

# Japanese Interpreters in Bangkok's International Hospitals

## Implications for Intercultural Communication between Japanese patients and Thai Medical Providers

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This study investigates intercultural communication in international hospitals, focusing specifically on two major hospitals in Bangkok that hire Japanese interpreters to facilitate communication between Japanese patients and Thai medical personnel. Although the use of interpreters is a common practice in major hospitals, it has not been adequately explored in the existing literature. An analysis of exploratory interviews with 7 hospital interpreters in 2011 demonstrates the unique and crucial roles that these interpreters play as “problem solvers” of miscommunication, enabling patients to receive optimum medical care. Moreover, the study brings to light the particular challenges this work poses for medical interpreters who must deal with such challenges as angry patients, the death of patients, and involvement in patients' psychosomatic therapy. The “emotional labor” involved in this work can lead to emotional exhaustion, compassion fatigue, and even burnout.

本研究ではタイ王国の国際病院における異文化コミュニケーションについて、バンコクの主要 2 病院で働く日本人通訳者の役割と課題を手がかりに考察した。2011 年に行った 7 人の病院通訳への探索的なインタビューを分析した結果、日本人通訳が「問題解決者」の役割を果たし、患者が適切な治療を受ける環境を整えていること、通訳が特に困難を感じている課題として、失礼な患者、患者の死、心療内科における治療などへの対処・対応が浮かび上がってきた。さらにこれらの課題に共通する感情労働は精神的な疲れ、共感疲労、燃え尽き症候群へと繋がり得るものであることが分かった。

### 1. Introduction

Providing multilingual and multicultural services is common practice in Bangkok's international hospitals. Along with people from English-speaking and Middle Eastern countries, Japanese residents in Bangkok constitute a significant portion of the number of foreign patients in Thailand. Hence, major hospitals hire Japanese-speaking staff to facilitate intercultural communication between Japanese patients and Thai medical providers. These language workers include both local Japanese-speaking Thai nationals as well as Japanese nationals. While this multilingual and multicultural phenomenon deserves more attention from researchers in various fields, to date, few empirical studies

have examined this issue. With these points in mind, based on their narratives, this qualitative study will consider the role of Japanese interpreters and the issues they face. It is important to start by documenting and analyzing how they understand their job so that detailed comparisons with other agents such as their Thai counterparts, patients, and doctors can be made in the future. Because of the exploratory nature of this study, in-depth interviews and fieldwork are utilized primarily to collect material for analysis and interpretation. To support this approach, a brief literature review in both the Japanese and English languages was conducted. The review confirmed that no qualitative research had been conducted on intercultural communication in cases of Japanese patients being treated by Thai medical providers in Thailand.

In the field of Japanese-Thai communication, researchers have predominantly studied business or business-related areas (Imai, 2010; Petison, 2010; Takeshita, 1999, 2006) with the exception of one survey study of Japanese elderly and healthcare providers in Chiang Mai Province (Fukahori et al., 2011). To date, no study has qualitatively examined Japanese-Thai communication in a medical context.

The majority of Japanese researchers in intercultural medical communication have focused on the context of Japanese providing medical services to foreign residents in Japan (Fujiwara, 2006; Kawamura & Sun, 2007; Miyabe, Yoshino, & Aguri, 2009), and they have rarely looked at Japanese people receiving medical care overseas. The literature in English offers various studies, including those on medical interpreters (Flores, 2005; Lee, 1997; McDowell, Hilfinger Messias, & Dawson Estrada, 2011). These studies have provided important insights, yet they share a similar framework with the Japanese research, in that they tend to consider interpreters as tools for providing new immigrants access to medical services. Nevertheless, a few influential qualitative research studies do exist. For example, Angelelli (2004), Hsieh (2006, 2007, 2008), and Hsieh, Ju, and Kong (2010), have illustrated the complicated roles of and issues related to medical interpreters. However, these studies are limited to cases in the United States. Among these, Angelelli (2004) argues that the once-dominant theory on interpreters—the conduit or translation machine model of the interpreter—has been challenged and altered because of its inadequate recognition of the interpreter's visibility. She suggests that the interpreter, along with other co-participants, is the co-constructor of the definition of reality in an interaction. Lee (1997) agrees with this in the sense that the hospital interpreter is more than a linguistic instrument to be used in the provision of medical treatment at a hospital. This argument partly inspired me to focus on the extended role of and issues concerning Japanese interpreters in this study.

## **2. Research Context Setting**

### **2.1 International Hospitals in Bangkok, Thailand**

The presence of foreigners is much more noticeable in Thailand than in Japan, and many foreigners use medical services. Approximately 1.4 million foreign patients were estimated to have received medical care in Thailand in 2007 (NaRanong & NaRanong, 2011). To cater to this significant demand for medical services from foreigners,

multilingual support is a necessity and not merely an optional extravagance in international hospitals.

The International hospitals in this study are privately operated, being marketed exclusively to foreigners and affluent Thai people. Such hospitals in Thailand have certain unique features compared to those in Japan. First, they are owned by companies and thus can set specific management policies, one of which is to remain luxurious and 'international'. Second, the doctors and the hospitals can determine medical fees, unlike in Japan where they must follow public health-insurance guidelines. While this often results in higher medical fees, it also allows these Thai health care providers to use more expensive, state-of-the-art medical equipment and procedures. Third, major international hospitals are accredited by an American accreditation body, the Joint Commission International (JCI), which ensures the quality of medical services. Fifteen Thai hospitals have been awarded accreditation by the JCI, in contrast to only two in Japan. Lastly, English is widely understood in these institutions, and English-Thai interpreters are not considered to be necessary, particularly because many doctors and other personnel have been educated and trained in English-speaking countries.

