doctor J and Doctor P indicate that the quality of interpreter-mediated communication largely depends on the doctor's capabilities of sensing subtle signs of potential misunderstandings and effectively navigating the conversation. This suggests that interpreters who are faithful to the Code may risk failures of communication if the clinician is not sufficiently experienced to accommodate the risk and, if necessary, effectively lead the interpreter to appropriately deviate from the neutral conduit model set out in the Code.

Many interpreters are also aware that language rendition is not the only determinant of successful cross-linguistic health communication. Hsieh (2006a) found through interviews with 26 interpreters in 17 languages that the interpreters faced conflicts between this awareness that it may be necessary to deviate from the professional role for the patient's sake and their sense of responsibility for fulfilling a given 'professional' role.

[W]hen a speaker cannot be a competent participant, an interpreter feels the pressure to depart from a conduit role in order to facilitate the provider-patient interaction... the interpreter's ability to adhere to a conduit role is dependent on other speakers' communicative skills and behaviors (Hsieh 2006a: 729).

Hsieh (2009) criticised The Cross Cultural Health Care Program, a US-based not-for-profit organisation which provides training for health care interpreters, for imposing unrealistic

expectations on interpreters. According to Hsieh, this organisation emphasises linguistic accuracy and neutrality, and requires interpreters to always use the first person 'I' when interpreting. Hsieh (2009) argued that the training provided by the organisation does not sufficiently reflect the complex reality of cross-linguistic communication.

Training programmes for interpreters in Australia may have the same issue. I have participated in several training programmes and workshops for professional interpreters, in which the instructors emphasised accuracy, impartiality and confidentiality as the essential tenets which professional interpreters must observe. Some of them also instructed interpreters to always speak in the first person when performing interpreting tasks, as instructed in the AUSIT Code of Ethics (AUSIT 2012: 14). NSW Health Care Interpreting Services gives a similar instruction to health care interpreters.

Interpreting in the first person (direct speech) – Interpreters speak in the first person, i.e. in the same grammatical form as the speaker and say "I am unwell" instead of saying "The patient says that she is unwell". This minimises confusion, enhances accuracy in form and content as well as reinforcing the role of the interpreter as a neutral facilitator of communication (2014:17).

I have experienced as an interpreter conversations in which this first person method was not the best option. It was difficult for me to insist on using the first person when interpreting in cases in which, for example, the doctor asked me, "What did the patient just say?" or "Can you explain what I have just said to the patient just to make sure?". In such cases, I did not find it particularly useful to explain to the patient and the clinician that an interpreter is supposed to use the first person pronoun when interpreting. If I had stuck to direct speech mode, the conversation would have become awkward, as the doctor asked me to directly intrude into the conversation. When the doctor directs the conversation in this way, the interpreter will be obliged to reorient the lines of the conversation between the patient and the doctor.

This issue may also arise when the doctor uses teach-back, a best-practice communication technique to make sure that the patient fully comprehends the conversation in the consultation (Xu 2003). Health literacy guidelines for health professionals by the Australian Commission on Safety and Quality in Health Care (2015) also encourage clinicians to use this technique.

Using strategies to confirm that the information provided meets the patient's needs: these kinds of strategies include asking people to recount the information given to them by a healthcare provider to check understanding. One well known example is 'Teach-back' where the healthcare provider asks the patient to state in their own words the key points in the discussion (Australian Commission on Safety and Quality in Health Care 2015: 4).

Direct speech interpreting may make the patient confused when the clinician uses the teach-back technique because the patient is likely to feel that the interpreter is asking the patient to repeat the information given by the clinician to the *interpreter*, not back to the clinician. This rabbit-hole is only avoided if the interpreter steps out of the neutral conduit role and explains context and purpose, "The doctor is now asking you to describe how you would take the medications to make sure he/she has explained it properly to you".

So far, I have analysed the accounts of Australian medical practitioners to identify gaps between the Code and how they use interpreters. In the next section I analyse the accounts of patients on their responses to interpreters who act, as obliged to under the Code, as *non-person* or *conduits* performing literal language conversion.

The limitation of word-to-word interpreting

Emi is a Japanese-speaking woman who considers that her imperfect English grammar has prevented her from improving her English communication skills. She has suffered from an ischemic ulcer on the sole of her foot since she was a teenager. She had been seeing a doctor for treating the ulcer in Japan, and continued to see GPs, a vascular specialist and a podiatrist in the years since she moved to Australia nearly ten years ago. Emi said that she

did not feel that professional interpreters she met in medical consultations in Australia fully rendered what she wanted to say. She felt that her opinions were ignored by her doctors.

I got the ulcer seen by a vascular specialist and a podiatrist. I got the hospital to call an interpreter. When I talked with the doctors through the interpreter, they forced me to apply an ointment, which I had used for three days and found ineffective. I was told to keep using it. I did so for another two weeks. They said something that didn't make sense [*ie.* to continue using a treatment that wasn't working], so I wondered whether they were really listening to me.

I haven't felt [that the interpreter was not interpreting accurately]. But even if the interpreter tells the doctor 100% of what I say, doctors in Australia are *atamaga katai*. They just say, "Yes, yes". They choose to perceive what I am saying in whatever way they want, by saying, "I understand". Japanese people are modest. We usually don't clearly say what we think. So, even if I am upset and wish to say something in an assertive way, that feeling is not expressed in English when my statements in Japanese are literally interpreted into English.

Emi described Australian medical practitioners she had met as *atamaga katai*. In Japanese, a person who is *atamaga katai* is not open to alternatives. By using this expression, Emi meant that she had difficulties in suggesting to her clinician that she did not believe that the ointment was effective.

While the interpreter fulfilled their prescribed role, Emi did not find it very helpful. As Emi said, Japanese people often do not clearly express their feelings or ask explicit questions not only in medical consultations but also in general conversations. In Japanese culture, it is often the listener's role to notice the speaker's unstated questions and opinions. The last thing many Japanese people want to do is to disrupt the relationship with their counterpart by making an unnecessarily explicit statement.

If a Japanese patient wants to suggest that a prescribed medication is not effective, they usually start with roundabout expressions such as "I am wondering what this medication is made of and how it works..." and "Doctor, how many days should I allow until I start seeing that the medicine is working?". While it is sometimes the case that the patient is actually seeking information which a direct answer to their question provides, in most cases

roundabout expressions such as the one in this example imply that the person is providing negative feedback and is requesting a rethink. Emi wanted the clinician to consider switching medications.

A Japanese patient often indirectly expresses their concerns because they find it offensive and disrespectful if they explicitly state their needs. This applies not only to patient-doctor communication but to conversations in general. In Japanese culture, a speaker often needs to pay great attention to the wording of their statements so that the listener will not take it personally. In the case of the above example, a patient needs to come up with a roundabout but noticeable expression so that it will not sound like “the medication *prescribed by the clinician* is inefficacious”. Through my life in Australia, I have realised that Japanese roundabout expressions often confuse Western listeners and may engender frustration for not knowing the Japanese speaker’s intention.

In an observation of people’s interactions in Japan, Hall (1976) pointed out that when two Japanese people converse, both of them anticipate based on their cultural knowledge what the other party is thinking and expecting, even if it is not explicitly mentioned. Silence in communication also has powerful implications in Japanese culture as Japanese people consider that “[s]peech is rather associated with idle inactivity and procrastination since action can start only when speech stops” (Lebra 2004: 184). Silence in conversations in Japanese culture conveys subtle but culturally specific messages which literal interpreting cannot express.

Yuri, a Japanese mother of two girls, explained difficulties she faced when she wanted to let a nurse know that she needed help with taking care of her baby directly after she gave a birth to her first baby in an Australian hospital. At that time Yuri had spent only a few years in Australia, and did not understand the difference in the communication style between Japanese and Australians.

I wish if I could have had our first baby in Japan. It was tough when I had her in Australia because it was for the first time in my life to have a baby. In Australian culture, you can't get anything unless you speak out. You can't get help if you're only waiting. But I didn't know that at that time.

It is often emotionally draining for Japanese people to be 'assertive' in an Australian sense. In order for Japanese people to look assertive in the eyes of Australians, they need to state their needs in a way which is considered to be arrogant and disrespectful in Japanese culture.

Stevens and Lee (2002) investigated struggles faced by American and Australian women in using Japanese medical services during their pregnancies. These women experienced difficulties in receiving their preferred pain relief measures because a limited variety was available in Japan, compared to the USA and Australia. Stevens and Lee argued that what made the experiences of these women tougher was a cultural barrier which they faced when they tried to make their requests understood by their Japanese doctors and midwives. In the study, most Japanese mothers and Japanese doctors did not consider the limited availability of analgesic measures as a problem.

An ethnography of pregnant Japanese women in Tokyo (Houston 1999) found that Japanese women frequently viewed pain in delivery as an initiation ritual. The study found that Japanese women had a negative view towards using artificial pain relief because it lets a mother-to-be skip the extreme pain of delivery through which they would prove their competence as a mother. This is a common view among Japanese people. I have also heard people in Japan saying that a mother loves her child because she experienced the excruciating pain of delivery. In Japan, analgesic measures are considered only if the mother-to-be needed to undergo surgery or other special procedures due to gestational health problems.

In the study by Stevens and Lee (2002), the difficulty faced by pregnant Western women did not make sense to their Japanese doctors because their requests were beyond the

imagination of these doctors. Stevens and Lee (*ibid.*) critique the ignorance of Japanese health professionals about cultural diversity and patient rights in decision-making.

Emi's account also suggested the cultural limitations of the language-conduit interpreting model. The involvement of an interpreter in Emi's case resulted in an exacerbation of the existing cultural misunderstanding. Neutral language rendition by the interpreter failed to communicate important culturally nuanced messages.

Emi indicated that explanations by the specialists made no sense to her. The interpreter provide no interventions which could have prompted the specialists to probe deeper into Emi's concerns, or which could have encouraged Emi to be more proactive in expressing her concerns. The specialists closed down the opportunity to hear from Emi regarding her concerns about the inefficacious ointment and what she would like to do with the ulcer. This communication failure is largely attributable to the clinicians' communication skills.

The action by the specialists also closed down the opportunity for the interpreter to remedy this failure. Interpreter-mediated medical encounters often rely on the clinician's communication skills and cultural mediation by the interpreter by stepping beyond the neutral conduit role. Emi's case explicated that rigid adherence to the Code does not permit either of these failsafe mechanisms to be used.

It is difficult for speakers who do not have common cultural and social understanding to find how to express their culturally nuanced ideas. This may require changing the flow of conversation and making considerable efforts in choosing a culturally appropriate tone of voice and words. Emi could not express her intent to her Australian doctors while she was able to do so to her previous doctor back in Japan.

