Medical Interpreter Education in Japan: History, Current Status and Prospects

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ABSTRACT

There is a growing need to speak English in medical settings in Japan, especially as Tokyo has been selected as the host city of the 2020 Summer Olympics. The objective of this paper is to explore the current status of medical interpreter education in Japan and to detail future directions based on the analysis. A literature review was conducted using three databases. In addition, we searched the internet for Japanese organizations that train medical interpreters, and accessed their publications. Our findings suggest that future educational system for medical interpretations may require: (1) a training system to raise awareness of medical interpreters as active participants of conversation, (2) multi-layered national education systems and corresponding training manuals, and (3) a national accredited licensing system. The working environment for medical interpreters in Japan is currently under development and further preparation is needed. The review shows that more educational programs are being developed by both the government and private sector, and the inclusion of evidence-based curricula is a key focus. These developments should ensure that three of the greatest challenges to medical interpreting in Japan will be addressed by 2020.

KEYWORDS

healthcare, medical interpreting, training, curriculum, interpreter education

1. Introduction

1.1. Background

It is estimated that the number of foreign residents in Japan exceeded 2,034,000 in 2010 and that 9,044,000 foreigners visited the country in 2012 (Ministry of Justice, 2010, 2012). It is likely that the number of international visitors will continue to increase. This influx of visitors ensures that there are many opportunities to communicate with foreigners, including those who speak English. In the Tokyo metropolitan area, many advertisements are designed for an international audience, and some department stores provide services in languages other than Japanese, such as Korean, Chinese, and English. Tokyo is not the only Japanese city to become more international. Other cities like Nagoya, Osaka and Kyoto are also following this trend.

There is a particular need in medical settings to use English to communicate, especially as Tokyo has been selected as the host city of the 2020 Summer Olympics, and medical tourism has emerged as a new area of business (Nishimura 2011). To attract patients from all over the world, companies must be able to use a diverse range of languages. Language barriers may place the health of foreigners at risk when they have difficulty accessing health care and communicating with medical professionals without interpreters.

Communication via an interpreter is associated with several problems. Traditionally, most medical interpreting in Japan was done on a voluntary basis, relying in an ad hoc manner on bilingual individuals (Nadamitsu 2008). Family members and untrained hospital staff often volunteer to interpret, despite the fact that they may commit many errors (Flores *et al.* 2003). In some cases, ad hoc

interpreters are drawn from the immediate environment. They usually work as medical professionals and thus play a dual role. Moreno *et al.* (2007) assessed the linguistic competence of dual-role staff interpreters and found that one in five had insufficient bilingual skills. This is clearly a dangerous situation because using untrained medical interpreters could lead to clinical errors (Flores *et al.* 2003). Despite this situation, the preparation of medical interpreters remains inadequate for many languages. To avoid erroneous interpreting conducted by ad hoc interpreters, proper training of medical interpreters is urgently needed.

To discuss how medical interpretation in Japan could be transformed, this paper explores the current status of medical interpreter education in Japan and aims to suggest future directions based on the analysis. Currently, the most frequently used language in medical interpreting depends on the region in Japan. Although Portuguese is the most spoken foreign language in Japan, in the present study, we focused on English-Japanese interpreting.

1.2. The role of the interpreter

Anderson (1976: 214) explored the role of the interpreter from a sociologist s viewpoint. He presented three aspects of the role of interpreters: “1) The interpreter as a bilingual; 2) The interpreter as a man in the middle, subject to client expectations that are often conflicting; 3) The interpreter as a power figure, exercising power as a result of monopolization of the means of communication.” As the interpreter is bilingual, he or she is often the only person to understand both languages and stays away from dominance, remaining neutral. To maintain impartiality, the interpreter does not belong to either party, each of which tries to project their expectations

onto the interpreter from their respective positions. Wadensjö (2001: 367) also argued that "in interactions between representatives of the society and layman, talking to each other in different languages, the Dialogue Interpreter takes/is given a unique, and potentially a powerful, middle position."

These studies suggest that the role of the interpreter varies according to the type of interpreter, the setting, and dimension. An interpreter is not only bilingual, but also a mediator, a person in the middle, and a power figure in communication. Pöchhacker (2003) described the interpreter as the mediator in three inherent dimensions: cognitive (mediating conceptual relations); cultural/linguistic (mediating intercultural relations); and contractual (mediating social relations). The interpreter works as a mediator between the text producer and receiver. S/he must also mediate between one culture/language and another, and must understand the social status of both parties and adjust the social relations through interpreting.

