International Journal of Business, Human and Social Sciences
ISSN: 2517-9411
Vol:10, No:10, 2016

Relationship-Centred Care in Cross-Linguistic Medical Encounters

Nami Matsumoto

***Abstract*—** This study explores the experiences of cross-linguistic medical encounters by patients, and their views of receiving language support therein, with a particular focus on Japanese-English cases. The aim of this study is to investigate the reason for the frequent use of a spouse as a communication mediator from a Japanese perspective, through a comparison with that of English speakers. This study conducts an empirical qualitative analysis of the accounts of informants. A total of 31 informants who have experienced Japanese-English cross-linguistic medical encounters were recruited in Australia and Japan for semi-structured in-depth interviews. A breakdown of informants is 15 English speakers and 16 Japanese speakers. In order to obtain a further insight into collected data, additional interviews were held with 4 Australian doctors who are familiar with using interpreters. This study was approved by the Australian National University Human Research Ethics Committee, and written consent to participate in this study was obtained from all participants. The interviews lasted up to over one hour. They were audio-recorded and subsequently transcribed by the author. Japanese transcriptions were translated into English by the author. An analysis of interview data found that patients value relationship in communication. Particularly, Japanese informants, who have an English-speaking spouse, value trust-based communication interventions by their spouse, regardless of the language proficiency of the spouse. In Australia, health care interpreters are required to abide by the national code of ethics for interpreters. The Code defines the role of an interpreter exclusively to be language rendition and enshrines the tenets of accuracy, confidentiality and professional role boundaries. However, the analysis found that an interpreter who strictly complies with the Code sometimes fails to render the real intentions of the patient and their doctor. Findings from the study suggest that an interpreter should not be detached from the context and should be more engaged in the needs of patients. Their needs are not always communicated by an interpreter when they simply follow a professional code of ethics. The concept of relationship-centred care should be incorporated in the professional practice of health care interpreters.

***Keywords*—**Health care, Japanese-English medical encounters, language barriers, trust.

I. Introduction

THIS study explores patient experiences of cross-linguistic medical encounters, with a particular focus on medical encounters by Japanese speaking patients in Australia. The aim of this study is firstly to explore the reasons Japanese-speaking patients prefer spouses as communication mediators in Australian medical encounters. The secondary aim is to explore the gap between the patients' perceptions of health care interpreters and the ideal interpreter-mediated health communication model articulated by interpreters and scholars in interpreting studies. This ideal model has been widely adopted in Australia and a number of other Western countries. However, the model is exclusively focused on the linguistic aspects of communication, and tends to see forms of communication support which rely on aspects other than linguistic accuracy, such as the social and symbolic relationships of speakers and an ethos of care and responsibility, as the cause of misunderstandings.

The ultimate goal of interpreting services is to overcome language barriers. Australia has a large number of immigrants, and that they are an important source of human capital and population growth. Providing all migrants with equal access to public services by overcoming various obstacles, including language barriers, is of utmost importance for the country. This idea is enshrined in the *Racial Discrimination Act 1975* at a federal level.

Interpreters play an important role in ensuring that non-English speakers have equal access to health and other essential public services. A body of literature has found that using professional interpreters has a positive effect on the quality of patient-doctor communication, and argues that successful communication is largely owed to the accurate exchange of messages [1]–[3]. However, a number of studies on the other hand argue that professional interpreters are underused in health care services in Australia [1], [4], [5] and New Zealand [6].

Professional interpreters are underused in Australian health care even though state health care policies and guidelines require health care facilities to use interpreters accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) [7]–[9]. Professional interpreters with NAATI credentials are required to abide by the AUSIT Code of Ethics, a compilation of professional tenets for interpreters and translators. The Code has been created and developed by the Australian Institute of Translators and Interpreters (AUSIT). Applicants who wish to obtain the NAATI credential for a professional interpreter must demonstrate their knowledge of the Code. Moreover, at every three-year revalidation of their credential, interpreters must provide evidence of their continuous participation in professional development events designed to maintain and update their knowledge of the Code.