There are many exclusive international hospitals that cater to foreigners and affluent Thais, and they provide facilities that are similar to those of five-star hotels. Equipped with restaurants, famous coffee shop franchises, bookstores, and boutiques, these hospitals usually have multilingual reception staff and hospital-affiliated interpreters for foreign patients. Some even house branch offices of the immigration bureau so that patients can extend their visas without making long trips to the main office. These hospitals follow the general policy of 'Offer whatever amenities patients may want and charge them accordingly.' While there are more Thai patients than foreign patients at these international hospitals, the ratio is reversed when considering the revenue base at some institutions, illustrating the great importance of the foreign patient market.

Above, I have provided a general description of exclusive international hospitals in Thailand. I will now focus on two particular hospitals that are highly dependent on the Japanese market.

## **2.2 Japanese patients**

Despite the Great East Japan Earthquake and the massive flood in Thailand in 2011, the number of Japanese travelling to Thailand in that year was 1.14 million, down by a mere quarter million from the previous year (Japan Tourism Marketing, 2012). Thailand is still a very popular destination for tourists and pensioners who enjoy the benefits of a strong yen. In addition, Thailand, and the Bangkok metropolitan area in particular, is a bridgehead for Japanese auto manufacturers. More than 46,000 registered Japanese live in Thailand, and 70% of them reside in Bangkok, making it the fifth largest city for Japanese residents outside Japan, after Los Angeles, New York, Shanghai, and London (Ministry of Foreign Affairs of Japan, 2011).

No statistics are available regarding the number of Japanese who visit hospitals in Thailand, but according to the estimates of NaRanong and NaRanong (2011), the number is somewhere between 50,000 and 80,000. Generally, Japanese are believed to

use hospitals that are introduced on the Japanese Embassy's website: Bangkok Hospital, Bumrungrad International Hospital, Samitivej Sukhumvit Hospital, and four others (Embassy of Japan in Thailand, 2010).

At the two hospitals under study here, most patients are residents and the number of medical tourists is relatively small. According to the manager of the Japanese department, about 80% of Japanese patients ask for interpreters, something that implies a lack of Thai or English proficiency on their part. In contrast, at public hospitals, English is rarely used, let alone Japanese, making it next to impossible for Japanese patients to seek treatment there. Thus, the foreign language ability of Japanese patients can be considered to influence their choice of hospitals, and their propensity to use the international ones. One of the most popular hospitals among Japanese treats 300–400 Japanese patients a day, accounting for about 30%–40% of the total number of patients there.

### **2.3 Hospital Interpreters**

The following descriptions of hospital interpreters are constructed on the basis of information acquired through interviews with Japanese department managers and interpreters at the two hospitals being studied here. According to the interviewees, approximately 10–20 interpreters are affiliated with the Japanese language department, including both full and part-time workers. While their ages vary widely (20s–60s), the majority of them are female. Most interpreters are directly hired by the hospitals, with recruitment being determined by managers of the Japanese department who examine an applicant's linguistic ability, work experience, and medical knowledge. Some interpreters such as registered nurses, graduates in the pharmaceutical sciences, and those who previously worked for health insurance companies have considerable experience in medical-related fields.

Thai natives outnumber Japanese natives owing to the difference in pay standards between Japanese and Thai interpreters. Due to immigration laws, an employer is required to pay even a novice interpreter who is a Japanese national more than it would pay an experienced Thai interpreter. Thus, it can be seen as a rational decision for a for-profit hospital to hire more low-cost interpreters than high-cost ones.

Because there is no specific qualification for medical interpreters, linguistic proficiency varies greatly: while some Thai interpreters have native-like proficiency in Japanese, others have not passed Level 2 of the Japanese Language Proficiency Test. The training of interpreters differs from hospital to hospital and also depends on the skill level of each individual. Typically, on-the-job training ranges from three to six months.

The job of interpreting is complex. First, interpretation services are provided 24 hours a day. Providing interpretation in the consultation room is important, yet it is only part of the job. Hospital interpreters also support Japanese inpatients, attend phone calls for scheduling and rescheduling appointments, work at the Japanese reception desk, and liaise with insurance companies. It is also noteworthy that patients pay no extra charge for using these interpreting services.

### 3. Methodology

#### 3.1 Research Method

This study was part of a larger study that examined the characteristics of intercultural communication at international hospitals in Bangkok through interviews with interpreters, patients, and doctors. The material used in this study consisted mainly of in-depth interviews with seven interpreters (five Japanese and two Thai) and fieldwork. Participants were recruited from two different hospitals through their Japanese department managers. In addition, three Japanese department managers, six Japanese patients, and five doctors were interviewed to enrich the understanding of the broader context. Because the objective of the study was to consider Japanese interpreters' roles on the basis of their narratives, the focus was placed on the interviews with the five Japanese interpreters. The other interviews, such as those with the Thai interpreters, managers, and doctors, are treated as supplementary materials to deepen the understanding of the study's context, and these will be analyzed further elsewhere.

I conducted the main interviews in February and August of 2011. All interviews took place in person, were in Japanese, were audio recorded, and lasted approximately from one to two hours. The demographic data on the interpreters are listed in Table 1. The main questions addressed the following three areas: how the participants became interpreters, their general job description, and their critical experiences at work. Other questions were asked where appropriate to encourage the participants to elaborate on their narratives. All excerpts from the interviews in this paper were translated into English by the author and checked by a third-party translator.

Following this, interview transcriptions were analyzed to identify underlying themes across interviews using the KJ (KawakitaJiro) method (Kawakita, 1967), which is considered similar to the grounded theory method (Glaser & Strauss, 1967) with respect to constant comparison. However, while the goal of the grounded theory method is to generate a theory, the KJ method aims to generate a comprehensive explanation that emerges from the analysis and to provide a new perspective or framework for a better understanding of the phenomena. This feature of the KJ method, which puts greater emphasis on technical aspects than on generating a theory, better fits the explorative purpose of this study.