My Japanese doctors told me, "You've been suffering from it [the ischemic ulcer] and been able to control it to some extent so that it won't deteriorate. This means that, rather than having your doctor give you unnecessary treatment, you know your own body better than we do, so I think you should deal with it in a way you

would like. I don't think you should be pushed around by doctors to make it worse and come back to us".

Emi stopped seeing the Australian specialists since the interpreter-mediated consultation, and the ointment which she felt made her ulcer worse.

Two other Japanese informants, Sanae and Chie, also told me that they felt that they were not heard by their Australian doctors when they communicated without any language support.

Sanae: They don't listen to their patients. They're judgmental. I've seen many doctors so far, for my children, too. I noticed that I tell more to doctors who sincerely listen to their patients. Such doctors always make holistic diagnosis by comprehensively listening to what I tell them, including extra information. If a doctor has good communication skills, I think the patient would feel peace of mind. When I speak in English, I am comfortable to see a doctor who engages in general conversation. I think it's a really important point.

Chie: I couldn't tell whether they were really listening to me or not. Even when I asked them questions, they only said, "Well... well...". After all, I only got some prescribed medicine, which ended up not working. So, I thought I would never see them again.

If Sanae's case had involved an interpreter, they would have interpreted general conversations between her and her clinician. This would have helped building a rapport between Sanae and the clinician and between Sanae and the interpreter, as long as the interpreter understood that Sanae did not necessarily expect information exchange in the consultation. Sanae rather wanted the clinician to recognise and respond to her needs.

Nodding is also a culturally specific characteristic of the Japanese communication style which neutral language rendition cannot effectively support. In a pragmatics analysis of nodding and *aizuchi* – “short utterances roughly equivalent to English ‘uh huh’ and ‘yeah’” (Kita & Ide 2007: 1242) – in conversations between Japanese speakers, Kita and Ide found that “nod sequences seem to be associated with positive affect as the two participants started to smile as soon as the sequence started... which indicates that establishing rapport

is an important function of simultaneous nodding (*ibid.*: 1248). The researchers pointed to the importance of nodding and *aizuchi* in Japanese culture by drawing on a study by Maynard (1993) who found that Japanese speakers nodded three times more often than American English speakers. Clinicians in the accounts of Emi and Chie used speech utterances equivalent to *aizuchi* (“yes, yes”; or “well, well”). Emi and Chie described disappointment that the clinicians were not listening to them despite using the linguistic measure that in Japanese would have indicated active listening.

The accounts of the Australian clinicians and Japanese-speaking patients suggested that various factors should be considered when assessing the effectiveness of communication intervention in cross-linguistic medical encounters. While using a professional interpreter who is faithful to the Code is one of the possible solutions, it should also be noted that there are many different potential paths to good cross-linguistic patient-doctor communication. My own experience as a professional interpreter may reaffirm this point. I have received questions from Japanese patients when I was serving as an interpreter. One of them asked me about how they could buy prescribed medicine after the consultation; and another one asked me which specialist they needed to see first, and how they could make and confirm subsequent appointments. There was also one who asked me to help her find a public phone to call a taxi to go home from the hospital.

Medical consultations usually do not cover such information unless the patient specifically asks the clinician. I understood why these patients asked me these questions and requests. They anticipated that Japanese residents in Australia would share the understanding that they all have limited knowledge of Australian society, and that they would help each other. I gave quick answers to most of these questions to the degree which my knowledge allowed. I also helped the patient find a public phone. Since I knew that what I did was in breach of the Code, this never made me comfortable even though the patients appreciated it. These

situations demonstrate the need for the clear clarification in guidelines of the role of health care interpreters.

Miho is a Japanese woman who came to Australia following her marriage to an Australian man. She gave a birth to her first baby in Australia, and used a professional interpreter several times during her pregnancy. She also used a health care interpreter for consultations on other health concerns.

Miho said that all interpreters whom she met did not simply interpret the communication but prompted her to say her needs to her Australian doctors. Miho found one particular interpreter extremely helpful compared to others, and explained why.

I stopped saying what I really wanted to say, thinking, "Maybe I should not say this much". But one of the interpreters I met picked up what I really wanted to say. The degree of my satisfaction with other interpreters is about 80%, compared to this interpreter [with whom I am 100% satisfied]. This particular interpreter understood what I was hesitant to say. She noticed when I was wondering, "Should I stop explaining here, should I avoid making any further mess?". She told my doctor what I really wanted to say. I don't think that this interpreter has ever said anything unnecessary.

While the interpreter supplemented Miho's statements, Miho indicated that the intervention did not distort her original intention. The interpreter helped Miho avoid a situation in which misunderstanding would be attributed to her for not clearly saying her needs. An interpreter with this skillset may have been able to assist Chie in her attempts to question the doctor.

The accounts of informants suggested that in a cross-linguistic encounter, a patient may not always expect that the communication mediator act as a *non-person* or a *conduit* who simply performs neutral language conversion. Interpreting which is performed rigidly in accordance with the Code may fail to communicate the patient's needs to their clinician.

Effective communication intervention from an English-speaker's perspective

Jo is an English-speaking Australian woman who was temporarily residing in Japan. Jo accompanied her husband when he was assigned to a position in Japan. Jo had never undertaken formal Japanese language training. She said that she had difficulties in having everyday conversation in Japanese. One day, her four-year-old daughter pushed a small object into her ear and could not take it out. Jo took her to an emergency health service in Tokyo.

The doctor and nurses at the health centre which Jo took her daughter to first had limited proficiency in English. The centre had no interpreter or bilingual staff member who could mediate the communication. The Japanese-speaking doctor and nurses made a special arrangement for Jo and her daughter so that they did not have to explain anything in Japanese on the way to, and at, the hospital to which the daughter was referred.

The doctor could see that there was something in her ear but was unable to remove it. The doctor suggested that we go to a university hospital, to the emergency department there, so that someone with better tools and means could help us. To do that, the Japanese-speaking nurses at the clinic called the head of the hospital to let them know that we were coming. I think that was very helpful. Also, they put together an information package for me to take.

They wrote a couple of messages in Japanese: one for a taxi driver to take me there, and another for the person at the reception. That was extremely helpful. They printed out a map for me and the message for the taxi driver. So then, it was pretty straightforward. I got in a taxi, showing [the message and the map to] the taxi driver, going there, presenting the [information] package that had an x-ray and a referral. The doctor told to me to go to this hospital because it was a teaching hospital and because he knew that there were a lot of English speakers there.

Jo's account suggested that communication support which went beyond neutral language rendition was also helpful for an English-speaking patient. Given that Jo had limited knowledge of the Japanese language and Japanese culture, communication intervention and the referral arrangement by the Japanese health staff were essential for Jo to access necessary health services for her daughter in Japan. The caring attitude of the Japanese

clinician and nurses toward Jo and her daughter was one of the factors which made her experience favourable. Jo also said that playful emotional support from an English-speaking doctor in addition to Japanese-English interpreting was also a positive factor.

What they did was to assign English-speaking... I don't know whether he was a student doctor. He didn't actually do the procedure on my daughter but acted as a translator [*sic.*] for a Japanese doctor. He was really good at keeping my daughter calm because she was quite upset by that stage. He asked her what she liked, what cartoon characters she liked on his phone, a Peter Pan video for her to watch while she was waiting. That little touch was really helpful because we did have to pin her down for them to keep her still.

The act of the bilingual doctor in Jo's account suggests that the neutral conduit model of professional interpreters can be in conflict with expectations held by clinicians and patients of communication intervention in a cross-linguistic encounter.

The accounts of informants in this chapter as well as that of Jo raise the question of whether it is truly ethical to educate clinicians and patients that they should use a professional interpreter on the grounds that they are following a professional code of ethics. The accounts also gave rise to a question as to who benefits from the interpreter's compliance with the Code, as the professionalisation of interpreting in Australia has been driven through state-led collaboration between professional associations of interpreters, Australian governments, and the language service industry. In the subsequent chapter, I explore state-based and industrial regulation and surveillance of interpreters as a way of managing and structuring the industry, and its implications for health care.

6.5 Summary

This chapter explored the relationship between compliance with the professional code of ethics by interpreters and patients' satisfaction with interpreter-mediated health communication. I began this chapter with a review of the societal function of professions, and argued that not every profession carries the same significance to society. Interpreters,

like many newly established professions, seek a respected position in society, and are exposed to a series of regulatory strategies and policies which underpin the evolution of their profession.

The professionalisation of interpreting in Australia may largely depend on the instrumental appropriation of NAATI credentials and the AUSIT Code of Ethics. The accounts of Japanese-speaking informants who have spoken through NAATI-credentialed interpreters suggest that this appropriation may not necessarily serve for the interests of the users of interpreting services. It can be said that the professionalisation of interpreting may be favourable predominantly for interpreters aspiring for a higher societal recognition as well as governments and language service agencies which are striving for achieving greater efficiency. Distinguishing professional interpreters from non-professional ones based on credentials is likely to make administration easier. It may be the case that the professionalisation of interpreting in Australia has been progressing partly through the denial of elements which do not conform to the aspirations of interpreters and policy makers. Instrumental focus on the Code may distract interpreters from being responsive to the needs of patients and clinicians.

The accounts of Japanese-speaking informants also suggested that assumption that compliance with the AUSIT Code of Ethics by professional interpreters always guarantees satisfactory interpreting services and the protection of the patient's rights may create an illusory image of professional interpreters. The interview data suggested that the outcomes of interpreter-mediated communication largely depend on the capabilities of the clinicians of sensing subtle cultural and personal hints and cues from their patients. Findings suggested that it should not be assumed that only professional interpreters with NAATI or similar credentials can protect patients' rights.

Freidson, drawing on his experience of the medical professional, indicated that the occupational control of practice differs from that by central authority (1989: 426). In the case of the professionalisation of interpreting in Australia, the distinction between interpreters and central authority in the occupational control of interpreting practice is not so obvious. The profession of interpreting both regulates itself, and is regulated by the state, to the same model of practice. In the next chapter, I examine the implications of collaboration between interpreters, the state, and the language service industry for the performance of interpreters and the perceptions of health care interpreters held by clinicians.

Chapter 7 Efficiency before effectiveness: the casualisation of health care interpreting in Australia

This chapter explores state-based structural control over the professional practice of interpreting in Australia. The chapter starts with an overview of the language service system in Australia and how the language service system is linked to the health system. I explore how the national accreditation body, the professional representative organisation and industry engage in regulatory practices which at their most extreme involve surveillance of interpreters at work. I then examine how these practices may limit opportunities for patients to satisfy their communication needs, contrary to the original intent of the Australian language service system. I use the prism of structural violence to explore the impact of regulatory practices directed at interpreters on the profession of health care interpreting.

