Communication challenges for healthcare interpreters within a multicultural society: intercultural or ethical?

Author:
Ra, Sophia

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Sophia Ra

A thesis in fulfilment of the requirements for the degree of

Doctor of Philosophy

School of Humanities and Languages

Faculty of Arts and Social Sciences

March 2022

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Conference presentations

Thesis abstracts and earlier versions of some sections of Chapters 2, 4, 5, and 6 have been presented at conferences.

Conference presentations

Ra, S. (2021, November 19–20). *Healthcare interpreters' challenges: Intercultural or ethical?* [Paper presentation]. AUSIT National Conference, Perth, Australia.

Ra, S. (2019, June 14–16). *The role of intercultural competence in interpreter-mediated healthcare interpreting in a globalized and transnationalized age*. [Paper presentation]. The 9th Critical Link Conference, Tokyo, Japan.

Ra, S. (2018, November 16–17). *"What do you mean?" A definition of culture & intercultural communication in interpreting studies*. [Paper presentation]. AUSIT National Conference, Adelaide, Australia.

Ra, S. (2017, November 17–18). *Healthcare interpreters' professional judgement and its unintended consequences.* [Paper presentation]. AUSIT Mini Conference, Canberra, Australia.

Ra, S. (2017, February 24–25). *Should healthcare interpreters provide cultural information?* [Paper presentation]. First International Conference on Legal and Healthcare Interpreting, Hong Kong, China.

Ra, S. (2016, November 18–19). *Healthcare interpreters' voices.* [Paper presentation]. AUSIT Mini Conference, Melbourne, Australia.

Ra, S. (2016, June 29–July 1). *Intercultural communication challenges in interpreter-mediated medical encounters*. [Poster presentation]. The 8th Critical Link Conference, Edinburgh, UK.

Ra, S. (2016, May 24). *Intercultural communication challenges in interpreter-mediated medical encounters*. [Paper presentation]. UNSW Interpreting and Translation Seminar Series, Sydney, Australia.

Ra, S. (2015, November 13). *How to improve the quality of healthcare interpreting?* [Paper presentation]. AUSIT NSW Mini Conference, Sydney, Australia.

Ra, S. (2014, November 19–20). *Diverse cultural beliefs between migrant patients and Australian doctors: What can interpreters do?* [Paper presentation]. UNSW Postgraduate Conference, Sydney, Australia.

Ra, S. (2014, November 1–2). *Cross-cultural communication challenges: Healthcare interpreting for Korean-speaking patients in Australia*. [Paper presentation]. AUSIT National Conference, Brisbane, Australia.

Ra, S. (2014, October 17–18). *Cross-cultural communication training in Australian healthcare interpreting*. [Paper presentation]. Ewha Research Institute for Translation Studies & Korean Association of Translation Studies International Conference, Seoul, South Korea.

Journal article

Ra, S. (2017, April). Intercultural communication: Challenges in interpreter-mediated medical consultations. *AUSIT In Touch Magazine*, *25*(1), 3.

Acknowledgements

Doing a doctoral degree while working as a freelancer, teaching part-time, and having two little boys was not a simple task. It took discipline, endurance, focus, and hard work. However, I could not have completed this journey if I had not had support from so many people.

To begin with, I am indebted to both my supervisors, Professor Sandra Hale and Professor Ludmila Stern, for their generous assistance, constant encouragement, and constructive comments. Their valuable and meticulous input into the research is immensely appreciated. It has been an honour and a privilege to work closely with and to learn from them.

I would like to thank Professor Jemina Napier, of Heriot-Watt University in Edinburgh, Scotland, who supervised me when I conducted my master's degree in community interpreting at Macquarie University. She inspired me to undertake a career in research.

Eva Melhem, translation service manager at the Western Sydney Local Health District, supported the project as a principal investigator while collecting data at Westmead Hospital. Organising the observation sessions with various Korean interpreters and getting consent forms from all the participants were very complicated processes. I would like to thank her for all the time and effort she put into the project. I am also appreciative of the Research Ethics Office at WSLHD for granting ethics clearance for the project.

I would also like to express my deepest appreciation to my annual progress review panel members—Dr James Lee, Associate Professor Karyn Lai, and Dr Long Li—for providing useful advice on my study. Thanks also to fellow PhD mates—Dr Xin Liu, Dr Han Xu, and Dr Vicky Wong—for simply being there and providing moral support. I am also indebted to Kaliope Katsikaros for her assistance with the copyediting of this thesis.

My gratitude goes to the research participants without whose generosity in terms of time, information and commitment, this project would have been incomplete. Patients, interpreters, and healthcare professionals allowed me to observe their interactions at critical moments. In particular, I want to express my sincere gratitude to the interpreters who generously took time

Abstract

As one of the leading countries in community interpreting service provision, Australia provides a range of professional interpreting services within the public health system; interpreters who work in this system must be nationally accredited/certified and should abide by a professional code of ethics. Despite the national standard, in reality, healthcare interpreters still face various challenges due to different reasons.

The main motivation for this study was to ascertain if intercultural communication challenges are paramount in healthcare interpreting settings and whether the interpreter is compelled to play the role of 'cultural broker', which goes counter to their prescribed role in the Code of Ethics (AUSIT, 2012). This thesis critically explores the concept of culture and intercultural communication as the first step to understanding its link to interpreting challenges.

Using a mixed methods approach, this thesis explores the existence of intercultural issues that can cause interpreting challenges and the interpreters' perceptions about the extent to which they can offer cultural brokerage. The data were collected via observations of Korean<>English interpreter-mediated medical encounters, semi-structured one-on-one interviews with the same interpreters who participated in the observations, and an online questionnaire with healthcare interpreters of any language combination working in Australia. The findings of the research showed that most of the challenges were not attributable to intercultural issues, but rather to cross-linguistic differences, deficient interpreting skills, ethical dilemmas, and interpreters' working conditions. The results also found a lack of clarity from the interpreters about what they understand as constituting intercultural communication challenges and their need to act as cultural advisors. The results suggest that interpreters who were provided with the now outdated guidelines from the 1970s and early 1980s were more likely to perceive their role as that of a cultural advisor as well as an interpreter. Interpreters who were university trained in subsequent decades did not hold the same perceptions. The findings of this study clearly demonstrate that intercultural misunderstanding is not a critical issue for interpreters and that culture is often mistakenly blamed for interpreters' unethical behaviour or incompetent interpreting. The study clarifies

vague notions of culture and provides a more transparent taxonomy of interpreting challenges in healthcare settings.