#### 3.2 Participant Characteristics

The 7 participants (6 females, 1 male) worked at one of two international hospitals in Bangkok, and all were directly employed full-time employees of their respective hospitals. While all had received tertiary education and were competent in the working languages, none had officially trained at an educational institution to become an interpreter. Other demographic data on the interpreters are listed in Table 1.

Table 1. Participants

	Nationality	Age	Sex	L1	L2	Years	Remarks
A	Thai	20s	Female	Thai	JPN	1	Graduated in pharmacy in

							Thailand. Three years in Japan (one year at language school and two in vocational college). Passed JLPT N2 before vocational college.
B	Japanese	40s	Female	JPN	English	4	Experience as nurse (17 years) in Japan. Has lived and worked in USA, Singapore.
C	Japanese	30s	Female	JPN	Thai	6	Experience as nurse (6 years) in Japan.
D	Thai	20s	Female	Thai	JPN	2	Graduated university in Bangkok. Thai father and Japanese mother. Born in Japan and grew up in Bangkok. Native-like proficiency in Japanese with Thai accent.
E	Japanese	20s	Female	JPN	Thai	5 (E2, T3)	Graduated university in USA. First two years as Japanese-English interpreter and last three years as Japanese-Thai interpreter.
F	Japanese	30s	Female	JPN	Thai	4	Graduated university in Japan. Worked three years as interpreter at a Japanese company
G	Japanese	30s	Male	JPN	Thai	1	Worked in a medical insurance company (10 years) in Bangkok

Participants are listed in order of interview date.

## 4. Findings

### 4.1 Japanese Interpreters as Problem Solvers

Both Thai and Japanese interpreters are assigned the same jobs as outlined in the previous section, but in reality, Japanese interpreters perform an additional role—that of “problem solver”. When communication between a Thai interpreter and a Japanese patient becomes difficult or problematic for some reason, Japanese interpreters tend to take over and handle the situation. Such problems are mainly caused by the patient’s psychological state (e.g., being angry or intoxicated), linguistic features (e.g., dialect, age), and symptomatic state (e.g., critical, terminal, or psychiatric cases). For example, a Thai interpreter described how she decides when to ask a Japanese interpreter to take over:

*Our job is supposed to be the same, but if the patient has a real problem, I call a Japanese interpreter. I know it is better to make it a Japanese-Japanese communication. Like, some usage of words or subtle nuances for elders...(Interpreter A, Thai)*

「(日本人とタイ人の仕事は)一緒ですけども、本当に問題のある患者さんがいるならば日本人にいてもらいます。日本人同士だと話すことが分かりやすいので。言葉とか敬語の使い方とか」(通訳 A、タイ人)

These words reflect the idea that Japanese interpreters can better handle difficult patients because they share the same language and culture. It was repeatedly mentioned that there were occasions when Japanese interpreters were indeed able to solve or ease difficult situations. One Japanese interpreter gave an interesting example of the problem-solver role in relation to Thai interpreters:

*Even if the same explanation was given by Japanese and Thai . . . OK, suppose, “We don’t offer that service in this hospital.” To a Thai, they would reply, “Why is that?” and to a Japanese, “Oh, you don’t. OK, then.” This really would happen. (Interpreter F, Japanese)*

「同じように説明したとしても、『それは当院ではできないんです』というふうに日本人が言った場合と、タイ人の子が言った場合。タイ人の子が言ったら、『なんでなんだ?』ってくる場合でも、日本人が言うと、『ああ、できないんですか』っていうふうになる。」(通訳 F、日本人)

This remark suggests that not only sharing the language and culture but also being a Japanese person can contribute to resolving a problem. While such a reaction may underscore a mistrust of Thai people among some Japanese, as well as an unconditional trust of fellow Japanese, another Japanese interpreter explained the reason for such a response by recalling a “common experience” of Japanese people in Thai society:

*I kind of understand it because I've lived here long enough. I trust our staff here: we work together, and I know that they know their job very well. But outside the hospital, say, when I went shopping, I'd ask "Where can I find such-and-such," and one shop assistant may say, "We don't have it." But if I ask another shop assistant, she may say, "You'll find it in such and such a place..." Or if I spent some time looking for it myself, then I could find it. Irresponsible, I would say! With those experiences, I think, patients can't help worrying whether the Thai interpreter is saying something not so certain again. I think I have lived here long enough to feel that myself sometimes. (Interpreter E, Japanese)*

「私もタイに住んでるので分るんですが、ここのスタッフは一緒に働いているから信用できるし、業務内容をしっかり分ってることを知っていますが、普段買い物とかに行ったりして、『□□はありますか?』『ないです』って言われて。で、他のスタッフを探して聞くと『あります』って言われたり、あと自分であるはずだと思って頑張ってみるとあったり、っていう適当な部分があるので、そういう経験があると、適当に言われてるんじゃないのかっていう不安があるんじゃないかと思います。私も長く住んでいるので自分で感じる場所があります。(通訳 F、日本人)

Whilst it is important not to make over generalizations about such experiences, it is interesting to note that other studies have also provided similar explanations. A previous study (Takeshita, 1999), for example, deals with Japanese people's images of Thais. In that study, the Japanese informants' images of Thai people were sometimes negative, and Thais were portrayed by the Japanese informants as being "shrewd and selfish because they refuse to face what seems to a Japanese to be a serious trouble" (p. 202). Similarly, they were described as "not being as diligent as Japanese" (p. 202). Takeshita's findings are consistent with the interpreter's explanation. In fact, her argument accords with the pattern in which Japanese patients ask for Japanese interpreters when they have difficulty in communicating through Thai interpreters.