7.1 Regulating health care interpreting

Most health care service providers in Australia access interpreters through a language service agency. The Translating and Interpreting Service (TIS National), which is part of the Department of Immigration and Border Protection of the Government of Australia, pioneered Australian interpreter service systems (Oktay 2015; Phillips 2010). Major public language service agencies in Australia include TIS National, Victorian Interpreting & Translating Service (VITS), a number of language service sections in NSW Health; and private agencies include Oncall Language Services, All Graduates Interpreting and Translation Services, ezispeak, and Translationz.

Most professional interpreters who work with health care providers in Australia are self-employed. Most of them sign casual employment contracts with multiple language service

agencies. Language service agencies send interpreters to their clients when they request interpreters.

A small number of health care facilities directly employ interpreters in areas where there is high demand for language support in specific languages. The website of the Royal Melbourne Hospital (The Royal Melbourne Hospital *n.d.*), for example, states that language services in Arabic, Chinese (Cantonese, Mandarin), Greek, Italian, Turkish and Vietnamese are readily available through the hospital's Transcultural and Interpreter Service unit. Austin Health and Western Health in Melbourne also directly employ interpreters for languages in high demand, such as Greek, Italian, Mandarin, Macedonian and Arabic (Austin Health 2017; Western Health 2013).

There has been an increase in the number of interpreters and translators who have obtained NAATI credentials. NAATI credentialled over 4,000 interpreters and translators in over 60 languages in 2015, and NAATI-approved educational institutions have given credentials to approximately 15,000 students since 2000 (NAATI *n.d.e*). In the fiscal year 2014/2015, TIS dispatched over 2,500 contract interpreters in more than 160 languages to approximately 85,000 on-site interpreting assignments and approximately 1,200,000 telephone interpreting assignments (DIBP2014b; DIBP 2015). Oncall Interpreters & Translators has a pool of over 4,500 interpreters (Oncall Interpreters & Translators 2015).

State-led quality assurance for interpreting services

The interpreter credentialing and service systems in Australia are implemented at a national level. The nine governments of Australia, namely the federal, state and territory governments, own NAATI (NAATI *n.d.d*).

The mission of [NAATI]... is to set and maintain high national standards in translating and interpreting to enable the existence of a pool of accredited translators and interpreters responsive to the changing needs and demography of the Australian culturally and linguistically diverse society... As the provider of

accreditation/certification services for translators and interpreters in Australia, NAATI aims to provide quality services and be accountable to the individuals and organisations which benefit from NAATI services. (NAATI *n.d.a*: 1).

AUSIT is a professional association for interpreters and translators. While AUSIT and NAATI are two different organisations, they complement each other in maintaining and promoting the national standards for interpreters and translators in Australia.

AUSIT and NAATI work together to set, maintain and monitor standards in the translation and interpreting profession in Australia. AUSIT recognizes NAATI accreditation as the minimum basic qualification for practising as a professional translator or interpreter in Australia. NAATI endorses and promotes the AUSIT Code of Ethics for interpreters and translators (AUSIT *n.d.b*).

The Australian government supports these two organisations to ensure that interpreters comply with the Code. The Mystery Shopping programme run by the Translation and Interpreting Service (TIS) of the Australian Department of Immigration and Border Protection randomly allocates evaluators mainly to telephone interpreting sessions which it provides. TIS does not state what types of consultations it listens in on, or if obtains permission from customer and the user to listen in on the consultation. In general discussions with doctors, no doctor can recall being asked if the consultation could be heard by TIS for quality management purposes, though they are aware that the agency has the capability to listen in on consultations. Patients are also not informed of this surveillance system.

The organisation occasionally discloses a summary of the results of this monitoring in their monthly newsletter, with achievement rates in specific items in line with the Code. A summary of the agency's mystery shopping report from February 2015 was published in News for Interpreters, the TIS' newsletter for interpreters (TIS National 2015). The ethics and professionalism category covers criteria such as impartiality, facilitation of communication, disclosure of conflict of interests, and no prematurely terminating or prolonging of calls. As I discussed in Chapter 6, while the AUSIT Code of Ethics does not

explicitly encourage interpreters to perform word-to-word interpreting, TIS' Mystery Shopping is likely to lead interpreters to provide word-to-word interpreting to avoid negative feedback which might result in their modifying messages in a way such that they could be better understood by the speakers. Members of the staff of TIS contact some of the interpreters who are found to have failed to meet the standard to give them instructions to improve their behaviour (*ibid.*).

Cost-efficiency in health care interpreting services

In Australia, the agency-based language service system is closely linked to the cost-efficiency of health care interpreting services, in that they are interested in the extent to which the service can convert its resources to achieve the maximum possible outputs (interpreting services) against the minimum inputs (OECD 2010). Unlike the United States where health care professionals often need to weigh the cost for interpreting services relative to possible benefits for the patient, in Australia, the federal (see Chapter 1) and state governments (e.g. NSW Health 2006; Queensland Health 2012b) subsidise health care interpreting services. Current developments to increase the cost-efficiency of TIS include encouraging the move from on-site to telephone interpreters, introducing automated language services in high-traffic languages and restricting bookings and complaints to online, rather than through direct communication with staff by telephone or fax.

The scholarly literature has interrogated the cost effectiveness of interpreters – that is, the extent to which health care interpreters may achieve the objective of quality, safe interpreting for a given cost, especially compared to other options (OECD 2010). Jacobs and her colleagues (2001) analysed the relationship between the provision of professional interpreting services and patient's access to health services in 4,380 adult Spanish- or Portuguese-speaking patients in New England, the United States. While the researchers found that the use of professional interpreting services is likely to improve patient access to

health services, they raised a concern that increasing health care interpreter services may not be a cost-effective strategy.

[T]he study did not address the questions of improvement in quality of care and health outcomes or cost-effectiveness... increased delivery of services alone does not necessarily result in quality improvement or better health outcomes. Given current concerns about cost containment and quality of care in health care, these are important areas for future research (Jacobs et al. 2001: 473).

Jacobs, Sadowski and Rathouz (2007) studied the cost-effectiveness of enhancing Spanish-English interpreting services in a hospital, using patient satisfaction, overall costs, length of stay and reduction in subsequent ED visits as the outcomes. They compared this with the cost-effectiveness of using language concordant physicians. The enhanced interpreting service had no effect on costs overall, but did not improve the outcomes. The use of Spanish speaking physicians on the other hand did result in greater patient satisfaction and reduced subsequent ED visits. The daily cost of the enhanced language service was \$234 per Spanish-speaking patient. The daily cost of employing Spanish speaking physicians was \$92 per Spanish-speaking patient. The daily cost for providing enhanced interpreting services accounted for 1.5 % of the average hospital daily expenditure.

An analysis of literature and evidence related to financing health care interpreting services in the United States found that the use of professional interpreting services may help avoid costly litigation resulting from miscommunication (Ku & Flores 2005).

In a review of the relationship between Australian health care policies and health care interpreting services, Garrett (2009) argued that tightening health budgets limited health care interpreting services.

By the 1990s [in Australia] the accelerated efficiency drive led to a concern about the quality and effectiveness of health interventions... As health care budgets tightened, so too did the budgets of interpreter services... Some interpreter services responded by introducing operational policies such as fee charging for selected services or facilities or capping of particular service types. Others limited their

service provision to the public hospital sector and carefully prioritised interpreter calls in terms of their perceived urgency or complexity (Garrett 2009: 46).

Eagar, Garrett and Lin (2001) argued, in an analysis of the Australian health care system, that Australian health care funders and providers are inclined to cost-effectiveness as budget has been increasingly tightening since the late 20th century. The separation of the interpreter from the client and context reinforces the capacity of the interpreting service to drive an efficiency-based agenda.

7.2 Structural violence in health care interpreting

In the state and federal language service systems, interpreters are required to follow the prescribed protocol for providing interpreting services. Health care interpreters in Australia therefore maintain 'professional detachment' from the patient and the context (AUSIT 2012: 9). Professional detachment entails emotional distance between the interpreter and the patient.

Johan Galtung (1969) coined the term *structural violence* to elucidate social and institutional structures which generate barriers for people to satisfying their basic needs. Galtung described structural violence as "a blueprint, as an abstract form without social life, used to threaten people into subordination" (1969: 172). Structural violence is different from personal physical violence in that the former involves no apparent subject-object relationship. In Galtung's words, "[w]hen one husband beats his wife there is a clear case of personal violence, but when one million husbands keep one million wives in ignorance there is structural violence" (*ibid.*: 171).

Structural violence can be a non-direct threat to the lives or well-being of certain groups of people. It is ubiquitous violence. When structural violence is exercised, "there are no concrete actors one can point to directly attacking others, as when one person kills another" (Galtung 1969: 171). Structural violence may be at play in interpreter-mediated health

communication in Australia when the interpreter maintains their 'professional detachment' from the patient and the context. It may demand submission from migrant patients to acculturation to the prescribed communication model. It may mute the voices of migrant patients. As in the comment by Yuri in Chapter 6, a patient from non-Australian background may not know how to be assertive about their needs in an Australian health care context. Her account suggested that having a neutral, detached interpreter would make no difference unless the patient understands the norms in the context and adjusts their behaviour.

In an ethnography of methadone replacement therapy for heroin addicts in the United States, Bourgois (2000) criticised the therapy which is backed up by quantitative, scientific evidence for obscuring "the power/knowledge trap of drug treatment debates that camouflage moral judgements behind medical objectivity" (2000: 168).

In an attempt to reduce structurally imposed social suffering by applying one's knowledge to promote one particular drug treatment modality or public policy over another, the specific intellectual risks merely tinkering with the efficiency of biopower and missing the more complicated picture of the multi-faceted ways power operates. Even the best of intentions to help or to serve the socially vulnerable can also simultaneously perpetuate – or even exacerbate – oppression, humiliation and dependency of one kind or another. (*ibid.*: 168-169)

Drawing on Michel Foucault (1977), Bourgois pointed to moral images attached by the state and medical authorities to methadone and heroin, positing the former as legal and productive, and the latter as illegal and destructive. According to Bourgois, these moral categories ruled out the possibility for heroin to be used to help street drug addicts maintain their social lives.