1.3. The role of the medical interpreter

Medical interpreting is classified as liaison/dialogue interpreting in community interpreting. This signifies consecutive interpreting in conversation in both the target and source language in a community setting. Roberts (1997) argued that medical interpreting clearly places restrictions on the interpreting setting (in a hospital) and that this is reflected by its terminology. Furthermore, unlike conference interpreters, medical interpreters—like liaison/dialogue interpreters—have a presence in the interpreting situation. Therefore, as Roy (1993: 352) indicated, the "interpreter is an active, third participant with potential to influence both the direction and the outcome of the event."

Traditionally, interpreters were not considered party to the conversation; rather, they were seen as language-switching operators (Reddy 1993). However, some researchers have cast doubt on that perspective. Bolden (2000) analyzed two interviews between English-speaking physicians and Russian-speaking patients. She examined the role of the medical interpreters and concluded that they specifically seek medically relevant information from the patients and convey that information to the care providers. Essentially, the role of the interpreter demands that they participate in communication. The same idea was presented in Angelelli s ethnographic study (2004) of bilingual medical interactions, which showed that the interpreter actively influenced the medical encounters, instead of playing a default invisible role. As Angelelli (2004) pointed out, medical interpreters by themselves are more active co-participants than mechanical language converters.

This tendency towards active involvement has also affected practical medical-interpreting associations. The US National Council on Interpreting in Health Care (NCIHC) (Avery 2001), founded in 1998, presented findings on the practical role of medical interpreters. Like others, they argued that in the health-care setting, the interpreter cannot remain a passive, uninvolved party. Roberts (1997) suggested some roles of medical interpreters other than active participation. These included assistant (service provider for patients); cultural broker (cultural bridge); advocate (advocating for patient rights); and conciliator (conflict mediator). However, whether these functions should be explicitly included in the role of the medical interpreter is still under discussion.

According to the Cross Cultural Health Care Program (2014: 11), “The idea of interpreters moving from role to role as necessary, but always staying as much in the background as possible, is called

incremental intervention." The authors suggested four roles of medical interpreters: Conduit (simply relaying information from the source to target language); Clarifier (intervening when needed to ask for clarification); Cultural Broker (explaining a cultural framework); and Advocate (speaking for the patient to protect their rights). Figure 1 represents incremental intervention. The largest part of the pyramid is the role at the bottom. Interpreters usually serve in the conduit role. The medical interpreter must switch from role to role, depending on the need of the particular setting and patient and healthcare provider.

In Japan, no specific roles have been defined for medical interpreters. They work in all areas of outpatient consultation, and thus function in a wide range of situations. These may include explaining written forms such as the medical visit form, direction at reception (e.g., presentation of the medical identification card), medical consultation and examination, payment, and prescriptions (Mizuno 2008).

FIGURE 1

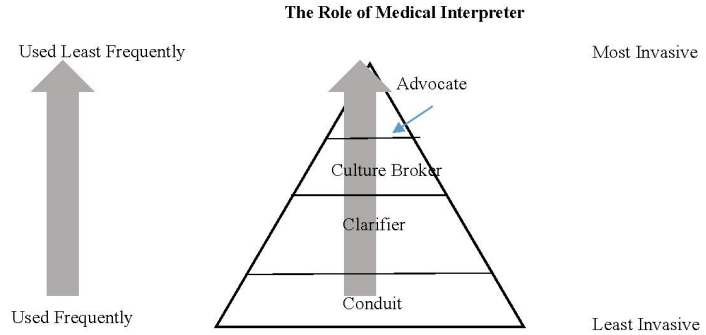

Figure adapted from Cross Cultural Healthcare Program (2014: 10).

1.4. Objectives

This paper explores the current status of medical interpreter education in Japan and aims to detail future directions based on the analysis.

2. Methods

A literature review was conducted using Pubmed, CiNii, and Google Scholar. We also searched the internet for organizations responsible for the training of medical interpreters in Japan, and papers published by these organizations. The literature search focused on the period January 1992 to December 2015.

3. Findings

We found twelve organizations responsible for medical interpreter education during the period 1992 to 2015. Traditionally, it appears that in Japan, medical interpreters have studied by themselves. According to a report by the Mino English Medical Interpreters Study Group, before more formal training of medical interpreters was introduced, learners held study groups and studied together periodically. In the sessions, the interpreters read excerpts from a Family Medical Dictionary in English and conducted role-plays of simulated medical interviews (Nishino *et al.* 2004). With a growing need for trained medical interpreters and a more formal, systematic training system, training programs were implemented in various regions from the 1990s onwards.