Various multicultural health and other government service policies [10]–[12] and studies [13]–[15] refer to the concept of accuracy, which is one of the main tenets in the Code, in emphasising limitations of untrained interpreters, patient family members and other bilingual individuals in providing communication support. These studies are critical of situations

Nami Matsumoto is with ANU Medical School, Australian National University, Florey Building 54 Mills Road, Acton ACT 2601, Australia (phone: +61 2 6125 1302; e-mail: nami.matsumoto@anu.edu.au).

in which the use of nonprofessional interpreters is widely taken for granted in the clinic. However, patient satisfaction with interpreter-mediated medical encounters does not solely depend on linguistic accuracy. Following an analysis of differences in technical competencies between professional interpreters and non-professional interpreters, a comprehensive literature review by PASS International concluded that "… satisfaction with the medical encounter and the effectiveness of the interpreting strategy are often determined by the individual problems and specific social circumstances of each patient" [16]. This conclusion indicates that socio-cultural factors also affect the quality of interpreter-mediated communications.

NAATI credentials do not take into account situational differences. There is no special credential for health care interpreters within the Australian language service framework. Because of this broad coverage, the ideal model of interpreter-mediated communications in the Australian context overlooks the contextual details of each communication setting. As a result, the model does not reflect the real experiences of service users, especially the socially vulnerable. This is particularly the case when it is applied to patient-doctor communication.

An exclusive focus on the accuracy of language rendition may narrow down cross-linguistic communication to be the mere conversion of grammatical components. Gill and his colleagues argue that "… interpretation, done well, is not simply a matter of mechanically matching words in one language with words in another" [17]. Additionally, Green, Free and Bhavanani have found that families in certain migrant groups expect that their young members help the other members who are not fluent in English, and that such expectations and behaviour together give them a feeling of togetherness [18]. These studies suggest that it is problematic to point only to the accuracy of language rendition in drawing a conclusion that using the family of a patient as an interpreter should be avoided.

Few studies have empirically investigated the relationship between a patient, an interpreter, and their doctor on patient satisfaction with the communication. Kuo and Fagan have found that Hispanic patients value family bonds over individual professional relationships, and that such patients are highly satisfied with using family members as interpreters because of the degree of comfort which they can feel [19]. Gray, Hilder and Donaldson reported that clinicians in a New Zealand primary health centre are highly satisfied with non-professional, mostly family, interpreters in on-the-day consultations, and suggested that a relationship of trust and cultural advocacy for the patient are no less important than the accuracy of language rendition [6]. Although these findings are predominantly concerned with primary health care, they suggest that a trust-based relationship between the patient and the language mediator affects the quality of the health communication.

II. Method

This study analysed the data collected through semi-structured interviews with 16 Japanese-speaking informants and 15 English-speaking informants who experienced Japanese-English medical encounters. For the purpose of gaining deeper insights into the research topic, four Australian doctors were also interviewed. These doctors are familiar with using interpreters in the clinic. Additionally, throughout the research project period, the author attended several professional development workshops for interpreters both in Japan and Australia. The author also attended a seminar designed for elderly Japanese migrants in Sydney on how to access Australian health services. The fieldwork sites were Tokyo, Saitama, and Fukushima in Japan; and Melbourne, Canberra, and Sydney in Australia. Ethics clearance was obtained from the Human Research Ethics Committee of the Australian National University (Protocol Numbers: 2013/556, 2015/109)

Some patient informants were interviewed on repeated occasions, with each interview lasting up to one and a half hours. Interviews were either in person or by telephone or Skype. There was a tendency for in-person interviews to last longer than remote ones. The former ones covered broader topics compared to the latter ones, and informants were more engaging when speaking in person than through a communication device. Conversations in in-person interviews expanded to topics which were ostensibly not directly relevant to medical encounters. However, the conversations provided deep insights from the study participants into the broad aspects of cross-cultural communication.