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List of abbreviations

AIMA - Australian Institute of Multicultural Affairs

AUSIT - Australian Institute of Interpreters and Translators

CALD - culturally and linguistically diverse

ETIS - Emergency Telephone Interpreter Service

HCIS - Health Care Interpreter Service

HCIS PDC - Health Care Interpreter Service Professional Development Committee

HREC - Human Research Ethics Committee

LOTE - Languages Other Than English

NAATI - National Accreditation Authority for Translators and Interpreters

NCIHC - National Council on Interpretation in Health Care

NEAF - National Ethics Application Form

NESB - non–English speaking background

NHMRC - National Health and Medical Research Council

NUM - Nursing Unit Manager

PI&CF - Patient Information and Consent Form

SAC - Scientific Advisory Committee

SSA - Site Specific Assessment

TAFE - Technical and Further Education

TIS - Telephone Interpreting Service

TIS National - Translation and Interpreting Service

WSLHD - Western Sydney Local Health District

Chapter 1 Introduction

When I first started practising as an interpreter in community settings in 2006, I believed I would be adequately equipped to effectively manage every interpreting challenge I might encounter, since I had completed a master's degree in translation and interpretation and had been professionally accredited by the National Accreditation Authority for Translators and Interpreters (NAATI). Contrary to my expectations, however, during my work I regularly encountered dilemmas, professional and moral, in which I had to make professional judgements for which I had not received any guidance in class. It seemed to me that some of these dilemmas arose from cultural differences between the participants in those interpreted interactions—in my case, Korean patients in Australian settings. This was especially pronounced in healthcare settings where informal, personal, and even intimate, conversations generally took place. For example, I often met patients who gave indirect and wordy answers to doctors' questions, and requested that older male doctors perform their surgery, and I encountered situations in which the eldest son of elderly patients made decisions about medical treatment on their behalf. Through my interpreting experience and observations, I concluded that the patients' behaviours and their health beliefs were grounded in the culture of Korea ('Korea' henceforth refers to South Korea), the country they came from. Various questions arose in my mind, including: Should I explain why patients give indirect and wordy answers to doctors? Should I summarise patients' utterances when some of them are not directly related to the doctors' questions? Should I explain to doctors why patients prefer older male doctors? Should I explain the norms of male decision-makers in

the family and filial piety in Korean culture? As an interpreter, I was confused and frustrated that I did not have any guidance on what to do in such situations. Additionally, in the early days of my interpreting practice, when making decisions on such dilemmas, I had a feeling of wanting to help people from Korea, the country that I came from and considered it my duty to explain Korean culture to Australian service providers because I was the only one on those occasions who understood both the Korean and the Australian cultures. The questions then were: Do I really know what Korean culture is, and does everyone from Korea share the same understanding of Korean culture? This curiosity lingered, and I started having personal conversations with interpreters of other languages on the issue of cultural differences that arise in community interpreting. I was struck by the fact that there were many commonalities in the cultural characteristics of my experiences and those of European language interpreters. Interestingly, I also found disparities among interpreters within the same language combinations. This discovery of contradictory and multifaceted perceptions of cultural differences was a realisation, and I wanted to discover more about interpreters' challenges that were due to cultural differences and which created ethical dilemmas.

The research undertaken in this thesis arose from the recurring personal and professional challenges and dilemmas that occur during situations in which a practising interpreter in community settings has to make accurate and balanced judgements when faced with ethical and moral dilemmas. Based on empirical data of participant observations of authentic interpreter-mediated healthcare encounters, post-observation interviews with interpreters, and an online survey of healthcare interpreters working in Australian settings, this thesis attempts to answer my questions, including whether intercultural issues are significant challenges for healthcare interpreters, what other challenges healthcare

interpreters face, and how healthcare interpreters act when they face such challenges in interpreter-mediated medical encounters.

The original research question aimed to examine whether the challenges that Korean interpreters face in medical encounters are due to intercultural differences between the patient's Korean culture and the healthcare professional's Australian culture. My underlying assumptions were that Australian culture is a Western culture and Australian healthcare service providers are mainly Anglo Celtic. I started my research based on these assumptions until I started to observe a wide ethnic diversity among healthcare professionals. According to the Australian Institute of Health and Welfare (2018), a substantial part of the healthcare workforce in Australia is formed of migrant and/or overseas-trained health workers. For example, "in 2016, 33% of medical practitioners employed in Australia received their initial qualification overseas" (p. 3). Even though overseas-born doctors may also be of Anglo-Celtic origin, they bring their cultural diversity into a mainstream Australian culture. In line with census statistics, I also witnessed the diversity of the healthcare professionals' ethnic backgrounds throughout the data collection process. In order to situate my inquiry in context, I will begin by briefly describing the demographic changes in Australia over the past two decades.

1.1 Background: Demographic changes in Australia in the 21st Century

There has been a large increase in migration worldwide in the 21st century. International statistics released in 2020 by the United Nations recorded 272 million migrants worldwide, up from 220 million in 2010, and 150 million in 2000 (United Nations, 2020, p. 10). More than 40 percent of all international migrants (112 million) were born in Asian countries (United Nations, 2020, p. 26). Oceania, which includes Australia and New Zealand,

was found to host the sixth largest number of international migrants in the world, being among the most preferred destinations of international migrants. Since 2014, the largest number of migrants in this region also came from Asia, and the number of Asian-born migrants in Oceania increased by 4.6% per annum over the 17-year period between 2000 and 2017 (United Nations, 2017, p. 13).

According to the 2018 to 2019 migration summary report by the Australian Bureau of Statistics (2020), the net estimated number of overseas migrants living in Australia—that is, the net gain of population through immigration to Australia—between 2018 and 2019 included 239,600 permanent and temporary citizens and unknown residents, with temporary visa holders comprising the majority of overseas migrant arrivals (64.3%). A census of the Australian population only confirms how culturally and linguistically diverse Australia is. In Australia, residents of more than 200 languages speak their native language at home, have more than 100 religious affiliations, and claim more than 300 different ancestries. Numbers of migrant arrivals from South and Central Asia and North-East Asia are now higher than from Europe, with South and Central Asia contributing the greatest number of migrants in 2019 (Australian Bureau of Statistics, 2020).

1.1.1 Multiculturalism in Australia

At the time of the first English-speaking European settlers arriving in Australia in 1787, Australia was a linguistically and culturally diverse land with an estimated 700 Aboriginal languages (NAATI, 2018). However, during the time of colonisation in the early 1800s, the population of colonisers was predominantly white English-speaking with the majority of immigrants being of British origin (Slatyer, 2015). Even though the colonisers needed to communicate with the Indigenous population, a process inextricably tied to

approaches to interpretation (Gentile, 2017), their arrival and the repressive government policies towards the Indigenous population (NAATI, 2018) undermined traditional laws, customs, and religion as well as the state of Aboriginal languages, leading them to a significant decline. When people of non-European origin, mainly Chinese, arrived during the Gold Rush, between 1851 and 1880, a degree of tension and hostility was created between them and the early European settlers, which then led to the White Australia policy with its expected result of 'assimilation' of migrant groups (Blignault et al., 2009; Gentile, 2017). This policy prevailed until after World War II. Migrants from Europe and Asia arriving between 1945 and 1975 almost doubled the Australian population from 7.5 million to 13 million, which eventually led to the elimination of the White Australia policy in 1973 (NAATI, 2018; Ozolins, 1993). Despite this, prior to the mid-1960s, assimilation was the main settlement philosophy, and migrants were expected to be "assimilated into Australian society without undue strain" (Slatyer, 2015, p. 15). During the 1970s, however, such beliefs started to change, as Australia's national identity shifted "from racially-based white, British Australia, to a diverse, multiethnic, and officially multicultural Australia" (Moran, 2011, p. 2156).

In 1973, the policy of multiculturalism was officially introduced in Australia by the then Minister for Immigration, the Hon. A. J. Grassby (1973), in an attempt to ensure that all immigrants would be welcomed in Australia and be committed to ethnic pluralism, whereby "each ethnic group desiring it, is permitted to create its own communal life and preserve its own cultural heritage indefinitely, while taking part in the general life of the nation" (p. 3). In 1979, based on the review of post-arrival programs and services for migrants by the chairman of migrant services and programs, known as the Galbally Report (Galbally, 1978), the Australian Institute of Multicultural Affairs (AIMA) was established to take further steps

to encourage multiculturalism (Gentile, 2017; Slatyer, 2015). The Australia of the 1970s and 1980s was characterised by "a celebration of cultural and linguistic diversity, strong health and welfare support for 'ethnic minorities', and Governmental commitment to the rights of minorities" (Garrett, 2009, p. 71).