In Foucault's framework, power and knowledge constitute one another, and in that process they set the parameters for disciplining social life. He argues that academic, medical, and juridical fields of study and practice emerged historically as central components of social control through the construction of epistemological frameworks defined as legitimate science and health (Bourgois 2000: 168)

Bourgois' critique may also apply to the political discourse of health care interpreting which is centred on NAATI credentials and the AUSIT Code of Ethics. This discourse positions "unsafe, poor-quality" non-professional interpreters on one side of a rigid dichotomy and "safe, good quality" professional interpreters faithful to the professional tenets in the Code of Ethics on the other.

The AUSIT Code of Ethics emphasises the importance of interpreters' "professional detachment, impartiality, objectivity" (AUSIT 2012: 4). Standards and guidelines for health care interpreters and language service agencies in Australia corroborate this idea, by insisting that interpreting by a patient's family member is partial and subjective (NSW Health Care Interpreter Services 2014; Oncall Interpreters & Translators 2015; The Royal Australian College of General Practitioners 2010).

The structure of the language service interpreting industry limits the possibility of interpreters demonstrating agency and undermines their social status – one of the intended outcomes of professionalisation. Five Arabic-Swedish and Turkish-Swedish interpreters who participated in a focus group in Sweden (Fatahi 2010) indicated dissatisfaction with their marginalised social position as a result of the efficiency-driven on-demand service system.

As interpreters in Sweden mostly work part-time on a consultation basis they have no long-term secure career opportunities, thus recruitment and professional development may be hampered. This creates low interest in this work, which may in turn lead to lack of competence among healthcare interpreters (Fatahi 2010: 83).

While Fatahi also rejected the use of patient family members because "they are often acting as a third participant in the encounters rather than a neutral language link (*ibid.*: 72), he pointed to the social aspect of cross-linguistic health communication.

Since a clinical encounter through an interpreter is a kind of social interaction, accuracy in the translation is probably just a part in the assessment of the quality of the interpretation enterprise. Experiences of sociologists, psychologists and anthropologists could probably add important inputs into a realm that needs more knowledge (*ibid.*: 83).

The efficiency-driven interpreter service system in Australia which centres on the neutral conduit model may only satisfy the interests of the state, language service agencies and professional associations for interpreters. It is likely to be beneficial for neither patients nor interpreters. As I argued in Chapter 6, interpreters tend to find the large part of their professional identity in the Code. Interpreters work within the interpreter service system which promotes the detached, neutral conduit model. NAATI credentials and the AUSIT Code of Ethics can be appropriated as a lure which makes interpreters believe that they are essential to establishing their status as professionals. As shown in Chapter 6, while professional interpreters are required to abide by the Code in order to be accredited as professionals, their role is loosely defined, and the interview data in the chapter suggested that patients and clinicians may appreciate the interpreter's deviation from the neutral conduit model. The complex interrelation between interpreters' aspirations for a higher social status and the pursuit of efficiency by the government and the language service industry may obscure issues of real importance in cross-linguistic communication.

Promoting refugee interpreters: entrenching marginalisation?

Australian education providers are also inclined to support the efficiency-oriented, state-led interpreter credential and service systems. A paper which promotes an interpreter training programme in a Melbourne-based university, based on favourable feedback from Burmese and Swahili students who were taking the programme in the university, Lai and Mulayim (2010) emphasised the importance of government funding in training refugees as professional interpreters.

Australian states have set up subsidised programmes for migrants in certain language groups to undergo interpreting training in an Australian tertiary education facility. The Victorian government, for instance, offers scholarships for students who will engage in diploma courses at RMIT University in 2017, in Assyrian, Chaldean, Karen, Lao, Punjabi,

Rohingya, Samoan, Somali, Thai, Vietnamese, Greek, Italian, Macedonian and Tamil (Victorian Multicultural Commission *n.d.*).

This ostensibly altruistic scheme is “in line with changing humanitarian and refugee intake patterns and the consequent emerging demand for interpreters in the new community language” (Lai and Mulayim 2010: 49). While it is likely that there will be higher demand for communication support accompanying an increase in the number of refugees, it is not clear whether an increase in the number of government-funded places for students with refugee backgrounds to undergo training to obtain NAATI credentials will satisfy communication needs in ethnic minority communities.

More importantly, emphasising the altruistic aspect of providing norm-oriented interpreting to wider communities camouflages the negative side of the funding scheme. This scheme is based on a mutually beneficial relationship between the government and academia. The former provides funding to applicants to undertake an interpreter training course. Through this scheme, former refugee students are trained to observe the given tenets of the interpreting profession while owing the government for their career opportunities.

Refugees working as interpreters face some of the challenges documented for refugees and immigrant organisations who work in resettlement, where institutional policies result in them favouring organisational interests over citizen participation (Acheson & Laforest 2013). Case studies of mental health care for refugees in the UK (Tribe & Keefe 2009) raised issues related to training former refugees as interpreters. Tribe and Keefe argued that “the issue of employing interpreters who are also or have been refugees and the issue of possible re-traumatisation or secondary traumatisation requires careful consideration” (Tribe & Keefe 2009: 420). In Norway, refugees who were trained as interpreters were provided with supervisory support recognising that interpreting was a “difficult and lonely job” (Sande 1998: 403).

In addition to the stresses of a job that grounds its professional practice in a position which often causes the interpreter to face dilemma navigating between the state and one's community, the labour market in Australia for interpreters is of concern for refugee interpreters. The casualisation of the Australian interpreting labour force, with most interpreters working part time, on an on-call basis, does not offer long term employment to most interpreters, particularly those working in minority languages. Thus, training refugee interpreters – which on the surface seems a sensible language solution – may risk entrenching marginalisation for this subpopulation.

Cultural barriers facing patients in the efficient interpreting service model

In Australia, it is considered that the patient-doctor relationship is based on a trust that the doctor serves the patient's best interest (Australian Medical Association 2011), not a relationship between "a patient seeking help and a doctor whose decisions were silently complied with by the patient (Kaba & Sooriakumaran 2007: 57). While it is normal that a patient clearly states their needs to their clinician in Australia, as discussed in Chapter 5, being assertive and explicit is often associated with the lack of communication skills in Japan (Travis 1998; Yamada 1997).

In Australia, language service agencies select interpreters to be sent to the clients based on the language of the non-English speakers and the interpreters' NAATI credentials and residential addresses. Except for the gender of the interpreter, the selection of the interpreter is at the agency's discretion. This system does not take into account the positive impact of the relationship between the interpreter, the patient and the clinician. It is not possible for a clinician to request a particular interpreter. If the clinician insists, TIS requests that the requesting service sign a disclaimer absolving the service of medicolegal responsibility for the TIS-employed interpreter that they have chosen. This unusual

interpretation of civil liability for a service that TIS provides and charges for has never been tested in the courts.

The Australian interpreter service system has failed to take into account the impact of the complex cultural mediation by the interpreter on the quality of interpreter-mediated medical consultation. Many studies addressing poor communication in cross-linguistic interpreting routinely conclude with exhortations for education to be provided to users on how to use a professional interpreter (Giacomelli 1997; Hale 2011b; Leanza 2005). Such exhortations reflect the industrial organisation and regulation of interpreters, where patients as well as interpreters and health professionals are co-opted into one model of how to communicate.

The account of Doctor G, a Japan-born clinician, suggests that the Western communication norms and the neutral conduit model may be a large burden on Japanese-speaking patients in Australia. Doctor G undertook her medical training in Japan and Australia, and she has worked both in the clinic and research. At the time of the interview, Doctor G was working in two different health care facilities in central Sydney. In both facilities, she regularly sees patients from diverse cultural and social backgrounds.

Doctor G is aware of the cultural barriers which Japanese patients face in accessing Australian health services. Doctor G has met a large number of Japanese migrants, most of whom are over sixty years of age, through health-related community events. She told me her impression of these Japanese patients.

What I learnt is that [old Japanese migrants] know nothing at all [about health care services in Australia]. They are defensive and resist the process of going backwards and forwards between GPs and hospitals for examinations, like blood tests. So are they when they use other community services, calling them to make an appointment, and waiting. They are also not willing to pay for such services. I guess they would be happy if these services were all free of charge. They ask me how much these services cost, but the prices vary. They see me as something like an emergency help line [because I speak Japanese], but that's not the case. In the case of emergency, they should call "000", not me.

Doctor G described Japanese-speaking patients in Australia as “looking for places where they can consult in Japanese all the time”. In Australia, a patient is responsible for seeking for necessary services and being proactive in engaging with their doctor and treatment.

Doctor G’s observation that Japanese patients are not willing to pay for health services may indicate that they do not fully trust that a service provider will not take advantage of their lack of cultural knowledge and limited English proficiency. The Japanese National Health Insurance covers 70-90% of health care costs when the treatment is in the list of approved procedures of the Ministry of Health, Labor and Welfare (Nanao City 2016). Those who are eligible for this scheme pay the monthly premium which is determined based on the member’s household income as well as out-of-pocket upon using a health service. While Japanese people are familiar with paying fees for health care services, Doctor G observed that senior Japanese patients were wary about health care service fees in Australia. Their ostensibly stubborn attitude may indicate that they are carefully assessing the value of the service against the price.

In a seminar for senior Japanese residents in Australia, I observed that none of the participants appeared to be stingy or stubborn. They were all deeply engaged in talks by guest speakers. I had no doubt that they were putting effort into finding the best way for them to comfortably use Australian health care services. I observed that it was difficult for the participants to understand how the Medicare scheme works because they are familiar with the Japanese system. A Japanese-speaking informant Ryo mentioned that he was confused with Medicare when he needed to see a GP in Australia. As I mentioned in Chapters 3, in Japanese culture, people tend to shut out outsiders to maintain the ‘purity’ of their identity. Even though most participants in the seminar chose to become permanent residents of Australia, this Japanese concept which is deeply enmeshed in their mind persistently resisted their efforts to comfortably use the Australian health system.

I observed their struggle also in the Q&A sessions. I sensed their unwillingness to give up on their old familiar ways which they had been intuitively following back in Japan. Following a speech on general hospital admission and discharge procedure in Australia, a number of participants double-checked that a discharged patient needs to see a GP for follow-up consultations, not the same clinician that they had seen in the hospital. They implied that they were not comfortable with this practice, in the form of Japanese roundabout expression which I mentioned in Chapter 5. Visiting different facilities at different stages of treatment may make a Japanese patient anxious as in Japan, a patient is charged for an additional 'initial consultation fee' when they change facilities during the course of treatment.

Irrespective of the number of years of their stay in Australia, uncertainty about the consequence of behaving like a local Australian was probably the major reason why they appeared to be unwilling to pay for the services in Doctor G's view. Doctor G may have been a little overwhelmed by senior Japanese patients who constantly depend on her as a convenient source of information in Japanese. Therefore, Doctor G was not able to read their tacit messages in the form of questions about fees, while these questions carried their underlying anxiety about using health services within an unfamiliar system.