3.1. History of Programs for Training Medical Interpreters

According to MIC Kanagawa (2006), programs organized by non-profit organizations include: Hokushin Foreigner Health Network (established in 1992), International Volunteer Center Yamagata (1994), MEDICOF Shiga (1999), Multi-cultural center Kyoto (1999), Miyagi International Association (2001), Medical Interpreter Research Association (MEDINT, 2003), and MIC Kanagawa (2006). Programs of educational organizations include: lectures and workshops in medical interpreting at Tokyo University of Foreign Studies (2010), lectures on medical interpreting at Nagoya University of Foreign Studies (established in 2015, currently running), lectures and workshops on medical interpreting at Osaka University (from 2015, currently running). Most of the courses are for postgraduates, or short lifelong education courses for adults.

3.2. Current Status of Medical Interpreter Training

3.2.1. Features

We present an example of a curriculum created for the Ministry of Health, Labour and Welfare (2015) by an outsourced organization (Table 1). It illustrates the nature and standard of the current medical interpreting education system.

Table 1 Curriculum Standard for Medical Interpreters ('Can-Do' list)

KNOWLEDGE
- Understands and has knowledge of health, the medical profession and patients, cultural and social diversity and how it affects communication
- Uses appropriate terminology, and has basic knowledge regarding healthcare
- Understands patients rights in healthcare

COMPETENCY AND SKILLS
- Competent in the mother tongue and second language - Conducts dialogue consecutive interpreting - Skilled in multicultural communication, and responds appropriately to each specific setting - Manages the flow of conversation in a medical interview session - Prepares in advance and collects relevant information - Acts as a cultural broker, if needed, and only with the client s agreement - Manages own physical and mental health and prevents infection - Reflects on own performance, and constantly tries to maintain and improve his/ her skills
ETHICS
- Understands the role of the interpreter, and follows the code of ethics and standard practice - Acts with responsibility and professional conduct - Respects human rights and/or treats everyone with respect - Interprets faithfully, understanding the true sense of the speaker s speech - Maintains neutrality - Ensures that all information is kept confidential - Understands the limits of an interpreter s role, and manages interpreting requests accordingly

Based on this curriculum standard, medical interpreter candidates receive 37.5 hours of lectures and 30 hours of practical training.

3.2.2. Admission Requirements

Admission requirements vary from one organization to another. However, in general, college-level education and 3 (or more) years of professional work experience as an interpreter are required. Language proficiency is not specified, but typically screening tests are used to

assess English proficiency with a TOEIC score of at least 650 required for admission (Ono 2013). Some organizations require submission of a validated language proficiency test equivalent to this level. There was no division by level of language proficiency, and in most cases there was only one class for each language. Generally, the Japanese-English class had a high level of language proficiency when compared with other languages and classes. This is because many people study English in Japan and as a result competition to join this class was fierce. For some other languages less widely spoken in Japan, there were far fewer participants wanting to learn medical interpreting and admission requirements were lower.

3.2.3. Program Completion Requirement

In most of the training programs for medical interpreters in Japan, a Certificate of Completion was awarded when participants satisfactorily completed the course, with attendance of around 65% (Multi-cultural center Kyoto 2015). This is similar to course completion requirements at Japanese universities. In most cases, participants were required to pass a comprehensive final exam.

3.2.4. Course Requirements to Receive a Certificate of Completion

To receive a certificate of completion, most of the programs required participants to obtain a grade of at least 70% on all exams, including written and practical skills-based tests for interpreting (Multi-cultural center Kyoto 2015).

3.2.5. Curriculum

Table 2 presents an example of a recent curriculum for medical interpreting education. Again, it is based on the program created by

an outsourced organization for the Ministry of Health, Labour and Welfare (2015).

Table 2 An Example of a Curriculum for Medical Interpreting in Japan in 2015

COURSE CONTENT (Total: 37.5 hours)
1. Basic anatomy of the human body
2. Role of the medical interpreter
3. Research skills for medical terminology
4. Professional conduct
5. Basic knowledge of the human body and disease
6. Basic knowledge of medical/clinical tests
7. Basic knowledge of medication
8. Practical interpreting skills
9. Basic knowledge of the Japanese healthcare system
10. Understanding cultural and social diversity
11. Communication skills of a medical interpreter
12. Self management of medical interpreters for a better performance
13. Mock interpreting
14. Code of ethics and code of conduct for medical interpreters
15. Lists of terms used in medical settings

If participants successfully complete this curriculum, they are awarded a certificate of completion, although this is not an official accreditation.