With continued public debate as to what constitutes 'Australian values' and what 'multiculturalism' means in Australian society (Vasta, 2015), cultural, social, and ethnic diversity may be described as the most distinctive characteristics of recent Australian culture, following decades of large-scale immigration. Within such understandings of multiculturalism in various forms, "the essential role of appropriate language services for successful settlement, particularly in the early stages" was emphasised (Slatyer, 2015, p. 17) and will be discussed in Section 1.2.

1.1.2 Korean migrants in Australia

According to the community information summary published by the Australian Department of Immigration and Citizenship (2014), the first opportunity for a large number of Korean immigrants to arrive in Australia from South Korea occurred in 1969 as part of the skilled migration program, in which they were employed in the metal refining, steel construction, and welding industries (Han & Han, 2010). This was a new type of Korean migration to Australia since the Korean War (1950–1953), when Korean women migrated to Australia as 'war brides' and Korean children were adopted by Australians. During the mid-1960s and 1970s, to replenish a shortage in the workforce in jobs that were considered unsafe and demeaning, the Australian Government began to actively expand its recruitment of labour from Korea in areas such as cleaning, truck driving, and delivery services (Han & Han, 2010). Due to these characteristics of early migration by Koreans to Australia, first-

generation Korean immigrants commonly worked in areas for which learning English was not essential and in which there were limited opportunities to mix with other ethnic groups. Conversely, post-war brides and adopted children were exposed to the mainstream language and culture as soon as they arrived, as there was limited access to Korean communities in Australia. Thus, many lost the ability to speak their native Korean, to a greater or lesser degree. According to the community information summary provided by the Department of Home Affairs (2018), 500 Korean-born immigrants moved to Australia each year from 1976 to 1985. However, there had been only 468 Korean-born residents in Australia at the time of the 1971 census. From 1986 to 1991, more immigrants arrived from Korea—an average of approximately 1400 each year. As a result of this increase, more than half of Korean-born residents currently in Australia have arrived in the country in the past 20 years, as at the time of writing this thesis. According to the 2016 Census (Department of Home Affairs, 2018), 90.1% of Korean-born individuals in Australia speak Korean at home, and 33.1% do not speak English well or at all. As a result, Korean is the 11th most-spoken language in Australia, excluding English and Indigenous languages, and following Mandarin, Italian, Arabic, Cantonese, Greek, Vietnamese, Spanish, Hindi, Tagalog, and German (Department of Immigration and Border Protection, 2014).

1.2 Current status of community interpreting in Australia

With the non–English speaking background migrant intakes, the Australian Government started providing free English-language classes to new arrivals in 1948 as part of their assimilation policy under which migrants were expected to learn the Australian English language and culture and 'fit in' (Ashton et al., 2017; Gentile, 2017; Slatyer, 2015). For this reason, until the early 1950s, interpreting for community services was unregulated

and was performed by volunteers (Gentile, 2017, p. 28). However, a growing awareness of the need for community interpreting in Australia developed in the 1950s (Ozolins, 1991). According to the 1991 report prepared by Ozolins and the National Languages Institute of Australia, in the late 1940s and 1950s, most interpreters were individuals with only slightly better English language skills than other migrants of a non-English speaking background, rather than professional interpreters. Before the 1970s, a vast majority of interpreting services were ad hoc services provided by bilingual staff, who included taxi drivers, kitchen hands, fruiterers, migrant children (Gentile et al., 1996, p. 26), cleaners, and low-level clerks (Ozolins, 1991, p. 20). After the Australian Government policy of multiculturalism in 1973, government expenditure on migrant welfare and assistance was substantially increased and, as a result, the 24-hour Emergency Telephone Interpreter Service (ETIS) was established in 1973 by the Department of Immigration (Blignault et al., 2009; Chesher, 1997). It was primarily aimed at emergency situations, such as police or medical emergencies, accidents, and life-threatening cases (Ozolins, 1991, p. 23). ETIS began in Sydney and Melbourne with eight languages available (Slatyer, 2015). Gradually, the number of languages increased, and the proportion of non-emergency calls began to rise. Accordingly, in 1974, ETIS was renamed the Telephone Interpreting Service (TIS) and later, the Translation and Interpreting Service (TIS National), becoming a nationwide service with more than 160 languages provided as of 2021 (TIS National, 2021).

As the first specialised healthcare interpreting service operating at a state level, in 1974, the Hospital Interpreter Service was set up in New South Wales (NSW) with four languages in a children's hospital (Chesher, 1997). In 1977, this service developed into the Health Care Interpreter Service (HCIS), which provided state-wide 24-hour services in various languages, including Arabic, Greek, Macedonian, Portuguese, Serbo-Croatian,

Spanish, and Turkish (Ashton et al., 2017, p. 8). In 1978, five languages were added: Cantonese, Mandarin, Cambodian, Laotian, and Vietnamese. Korean was first introduced in 1987 in promotional publications about health information as part of the NSW Department of Health initiative "designed to reach and support non-English speaking residents" (Ashton et al., 2017, p. 109). For the culturally and linguistically diverse (CALD) patients to receive equal access to healthcare services, NSW Health policy states that it is NSW Government policy for professional healthcare interpreters to be employed to facilitate communication between people who are not fluent in English, including people who are deaf, and the staff of the NSW public health system. The use of professional interpreting services allows health professionals to fulfil their duty of care, which includes obtaining valid consent from patients (NSW Health, 2017).

As one of the leading countries "in the provision of community interpreting and translating services, and in the regulation and training of interpreters and translators for that provision" (Chesher, 1997, p. 278), training and accreditation/certification systems have been well developed in Australia—a topic that will be explored in the following sections.

1.2.1 Accreditation/Certification system for interpreters in Australia

As explained above, since the 1970s the quality of interpreting services has caused concern, especially regarding unprofessional ad hoc interpreters (Slatyer, 2015). In 1977, after the Australian Government and various non-government institutions introduced interpreting services, an attempt to establish standards for qualifications and professional accreditation for interpreters and translators resulted in the establishment of NAATI by the Department of Immigration and Ethnic Affairs (Gentile, 2017; Ozolins, 1991). NAATI provided a unique accreditation system for credentialing translators and interpreters at

various levels in many languages (Ozolins, 1998), and national standards for interpreters in the community were developed in Australia for the first time around the world (Gentile, 2017). Today, NAATI credentialing "provides quality assurance and confidence to consumers who rely on translator and interpreter services to participate effectively in our society. It also gives credibility to agencies that engage certified practitioners" (NAATI, 2021, para. 3). In 1978, NAATI settled on the five-tier system of credentials: Level 1 – Language Aide, Level 2 – Interpreting for general purposes and as part of one's duties, Level 3 – First Professional Level, Level 4 – Advanced Professional Level, and Level 5 – Senior Advanced Level. At the time, Level 1 was the basic level, involving bilingual communication rather than interpreting, and candidates were not accredited separately as interpreters but only as "language aides" (Gentile, 2017, p. 199). Then, in 1987, the nomenclature was changed from numbered levels to descriptions of competence at each level. Between 1987 and 2018, during which period the data for the study were collected, the levels of NAATI accreditation for interpreters were as appear below in Table 1-1.

Table 1-1

Levels of NAATI Accreditation for Interpreters (Slatyer, 2015, p. 27)

Conference Interpreter (Senior) (formerly known as Level 5)	This is the highest level of NAATI interpreting accreditation. It reflects a level of excellence in conference interpreting, recognised through demonstrated extensive experience and international leadership. It encompasses and builds on the competencies of Conference Interpreter accreditation.