Data were collected during the period from November 2013 to December 2015. Participants were recruited through snowball sampling, except for two English-speaking ones. These two participants were recruited through random sampling by advertisement. Japanese local international exchange associations provided support in distributing the advertisement.

Written informed consent was obtained from all participants prior to the interviews. There was no withdrawal of consent. Interviews were held either in Japanese or English. All interview data were audio-recorded, and subsequently transcribed by the author. Japanese transcripts were translated into English also by the author.

III. Results

None of the 31 patient informants preferred professional interpreters to family members or other means of language support. Instead, Japanese informants tended to prefer a family member, particularly a spouse or partner, as a communication mediator to a professional interpreter. No English-speaking informants differentiated professional interpreters from family or friends. Although scholars argue that the low uptake of professional interpreters in Australia is largely attributable to a lack of awareness of professional interpreting services on the user side [4], [20], an analysis of interview data suggested that language incongruent consultations for Japanese people held deep social and symbolic complexity, for which professional interpreters were often poor solutions.

The following excerpts from the accounts of three Japanese informants exemplify this complexity. The first Japanese informant, who has been suffering from an ischemic ulcer and

seeing vascular specialists for over two decades both in Japan and Australia, gave her account of communication mediation by her English-speaking Australian husband:

> Jp. 1: He understands my symptoms, so he can explain them in detail. It's like how mothers can explain well about their own children.

The husband of this informant speaks extremely limited Japanese; therefore, the members of this couple usually communicate with each other in either limited Japanese or limited English. Nonetheless, the informant trusts that her husband can fully explain her symptoms and needs to her doctor. The analogy for advocacy used by this informant comparing her husband's position as like that of a mother suggests that she appreciates trust-based communication, and feels comfortable with entrusting her opinions to her husband. Meanwhile, this Japanese informant is critical of the performance of a professional interpreter. The informant acknowledges the decent level of overall accuracy of language rendition by the interpreter whom she met at a hospital. However, she criticised the interpreter for one instance in which they summarised her statement:

> Jp. 1: I know it is offensive to say, but I have doubts about the interpreter's English and interpreting skills. I asked the interpreter to tell my doctor what I wanted to say, but it was never fully communicated. 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."

This Japanese informant said that her Australian husband communicates her opinions and requests in a more assertive and persuasive way to her doctor than a professional interpreter does. She considers that it is important to effectively communicate her needs with her doctor regardless of the accuracy of language rendition. She pointed out that the difficulty in conveying her thoughts is caused by the difference in the way of expressing ideas between Japanese and Western cultures:

> Jp. 1: 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 words when it is said by a Japanese interpreter. Since the words don't convey my emotion as it is, it's sometimes not communicated.

The husband of this informant told her doctor her needs in a way which was comprehensible in the Australian context. In so doing, the husband used English words and expressions which were not precisely equivalent to what the informant said in Japanese. This informant described her husband as being good at communication and capable of understanding and rendering her messages even if she does not explicitly state them.

Two more Japanese informants who are married to English-speaking men gave similar accounts. They mentioned that their partner can communicate and satisfy their unstated needs more effectively than a professional interpreter could. Their accounts also suggest that communication support which goes beyond mere language rendition is vital for achieving optimal health outcomes.

> Jp. 2: I feel peace of mind when [my husband] comes with me. Also, I can double-check with him. Since we live together, he sees how I've been and what's been happening. So, I can double check with him. Since my husband sees me every day, when I want to explain my condition to my doctor, for example, he knows how I've been coughing and which part of the body has been painful. If I don't know what I should say when I want to explain such things in English, I can have him explain in place of me. He answers my questions if I ask him even during a consultation, but he never cuts in between me and my doctor. But I still can have eye contact with my husband if I need to check something.
>
> Jp. 3: When I got confused in the conversation with my doctor, [my husband] stopped the conversation, and checked that I understood what the doctor was saying. Sometimes he just let the conversation go, and, after going back home, he asked me to explain what the doctor said.