4. Discussion

4.1. Findings from the Review

Three main findings emerged from our review of medical interpreter education in Japan. First, training systems for medical

interpreters were divided into two main types: (1) Programs organized by non-profit organizations such as municipal offices and NGOs, and (2) Programs organized by educational organizations such as universities and private companies for English education. The education systems were all established in the 1990s, relatively recently in comparison with sign language interpreter education, which dates back to the 1970s. Programs organized by non-profit organizations were developed according to local needs, complete with an agency for dispatching trained medical interpreters. Almost all courses organized by educational organizations were not linked to a placement agency to assist with finding jobs after training.

A second finding was that there are currently no officially accredited programs in Japan. There are many examples of accreditation systems abroad, e.g., The Cross Cultural Health Care Program (CCHCP) in the United States offers a 40-hour training program for medical interpreters, which leads to certification/accreditation on completion. In Australia, the National Accreditation Authority for Translators and Interpreters Ltd. (NAATI) established in 1977 provides a nation-wide certification for community interpreters including medical interpreters. These examples could be considered when establishing accreditation for medical interpreters in Japan.

Third, medical interpreter education in Japan appears to be different from other interpreter education in that a distinction was not made between different levels of language ability. Requirements for training are high and most of the organizations offering training in this field require either practical experience as an interpreter, a medical background, and/or a high language proficiency level.

4.2. Problems with current medical interpreter training in Japan

In Washington D.C., a qualification and training program for medical interpreters has been established (Wood 2002). However, it is evident that this and other such programs developed in Japan do not cover all the important skills necessary for medical interpreting.

Ono (2013) conducted a systematic review of international literature and revealed five core competencies for the profession: (1) maintaining accuracy and completeness; (2) knowledge of medical terminology and the human body; (3) behaving ethically and making ethical decisions; (4) nonverbal communication skills; and (5) cross-cultural communication skills. Currently, most of the programs in Japan are not based on evidence, however, these five competencies could be considered the basic skills needed for medical interpreters and could be referred to as evidence when training systems for medical interpreters are established.

Some Japanese interpreters may be considered professional in that they studied abroad and received official certification there, but most have no formal qualifications as medical interpreters. The role of medical interpreter is currently undertaken on a volunteer basis, but a more organized system of professional interpreters could be established by preparing a more structured accreditation and training system (Nishino *et al.* 2004).

4.3. Limitations of the present review

There are limitations to the present study. The academic and pedagogic frameworks developed in Western countries to accommodate the citizens of those countries, need to be imported to Japan with extensive changes because the goal of medical interpreting

in Japan is to serve foreigners rather than its own citizens. The goals are more commercial, rather than political or social. Japan is a ethnically homogeneous country with a very large population of foreign visitors. Nonetheless, there are findings from the international literature that may contribute to the future development of medical interpreter education in Japan.

4.4. Future Prospects for Medical Interpreter Education in Japan

Our findings suggest that a future educational system for medical interpreting may require: (1) a training system for interpreters to raise awareness of medical interpreters as active participants of conversation, (2) multi-layered national education systems and corresponding training manuals (Ono 2014: 158), and (3) a national accredited licensing system (Ono 2014: 158). There have been some attempts to focus on the future of medical interpreting in Japan. A Japan chapter of the International Medical Interpreters Association, a US-based international body, held a symposium to discuss the establishment of accreditation for medical interpreters in 2014. In 2015, the Ministry of Health, Labour and Welfare released references for medical interpreter education on the internet, and provided textbooks free of charge. Accreditation and a unified training system for medical interpreters are developing and are expected to be completed in the near future. Millerson (1964) presented a list of characteristics that members of a profession should have. These included skills based on theoretical knowledge, education and training, a code of professional conduct and a powerful, professional organization. Considering the medical interpreter education programs and accreditation systems that have been effectively implemented abroad, we hope that the professionalism of medical interpreters in Japan will be developed.

5. Conclusion

We reviewed the history, current status, and future expectations of medical interpreter education in Japan using a literature search. Currently, the environment for medical interpreters in Japan is under development, and further work is needed. However, results of the present review indicate that more educational programs are being developed both by the government and private sectors, and an evidence-based curriculum is also being developed. Ideally this preparation should be completed before the Tokyo Olympics in 2020.

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