Conference Interpreter (formerly known as Level 4)	This represents the level of competence required to handle complex, technical, and sophisticated interpreting, in both consecutive and simultaneous modes, in line with recognised international practice. Conference Interpreters operate in diverse situations, including at conferences, high-level negotiations and court proceedings and may choose to specialise in a particular area(s).
Professional Interpreter (formerly known as Level 3)	This represents the minimum level of competence for professional interpreting and is the minimum level recommended by NAATI for work in most settings, including banking, law, health, and social and community services. Professional Interpreters are capable of interpreting across a wide range of semi-specialised situations and are capable of using the consecutive mode to interpret speeches or presentations.
Paraprofessional Interpreter (formerly known as Level 2)	This represents a level of competence in interpreting for the purpose of general conversations. Paraprofessional Interpreters generally undertake the interpretation of non-specialist dialogues. Practitioners at this level are encouraged to obtain Professional Level accreditation.

Interpreter Recognition	This credential is an acknowledgement that at the time of the award the applicant has had recent and regular work experience as an interpreter, but no level of proficiency is specified. In order to be granted NAATI Recognition, the applicant must provide proof of English proficiency and complete an introductory NAATI workshop or related activity. There is no NAATI testing of a Recognition applicant. Recognised interpreters are encouraged to obtain accreditation as it becomes available.

Although completing a course of study in translation and/or interpreting at an Australian tertiary institution approved by NAATI and successfully passing in-house examinations was also a path to becoming an accredited interpreter, testing by NAATI was the principal means of gaining accreditation (Slatyer, 2015). That is to say, pre-service training was not compulsory for interpreters who were accredited before 2018. Since education and training were not compulsory in order to sit for the accreditation tests, some interpreters were not equipped with a thorough understanding of the interpreter's role and ethical challenges even if they did pass the accreditation test (Slatyer, 2015).This was the case even though there was a component that tested candidates in professional ethics, which they had to be familiar with in order to pass. Furthermore, although questions concerning the Code of Ethics of the Australian Institute of Interpreters and Translators (AUSIT) were included as a part of the accreditation examinations, the questions required short-answer responses to scenario-based problems rather than real-life performances in authentic

situations (Hale et al., 2012; Slatyer, 2015). Also, professional development was not compulsory, and accreditation was permanent with no expiry date if credentials had been obtained before 2007—unless the interpreter transitioned to the new NAATI certification system introduced in 2018.

On 1 January 2018, NAATI introduced a new certification system, which replaced the previous accreditation system (Department of Social Services, 2018). The major changes included prerequisites to sit the examinations; the introduction of specialisations (health and legal) for interpreters; and the introduction of live interpreting tests, including telephone interpreting and post-certification professional development, in order to recertify every three years. Live interpreting tests were introduced in the new certification system to test the ability to manage various interpersonal, communicative, and ethical challenges that interpreters might face in the interpreted interaction. That being said, at the time of the data collection for this study, the new certification system had not been introduced, and all the interpreting participants in my study were accredited under the pre-reform accreditation system. Thus, the accreditation system that preceded the 2018 reform was the basis for my study.

Most research studies in healthcare interpreting, conducted by interpreting practitioners, have been undertaken in the United States or in European countries where healthcare interpreting systems are not the same as in Australia in terms of a national accreditation system and approach to the interpreter role. Unlike Australia, which has a national accreditation system and comprehensive training programs available nationwide for healthcare interpreters, untrained interpreters or bilingual staff, therefore, have participated in studies conducted in other countries (Angelelli, 2004; Dubslaff & Martinsen, 2005). This thesis will explore common practices in Australian healthcare interpreting settings, where

nationally accredited interpreters work with specific guidelines for healthcare interpreters and abide by a national Code of Ethics.

1.2.2 Vocational and university courses to train community interpreting professionals

In Australia, the tertiary education sector has primarily provided education and training[1] programs for interpreters via Technical and Further Education (TAFE) institutions and universities (Slatyer, 2015, p. 11). Before the 2018 reform explained in Section 1.2.1, there were no compulsory pre-service education and training requirements for community interpreters in Australia, partly due to a lack of recognition of their need (Hale, 2007). Although there were some courses in community interpreting, for example, conducted by TAFE, they varied significantly in scope, duration, and focus.

In addition to discrepancies in the quality and effectiveness of the various programs for community interpreters, there have been some negative attitudes expressed towards education and training, especially among experienced practising interpreters who are NAATI-accredited but untrained (Hale, 2007, p. 164). Despite this, researchers argue that interpreter competence needs to be developed through high-quality systematic education and training, and to be verified through a comprehensive and effective accreditation system (Hale, 2007; Pöchhacker, 2004). Another ongoing challenge in the education of interpreters in Australia is that formal higher education is only offered in languages of greater demand—

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[1] In this thesis, I use the term 'training' to mean skills development and 'education' to mean theory and research-based academic programs.

such as Chinese, Korean, Japanese, Spanish, French, Russian, Indonesian, and Arabic—due to the lack of language-specific models and resources for feedback sessions (Hale, 2007; Slatyer, 2015) and the difficulty of finding teaching staff in some languages (Gentile, 2017). Korean, fortunately, is one of the main languages offered by education and training programs in various institutions and universities. It is also worth mentioning that there is overseas demand for interpreters in the Korean streams to be trained in Australia in order to work in their home countries. Researchers (Crezee, 2013; Hale, 2007) also argue that specialised education and training is essential for interpreters to work in special settings, including the legal and medical contexts.

1.3 Practical challenges faced by community interpreters

Even though there exists a system of accreditation/certification for interpreters and vocational and university courses to train competent community interpreters in Australia, this does not remove the practical challenges that arise during the interpretation process. Linguistic challenges are among the main ones experienced by community interpreters. They include the requirement of a native or near-native competence in the two languages involved—including a mastery of grammar, register, and style—and also an understanding of the pragmatics of both languages. Also, interpreters often need to clarify with the speaker some domain-specific technical terms according to the circumstances. Crezee and Jülich (2020) argue that seeking clarification of the appropriate healthcare terminology should not be regarded as a sign that the healthcare interpreter is not professional (p. 224). However, it is important to mention that interpreters should be able to also convert the message pragmatically at the discourse level rather than at the sentence or word level (Hale, 2007). For this reason, Hale (2013b) argues that professional interpreters will not normally need to

make any explicit clarifications if they bridge the pragmatic differences in a pragmatically accurate interpretation. That is to say, competent interpreters should be able to overcome linguistic challenges when they accurately interpret at a pragmatic level. Under the assumption of the interpreter overcoming linguistic challenges, one of the most significant discussions of the interpreters' challenges in healthcare interpreting addresses whether cultural differences remain one of the main challenges for community interpreters and whether the interpreter plays the role of cultural broker.

1.3.1 Intercultural communication challenges

Communication is often influenced by varied cultural beliefs among participants, especially in a multicultural society like Australia. As mentioned in the previous section, linguistic challenges experienced by interpreters include an expert knowledge of the two languages involved—their grammar as well the propositional and pragmatic dimensions of language—for interpreters to accurately render the message at the discourse pragmatic level. Unlike cross-linguistic differences, which can be detected in the language itself, cultural beliefs are not easily detected unless all participants are culturally aware and sensitive, since such beliefs go beyond the language itself. For this reason, dealing with intercultural differences in community interpreting has been one of the main topics of interest since the first international conference on community interpreting in 1995 (Carr et al., 1997).