These three informants were asked whether they would like to use professional interpreting services, and all of them gave negative responses. However, another Japanese informant gave a positive comment on a professional interpreter. She has spoken through several different professional interpreters, and stated that she appreciates support by one particular professional interpreter and her Australian husband. It should be noted that this Japanese informant gave this response because support by this professional interpreter went beyond simple language rendition.

> Jp. 4: I stop saying what I really want to say, thinking, "Maybe I shouldn't have to say this much". But one of the interpreters I met picked up what I really wanted to say [even though I did not actually say it]. The degree of my satisfaction with other interpreters is about 80%. I thought that an interpreter would state what I say, and that would be how interpreting works. But that particular interpreter understood what I was indecisive about. She noticed when I was wondering whether I should stop explaining here and whether I should avoid causing any further confusion. The interpreter then told my doctor what I really wanted to say. I don't think that this interpreter has ever said anything unnecessary.

This excerpt indicates that the cultural and personal sensitivity of one particular interpreter contributed to successful cross-linguistic communication. In fact, the behaviour of this interpreter deviated from the ideal role of professional interpreters given in the AUSIT Code of Ethics. According to the Code, an ideal interpreter is "…faithful at all times to the meaning of texts and messages… without omission or distortion… and not responsible for what the parties communicate, only for complete and accurate transfer of the message" [21].

While all of the 12 Japanese informants partnered to native English speakers entrusted their opinions to their partner, none of the 7 English-speaking informants partnered to Japanese speakers did so. While Japanese informants tend to consider their partner as the ideal communication mediator, English-speaking informants gave different responses. None of

the English-speaking informants drew boundaries between a professional interpreter and a non-professional interpreter and between a family member and a stranger. They tended to emphasise their autonomy as a patient in medical consultation. In fact, a few of them pointed out that language mediation by their Japanese partner is not necessarily effective and does not have an impact on communication outcomes. In the following account, an English-speaking informant describes frustration with his Japanese wife who was hesitant to interpret all his questions to his Japanese doctor.

> En. 1: Maybe my wife thinks I am asking too many questions… Sometimes I have to push her a little bit…

The wife tried to maintain the taken-for-granted Japanese patient-doctor relationship by limiting the number of questions. In Japanese culture, a patient who asks a large number of questions and makes many requests to their doctor tends to be considered disrespectful. Such a patient could be understood by the doctor as distrusting the capability of the doctor. While this informant was slightly critical about the attitude of his wife as a mediator, he was also aware of subtle implications which gender and ethnic difference have in Japanese culture, and that Japanese women are particularly subject to them:

> En. 1: The man is asking, and the woman isn't asking… the response would be different for a man. I think when a Japanese woman asks questions, you get a sense that a woman shouldn't ask… you get that, you get that feeling sometimes. Not every doctor… but I sometimes, occasionally, get that… I'm a man, and I'm a foreigner. The doctors can see I'm being persistent and keep asking the same questions, and they give up [expecting me to act like a Japanese person].

This informant did not expect his wife to explain ideas which he did not explicitly state. His account also suggests that he considers that having his wife communicate with his doctor on his behalf could have a negative impact on the power balance between him and his doctor. He maintained his position as the main participant in the communication while his wife provided only language support when necessary. He felt that he was treated better than other people due to being a male English-speaking foreigner.

The account of another English-speaking informant also shows that he maintained his autonomy as the main participant in the medical consultation while he was accompanied by his Japanese wife.

> En. 2: When I have an operation, usually my wife comes with me to the hospital, so if necessary, she comes to the explanations because we are a couple. She has to understand, I have to understand. So we have to understand together.
>
> Researcher: Does she explain to you?
>
> En. 2: Not really, sometimes I explain to her [laughs].
>
> Researcher: Do you think having a Japanese person between you and the doctor improves the atmosphere?
>
> En. 2: I don't think so. I think that it's the same.

Japanese informants tend to expect their English-speaking partners to modify their statements so that their English-speaking doctor will understand their messages. They also expect their English-speaking partners to explain ideas which they do not explicitly state. In contrast, English-speaking informants tend to not involve their partners in the conversation as a speaker or advocate. The attitude of English-speaking informants is more compatible with the ideal interpreter model, which sees the interpreter as always faithful to, and responsible only for, explicitly stated messages.