Interestingly, being a problem solver does not necessarily mean that an interpreter needs to be experienced or to have extensive knowledge about the job. On the contrary, one interpreter remembers the time when she had just started her job and was called to take over from a veteran Thai interpreter in attending to a patient:

*I knew nothing about the job then. Anyway, I asked what he wanted to know. But I didn't know the answer to the question. So I asked the Thai interpreter who had tried to handle his complaints before I did, and I gave him the exact same answer as the Thai interpreter had. But this time, he understood, saying, "If a Japanese is saying so . . ." (Interpreter E, Japanese)*

私はまだ何も分からない状態でした。とりあえず、『どうしましたか?』って質問を聞いたんですが何て答えて良いか分からない。結局私の前に対応していたタイ人通訳に質問して同じように説明しまし

た。なのに、『日本人が言ってるならそうなのか』って納得されたんです。(通訳 E、日本人)

This incident illustrates that for some Japanese patients, the ethnicity of the person providing information plays a critical role in determining the perceived credibility of that information. Interestingly, the ethnic attributes of an interpreter seem to outweigh the skills and experiences of that person when it comes to building trust between a patient and an interpreter.

It is also noteworthy that Japanese interpreters accept this problem-solver role rather willingly. One Japanese participant indicated her perception of the role as follows:

*Thai interpreters ask Japanese to take care of “difficult” patients . . . They would expect the same service in Thailand as they do in Japan. That is . . . Thais wouldn’t do that much. But because we are Japanese, we know what and why they ask for something. So, I would say “of course, you would like such-and-such”, ahead of their uttering their demands. Then, they smile, say “thank you,” and go home happily. (Interpreter B, Japanese)*

「タイ人は『困った』日本人がいると、日本人に振ってくるんですよ。(中略)日本だったらこれくらい求めるだろうっていうのをタイで求める人たちですね。それは、タイ人にとってはそこまではちょっとしないっていうレベルなんです。でも私たちなら分かるから、『そうですね』って先回りしてやってあげれば『ありがとう』って、笑顔で帰るレベルの方なんですよ」(通訳 B、日本人)

Most Japanese participants in this study repeatedly used phrases along the lines of “do it even before they ask,” and they expressed the importance of taking a preemptive measure to meet a patient’s needs. Furthermore, they indicated that this action is considered a “Japanese thing” and is commonly expected by both interpreters and patients alike. Moreover, because this is a “Japanese thing,” Japanese interpreters seem to have legitimacy over Thai interpreters, and Japanese interpreters have accepted this as an important part of their job. On the other hand, by making this process of taking care of difficult patients a cultural issue, Thai interpreters may feel that they are allowed to pass these patients on to Japanese interpreters in the interest of efficiency.

## 4.2 Emotional Labor and Compassion Fatigue

In the previous section, the Japanese interpreters’ problem-solver role was illustrated in relation to their Thai counterparts. In this section, issues concerning the interpretation of difficult cases are examined.

### 4.2.1 Expected management of emotion for interpreters

In general, interpreting is considered to be quite demanding mental work. Hospital interpreting, as found in this study, is physically demanding work as well, requiring long

working hours, including night shifts. In addition, we cannot overlook the emotional aspect of such labor.

The concept of emotional labor, introduced by Hochschild (1983), is defined by three features: (1) it requires face-to-face contact with the public, (2) it requires the worker to produce an emotional state in another person, and (3) it allows the employer to exercise a degree of control over the emotional activities of employees through training and supervision. As displayed in the previous section, it is clear that hospital interpreting involves face-to-face communication and that it is vital to be able to manage the emotional state of patients. In this section, the third feature will be discussed, reinforcing the emotionally demanding aspect of such work.

An important element in the third feature is the intention of the employer. During one interview, a Japanese department manager suggested that the hospital explicitly directs interpreters to base their emotional responses on “empathy”.

*Well, the management section receives comments rather often from doctors, such as, “That interpreter is no good.” I ask, “Why?” They say, “Patients don’t trust her.” I think doctors can tell whether the interpreter has empathy for the patients. With these comments, I understand the doctors are criticizing me for not instructing the interpreters to provide due “hospitality”. “That interpreter is no good.” I get this from patients, too, of course. (Japanese department manager, Japanese)*

結構ね、ドクターから指摘されるんですよ。マネージメント通して。「この通訳はダメ。」「なんで?」「患者さんに信頼されてない」。シンパシーを感じていないというのは分かるみたいです、ドクターが見ていると。(感情を見せないタイプの通訳は) それイコール、「ホスピタリティーもない」って判断されて批判を受けますよね、私は。「あの通訳ダメだ」って。患者さんっていうのも、もちろん当然ありますよ。(日本人部門マネージャー、日本人)

He further explained his belief that providing patients with empathetic emotional support constitutes a major part of the hospitality required at the hospital. He also suggested that when he receives a complaint from anyone insinuating that an interpreter’s attitude was not empathetic, he gives the interpreter specific instructions to improve their attitude or emotional pattern. Through their ability to empathize, interpreters are expected to read the patient’s emotions preemptively and to smile, show concern, be pensive, or act otherwise as appropriate in the relevant context. This role or concept of the interpreter is well shared among those who perform this work. One interpreter stated the following while explaining the qualities of a good interpreter:

*As an interpreter, I think that there is something more than just to interpret what the doctor says and then convey what the patient says to the doctor. I think that’s not the only job for me. If I limit myself to that purpose, I cannot be a good interpreter. If I take an “I am just an interpreter, it [showing empathy to patients] doesn’t concern me” kind of position, it would not*

*be enough to work here as an interpreter of Japanese nationality. I should take it seriously that we are helping patients who live outside of Japan. If I say "I am just an interpreter" like, "That is the hospital's fault, not mine. I am just an interpreter. Ask for the superiors. When they talk, I will interpret," well, that is not the kind of stance we should take. (Interpreter E, Japanese)*

「通訳として、ただ、こう...先生の言ったことを訳して、患者さんの言ったことを先生に伝えてっていう、それ以上のことはやっぱりあると思います。なので、そこだけが仕事じゃないと思いますね。それだけが目的でやっていたら、本当に良い通訳にはなれないというか...「私の仕事は通訳だからそんなの関係ない」っていうふうにやっていたら、こっちで日本人としてここでやっていくにはちょっと弱いというか...やっぱり、海外生活をサポートしていくということをやったり...重きを置かないと...「私通訳だから関係ない」というふうに...「それ、病院のスタッフの失敗でしょ？私通訳だから関係ない。上の人呼んで。上の人が喋ったら私通訳するけど。」そういうようなスタンスでやっていたら、ダメですね。(通訳 E、日本人)

This participant's idea of a "good interpreter" echoes that of the manager noted earlier. She specifically suggests that the broader dimensions of interpreting work, which include not only the offering of linguistic support but also emotional support for patients, can be done best by Japanese nationals. Judging from these detailed explanations that are well-supported with examples, she appears to have internalized this idea well, rather than just vocalizing what she was told. This extract also indicates that such emotional labor is understood as being connected with the role of Japanese interpreters.