As discussed above, intercultural challenges can constitute cultural differences manifested in practice beyond purely language-related features. These can include turn-taking, body language, and the pitch or volume of a person's voice (Hale, 2013, p. 4), as well as participants' behaviours that are influenced by cultural beliefs (Crezee, 2013). Furthermore, intercultural issues can be complex, since cultural beliefs can change over time,

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and not all members of the same language community will behave in the same way in a similar context. Regarding cultural beliefs in the context of health services, the most frequently discussed topics in the literature are family dynamics and decision-making; attitudes to pregnancy, birth, and mental health; and end-of-life decision-making and truth-telling, especially when dealing with terminal illness (Goldstein et al., 2002; Kagawa-Singer & Blackhall, 2001). However, cultural beliefs are slowly changing, and not all members of the same linguistic community will make the same choices (Goldstein et al., 2002).

Furthermore, in discussing intercultural communication challenges, questions have been raised about the inconsistent use of the term 'culture' by interpreters and researchers (Hale, 2013b). Culture is often defined and used differently by researchers and lay people, and different definitions are adopted in different disciplines (Schnurr & Zayts, 2017). The literature shows a common tendency among interpreters and healthcare professionals to generalise the cultural trends of certain groups when they educate healthcare professionals (Abbato, 2011; Galanti, 2015). While it is important to clarify the distinction between generalisation and stereotype, and interpreters need to be culturally competent in understanding the cultural profiles of people from various countries, such information might not apply to a particular individual or context. Even the Code of Ethics (AUSIT, 2012) presents only two articles that refer to cultural elements, albeit without a detailed description of what 'culture' means in the context. Under the new NAATI certification system introduced in 2018, candidates need to pass both the Intercultural Competency and Ethical Competency tests to become eligible to sit a certification test, whereas ethical questions and cultural questions were part of the old test. To pass the Intercultural Competency test, candidates must "demonstrate adequate knowledge of social institutions, cultural beliefs and practices including the multiple and diverse values across a language group and, adequately identify

the intercultural issue(s) in the scenario as it (they) relate(s) to culturally and sociolinguistically specific concepts in a translation and/or interpreting situation" (NAATI, 2021). Although questions concerning social and cultural issues were included as part of the accreditation examinations, the questions required short-answer responses to scenario-based problems rather than real-life performances in authentic situations (Hale et al., 2012; Slatyer, 2015). However, candidates did have to demonstrate their familiarity with the Code of Ethics and justify their decisions to a certain extent.

Additionally, there have been inconsistencies in the use of the terms 'intercultural communication' and 'cross-cultural communication' in interpreting studies and bilingual healthcare studies. Although not all researchers agree on one definition, the most widely accepted among cultural anthropologists is that intercultural communication refers to interactions among interlocutors from different cultural backgrounds, whereas cross-cultural communication is used to "refer to comparative data, in other words, to data obtained independently from two different cultural groups" (Spencer-Oatey, 2000, p. 6). Specific studies on interpreting (Angelelli, 2004; Hsieh, 2016) that have claimed intercultural communication challenges as being prominent in community interpreting have rarely clearly outlined what was meant by the concept. This thesis critically explores the concepts of culture and intercultural communication as the first step to understanding the link to interpreting challenges.

In Australia, which is one of the leading countries for community interpreting services, patients from migrant communities have access to healthcare services with professional interpreters. This study is mainly focused on Korean-English interpreting, which has so far not been investigated in healthcare interpreting studies in an Australian setting. The study is significant because it is based directly on real-life situations in which

professional healthcare interpreters were involved, and empirical data was collected and analysed, thus contributing to our understanding of interpreted interactions in healthcare settings, including intercultural and other challenges, and interpreters' behaviours. This study will contribute to the growing area of research in healthcare interpreting by exploring the occurrence of communication challenges in interpreter-mediated encounters between Korean-speaking patients and English-speaking healthcare professionals in an Australian setting. However, the study and its findings apply to both interpreters of Korean (via observations and interviews) and other languages (via a survey).

Although the practices and training of healthcare interpreters in Australia are relatively more advanced than those of any other country, there has been a lack of empirical research into interpreter-mediated health encounters in Australia (Garrett, 2009), aside from some small-scale projects and unpublished case studies undertaken by interpreting students or practitioners in the Australian healthcare setting (Chesher et al., 2003; Slatyer, 1998). Most recently, researchers have attempted to explain the relationship between interpreting and intercultural communication in various settings, including healthcare (Cho, 2022; Hlavac & Xu, 2020). That being said, these studies were based on interviews with interpreters (Cho, 2022) and a survey with interpreters and service users of both English and Chinese (Hlavac & Xu, 2020), so the results relied entirely on the participants' responses rather than their behaviour in real situations. Crezee (2013) argued that the limited research using authentic data can be "due to the fact that such studies would include a complex process involving ethics approval and consent from all those involved in such encounters: health professionals, interpreters and patients" (p. 6). Indeed, the whole process of getting ethics approval for this study took almost 13 months in total, which will be explained in Chapter 3. Further, previous research studies in intercultural communication in healthcare interpreting have been

predominantly concerned with English–Spanish (Angelelli, 2004) or English–Chinese (Hsieh, 2016) language pairs, and determined that it was mostly untrained healthcare interpreters who became visible co-participants when bridging cultural gaps. It is unknown, however, whether existing findings are relevant to an English–Korean language pair in an Australian healthcare setting.

1.3.2 Ethical dilemmas and culture

Some researchers critique those peers who ascribe all communication problems to cultural differences (Felberg & Skaaden, 2012; Hale, 2013b). Culture is often blamed or conveniently used to explain away any institutional complications or interpreter incompetence or else unethical behaviour. Several studies have highlighted interpreters' unethical behaviours, which have been justified as attempting to bridge cultural differences (interpreter as 'cultural bridge'). A study by Hsieh (2007) of participant observations with two Mandarin interpreters in 12 medical encounters, found that the interpreter's assumed role as a cultural broker or a co-diagnostician led to ethical breaches and negative consequences. The interpreters from Hsieh's study argued that they volunteered medical information to the patients to save the healthcare provider's time and decided whether certain information provided by patients had medical value or not by assuming what the patients wanted to do or say. Hsieh (2007) expresses her concerns that these behaviours from the interpreters can be risky, as interpreters are not medical experts, and patients do not have the ability to evaluate the accuracy of the information provided by interpreters. Interpreters are also not cultural experts and cannot presume to know each patient's individual culture. It can be problematic when interpreters attempt to become 'helpers' for patients' wellbeing, as they might be more likely to unwittingly violate the principles of the Code of Ethics.

Unlike untrained ad hoc interpreters, whose practices have been examined in previous studies (Angelelli, 2004; Davidson, 2000), trained professional interpreters are required to abide by the AUSIT Code of Ethics. Thus, professional interpreters should be capable of interpreting accurately, remaining impartial, and maintaining confidentiality. However, based on anecdotal evidence and informal reports from practising interpreters, interpreters regularly receive requests from family members of patients to not interpret accurately when unpleasant truths are relayed by the healthcare professional or are asked by patients to provide advice on what medical decisions to make (Crezee & Jülich, 2020). On the other hand, some interpreters, especially novice and inexperienced interpreters, often breach the principle of impartiality because "they want to help their people" (Crezee & Jülich, 2020, p. 225). Thus, interpreters are often faced with difficult situations, which are not discussed in detail in the guidelines provided for them.

Some have wondered whether the generic nature of the Code of Ethics has possibly contributed to confusion, especially in the healthcare setting. Ozolins (2014) questioned whether "a generic code of ethics based on impartiality, confidentiality, competence and understanding of role boundaries is suitable for all contexts of professional interpreting" (p. 37). Similarly, Crezee (2013) argues that healthcare interpreters may occasionally be conflicted between the ethical conduct guidelines and a 'duty of care', meaning that "the interpreter must speak out if he or she is aware of situations which could endanger the patient's life, but situations he or she knows the health professionals are not aware of" (p. 20). Although "the duty of care for the clinical outcome lies primarily with the treating professional, and interpreters do not take responsibility for the health and wellbeing of the clients they interpret for" (NSW Health Care Interpreter Service Professional Development

Committee [HCIS PDC], 2014, p. 14), interpreters need to exercise professional judgement to make the right ethical choices.