Interviewed medical practitioners gave varied opinions on the patient's attitude towards interpreter-mediated encounters. One of the doctors showed an understanding that patients with certain cultural backgrounds prefer family members to professional interpreters because they do not feel comfortable with involving a stranger in their private matters.

> Dr 1: If they come in with a family member who by now actually has quite good English, they tell me "no" [to an offer to call a professional interpreter]. They want this family member to interpret for them, and they are quite clear about that because sometimes I think they feel that they trust that person. It's also that they don't want anyone external to know their business.

This doctor also mentioned her female Pakistani patient who was new to Australia and always preferred speaking through her husband to a professional interpreter. This patient initially turned down an offer of a professional interpreting service. However, she eventually agreed to use the service after she spent several months in Australia. As a result of accepting the offer, this patient became confident about speaking for herself, instead of having her husband speak for her. This patient is now capable of speaking through a professional interpreter and no longer needs language support from her husband. This case shows that the patient became capable of using a professional interpreting service once she became familiar with individual-focused Western patient-doctor communication. However, it does not suggest the relative effectiveness of using a professional interpreter to speaking through a family member.

The first doctor is aware that certain patients prefer family members because there is a relationship of trust between them. On the other hand, another doctor considers it confusing and disturbing if a mediating individual modifies the statements of the patient or advocates for them.

> Dr 2: A trained interpreter will try to translate what the patient says and tell what I'm saying to the patient, rather than making things up. Untrained interpreters don't understand how to translate and say something which is not what the patient said. So, I prefer a professional interpreter… When they speak through a family member, sometimes the family is just talking without interpreting.

In contrast to Japanese informants, this second doctor considers communication interventions which do not precisely render the verbal statements of the patient to be ineffective. This doctor prefers an interpreter who is faithful to the verbal statements of the patient, but does not take into account variant attitudes taken by patients with culturally diverse backgrounds. The idea expressed by this doctor is focused on individual-oriented communications and is congruent with the ideal practice of interpreting in the Australian context.

IV. Discussion

A. Limitation of Linguistic Accuracy

An analysis of interview data suggests that patients do not necessarily consider linguistic accuracy to be a significant determinant factor of their satisfaction with their health communication. This response was prominent among Japanese participants when they mentioned their partner as a language mediator. Japanese participants tend to strongly prefer their partner to a professional interpreter, despite the partner's shortcomings in Japanese. The partners of Japanese participants mostly paraphrased monolingual conversation in English, and played roles which went beyond neutral language conversion. Japanese participants overall gave highly positive responses to such interventions.

While Japanese participants did not consider the accuracy of language rendition as crucial when they recalled interventions by their partner, one of them was critical of a professional interpreter because they summarised what she said in the consultation. Her criticism indicates that Japanese patients may apply different criteria to their partner from those to a professional interpreter in assessing the quality of communication mediation. If a professional interpreter fails to build a rapport with a Japanese patient, they tend to fail to detect tacit messages which the Japanese patient often never explicitly states. The first Japanese informant pointed out this tacitness in the interview. The indirectness of Japanese people is not a new finding: Hall described over four decades ago a stark contrast between Japanese and Americans in terms of directness in communication [22].

If an interpreter fails to notice the real intention of the Japanese patient, the interpreting task will rely solely on the utterances of the patient and their doctor. The ideal interpreter model enshrines the accuracy of language rendition and distance between the interpreter and the patient. However, the analysis suggests that accuracy in language rendition is not necessarily a determinant factor of patient satisfaction with cross-linguistic consultations.

Using a professional interpreting service may ironically make the patient sceptical about the capability of the interpreter if the interpreter fails to build a relationship of trust with the patient. Rosenberg, Leanze and Seller have found that involving an interpreter who is a stranger to the patient is an obstacle to building a rapport between the patient and their doctor [23]. The finding from this study supports an existing study in which focus group sessions with multiple ethnic groups in Australia found that participants feel that professional interpreters often commit errors [1].