Although most Japanese interpreters in this study considered this quality to be an essential part of their job, they also believed that such emotional labor can be exhausting. Some participants confessed that this was the most challenging part of the job. McDowell et al. (2011) also discovered that dealing with emotional demands and sensitive situations is the most difficult aspect of medical interpretation. However, the degree of difficulty involved in emotional labor varies, depending on the context of the communication in question. In the interviews, the following three typical scenarios arose.

#### **4.2.2 Angry Patients**

Patients sometimes are understandably anxious and may be in great discomfort. Hence they may react differently than in normal situations. However, because interpreters acknowledge the patient's situation and patients also behave within certain boundaries, they usually cause few communication problems. Nevertheless, some patients become angry and act arrogantly, placing a heavy burden on interpreters.

*When some Japanese get angry, they use very strong language . . . . Maybe because I am a Thai . . . . “Shame on you! You can do only this much and still get paid? Quit right away!”. . . . Something like that. I don’t think that is the way people should talk . . . . He may not have said that if I were a Japanese. Whether Thai or Japanese, we are the same. We deserve better. Thai interpreters do interpret with the greatest of care. (Interpreter D, Thai)*

「日本人怒っちゃうことがあって、怒ったら凄い言葉を使うから…。それはタイ人だからそういうのかもしれないですけど、(中略)「恥ずかしくないのか、こういう仕事しかできなくて給料を貰うことが。辞めてしまえ！」みたいなことを言われたみたいなんですね。そういう言い方ないじゃないですか。(中略)日本人だったらそんな言い方をしなかったかもしれない。タイ人も日本人も同じなので、それは差をあげないように。タイ人でも心を込めて訳してあげています、働いています」(通訳 D、タイ)

These thoughtless remarks seem to have been made because the interpreter was Thai, and discrimination is evident here. Yet, interpreters need to respond politely and cautiously even to such patients. Clearly, the intensity of the emotional labor is quite high. However, blaming Japanese patients for discriminatory attitudes might be a very simplistic way to understand this phenomenon because Japanese interpreters also experience such verbal abuse and unreasonable requests. One Japanese interpreter in the study inferred that the self-esteem of some Japanese patients has become unreasonably bloated in Thai society. She recalled a time when she received a phone call from a patient to make an appointment with a dentist:

*[He said] “I want to see the doctor tomorrow.” I checked with the dental department and found out the dentist would be away the next day. So I said, “He is away tomorrow.” Right? Then he shouted, “Get him there. You fool! I said I want to see him tomorrow!” (Sigh) I don’t think they would say such a thing in Japan. I don’t know why, but there are many people who simply think they are superior in Thailand. (Interpreter B, Japanese)*

(電話口で)「明日先生に会いたい」と。歯科のほうに連絡すると、明日は先生が来ないと。で、「明日は先生が来ないんです」と連絡したら、「呼べよばか！おれが呼べって行ってんだろ！」です。この人本当に日本でこんなこと言ってんのかなって思ったんですけど。日本じゃ多分そんな風に言ってないのに、タイに来るとこういう人みたいにならぬか自分を勝手に偉く思ってる人が、いっぱいいますね」(通訳 B、日本)

The interpreter found these abusive words both surprising and frightening. She also mentioned that such people can be found more frequently among business people. This observation confirms Imai’s comment (2010) about newly stationed Japanese

expats: “There are some people who hold, at a subconscious level, an arrogant attitude along the lines of, ‘I, the chosen one from Headquarters, will handle the matter’; ‘I don’t see any meaningful activities of Thai employees’; ‘I am always better than Thai people.’” (p.38, author’s translation). These attitudes spread among business people and eventually influence communication at the hospital.

Another participant provided a different reason for the patients’ anger, relating it to their high expectations from the hospital. The analysis of advertisements of international hospitals also shows they actively advertise themselves as Japanese-friendly (Watanabe, 2012), thus sowing the seeds of high expectations among potential Japanese patients. When those expectations are not satisfactorily met, the patients may become disappointed, lose their temper, and use abusive language:

*Their expectations are quite high. This hospital is a private one. It is expensive. It is natural for them to expect good service. But there are times when we cannot meet their expectations. For example, they get angry when they have to wait for a long time. It is a little sad. (Interpreter A, Thai)*

「凄く期待されていて。この病院は私立の病院なので値段も高いし、良いサービスを期待しますね。ただ、時々、期待までできないこともあるので。例えば、長い時間待たされて怒っちゃうですね。ちょっとかなしい…」 (通訳 A、タイ)

Thus, the hospitals’ advertisements may, in fact, evoke a patients’ swollen self-esteem and thus widen the gap between the service they expect and the service actually provided by the hospital. The expectations surely need to be analyzed from the patient’s perspective, but it seems that a misguided sense of entitlement based on consumerism has spread among some Japanese in Thailand, something which is not that common in Japan, where healthcare is a public matter.