1.3.3 External factors that can impinge on interpreter performance

There are many factors other than cultural differences that can impinge on interpreter performance. Establishing the context of the medical consultation is important for healthcare interpreters to provide the most effective interpreting services and make the most accurate professional judgements when they face challenges during consultations. Even though the information provided by healthcare professionals prior to the consultation is limited, interpreters still benefit from being briefed by healthcare professionals.

As Ozolins and Hale (2009) argue, quality in interpreting needs to be the responsibility of all parties, including interpreters and other professionals who serve multilingual populations (p. 3); thus, interpreters and other professionals should work as a team (Hale, 2007). If there is a lack of understanding of each other's roles, communication breakdown can occur, or in some instances, interpreters may be asked to act in a manner inconsistent with the relevant professional guidelines and the code of ethics (Association of Professional Engineers Scientists and Managers Australia [APESMA], 2013; Crezee & Jülich, 2020). As an interpreter with sixteen years of experience in various community settings in Australia, I am aware of similar problems that interpreters face, including not being briefed prior to the interpreting session and being confronted by competing expectations from all parties.

In addition to interprofessional relationships, interpreters' working conditions can also affect the quality of interpreting (Hale & Stern, 2011). Physical conditions and breaks, the availability of background information materials, the need to be briefed about the topic

(Hale, 2011), and a lack of preparation opportunities (Stern, 2011) were all sources of frustration that interpreters expressed in a survey. This links to the issue of interprofessional relationships, as described above, since a lack of understanding from interpreting service users about the complexities of the interpreting process and the role of the interpreter, generally lead to poor working conditions (Ozolins & Hale, 2009). Indeed, based on a national survey of the conditions of interpreters working in Australia, Hale and Stern (2011) looked at interpreting practices in Australian courts and tribunals at that time and found that interpreters expressed "extreme frustration at the legal professionals' lack of understanding of the interpreting process and the need to be briefed about the topic" (Hale & Stern, 2011. p. 77). A lack of information provided prior to the assignment, as well as the absence of any briefing, can lead to interpreters being unable to interpret accurately. Despite attempts by researchers and educators (Tebble, 1998) to educate health professionals to brief interpreters, anecdotal evidence and my own experience suggest that briefing of interpreters prior to the interpreting assignment is very rare.

Although my original assumption was that intercultural issues pose the biggest obstacles for Korean interpreters in Australia, my study revealed many other factors that were much more prominent and challenging for interpreters, largely overshadowing any issues relating to intercultural differences.

1.4 Research aims and questions

This thesis aimed to address two main research questions in healthcare interpreting. The first question explored whether intercultural issues are a significant reason for interpreting challenges in interpreter-mediated encounters between Korean-speaking patients

and English-speaking healthcare professionals in an Australian setting. The first part of the thesis thus addressed the following sub-questions:

- Do intercultural issues pose significant challenges for community interpreters?

- What other challenges are faced by community interpreters?

- How do interpreters act when they face challenges in interpreter-mediated encounters?

In this light, the second research question explored the healthcare interpreters' perceptions of their own roles in intercultural communication. This includes the interpreters' perceptions of the definitions of intercultural communication and cultural differences, of their roles in such situations, and of strategies interpreters adopt to address intercultural communication difficulties—if any. The second part of the thesis thus addressed the following relevant sub-questions:

- How do healthcare interpreters identify and address communication challenges in interpreter-mediated medical encounters?

- Is there a consensus among interpreters of the same language group on what constitutes intercultural communication challenges?

- What are their strategies to overcome such challenges, if any?

To answer the above research questions, a mixed methods approach was chosen using both qualitative and quantitative methods to collect and analyse data. In Chapter 3, I present a detailed description of the research methods used in this study.

1.5 Thesis outline

As outlined above in Section 1.4, the main questions addressed in this thesis are whether intercultural issues pose significant challenges for interpreters in medical encounters

and how interpreters attempt to solve them. This thesis first gives a brief overview of the recent history of multicultural society in Australia and the origins of its community interpreting services (Chapter 1 *Introduction*). It then presents the motivation for the study and discusses assumptions held about intercultural communication challenges posing significant obstacles to interpreters. The chapter then highlights the many other factors that impinge on interpreting performance, and interpreters' knowledge and ability to abide by the professional Code of Ethics. It presents the thesis aims and research questions and an outline of its contents. Chapter 2 *Literature Review* begins by laying out the theoretical dimensions of the study and looking at the various approaches used to define culture and intercultural communication. It provides a critical review of the existing literature in relation to intercultural communication challenges, consisting of three major areas: (1) the link between culture and the patient's attitude to health; (2) standards and guidelines on intercultural healthcare communication; and (3) the role of the community interpreter, including in healthcare settings. Following the review of the existing literature, Chapter 2 identifies some research gaps, which include a lack of empirical research in healthcare interpreting in Australia, a lack of research in the Korean<>English language combination, and the need for a clear understanding of the terms 'culture' and 'intercultural communication'.

Chapter 3 *Research Methodology* describes the methodological approaches used in this study for the investigation of intercultural communication challenges faced by healthcare interpreters. It explains the rationale of the research design, followed by an explanation of the ethics applications and approvals procedure, and the three phases of the study: an ethnographic component involving participant observations of authentic interpreter-mediated healthcare encounters; a second ethnographic component, comprising post-observation interviews with interpreters; and a questionnaire component using an online survey of

healthcare interpreters working in Australian settings. It then describes the data collection and data analysis procedures, which use both qualitative and quantitative methods.

Chapters 4 *Exploring interpreter-mediated medical consultations: observations* and 5 *Interpreters' perceptions: semi-structured interviews* explore authentic interpreter-mediated healthcare encounters and post-observation interviews with interpreters. Chapter 4 presents the data collected, including participant observations in order of occurrence, and a complete description of what occurred prior to the consultation, during the consultation, and after the consultation. As pointed out in Section 2.6 in Chapter 2, not many studies have paid attention to the cultural, ethnic, or linguistic diversity of healthcare professionals and healthcare interpreters. Instead, the cultural, ethnic, or linguistic diversity of patients has been the focus. However, the diversity of the ethnic background of healthcare professionals was observed in my study, including within-group variations and individual traits. The data collected via observations of Korean<>English interpreter-mediated medical encounters showed that most of the challenges were not attributable to intercultural issues, but rather cross-linguistic differences, deficient interpreting skills, and ethical dilemmas.

Following an in-depth analysis of the professional challenges of healthcare interpreters and a comparison of intercultural communication challenges during my observations and in the literature, Chapter 5 discusses the findings of the post-observation interviews with Korean interpreters. It provides a description of the interpreters' views on intercultural communication challenges, ethical/professional challenges, and the strategies they use to deal with intercultural communication challenges. Chapter 5 then triangulates the data gathered during the post-observation interviews with the data presented in Chapter 4 on participant observations and compares the results with the literature. Chapter 5 concludes that what interpreters perceive as intercultural challenges are, in fact, often related to ethical

or other professional challenges, and their explanations of how to deal with communication challenges are also related to their ethical decisions. The results of semi-structured one-on-one interviews with the same interpreters who participated in the observations found a lack of clarity about what they understood as constituting intercultural communication challenges and their need to act as cultural advisors.