B. Issues with Individual-Centred Communication

Findings from this study also suggest gaps in the individual-centred practice of health care interpreting. This practice has been central to the framework of health care interpreting in Australia. This study has found a tendency for Japanese patients to expect their English-speaking partner to facilitate conversation in the consultation. Additionally, they often entrust their opinions to the partner. An existing study has also found this tendency among Japanese patients, referring to individuals who come to the consultation in place of the patient as "surrogate patients" [24].

English-speaking informants tend to see the presence of their Japanese partner differently. This study has found that English-speaking informants tend to maintain their autonomy and always participate in the consultation as the main speaker. In contrast to Japanese informants, they do not entrust their opinions to their Japanese partners. English-speaking informants do not consider their partners as cultural mediators or advocates even when they are present in the consultation room.

Findings from this study suggest that the ideal interpreter-mediated communication model is compatible with the stance taken by English-speaking informants. Anticipating certain behaviour from any patients regardless of their cultural background that conforms to Western norms may be the cause of a myopic professional-nonprofessional dichotomy. This dichotomy has been widely adopted in studies on health care interpreting [2], [25], [26]. This dichotomy is designed in favour of interpreters who aspire to professionalising their occupation through an esoteric monopoly, and demeans trust-based communication support by the family of patients, only on the basis of credentials.

This study has found the limitation of linguistic accuracy and the application of Western norms to overcome language barriers in health communication. Although the study only investigated Japanese-English cases, its findings may also be applicable to other cultural and ethnic pairs, particularly pairs of a Western group and a non-Western one.

Acknowledgment

The author deeply thanks Associate Professor Christine Phillips and Dr Graham Fordham at the ANU Medical School, and Associate Professor Paul Dugdale at the ANU Centre for Health Stewardship for their insights and expertise that greatly assisted the research.

References

[1] C. Brough, *Language Services in Victoria's Health System: Perspectives of Culturally and Linguistically Diverse Consumers*, Melbourne: Centre for Culture Ethnicity & Health, 2006.

[2] G. Flores, M. B. Laws, S. J. Mayo, B. Zuckerman, M. Abreu, L. Medina, "Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters," in *Pediatrics*, vol. 111, no. 1, pp. 6-14, Jan. 2003.

[3] E. A. Jacobs, D. S. Lauderdale, D. Meltzer, J. M. Shorey, W. Levinson, and R. A. Thisted, "Impact of interpreter services on delivery of health care to limited-English-proficient patients," in *J. Gen. Intern. Med.*, vol. 16, no. 7, pp. 468-474, Jul. 2001.

[4] N. Atkin, "Getting the message across-professional interpreters in general practice," in *Australian Family Physician*, vol. 37, no. 3, pp. 174-176, Mar. 2008.

[5] C. Phillips, and J. Travaglia, "Low levels of uptake of free interpreters by Australian doctors in private practice: secondary analysis of national data," *Australian Health Review*, vol. 35, no. 4, pp. 475-479, Nov. 2011.

[6] B. Gray, J. Hilder, and H. Donaldson, "Why Do We Not Use Trained Interpreters for All Patients with Limited English Proficiency? Is There a Place for Using Family Members?," *Australian Journal of Primary Health*, vol. 17, no. 3, pp. 240-249, Sep. 2011.