It is unlikely that migrant patients know how to behave as a 'normal' patient in Australia. Although it is easy to suggest that a migrant patient should behave in a way which Australians might describe as 'confident', it is easier said than done. I received the same caring but naïve suggestion from several local people when I just moved to Australia. When I had difficulties in receiving refund for an overpaid upfront tuition fee from an Australian education institution, a friend said to me that I needed to be a 'squeaky wheel' (make a noise to get something fixed), which was completely opposite to the Japanese concept of 'a nail that sticks out' (to be hammered down).

As in Yuri's case in Chapter 6, during the first few years of my life in Australia, it was emotionally draining for me to act assertively in a Western sense because assertiveness is usually taken as arrogance in Japanese culture. I assume that many Japanese people in Australia, particularly those who tend not to have people networks outside Japanese communities, may face difficulties in coping with this cultural difference even after spending several years in Australia. The Japanese participants in the seminar seemed to be describing a need for certainty in the consultation, which may be being misread as a lack of confidence because they do not know how to articulate it in a culturally and contextually understandable manner for Australian listeners.

7.3 Good interpreters and good patients: moral categories in the Australian interpreting service system

In this section, I analyse the ideal model of health care interpreting which was advanced by an Australian clinician. While the suggested model conforms to the efficiency-driven agenda adopted by the Australian government, the language service industry and professional associations for interpreters, the account of another Australian clinician indicated that the model may not always be either efficient or effective.

Doctor K is an Australian medical practitioner of Chinese background, who has nearly two decades of clinical experience. At the time of the interview, he was working at an ambulatory clinic in a Sydney-based hospital, where he often used professional interpreting services. Doctor K prefers an impartial, professional interpreter to a patient's family member. Doctor K was doubtful that any communication intervention which did not use the neutral conduit model could have a positive effect.

A problem arises if the interpreter or the patient family member starts giving their opinions, rather than telling me what the patient is saying. That will be the only problem when a professional interpreter or a family member whichever is used. If the interpreter sticks to proper interpretation, there is no problem. I have a problem with them when they start giving opinions. Usually, I ask very specific questions. If the interpreter starts giving an explanation, which is not coming from the patient,

then I know that they are giving their opinions. They are explaining or justifying something, and I know that they are not coming from the patient... You need to pick up which is a good interpreter and which is a bad one.

Doctor K's account is coherent with the ideal model of interpreters which the profession and industry promotes. Doctor K described an interpreter who gives their opinions as a 'bad' interpreter. An interpreter who renders only the verbal statements of the patient and their clinician is described as a 'good' interpreter.

On the other hand, Doctor G raised a concern about time constraint when she uses an interpreter who sticks to the neutral conduit model.

Using an interpreter takes twice as much time as not using any because only a limited amount of time is allocated to each outpatient consultation. This restricts the amount of information I can get from the patient at a time. So, I just hear very basic things, and that's it. I then have to make the next appointment with the patient.

While the interpreter service system is supposed to increase the efficiency of interpreter services, Doctor G's account suggested that an interpreter who acts as a neutral conduit may compromise effectiveness. A suggestion which takes into account cultural difference by an interpreter may help the health communication proceed more effectively within the same allocated time. When I interpreted a conversation between a Japanese expectant mother and a midwife in an Australian hospital, the midwife asked the woman if she would prefer to come to the hospital for the remaining appointments or share appointments between her GP and the hospital. The Japanese woman became confused and silent. In Japan, a pregnant woman usually sees an obstetrician for maternity check-ups, and sees the same obstetrician throughout the pregnancy. Although these were not the mother's words, I told the midwife, "Hana (the mother) does not understand your question. She might want to know the difference between the two options".

As shown in the analysis of the account of Emi in Chapter 6, the practice of health care interpreters is strongly focused on word-to-word interpreting. It should be noted that while NAATI gives professional interpreting accreditation to non-English languages and is developing a process for accrediting interpreting in some Australian Aboriginal languages, there is a significant difference in focus between these language groups. TIS only provide services for non-Australian languages. The interpretation of the AUSIT Code of Ethics therefore varies depending on whether the interpreting service is for Aboriginal people or non-English speakers from non-Australian backgrounds. As suggested in a qualitative study on the experiences of medical encounters in Aboriginal patients suffering from end-stage renal diseases and health care workers in Darwin (Cass et al 2002), the focus in health services for Aboriginal patients is on deepening the shared social and cultural understanding of illness experience between Australian health care providers and Aboriginal patients.

7.4 Utterance matters: placing the onus for successful cross-linguistic communication on patients

In this section, I analyse the accounts of patients on how clearly they needed to explain their needs in Japanese-English medical encounters. The section starts with an examination of communication support by a Japanese non-profit-organisation which an English-speaking patient highly appreciated. I analyse why she found their support effective, by drawing on the accounts of Japanese-speaking patients on negative experiences in similar situations in Australia.

There is no need to say everything: English communication support by a Japanese not-for-profit organisation

Emma is an English-speaking woman who had her first baby in Japan. Emma told me about a hotline service provided by a local not-for-profit organisation in Chiba Prefecture. The

service is dedicated to non-Japanese patients in Japan who need to use health services.

Emma used this service when she found herself bleeding during pregnancy.

We were somewhere outside our apartment. I called [the hotline]. I was quite impressed. You say the closest train station, and they will look up a doctor for you. The closest train station was City B, and they said “from City B, this is the closest doctor”. I would always call that number.

As Cathy and Will mentioned in Chapter 5, in Japan, the patient needs to choose which specialist or department they go to for an initial consultation. Emma appreciated the hotline service because she did not have to specify the health care service she thought she needed to use. Instead, she only needed to tell the operator her symptoms and where she was. The operator then found nearby clinics and specialist offices for her. While Emma thought that the hotline service was novel, most Japanese people intuitively expect that the service provider identifies the user’s unstated needs. The operator of the hotline gave Emma information which she did not specifically asked for but which she actually needed.

On the other hand, in Western cultures, as Travis (1998) explained, the communication norm is that people need to clearly express their needs.

This is quite different from the norm operating in Anglo society, where, as long as no one would be hurt, open expression of one's feelings and opinions is generally valued and appreciated, and people are encouraged to "say what they think" (*ibid.*: 59).

I have been called in as an interpreter for a telephone interpreting session in which the Japanese user was not exactly sure where they should forward the call, although it was not about health issues. The Japanese speaker wanted to know how to claim back their bond for a rental property which he had vacated several weeks before. He had not received any notice from the real estate agency or the owner – he did not mention how he was renting the property. When the Japanese speaker asked the operator for a suggestion on where they could possibly forward the call to, the operator answered that they were not allowed

to give any advice or suggestion to clients. Although I felt sorry for the Japanese speaker, I remained silent as I was also prohibited to perform any work other than neutral interpreting. I found this situation very awkward, and felt that what the operator and I were doing was inappropriate.

Literal interpretation lacking contextual proficiency

The account of Ryo, a Japanese-speaking legal professional, about his experience of using an emergency health service in Australia supports the above analysis. Ryo suffered from heat stroke after playing a game of tennis in Australia. A friend of his accompanied him to help him communicate with the clinician at the hospital. The friend is an English-speaking Australian anaesthetist who does not speak Japanese. This friend paraphrased the conversation with the clinician in simpler English for Ryo.

[The friend who came with me] spoke to me in English in a way in which I could easily understand what the doctor was saying. It was all in English, but I understood what he was saying because I had already been familiar with his English. It was difficult for me to catch the doctor's English. He didn't have a strong accent, but spoke fast. It's hard to understand conversation if you are not familiar with the speaker.

Ryo's account makes a similar point to that made by Japanese-speaking women partnered to English-speaking men. They said that they did not always understand their doctor's English but did understand their partners' English.

While acknowledging that communication intervention by his friend was helpful, Ryo faced difficulties when he tried to find out which GP he needed to see following discharge from the hospital. Ryo had no idea about GPs because he had never used a GP (Japan does not have a gatekeeper primary care system based in general practice). When Ryo tried to ask for general information on GPs, neither the receptionist nor the friend understood his intention.

Although I had already been familiar with the area where I was living, I still didn't know which GP I should go, and even whether I was eligible for a GP service. I had

only recently become eligible for Medicare. So, in this sense, it would have been helpful if there had been an interpreter or a Japanese-speaking hospital staff member, not for the purpose of literally interpreting conversation but providing me with basic information on the Australian health care system.

It would be helpful if they could think about how familiar the patient is with the local area, their visa status, whether they have Medicare, although such information is not directly related to treatment. In my case, I had become eligible for Medicare just before I went to the hospital, so I didn't have that plastic card. I only had a paper slip like a receipt. I was wondering whether I actually could use Medicare. Since I had never been to a GP, I had no idea about which GP I could go when I received a discharge letter for me. The letter said, "Dear GP, ...". I asked the hospital staff, but they only said, "Whichever GP will do." And I couldn't get much information on what the GP is.

Doctor G agreed that many Japanese patients in Australia "know nothing" about the Australian health care system. The lack of knowledge of the Australian health care system is a significant barrier for a Japanese patient to access appropriate services. The Japanese roundabout communication style further makes it difficult for a Japanese patient to ask a question in a way in which it is comprehensible to an Australian listener.

Ryo's question on which GP he could go implied that he needed basic information on what GPs are. It involved unstated questions on various aspects such as whether there is any difference between GPs in terms of the type of treatment they provide and fees, and whether he should choose a certain GP in accordance with his symptoms. Ryo's statement that he was not sure whether he was eligible for a GP service indicated that he was confused about the Australian Medicare scheme. He did not fully understand that not having access to Medicare does not mean that he cannot use any GP services in Australia. The fact that there is no difference in the level of cover by the Japanese national health insurance between public and private health services in Japan is likely to make most Japanese patients in Australia confused about the Australian Medicare scheme.

Another issue Ryo faced was that he did not fully understand that a GP makes an initial assessment to decide which specialist the patient needs to see if necessary. In Japan, private

specialists run their own clinics at a primary care level. If a patient is suffering from nasal symptoms, for example, they go to an ENT clinic; if they have an injury while playing sports, they go to an orthopaedic clinic. If they are not sure, then they often go to an internal medicine clinic. As the accounts of Cathy and Will in Chapter 5 and that of Emma in this section suggested, this difference can confuse Japanese patients in Australia, and non-Japanese patients in Japan.