#### 4.2.3 Facing a Patient’s Death

The degree of emotional labor is relatively small for straightforward medical cases, but, interpreters cannot avoid facing critical cases that may involve a patient dying. They are then expected to express empathy as a part of their job, even if they do not show it spontaneously. To express empathy inevitably requires interpreters to invest their emotion in identifying themselves with the patients and their families to some degree.

*I was told, “It’s not a complicated case, so just go and help them.” Well, I was a little nervous not knowing what the case was about then. When I got there, I found it was the last moments of a baby. The father asked, “Is he not breathing?” “Is he not coming back?” or something like that. I was . . . well, the doctor said, “I’m sorry. The heart has stopped already.” I didn’t know what to do . . . I was really . . . I know it was not my fault . . . But I could not do anything there. I couldn’t. Then, I finally cried. (Interpreter F, Japanese)*

「大丈夫だから、ちょっと見てきて」て言って、あたしもどんなケースにあたるのかなとドキドキしながら本当に。そしたら赤ちゃんの最期だったんです。お父さんが、『もう息をしていないんですか？』『もう戻らないんですか？』とか言うと、私ももう...先生は『もうダメです。もう心臓が止まりました』。それは私も、どうしようかなあと。

(中略) 本当に何か、自分が悪いんじゃないんだけど、その場において何もしてあげれなかったというのがもう...。わーんというような形で。(通訳 F、日本)

This example vividly demonstrates the demanding aspect of medical interpretation, which leaves interpreters emotionally exhausted. Many interpreters repeatedly stated that this emotional exhaustion, and in some cases even, burnout, was the reason why many of their former colleagues had quit. They recalled that these former colleagues displayed similar symptoms of compassion fatigue such as hopelessness, constant stress, and anxiety.

Najjar, Davis, Beck-Coon, and Carney Doebbeling (2009) noted a clear link between the empathic sensitivity of healthcare professionals and their vulnerability to compassion fatigue. This finding is reinforced by the interviews in this study. We have observed that the institutions explicitly instructed the interpreters to express empathy and that this instruction was widely internalized among the interpreters. However, no official training or education was provided by the hospital, leaving the problem to the individual interpreters. Quitting the job is one way out. Another possible defense is described by an interpreter:

*I tell myself I am here just to interpret. For example, the patient is critically ill and we know he won't last long . . . like cancer. Even in those cases, I just tell him what he has got and move on. We have to end this right there. Otherwise, fatigue will catch up with me. I used to listen to them [the patients] as I was supposed to, and I got really tired after work. And one day, I realized I didn't have to do this so much. To be straight with you, they are strangers after all. There is no point in me devoting myself that much. That's how I deal with it. (Interpreter G, Japanese)*

ただもう自分は通訳できてるだけって思って。例えば凄く症状が悪くて先があまりないとか、ガンとかね。そういうときでもそういう症状ですって言って、それはそれで終わりにしないと...。疲れちゃうんですよね...。そのまま聞いてるとやっぱり。仕事終わると疲れちゃうので...別にここまでしなくてもいいかなと思いだして。まあはっきり言えば他人なので、そこまでのめりこんでもしょうがないという感じですね...(通訳 G、日本)

This interpreter had reached the point where distancing himself from a case was the only way to protect himself. Considering the patient to be a stranger appears to be

quite far from, and even a direct contradiction of, the empathetic interpretation that is required by the supervisor. Yet, this interpreter is one of many who struggle to balance compassionate interpretation and fatigue. Although these excerpts were from Japanese interpreters, Thai interpreters bear the same burden. Another Japanese interpreter mentioned that it seemed to depend on one's personality, not nationality, whether one could stay on the job. However, as was discussed in the earlier section, there is a tendency for difficult cases to be assigned to or taken over by Japanese interpreters, and this could increase the pressure on them.

#### 4.2.4 Psychosomatic Medicine

As Angelelli (2004) argued, in an interaction, the interpreter is the co-constructor of reality, along with other co-participants such as doctors and patients. The area of psychosomatic medicine is one of the most prominent examples of this. Therefore, failing to participate in the interaction with confidence, owing to a lack of linguistic and cultural skills, could be a source of anxiety for the interpreters:

*Psychiatry or psychosomatic medicine . . . really difficult. Sometimes, the session gets really long. Interpreting her distress to the doctor . . . I am always worried if I can interpret at the 100% level. You know, it is a mental thing. And sometimes, I am even afraid to clarify some details with the patient . . . . (Interpreter A, Thai)*

ただもう自分は通訳できてるだけって思って。例えば凄く症状が悪くて先があまりないとか、ガンとかね。そういうときでもそういう症状ですって言って、それはそれで終わりにしないと...。疲れちゃうんですよね...。そのまま聞いてるとやっぱり。仕事終わると疲れちゃうので...別にここまでしなくてもいいかなと思いだして。まあはっきり言えば他人なので、そこまでのめりこんでもしょうがないという感じですね...(通訳 G、日本)

This participant expressed her concern that she has difficulty with the subtlety of language in psychosomatic medicine. Her worry also reveals the challenges of establishing culturally acceptable communication between a Japanese patient and a Thai doctor. She confessed that when the situation becomes too difficult, she does not hesitate to ask Japanese interpreters to take over. However, it is not easy even for Japanese interpreters to make a patient feel safe enough to talk about his or her problems:

*I think patients must be feeling, depending on the work of the interpreter on a particular day, "It wasn't really a good session today" or "I wonder if my explanation was correctly interpreted" or something like that. In this respect, the role of the interpreter is crucial—maybe the most important of all. Whatever the doctor said, it's really up to the interpreter to interpret. So, because of the interpretation, the patient might think, "Why did the doctor say such a harsh*

*thing to me today . . . .” or “There was a really detached statement during the session . . . .” or something like that. (Interpreter F, Japanese)*