[7] ACT Government, *Procedure: Language Services – Interpreters*, Canberra: ACT Government, 2015. Available at:

http://www.health.act.gov.au/sites/default/files//Policy_and_Plan/Language%20Services%20Interpreters%20Procedure.docx (Accessed on December 18, 2015).
[8] NSW Health Care Interpreter Services, *Interpreting in healthcare: Guidelines for interpreters*, Sydney: NSW Government, 2014. Available at: http://www.wslhd.health.nsw.gov.au/Health-Care-Interpreter-Service-/HCIS-Publications (Accessed on June 7, 2015).
[9] Queensland Health 2007, *Working with Interpreters: Guidelines*, Brisbane: Queensland Government, 2007. Available at: https://www.health.qld.gov.au/multicultural/interpreters/guidelines_int.pdf (Accessed on February 13, 2016).
[10] Government of Western Australia, *Language Services Policy*, Perth: Government of Western Australia, 2009. Available at: http://www.department.dotag.wa.gov.au/_files/language_services_policy.pdf (Accessed on March 11, 2013).
[11] The Royal Australian College of General Practice 2010, *Standards for General Practice*, East Melbourne: The Royal Australian College of General Practice, 2010. Available at: http://www.racgp.org.au/standards/123 (Accessed on May 9, 2013).
[12] Victorian Government Department of Human Services 2005, "Automatic equalization for digital communication," *Language Services Policy*, Melbourne: Victorian Government Department of Human Services, 2005. Available at: http://www.dhs.vic.gov.au/__data/assets/pdf_file/0008/594926/language_service_policy.pdf (Accessed on February 28, 2012).
[13] G. Juckett, "Cross-cultural medicine," in *Am. Fam. Physician*, vol. 72, no. 11, pp. 2267-2274, Dec. 2005.
[14] L. S. Karliner, E. A. Jacobs, A. H. Chen, and S. Mutha, "Do Professional Interpreters Improve Clinical Care?," in *Health Serv. Res*, vol. 42, no. 2, pp. 727-754.
[15] M. Youdelman, "The Development of Certification for Healthcare Interpreters in the United States," in *Translation & Interpreting*, vol. 5, no. 1, pp. 114-126, 2013.
[16] PASS International, "*Is the Use of Interpreters in Medical Consultation Justified?: A Critical Review of the Literature* ," Tessenderlo: PASS International 2008. Available at http://www.wrha.mb.ca/professionals/language/files/Article-MedicalConsult.pdf (Accessed on August 30, 2013).
[17] N. Gill, R. Rotter, A. Burridge, J. Allsopp, and M. Griffiths, "Linguistic Incomprehension in British Asylum Appeal Hearings," in *Anthropol. Today*, vol. 32, no. 2, pp. 18-21, April 2016.
[18] J. Green, C. Free, and V. Bhavanani, "Translators and mediators: bilingual young people's accounts of their interpreting work in health care," in *Soc Sci Med.*, vol. 60, no. 9, pp. 2097-2110, May 2005.
[19] D. Kuo, and M. J. Fagan, "Satisfaction with methods of Spanish interpretation in an ambulatory care clinic," in *J. Gen. Intern. Med.*, vol. 14, no. 9, pp. 547-550, Sep. 1999.
[20] C. Heaney, and S. Moreham, "Use of interpreter services in a metropolitan healthcare system," in *Aust. Health Rev.*, vol. 25, no. 3, pp. 38-45, Jun. 2002.
[21] The Australian Institute of Interpreters and Translators, AUSIT Code of Ethics and Code of Conduct, Canberra: The Australian Institute of Interpreters and Translators, 2012. Available at: http://ausit.org/AUSIT/Documents/Code_Of_Ethics_Full.pdf (Accessed on May 23, 2014).
[22] E. T. Hall, *Byond Culture*, New York: Anchor Press, 1976.
[23] E. Rosenberg, Y. Leanze, and R. Seller, "Doctor–patient communication in primary care with an interpreter: Physician perceptions of professional and family interpreters," in *Patient Educ. Couns.*, vol. 67, no. 3, pp. 286-292, Aug. 2007.
[24] E. Ohnuki-Tierney, *Illness and culture in contemporary Japan: an anthropological view*, New York: Cambridge University Press, 1984.
[25] J. Cambridge, "Information loss in bilingual medical interviews through an untrained interpreter," in *The Translator*, vol. 5, no. 2, pp. 201-219, Nov. 1999.
[26] K. Quan, *The High Costs of Language Barriers in Medical Malpractice*, Berkeley, CA: University of California, 2010.