While the professional ideal regards language as a standalone technical issue, the accounts of informants suggested that linguistic accuracy is merely part of communication barriers in cross-linguistic medical encounters. Ryo felt that the receptionist who said “whichever GP will do” was somewhat uncaring, although it is probably the case that they did not mean to be so. If a patient asked a question similar to that of Ryo in Japan, it would imply that the patient does not understand the health care system and needed basic information about it. The behaviour of communication mediators described by English-speaking patients in this thesis affirms this Japanese communication style. Ryo did not know how to make the intention of his question understood by Australian health staff.

Ryo also commented on the difference between Japanese and Australian cultures in terms of personal distance in a professional relationship. The difference between Japanese and Western cultures, including Australia, in terms of professional boundaries also has significant implications for how a Japanese patient may see the relationship between themselves and the individual who mediates the conversation. The concept of professional impartiality in Australian contexts may not be compatible with that in Japanese contexts. Ryo mentioned an ambiguous professional/private boundary in Japanese business culture. He said, “My workplace in Australia never holds drinking parties like Japanese companies. However, we still get along with each other”.

In Japan, interactions out of work hours, including drinking parties on weekdays and outdoor activities on weekends, have traditionally been central for forming professional relationships. Ryo meant that professionals in Japan are expected to join quasi-friend networks with their colleagues and clients because they are integral to their solidarity and harmony. In Japan, the line between private and professional lives is obscure. A business meal, for example, rarely refers to a short talk over casual lunch but rather, a long dinner at a restaurant followed by further drinking at a night club or bar. Topics of a business meal can expand to various personal interests. I have seen colleagues in my previous Japanese employment participating in their clients' private activities on weekends, such as golf, fishing and even moving houses.

It is possible that a Japanese patient does not feel like freely saying what they want to say through a professional interpreter with whom they have never exchanged their personal values. Many Japanese-speaking patients I have met as an interpreter asked me questions about my private life. The typical questions were whether I am married to an Australian man and how many years I have been in Australia. While I knew that I was not supposed to continue the conversation on these topics, I also knew that doing so is an important process of building a rapport with the Japanese patient. I minimised the private conversation but did not completely avoid it. The distance between the interpreter and the patient which the Australian interpreter service system defines as part of the interpreter's professionalism makes it difficult for the interpreter and the patient to exchange essential information for effective cross-linguistic communication.

Plurality in health care interpreting in Japan

The aim of health care interpreting in Japan differs across two contexts. The first context is related to health equity. Not-for-profit organisations, through collaboration with local governments, recruit and dispatch volunteer interpreters to health care facilities on demand

(Carreira-Matsuzaki & Sugiyama 2012; Kawauchi 2011; Nadamitsu 2008). The second context is related to inbound medical tourism. Private agencies collaborate with the Ministry of Economy, Trade and Industry in providing comprehensive escort services and travel arrangements to non-Japanese patients visiting Japan to undergo advanced treatment which is not available in their home country (Ministry of Economy, Trade and Industry 2014; Nishiyama 2010).

Health care interpreting in both contexts focuses on the patient's satisfaction with health services. In the private sector, businesses which coordinate medical tourism arrange an entire itinerary for their non-Japanese patient client, from their arrival in Japan to departure. Medical tourism coordinators are similar to travel agencies. They book a hotel for the patient, meet the patient at the airport, take them to the hotel, and arrange follow-up treatment in the patient's home country (Ministry of Economy, Trade and Industry 2014). In the public sector, volunteer interpreters provide comprehensive support to the patient often beyond language rendition (Committee to Review Standards for Medical Interpreters 2010).

Regardless of whether a health care interpreter works in the public or private sector, health care interpreters in Japan are expected to have a great degree of flexibility. Their prescribed mission is to help the patient familiarise themselves with Japanese health care services, and to make their experience as satisfactory as possible. As in the case of Cathy and Will in Chapter 5, in Japan, deviation from the neutral conduit role by a health care interpreter is perceived favourably.

In a case study of communication interventions by interpreters who stepped beyond the neutral conduit role in Japan, Iida (2012: 27) argued that deviation from the conduit role is often necessary in community interpreting, in order to help the non-Japanese client and the Japanese professional avoid misunderstanding due to cultural barriers. Iida also pointed to

the limitation of the AUSIT Code of Ethics, arguing that compliance with the Code may not always help effective cross-linguistic communication (*ibid.*: 35).

Difficulties faced by Japanese-speaking patients in expressing anxiety

Kaori is a Japanese-speaking informant in her thirties who recently gave birth to her first baby in Australia. She explained to me communication difficulties she faced in Japanese-English medical encounters. These difficulties were not related to the level of her English proficiency. Kaori had spent over a decade in Australia since she was a teenager. She has also completed a four-year bachelor's degree in tourism in Australia.

I don't usually ask questions. I was expecting that the doctor would prompt the conversation, and tell me more about pregnancy. But what's been happening is that I am asked, "Do you have any questions?" and I answer, "No," then they say, "Alright, see you next time". That's it for the appointment. I wonder whether it's been really OK while I am being left alone like this. I am pregnant for the first time in my life, and I even don't know what I should ask. So, I actually want some comments and advice from my doctor every time. But instead, they just say, "It's all done if you don't have questions." Therefore, I doubt the quality of their service.

Kaori's account reflects the Japanese moral expectation of a good patient. Kaori was worried that her doctor would think that she was rude if she asked a question. Kaori did not want to bother her GP with questions which she thinks most Australian mothers would not usually be concerned about. Kaori concluded by herself that showing feelings which an Australian doctor is unfamiliar with would disturb her doctor. There is similarity between Kaori and the old Japanese migrants described by Doctor G. Both have difficulties in changing intuitive and familiar ways derived from Japanese culture.

In Kaori's case, her concern was that asking an unusual question would disturb the flow of conversation and harmony between her and her doctor. Breaking harmony in the encounter would cause her to feel that she was a deviant and bad patient. However, it paradoxically resulted in a negative communication outcome due to the cultural difference.

As a Japanese woman and a patient, Kaori was not used to explicitly stating her needs and opinions in public interactions. Kaori was open and honest to her husband in private conversations. Despite the fact that Kaori is fluent in English, she often took her Australian husband with her to check-up appointments.

I can check with my husband whether the treatment I'm receiving is one which people normally receive. The maternity check-up in Australia is extremely simple, isn't it? It's very quick. They just say that there's no problem. That's it. So, in such a case, I can ask my husband, "Are maternity check-ups in Australia usually like this?"

While this was Kaori's first pregnancy, she had knowledge of antenatal care in Japan as she had her mother send books on pregnancy from Japan, and contacted her relatives and friends who recently had babies. Kaori mentioned the significant difference in the number of ultrasound examinations performed during pregnancy between Japan and Australia.

While in Australia, it is performed routinely once or twice through pregnancy unless the mother or the baby has health issues, it is performed at every appointment in Japan. The recommended frequency of maternity check-ups by the Japanese Ministry of Health, Labor and Welfare is every four weeks in the first trimester, fortnightly in the second trimester and every week in the third trimester (Ministry of Health, Labor and Welfare *n.d.b*).

Kaori described "being neglected" by her Australian GP. There was a misunderstanding between Kaori and the doctor. While Kaori was feeling that she was neglected, her doctor may simply not have noticed that she needed more support because she did not explicitly say so. Because of the feeling that she was neglected by her doctor, Kaori ended up building distrust in Australian health care services.

As a professional interpreter, I have been involved in a similar situation to that of Kaori. I was interpreting for a Japanese pregnant woman at a local hospital in Australia. She was close to her due date. At the end of the appointment, her doctor told her to go to the rehabilitation department to make an appointment for postnatal exercise sessions. The

patient was supposed to go to the reception, and ask them the location of the rehabilitation department. I was supposed to be responsible only for interpreting a conversation between the patient and the receptionist. However, the Japanese patient did not know what she was expected to do. It was obvious that she was expecting me to find out the location of the rehabilitation department, and take her there.

It was natural that, as a Japanese patient, she would expect me to be her representative. She had psychological proximity to me because I had worked as an interpreter in her consultations several times prior to this occasion. Long waiting times of over one hour at every appointment led us to engage in casual conversations, and so this pregnant woman had built trust in me.

I could have explained to her that my role is limited to language rendition, and that I was not supposed to take her to the department. However, I also knew that such response would give rise to an awkward situation. She would consider that I abandoned her while knowing that she was in trouble – a person lacking *omoiyari* (empathy – see Travis 1998). I faced a dilemma choosing between two different culturally anticipated roles. I eventually chose to follow Japanese norms. I asked the receptionist in place of the patient to tell me where the rehabilitation department was. I escorted the patient to the department. This event happened after I was signed off from the paid interpreting assignment. Regardless of whether I was serving as a professional interpreter or a benevolent individual, this Japanese patient expected me to support her in a versatile way in the cross-linguistic medical encounter.

Yuri, a Japanese woman who moved to Australia following marriage to her Australian husband, had an unpleasant experience in Australia also because she was acting as a passive, good Japanese patient. Yuri did not understand why she was ‘neglected’ by nurses in the hospital where she gave birth to her baby.

I thought I should wait until a nurse would come and help me. I was wondering why none of the nurses came to help me. In Japanese hospitals, staff members are very caring. This may be different at other hospitals. In that hospital, I felt that they were telling me, “You should not expect us to help you because you are the mother”.

Neither Yuri nor Kaori was keen on being the main participant in the communication. They preferred playing the role of a passive patient who does not offend their clinicians and nurses. The difference between these women is that while Kaori is fluent in English, Yuri spoke extremely limited English at that time. Due to the language barrier, Yuri missed a maternity class at the hospital. She thought she would not understand information the class gives because it would be provided in English.

I should've heard about [the maternity class], but I didn't go because I didn't understand English. I got lost in how to take care of my baby after delivery, but I was still expecting that nurses would show new mums how to take care of their babies. When I asked one of the nurses, she clicked her tongue in frustration. It was as if she was blaming me for not having been to the maternity class. I could see that she wanted to say to me, “Why did you come here without preparation?” I was expecting that the hospital staff would show me everything after I had my baby. But this was not their idea, perhaps. I also thought that the hospital staff treated Australian mums differently from non-Australian ones. They were nice to Australians. I thought they were cruel to me.

Being insecure and not knowing what to say to her doctor and nurses, Yuri was completely lost about how to use Australian health care services. The nurses did not understand why Yuri did not clearly state her needs while Yuri did not understand why the nurses did not come and help her. Until her husband told the nurses that she was feeling neglected, she had not known that the nurses were also facing difficulties in understanding her needs. Even if her doctor had arranged an interpreter, Yuri would have remained a passive patient, and would not know how she was supposed to speak through the interpreter. Yuri did not tell her doctor or nurses about her concerns because she was not prompted to do so.