患者さんとしても通訳の出来次第でやっぱり「今日はしっくりいかなかったな」「言ったことが伝わっているのが心配だわ」とかやっぱりあると思うんですよ。なのでやっぱり、そこは本当に通訳の役割が一番大きいというか...先生が本当に同じことを言っているけど、やっぱり通訳がどう訳すかによって患者さんとしては...。「なんかこうきつく言われちゃう」「なんか冷たい言い方されたわ」とか、そういうふうに感じられることもあるので... (通訳F、日本)

Mental health professionals tend to think that any talk they have with their patients might have serious clinical and therapeutic consequences (Hsieh et al., 2010). This excerpt clearly shows that interpreting plays a critical role in the therapeutic process and in defining the patient's reality. Thus, it is reasonable that the doctors might try to control the interpreted communication, but the opposite was revealed from the interviews. The majority of interpreters admit that although the choice of words in the interpretation is vital in the process, it is rare for them to be instructed in “how the information should be told.” Thus, interpreters have to speculate and determine how to say something on the basis of how the doctor actually says it, including the tone and nuance of a statement to be used when something is translated into Japanese. If this interpreter's explanation correctly described the process of interpretation, then doctors would have overlooked the complexity of medical interpretation, especially in the field of psychosomatics, because how and what a doctor says in Thai in a particular context may not be appropriate in Japanese medical culture.

Japanese interpreters in the study believed that their role included directing and maintaining a patient's emotional state to the optimum level for treatment. They utilize linguistic and cultural strategies that are legitimized by their being Japanese. This complex process poses linguistic, cultural, and therapeutic challenges to interpreters and simultaneously requires them to control their own emotions in order to keep themselves skilled at their job in this emotionally demanding environment:

*Well, doctors say, “Don't take your feelings back home, leave them here at the hospital.” I get that, but when I hear their stories, I can't help but think about how hard it would be for them. I am a human being, too. Accordingly, my empathy causes me to become involved in the patient's situation and suffer emotionally. I know . . . I know it is better to just interpret and not think too much about the patients, but it is obviously not easy . . . . I cannot go, like, “Ok, that is the end of the session. What's next?” So, what I do is . . . drag the feelings and say to myself, “She is getting better. So I don't have to worry about her.” Something like that. (Interpreter F, Japanese)*

先生も『自分、そこで通訳してこのまま家に持って帰らないで置いていけ』って言うんですけども、やっぱりそういう話を聞けば辛いんだなって。やっぱり人間ですから、感情的に患者さんが置かれている状況などを理解し

て辛くなることもあるので、そういう意味で精神的にはやっぱり...なるべくなら、なるべく通訳という...通訳なんだから患者さんのことまで考えなくても良いと思うんですけども、やっぱり...簡単にそんな、『終わりました、はい次』って、そういうのが中々難しいので。やっぱり引きずりながら。「良くなってきているから大丈夫だな」って言い聞かせながら、そんな感じで」(通訳 F、日本人)

Emotional exhaustion along with mental management can be observed here as the cost this woman pays to perform her interpreting job. Her struggle is not unique among interpreters, and these issues in psychosomatic medicine are widely recognized. However, just as in the context of interpreting for critical patients, the strategy to minimize this emotional cost is typically sought at the individual level.

## 5. Discussion and Conclusions

The goal of this study was to explore the issues and characteristics of Japanese interpreters in Bangkok's international hospitals by analyzing their narratives. Private international hospitals provide multilingual support for foreign patients, and Japanese patients constitute a major portion of this market. Hospitals are equipped with Japanese-speaking personnel and advertise themselves as Japanese-friendly. All these features contribute to building a unique context for intercultural communication between Japanese and Thai people.

On the basis of in-depth interviews with interpreters, two important characteristics were identified. The first was their role in relation to Thai interpreters. The Japanese were seen as problem solvers of difficult situations such as dealing with angry patients, critical cases, and psychosomatic therapy. Thai interpreters believe that Japanese interpreters can resolve complicated situations because they share a language and a culture with the patients. Furthermore, some incidents that have been described suggest that Japanese patients often prioritize the interpreter's being Japanese over his or her actual knowledge or job experience. Patients' discriminatory attitudes toward Thai people, combined with their unpleasant experiences in Thai society in general, were raised as factors that might play a role here. It was also important to note that Japanese interpreters think that taking over from the Thai interpreters in difficult situations is an important part of their job, and they also believe that they have the legitimacy to do so.

A second characteristic of Japanese interpreters was that their work involves intensive emotional labor. This was even more intense because they played the problem-solver's role for Thai interpreters. The hospital management expects an empathetic emotional expression from interpreters and instructs them accordingly, which is seemingly well internalized among Japanese interpreters. This empathy factor forces interpreters to identify with patients, which can emotionally consume the interpreters. The need to exercise control over their emotions can be extremely demanding,

particularly while dealing with difficult cases, and it can also lead to emotional exhaustion, compassion fatigue, and even burnout.

Smith (2012) concludes her study on the emotional labor of nurses with the remark that nurses need to make a conscious effort and have professional skills and organizational support to continuously work as emotional laborers. The same argument applies to interpreters, who also need organizational support. It is ironic that the more empathy an interpreter is able to express, the more likely she or he is to suffer from compassion fatigue.

A common feature of these characteristics is insufficient recognition of the Japanese interpreters' job. While they play an essential role in intercultural medical communication, the burden they bear has not been fully recognized. This burden is currently consuming interpreters both physically and emotionally. In conclusion, the hospitals need to provide two types of training and educational programs: one, for interpreters to learn how to deal with the emotionally demanding work of interpretation and the other, for both interpreters and doctors to seek possibilities for developing a collaborative style of providing therapeutic procedures, especially in psychosomatic medicine. Because there is neither any official qualification for hospital interpreters nor ethical standards established by an outside association, it is only the hospital that can actually take action. In this sense, responsibility lies with the hospitals. Therefore, these two initiatives, if undertaken by hospitals, would improve the interpreters' work environment and extend the number of years they stay on the job, improvements that would positively affect the quality of their work. This would, in turn, also improve the quality of medical care the hospitals provide, and improve patient satisfaction as well.