Chapter 6 *More voices from healthcare interpreters in Australia: online survey* analysed the results of the third phase of the study, which is the survey about intercultural communication challenges relating to healthcare interpreters' practices involving interpreters in different languages. The data gathered during the participant observations and the post-observation interviews with Korean interpreters were limited to the language combination of English and Korean. Therefore, to broaden my study and gain perceptions from a larger number of interpreters with diverse language combinations, the questionnaire extends the scope of participants to include more languages. Chapter 6 reports on the questionnaire design and the data collection and analysis procedure, and provides a description of the respondents' demographic information, views on intercultural communication challenges, perceptions of their roles, and views on their working conditions. Following a discussion of the findings of the online survey, it then triangulates the survey results by comparing them with the findings from the data presented in previous chapters on the participant observations and post-observation interviews. The results of the online questionnaire with healthcare interpreters of different language combinations working in Australia also found a lack of clarity from the interpreters about what they understand as constituting intercultural communication challenges and clearly demonstrated that culture is often mistakenly blamed for interpreters' unethical behaviours or incompetent interpreting. The results suggest that interpreters who were originally provided with the now outdated guidelines from the 1970s

and early 1980s were more likely to perceive their role as that of a cultural advisor as well as interpreter.

Finally, Chapter 7 *Conclusion* concludes the thesis with a summary and discussion of the main findings. Implications for healthcare interpreting practice and limitations of the study are discussed as well as recommendations for further research in the healthcare interpreting field.

Chapter 2 Literature Review

2.1 Introduction

In Chapter 1, the background of Korean migrants and the practice of community interpreting in Australia were explained, as well as practical challenges, including linguistic and cultural, that community interpreters may face during their practice. The current research arose from recurring personal and professional challenges, even frustrations, during situations where a practising interpreter in a community setting must make accurate and balanced judgements when faced with professional and ethical dilemmas. In particular, I wanted to pursue the cultural aspects of interpreting since I believed, through my interpreting experience and observations, that one of the biggest challenges in community interpreting is dealing with cultural differences. Chapter 2 begins by exploring the definition of culture from different perspectives: one with nation-based generalised views and the other with holistic views. It then explores important aspects of culture in healthcare settings in relation to healthcare communication between healthcare professionals and patients with different cultural backgrounds; these include linguistic aspects of intercultural communication and cultural beliefs in relation to health. Current research about the role of healthcare interpreters and users' expectations is reviewed, and research gaps identified. Lastly, various standards and guidelines are reviewed, particularly in relation to how healthcare professionals and interpreters should deal with intercultural differences.

2.2 Definitions

'Culture' is a term that has been defined in different ways. Schnurr and Zayts (2017) point out the challenges this creates for researchers, as the term 'culture' is conceptualised and used differently by researchers and lay people. Various definitions are adopted in different disciplines across the humanities and social sciences, such as anthropology, psychology, history, philosophy, international business studies, and applied linguistics (Schnurr & Zayts, 2017, p. 2). Among them, cultural dimensions as defined by Hofstede (1980, 2001) and Hall (1959, 1976) have been most widely adopted as a starting point when researchers investigate the relationship between language and culture. Hofstede (2001) defines culture as "the collective programming of the mind that distinguishes the members of one group or category of people from another" (p. 9). Culture can be manifested in many different forms—including beliefs, behaviours, rituals, and words—making language only one component of culture. In light of the above, culture can be defined as a complex whole, which includes ideas and behaviours shared by a group of people. Although people from the same group do not share the same culture in every possible aspect of their lives at the individual level, there are certain beliefs and behaviours that tend to be widely or commonly accepted by a particular group. For anthropologists, "culture has long stood for the way of life of a people, for the sum of their learned behaviour patterns, attitudes, and material things" (Hall, 1959, p. 43). The definition of culture and cultural differences has shifted as a greater realisation of the importance of intercultural communication in a modern society has developed. In the next section, generalised and holistic views of the definition of culture are explored as well as changes in how researchers have defined the so-called Eastern or Asian

culture, drawing from different disciplines, including anthropology, cross-cultural psychology, sociolinguistics, and applied linguistics.

2.2.1 Generalised views of the definition of culture

Early research on cross-cultural differences tended to focus on national cultures and view them as monolithic entities (Hall, 1976; Hofstede, 1980, 2001). Hall (1959, 1976), an American cross-cultural anthropologist, worked as a consultant for the United States Government to facilitate intercultural communication for Foreign Service Officers working overseas and for foreigners working in the United States. The major concept devised by Hall (1976) was the idea that there were cultural differences between what he called low-context and high-context cultures. High-context cultures, such as many Asian cultures and the African American and Native American cultures, are "ones in which most of the information is either in the physical context or internalized in the person, while very little is in the coded, explicit, transmitted part of the message" (Hall, 1976, p. 91), whereas in low-context cultures, such as Anglo–North American, German, and Scandinavian cultures, "the mass of the information is vested in the explicit code" (Hall, 1976, p. 91). Hall (1959) argues that miscommunications may occur when a person from a low-context culture communicates with one from a high-context culture, as they are more likely to be detached and distant from each other. For example, people from high-context cultures tend to be more observant of facial expressions, body language, changes in tone, and other aspects of communication and contextual information that are not directly spoken. On the other hand, people from low-context cultures will likely not be able to understand what is not directly spoken since they usually communicate in a more direct way, by explicitly speaking what they want to communicate (Hall, 1976).

Another influential piece of research on cross-cultural differences was that conducted by the cultural psychologist Hofstede, whose work was based on comprehensive studies of values in the workplace as manifested by various cultures. Hofstede (1980) analysed the characteristics of IBM employees in more than 70 countries and identified the five independent dimensions of national cultural differences:

1. Power distance, which is related to different solutions to the basic problem of human inequality. Hofstede claimed that Latin American, Asian, and African societies accept power inequalities, whereas Anglo-Saxon and Germanic societies have a lower acceptance of it.

2. Uncertainty avoidance, which is related to the level of stress in society in the face of an unknown future through the domains of technology, law, and religion. According to Hofstede, Latin American countries and Japan tend to avoid uncertain situations by minimising the possibility of unstructured situations by strict laws and rules, whereas Anglo and Nordic countries and China are more likely to rely on informal norms and behaviours in uncertain situations.

3. Individualism versus collectivism, which is related to the integration of individuals into primary groups. Hofstede classifies Anglo-Saxon, European, and other developed countries as having individualistic cultures and Asian, African, and developing countries as being collectivistic cultures.

4. Masculinity versus femininity, which is related to the attribution of specific emotional roles to men and women. Hofstede claims that 'masculine' cultures such as Japan and Germanic countries reflect "a society in which social gender roles are clearly distinct", and 'feminine' cultures such as those of Nordic countries stand for "a society in which social gender roles overlap" (p. 297).

5. Long-term versus short-term orientation, which is related to the choice of focus for peoples' efforts: the future or the present. China and East Asian countries are categorised as long-term-oriented countries that stand for "the fostering of virtues oriented towards future rewards, in particular perseverance and thrift" (p. 29). On the other hand, Anglo-Saxon, African, and South Asian countries are viewed as short-term-oriented countries that stand for "the fostering of virtues related to the past and present, in particular, respect for tradition, preservation of 'face' and fulfilling social obligations" (p. 359).

According to Hofstede (2001), different behaviours across cultures can be shaped largely by the individualism vs. collectivism dichotomy. People in collectivist cultures are more concerned with the interests of a group rather than the individual; on the other hand, people in individualist cultures are more concerned with the interests of individuals rather than of a group. Hofstede also argues that this difference affects how people see each other within the cultural network to which they belong. In collectivist cultures, individuals should maintain harmony to keep a good relationship with others. Therefore, direct condemnation or harming of others will lead to the loss of face in a culture in which the group must be taken into account when making decisions. Conversely, in individualist cultures, individual uniqueness and autonomy is valued. Based on his study, Hofstede argues that countries such as China and Korea are categorised as having more of the characteristics of collectivism, whereas countries such as the United States, Germany, and Australia are categorised as having more of the characteristics of individualism.