7.5 Summary

This chapter explored the national interpreter credentialing and service systems in Australia. It started with a review of an efficiency-driven agenda adopted by the systems and how they are linked to the Australian health care system. There has been growing interest in pursuing efficiency within both the language service and health care industries in Australia. The Australian government supports this movement. I argued that the proliferation of the casual employment of interpreters through language service agencies and the precepts of professionalism limit the agency of the interpreter in a cross-linguistic medical encounter. They are beneficial to the government and language service agencies as a strategy for cost efficient practice, but not necessarily to patients, clinicians and interpreters.

The imposition of a certain communication model on all patients regardless of their cultural backgrounds can leave their voices unheard. An analysis of interview data showed that the neutral conduit model of interpreting is not effective for communicating culturally nuanced messages which a patient often does not explicitly state. The Japanese moral category of a good patient makes it difficult for many Japanese patients to behave in accordance with Australian health communication norms. Simply increasing the number of credentialed interpreters does not necessarily improve the experiences of patients with diverse cultural backgrounds.

In the next chapter, I briefly review key findings from this thesis, and link them with findings from existing studies. I then suggest that it is necessary to review the current practice of health care interpreting in Australia, by pointing out a number of immanent risks in it. This thesis concludes with a suggestion for future studies to broaden research scope, in order to incorporate the views of patients with diverse backgrounds.

Chapter 8 Communicating real messages

This thesis explored patients' experiences of Japanese-English cross-linguistic medical encounters in the mirrored fields of Japan and Australia. I analysed interview data collected from informants against my hypothesis drawn from existing literature that there are socio-cultural factors which affect patients' decisions on the individual through whom they would like to speak in Japanese-English medical encounters.

Complex socio-cultural factors have significant implications on informants' experiences of their encounters with English-speaking clinicians. These factors include culturally-constructed gendered moral roles, trust relationships, shared socio-cultural knowledge between the patient and the interpreter and the symbolic capital associated with the English language.

8.1 Key findings and policy implications

This study has provided a number of key findings which help answer the four research questions, as well as suggestions for improving health care interpreting in Australia.

Regarding the first question, the analysis of interview data found that Japanese-speaking patients, particularly Japanese women who attach to the mastery of English an image of liberation from conservative Japanese expectations, tend to see Japanese-English medical encounters as emotionally challenging. Compared to English-speaking informants, Japanese informants, particularly those partnered to English-speaking men, tend to be under stronger pressure of speaking 'perfect' English.

This study found that there is the cultural construction of gender which frames Japanese women's preferences for, and expectations of, communication mediators in Japanese-English medical encounters. Japanese women who are partnered to English-speaking men tended to exclusively rely on their partners in Japanese-English encounters, irrespective of

the levels of their English proficiency and their partners' Japanese proficiency. Most Japanese-speaking women indicated that they would never use a health care interpreting service. This finding answers the second research question as to patients' perceptions of health care interpreters and the impact of their perceptions on the relationship between the patient, the clinician and the interpreter.

Most Japanese women partnered to English-speaking men entrusted their needs to their partners. Their partners therefore mainly communicated with these women's doctors. An analysis of the accounts of these women suggested that their English-speaking partners both embody freedom from Japanese norms while simultaneously performing a role of husband-advocate that reinforced gendered Japanese culture. A spouse is an insider, a trusted intermediary who will have the interests of the patient at heart.

A consultation involving a health care interpreter, whom these Japanese women recognise as an outsider, threatens the social order which they have built through the relationship with their English-speaking partners. Because of the boundary they draw excluding any communication mediator other than their English-speaking partners, Japanese women tend to apply different criteria to a professional interpreter from those they apply to their English-speaking partners when they consider the effectiveness of communication mediation. This finding suggests that advocacy and cultural mediation are as important as accuracy in health care interpreting. While this finding was mainly drawn from data from Japanese women partnered to English-speaking men, a high-stakes emergency case of a Japanese woman who is not partnered to an English-speaking man in Chapter 3 supports this finding beyond gender implications.

The accounts of English-speaking patients seeking health care in Japan indicated the opposite tendency. Many English-speaking patients did not have any particular preference about the type of communication mediator. English-speaking men seeking health care in Japan and who were partnered to Japanese maintained their agency in Japanese-English

medical encounters. None of their Japanese wives intervened in the encounters, and most did not attend the consultation with them. This suggests that the wives may have been playing the moral role of 'good' Japanese women who are quiet and obedient.

This study also found in relation to the third research question that it is not only the grammatical knowledge of language which creates communication barriers in Japanese-English medical encounters. It has shown that neutral language rendition may not always be the best solution to closing the gap between Western communication norms and Japanese ones. While an extensive policy review in this thesis found that the ideal interpreting model advocated in Australian language service policies is equivocal and likely to be interpreted as one almost equivalent to mechanical language conversion, Japanese-speaking informants indicated that they would engage in the medical consultation when the interpreter provides extralingual support. The accounts of Japanese-speaking patients indicated that it may be almost impossible for word-to-word interpreting to help English-speaking clinicians understand that reticence is often equivalent to politeness in Japanese culture. It is often the case that a Japanese patient implies a message which their verbal statement does not directly express.

The ideal model of professional interpreting in Australia does not incorporate the concepts of trust and bonding between the speaker and the interpreter. Instead, it focuses on accuracy and proficiency in both languages. In a study of patients' and residents' views of different types of communication support for Spanish-speaking patients in Rhode Island, Kuo and Fagan (1999) found that while both patients and doctors were highly satisfied with professional interpreters, patients were far more likely to feel that advocacy and system navigation after the consultation were important qualities of good interpreting. Patients were, not surprisingly, more likely to be satisfied with family members as interpreters (85% satisfied), than were resident doctors (60.8% satisfied). Telephone interpreters and hospital employees who were co-opted into interpreting were considered the least satisfactory

modes of communication support. Both hospital employees and telephone interpreters are unable to provide follow-up assistance and navigation support.

In relation to the fourth research question, this study found that Japanese people tend to attach special symbolic significance to the English language. The Japanese school education system and Japanese people's aspirations for the West as the symbol of modernity may have given rise to a view which sees English as symbolic capital. While mastery of English in fact has little implication for the learner's career prospects, the Japanese government and industries continually emphasise the importance of English as the global language in Japanese society. Many Japanese-speaking patients in this thesis indicated that they were ashamed when they found themselves not able to use perfect Western English. The accounts of Japanese-speaking patients suggested that the presence of an interpreter exacerbates their sense of shame. By contrast, almost no English-speaking patients indicated that they were ashamed of their limited Japanese proficiency. Instead, they indicated that the experience of language barriers increased their motivation to learn the Japanese language.

Answers to the four research questions suggest that the characterising of professional practice for interpreters as being a 'neutral language conduit' does not always meet the true communication needs of patients. This study has shown that it is sometimes unavoidable for an interpreter to adjust verbal statements by the speaker to a certain extent so that the speaker's culturally nuanced message will be understood in the intended way by the other speaker from a different culture. Interpreters in Australia demonstrate their professionalism through compliance with a national code of ethics which emphasises accuracy and professional detachment. This is monitored by at least one large interpreting company through surveilling interpreters' work and monitoring their word-to-word translation accuracy.

The casualisation of health care interpreting in Australia has limited the ability of interpreters to make a steady living out of their profession, with many interpreters doing “piecework” from their homes for employers who offer rapid-access telephone interpreting. Most interpreters who work in community settings suffer from the lack of public recognition of their profession and extremely low pay (Roberts 1997; Bell 1997). In order to improve health care interpreting to serve patients’ best interests, the productive and rewarding working environment for health care interpreters should not be compromised.

The language service industry in Australia is driven by an efficiency focus which prioritises the provision of interpreting using remote means. The disappearance of advocacy and trust from the professional skillset of interpreters stipulated under the Code means that the human relational aspect of interpreting can be set aside in favour of monitoring word-to-word transference. This means that remote interpreting – a far more efficient proposition for the industry in a large, linguistically diverse country like Australia – can be prioritised by the industry over on-site interpreting. Under the current Code of Ethics, advocacy and patient responsiveness are framed as risks to the disinterested practice of the professional. The promotion of this rhetoric about professional practice is a potential threat to the profession of interpreting in the long term, rather than developing it.

8.2 A versatile concept of ‘quality interpreting’

There are situations in which a professional interpreter who sticks to the detached, neutral conduit model will provide a better result than a relationship-focused interpreter. Examples of topics which the patient may find difficult to communicate through a family interpreter include “sexual health, gynaecological problems, sexual violation, domestic violence, or torture” (Burnett & Peel 2001: 546). A breach of impartiality by the interpreter commenting on the decision and behaviour of the victim of family violence creates an additional trauma for them (Special Broadcasting Services 2015).

Professional detachment also helps protect the interpreter, for example in complex mental health cases and those of patients from an ethnic minority group in which it is often difficult to maintain the anonymity of each member. Interpreters often consider that their role in on-site interpreting involves advocacy (Hsieh 2006b). Remote interpreting helps the interpreter sustain their practice as they can avoid advocacy expectations and give the patient the impression of confidentiality, and this also helps building a rapport between the patient and the health care provider (Phillips 2013: 513).

The concept of 'quality interpreting' is widely used by scholars, professional associations for interpreters and local governments concerning cross-cultural communication. There is a disparity in the understanding of this concept between interpreters and their stakeholders. From the perspective of professional interpreters and the Australian government, this concept is largely equivalent to the possession of NAATI credentials and compliance with the AUSIT Code of Ethics, whereas patients have more versatile perceptions.

At the same time, there is a general assumption (as stated by the doctors interviewed in this study) that a good interpreter is able to detect and interpret non-verbal or cultural cues. In the words of Blancato (2015), an Australia-based journalist specialising in languages, "[a]n interpreter or translator must not only know the literal words in both languages but have the ability to detect tone, intonation, irony, sarcasm... the list goes on" (Blancato 2015: 13).

Interpreters' compliance with the Code enables the provision of consistent interpreting services. This may make it easy for the service user to anticipate the kind of interpreting services they receive, as long as the user is familiar with the Code. The professional practice of interpreting in Australia is focused on the mechanical aspects of cross-linguistic communication. The problem which this thesis has identified with this practice is that it applies a general rule to any kinds of cross-linguistic communication, regardless of the context. The practice hardly adopts the views of patients.

Findings in this study have provided the perspectives of those who have actually used health care interpreters. Their accounts characterise cross-linguistic health communication as complex human interactions. It is noteworthy that communication needs described by most informants in this thesis were those for which health care interpreters often face role conflict between a professional who is faithful to the neutral conduit model and a communication mediator who satisfies the patient's communication needs (Angelelli 2004, Dysart-Gale 2005; Kaufert & Koolage 1984).