During the exploration of the characteristics of Japanese interpreters, it was suggested that Thai interpreters also feel overburdened and experience suffering. They face similar issues as do the Japanese, such as emotional labor. In addition, they confront quite different yet serious problems including the discriminatory attitudes of some Japanese patients. Although it was not this paper's intention to consider this issue in detail, it should be treated as a prime issue that needs to be explored in the future.

However exploratory, this study attempted to capture rarely-reported aspects of intercultural medical communication between Japanese patients and Thai medical personnel through an examination of the narratives of mainly Japanese interpreters. Despite the limited number of interviews, it covered several important issues, as mentioned above. The study will not be complete until the experiences of patients and doctors, who are the other important agents in this context, are included. It is my intention to conduct further research based on interviews with these people.

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## 7. References

- Angelelli, C. (2004). *Medical Interpreting and Cross-cultural Communication*. Cambridge: Cambridge University Press.
- Embassy of Japan in Thailand (2010). Major medical institutions, Private Hospitals. Retrieved 2012-01-20, from <http://www.th.emb-japan.go.jp/jp/mamechishiki/hospital.htm>
- Flores, G. (2005). The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review. *Medical Care Research and Review*, 62(3), 255-299.
- Fujiwara, Y. (2006). Midwifery care for people from diverse cultures at childbirth: Aiming for actualization of culturally congruent care. 『日本助産学会誌日本助産学会誌』(*Journal of Japan Academy of Midwifery*), 20(1), 48-59.
- Fukahori, H., Baba, Y., Hioki, F., Monkong, S., Intarasombat, P. and Malathum, P. (2011). Healthcare services for Japanese elderly long-staying in Thailand from the perspective of the patient and healthcare providers: A survey study. *Archives of Gerontology and Geriatrics*, 53(2), e168-e173.
- Glaser, B. G., and Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine Publishing.
- Hochschild, A. R. (1983). *The managed heart: Commercialization of human feeling*. Berkeley, CA: University of California Press.
- Hsieh, E. (2006). Conflicts in how interpreters manage their roles in provider-patient interactions. *Social Science & Medicine*, 62, 721-730.
- Hsieh, E. (2007). Interpreters as co-diagnosticians: Overlapping roles and services between providers and interpreters. *Social Science & Medicine*, 64, 924-937.
- Hsieh, E. (2008). "I am not a robot!" Interpreters' views of their roles in health care settings. *Qualitative Health Research*, 18, 1367-1383.
- Hsieh, E., Ju, H. and Kong, H. (2010). Dimensions of trust: The tensions and challenges in provider-interpreter trust. *Qualitative Health Research*, 20(2), 170-181.
- Imai H. (2010). 『タイでのビジネスプロトコル』 (*Business protocols in Thailand*), Bangkok: Bangkok Japanese Chamber of Commerce and Industry.
- Japan Tourism Marketing Co. (2012). Retrieved 2012-2-23, from <http://www.tourism.jp/statistics/outbound.php>
- Kawakita, J. (1967). 『発想法□創造性開発のために』 (*A method of idea generation*), Tokyo: Chuokoron-shinsha.
- Kawamura, C. and Sun, W. (Eds.) (2007). 『異文化間介護と多文化共生』 (*Eldercare in a multicultural society*), Tokyo: Akashi Shoten.

- Lee, E. (1997). Cross-cultural communication: Therapeutic use of interpreters. In E. Lee (Ed.), *Working with Asian Americans: A guide for clinicians* (pp. 477-489). New York: The Guilford Press.
- McDowell, L., Hilfinger Messias, DK. and Estrada, RD. (2011). The work of language interpretation in health care: Complex, challenging, exhausting, and often invisible. *Journal of Transcultural Nursing*, 22(2), 137-147.
- Ministry of Foreign Affairs of Japan, Consular Affairs Bureau, Consular Policy Division. (2011). 『海外在留邦人数調査統計 平成 23 年速報版』 (*Annual report of statistics on Japanese nationals overseas: Preliminary report*).
- Retrieved 2012-01-20, from <http://www.mofa.go.jp/mofaj/toko/tokei/hojin/11/pdfs/1.pdf>
- Miyabe, M., Yoshino, T. and Aguri, S. (2009). Development of a multilingual medical reception support system based on parallel texts for foreign patients. *IEICE Transactions on Information and Systems*, J92-D(6), 708-718.
- NaRanong A. and NaRanong V. (2011). The effects of medical tourism: Thailand's experience. *Bulletin of the World Health Organization*, 89, 336-344. Retrieved 2012-01-20, from <http://www.who.int/bulletin/volumes/89/5/09-072249.pdf>
- Najjar, N., Davis, LW., Beck-Coon, K. and Carney Doebbeling, C. (2009). Compassion fatigue: a review of the research to date and relevance to cancer-care providers. *Journal of Health Psychology*, 14(2):267-77.
- Petison, P. (2010). Cross cultural relationship marketing in the Thai context: The Japanese buyer's perspective. *International Journal of Trade, Economics, and Finance*, 1, 17-23.
- Smith, P. (2011). *The emotional labour of nursing revisited: 2nd edition*, Houndmills, Basingstoke, Hampshire, UK: Palgrave Macmillan.
- Takeshita, Y. (1999). Intercultural communication between Japanese and Thais through discrepancies in images. *Intercultural Communication Studies*, 8(2), 193-212.
- Takeshita, Y. (2006) Intercultural communication between Thai and Japanese people: A survey in Bangkok. *Intercultural Communication Studies*, 15(3), 150-159.
- Watanabe, Y. (2012) 「タイ王国の国際病院における異文化コミュニケーションの課題」 (Issue of intercultural communication at international hospitals in Thailand), 『相模女子大学文化研究』 (*Studies in Culture of Sagami Women's University*) , 25, 25-37.