The effectiveness of health care interpreting should not be assessed only from limited perspectives. It should not also be assessed solely against administrative efficiency. Quality interpreting is an intervention which leads to “ ‘successful communication’ among the interacting parties in a particular context of interaction, as judged from the various (subjective) perspectives... and/or as analyzed more intersubjectively from the position of an observer” (Pöchhacker 2001: 413).

It is important to note that it is not the case that Japanese patients tend to avoid professional interpreting services because they have high English and cultural proficiency which would allow them to use Australian health services to a satisfactory degree. This thesis has suggested an alternative reason – Japanese patients need communication support which is focused on bridging cultural differences, not simply word-to-word interpreting by an unfamiliar individual.

An analysis of comparative cases of Japanese informants, namely those of a single Japanese woman and two Japanese men, indicated that not all Japanese speakers are strongly affected by the Japanese cultural perception of strangers or symbolic capital attached to the English language. Varying perceptions of health care interpreters among patients may make it difficult to set up a clear role definition and guidelines for health care interpreters.

This study suggests that future studies need to broaden research scope, slightly shifting the weight from the precision of interpreting techniques, to the diverse perspectives of patients, and clarification of the constituent elements of a successful cross-linguistic health communication. Importantly, this may differ across different cultural groups.

8.3 Rethinking human interactions: the difference between human and machine interpreting

At present, research into improving communication with patients with limited proficiency in a country's dominant language focuses on the behaviour of service users, aiming in particular at increasing the use of professional interpreters. This thesis has suggested that doing so is not necessarily the optimal solution to improve the quality of cross-linguistic medical encounters. This thesis has rather suggested that it may not be sufficient to simply increase patients' access to word-to-word interpreting services.

The compelling issue is a lack of available means through which a patient can express their needs to their doctor in a cross-linguistic medical encounter. Such means include but are not limited to efficient, neutral language rendition. In 1960, a survey of major machine translation research centres in the USA by Bar-Hillel (1960) suggested that machine translation could not replace human translators. The task was indeed a complicated one, but the assurance that human interpreting could never be replaced by machine translation now seems outdated (Bojar et al. 2015).

The drastic revamp of Google Translate with the assistance of an artificial intelligence system developed by Google Brain since 2011 (*The New York Times Magazine* 14 December 2016) and Microsoft's Bing Translator has introduced somewhat intuitive open-source translation programs to the public. At the time of writing, Google Translate had used its more intuitive neural machine translation (replacing statistical machine translation) for interpreting to and from English and Chinese, French, German, Japanese, Korean,

Portuguese, Spanish and Turkish. Machine speech-to-speech translation through Google Translate is now available through a number of romance languages. Speech-to-speech translation systems, available as apps for smartphones, are evolving rapidly and are likely to play an important part in health communication in future. George in this study also relied on a smartphone app when he communicated with a Japanese-speaking clinician in northern Japan.

Human interpreters risk eventually being replaced by machines as long as the quality of human interpreting is defined by accuracy. Machines may be able to mount a competitive challenge against humans in regards to accuracy, and provide a far more efficient means of providing this service (Phillips 2013). This poses a real risk for speakers of minority languages or regional dialects, who may not be provided with adequate communication services through a multinational corporate product like Google Translate.

The description of machine translation technology by Guerra (2000) suggests that the role of human interpreters is now gradually shifting toward assisting machines, instead of human interpreters being assisted by machines.

The aim of MT [machine translation] seems much more clear: to achieve faster and cheaper translations... MT aims at replacing, to some extent, the need for human translation... but a human translator is always needed to edit what is translated by MT systems (Guerra 2000: 22).

A comment by some clinicians in a study by Perez and her colleagues (2016: 1242) that they are confident that they can communicate with migrant patients by using Google Translate makes this possibility seem realistic.

Findings in this thesis suggest that health care interpreting is not equivalent to converting one language to another by applying numerous rules. While Google Brain can distinguish cats from dogs based on its enormous data on the definitions of cats and dogs, this process is not the same as that in which a human child builds the knowledge of these animals (*The*

New York Times Magazine 14 December 2016). Interpreting is a complex cognitive process which requires the deep understanding of the context and the application of the interpreter's linguistic, cultural and social knowledge.

The listener's ability to understand and respond to unstated or indirect messages often determines the quality of communication in Japanese culture (Travis 1998; Yamada 1997). In interpreting from English to Japanese, it is often necessary for the interpreter to choose expressions suggestive of the original English statements, instead of equivalent expressions. In Japan, clear statements are often taken to be too strong or intimidating. Machine translation, even if it is assisted by artificial intelligence, is yet to be able to close such a cultural gap.

An anecdote which is often referred to in studies on Japanese translation and literature is the story of the famous nineteenth-century Japanese novelist Soseki Natsume, who taught his students to translate "I love you" in English into a Japanese sentence "*Tsuki ga kirei desune* [It is a beautiful moon, isn't it?]" (Kondo 2013: 125; Konno 2011: 14). He intended this anecdote to indicate that the feeling conveyed in English as "I love you" has more meaning and weight when transmuted through a metaphor about the natural beauty of the moon. The listener is being invited by the speaker to share in a private state about the emotions produced by beauty, as conveyed in the affirmation request from speaker to listener, "isn't it?" I entered "I love you" in English in Google Translate, and it showed "*Watashi wa, anata o aishite imasu* [I love you]". This expression is very direct and would be rarely used in a Japanese context, nor does it convey the delicate emotional statement of bond-making in Natsume's translation. I also entered "*Tsuki ga kirei desune*", and it was translated baldly as "The moon is beautiful". This also carries quite a different nuance from that which is carried in the sentence "It's a beautiful moon, isn't it?" Google Translate has, in effect, reduced "I love you" to an odd exclamation in Japanese, and "It's a beautiful moon, isn't it?" to a banal descriptor of the night sky in English.

8.4 Risks of pseudo-machine human interpreting

The language service industry and interpreting professional associations rarely point to the difference between human and machine interpreting. A focus on the improvement of the accuracy of machine interpreting, the equivocal professional tenet of accuracy and technology-managed interpreting service systems may make human interpreters to be competitors of machine interpreting. As I argued in Chapter 6, interpreters are required to work in a way in which they improve efficiency. The Australian language service industry promotes telephone interpreting as a state-of-art language solution, emphasising around-the-clock availability with reduced waiting time by virtue of intelligent interpreter search programmes (DIBP *n.d.b*; Victorian Interpreting & Translating Service 2017).

In telephone interpreting, interpreters cannot rely on extralingual cues, and are often given no contextual information prior to the interpreting session, except for the name of the service provider. Conversation in telephone interpreting immediately starts once the interpreter is on the line. Therefore, the interpreter needs to start interpreting, like a machine, without preparation to understand the context, such as reading relevant documents and receiving a briefing. The availability of interpreters for telephone interpreting is managed by computer systems, and service quality is constantly monitored. Professional interpreter associations have failed to differentiate human interpreters from machines, despite the original intention in setting up codes of ethics to promote and protect the interpreting and translating professions.

The current orientation of the professionalisation of health care interpreting in Australia involves four risks. The first risk is for health professionals. Without cultural interventions by the interpreter, the health professional may overlook important cultural signs in the patient, while they are obvious only to those who share the same cultural background with the

patient. The second risk is for interpreters. The professionalisation of interpreting may undermine the original objective of Australia's national interpreting services – to improve real communication between Australians who speak different languages. The focus on professional distance and accuracy over advocacy and complex interpretation of nuance poses a risk that human interpreters may eventually be replaced by capable machines equipped with advanced artificial intelligence which major technology companies such as Google have been developing. The casualisation of interpreters may also chase away skilled interpreters. This is linked to the third risk, which is for the language service industry. Compromising effectiveness for the sake of efficiency may eventually result in undermining the credibility of the industry and its credentialing system.

The final and most important risk is for migrant patients. Rigid compliance with accuracy and impartiality by the professional interpreter tends to mute the patient's voice, in that it places boundaries around the actions of interpreters that may help patients to better communicate their needs. This could ultimately affect the trust relationship between the patient and the clinician. This thesis has shown that the patient and the clinician are likely to expect the health care interpreter to be a participant in the interaction, rather than a neutral language conversion device. Their extralingual intervention has a significant impact on the trust relationship between the patient, the clinician and the interpreter.

If professional interpreters are rendered readily replaceable by machines available on open source platform like Google Translate, then the consultation is no longer private, but is in fact being conducted in the open world of cyberspace. No patient should trust that their health care communication is not able to be accessed by others. Telephone interpreting also risks confidentiality because it is not possible for the patient to see who is in the room where the interpreter is speaking on the phone, which is likely to be a speaker phone. It is also not possible for the patient, the clinician and even the operator of the language service agency to confirm the identity of the interpreter on the phone. While the voice recognition

system recently introduced by TIS National can mitigate this risk, overreliance on technology is dangerous.

There is an urgent need to extend the Code of Ethics to incorporate, at least for health care interpreters, a focus on patient responsiveness, in addition to accuracy and impartiality. This brings the tasks of interpreters in line with the tasks of health care workers who also balance responsiveness with impartiality. The industry needs to find a way to work with machine interpreting systems to supplement the suite of services to improve communication, recognising the limitations of machine interpreting. The ability to assess the quality, skill and limitation of language interpreting provided by family interpreters should be taught to medical students and health professionals (Gray, Hilder & Donaldson 2011: 246).

This study has focused on Japanese speakers, and its findings are unlikely to be generalisable to speakers of many other languages. In order to find out why people with certain cultural backgrounds may not be comfortable with speaking through a professional interpreter, further investigations are required into a wider range of ethnic groups. Such studies are particularly important for countries which already have great cultural diversity, including Australia. Given that there has been an unprecedented increase in the movement of people across borders at a global level, such studies should also provide meaningful inputs to other countries which are yet to face a larger influx of migrants.

The nature of communication varies depending on the context, the language pair and the cultural beliefs held by the speakers. An interpreter needs to have not only the grammatical knowledge of the relevant languages but also cultural knowledge which allows them to sense the tacit messages of the speakers, and use it in rendering true messages between the speakers who do not share the same cultural and linguistic background. Demand for more effective and more efficient language solutions in health care will continue to increase. This

exploration of Japanese patients' experiences of medical encounters with English-speaking clinicians throws into relief the benefit of trust-focused, context-based communication intervention in cross-linguistic medical encounters. This benefit should not be compromised for the sake of efficiency. This thesis suggests the necessity of introducing patient-centred communication as central to good quality health care interpreting.

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