When comparing Korea to Australia, based on Hofstede's (1980) cultural dimensions, the biggest difference is the level of individualism, which Hofstede measured using the individualism index by which the degree to which people in a society are integrated into

groups is explored. With an individualism index value of 18 out of 100, he concluded that Korea is a collectivist society in which loyalty is paramount, surpassing most other societal rules (Hofstede, 2001, p. 214). He regarded Australia, with an individualism index value of 90 out of 100, as a highly individualistic culture, in which there is a common understanding of people looking after themselves and their immediate families, rather than considering the group. In collectivist cultures, which includes the traditional Korean culture, individualism can connote selfishness, whereas sacrifice and obedience can be seen as virtues. Hofstede (1980, p. 229) further links these cultural dimensions of individualism and collectivism to shame and guilt. When a misdeed has been committed, the individual in the individualistic culture will feel guilty, driven by individual conscience, whether or not such a misdeed is known or judged by others. This is because in the group in the individualistic culture, honesty and personal accomplishments are valued more than harmony. On the other hand, a person in a collectivist culture will feel shame before others in a group, as the source of shame comes from whether such a misdeed is known to others rather than the misdeed itself. Another unique concept that can be noticed in collectivist cultures is face. Losing face means being embarrassed or humiliated, especially publicly, and is "an expression that penetrated into the English language from the Chinese; English had no equivalent for it" (Hofstede, 2001, p. 230).

However, it is important to remember that significant changes have been occurring over the past few decades. Due to globalisation, migration movements, intermarriages, international trade and travel taking place, and media and entertainment becoming internationalised, the world is becoming more homogenous. These factors are likely to blur the strict boundaries of the aforementioned cultural dimensions. Thus, such generalised

views of cultural dimensions have less relevance in the contemporary world, and a modified approach to their analysis is required.

2.2.2 Holistic definitions of culture

Such dichotomous views of culture, as discussed above, came under criticism for "the relative static and restrictive nature of the dimensions" (Schnurr & Zayts, 2017, p. 4), especially in the field of sociolinguistics and applied linguistics. The section above discussed the differences between Korean and Australian cultures, described as collectivistic and individualistic, respectively, by Hofstede who identified the traditional values in Korean culture as hierarchical, collectivistic, feminine, uncertainty-avoiding, and long-term oriented. However, many researchers in various fields—including linguistics, cultural studies, and education—came out in opposition to Hofstede's theory, arguing that traditional values may be eroded by more recent values, as traditional collectivistic culture begins to merge with aspects of individualism (Furrer et al., 2000; Jones, 2007; Kubota, 2001). Furrer et al. (2000) claimed that "the dimensions of Hofstede may be criticised for a number of reasons, especially regarding the internal validity of the dimensions and the method of constructing the scales (p. 358)", and Kubota (2001) contends that such a theory, based on Western culture, tends to generalise certain cultural phenomena as national characteristics. Jones (2007) cites cultural homogeneity, national divisions, and political influences as problematic aspects of Hofstede's theory, although he argues that Hofstede's work is still regarded as the most significant cross-cultural study in business settings. Another issue that Jones sees as problematic is its relevance, since the cultural orientations of certain nations as described by Hofstede are very much out of date.

One of the main criticisms against employing generalised views to define culture is that culture can change over time in one group through contact with other cultures. S. Kim (2015) conducted a survey in Korea using structured questionnaires on 354 patients and their family members. He discovered among Koreans a combination of values and beliefs, both traditional and modern, Western and Eastern, in areas such as patient autonomy and end-of-life decision-making. Regarding the question of who the most appropriate person would be to make decisions for treatments at the end-of-life, 78.3% of respondents indicated a desire for a substantial degree of involvement in decision-making, rather than deferring to family members or medical staff. This is in contrast to previous studies in which older Korean Americans regarded family involvement as a cultural norm (S. Kim, 2015, p. 233). In this study, an exploration of the concept of 'culture' was not the main aim. However, the survey results showed how so-called collectivist cultures can be reshaped over time and can be multifaceted, depending on context. Even though the study depends on narratives of study participants in a very small area of the medical context, the results are still meaningful to verify such changes in collectivist cultures.

With continued public debate as to what constitutes 'Australian values' and what 'multiculturalism' means in Australian society (Vasta, 2015), cultural, social, and ethnic diversity may be described as the most distinctive characteristics of Australian culture following decades of large-scale immigration. However, changes in defining Australian culture have also been shown over time. In 2012, Vasta (2015) conducted 51 interviews with Australians of seven different backgrounds: Chinese, Ghanaian, Indian, Italian, Lebanese, Sudanese, and Anglo Australian. Of the 51 interview participants, 10 were aged between 19 and 28. Participants in this study were asked to talk about the values and ideas that had significant meaning in their lives and to discuss the similarities and differences between the

values of their ethnic communities and other ethnic groups. Based on the interview results pertaining to Australian values among young Australians, including native-born Anglo Australians and second- or third-generation migrants, the younger generation indicated transnational identities and a multicultural sense of belonging (Vasta, 2015, p. 291). The complexities of contemporary Australian culture have resulted from various economic, political, religious, linguistic, and geographic factors. Another interesting finding of this research was a greater difference regarding the cultural beliefs and values shaping identity between generations, rather than between ethnic groups. Younger Australians with different ethnic backgrounds highlighted generational differences, in which first-generation immigrants preserved their cultural heritage, whereas second- or third-generation immigrants navigated between their cultural traditions, Australian identities, and a sense of belonging to mainstream dominant Australian culture.

Another criticism of generalised definitions of culture is that the possibility of people belonging to multiple cultures can be overlooked if using nation-based generalised views to define culture. Although Hofstede also acknowledged the existence of subcultures within cultures, Galanti (2015) defined subcultures as follows:

Within most cultures, smaller groups of people share certain characteristics not shared by the culture at large. Anthropologists call such groups subcultures. Subcultures may be based upon a variety of things, including ethnicity, occupation, activity, or sexual orientation (p. 10).

For this reason, people who have the same ethnic background can have different cultural beliefs depending on where they live. Using semi-structured interviews, H. Park et al. (2015) conducted a study of Korean mothers and their fifth-grade children residing in rural Korea, urban Korea, and Koreatown in Los Angeles, in which they assessed the participants'

value orientations. The purpose of this study was to discover the factors influencing individualist–collectivist cultural values. An American group with people of various European backgrounds was interviewed to provide an approximation of the values of so-called individualistic cultures. The European American participants were deliberately chosen for this study to accurately represent the individualistic values of Americans. American society is multicultural; therefore, the sample was not limited to Anglo Americans. Interpersonal dilemma scenarios were used to assess respondents' cultural value orientations. Eight hypothetical scenarios were used for this study, in which four scenarios involved Korean family members (e.g., 'two sisters are fighting over one t-shirt') and four scenarios involved school situations (e.g., 'two students want to work together and submit one poster for a class project that requires an individual submission'). Each scenario was categorised into themes and classified again according to the level of individualism or collectivism demonstrated based on the respondents' decisions and justifications for what they would do. According to the results, all three groups of Korean participants demonstrated more signs of collectivism in the home domain than in the school domain. In the school domain, all three groups of Koreans were as individualistic as their European or American counterparts. However, in the home domain, the Korean mothers and children were more collectivist than European or American participants, although there was no substantial difference among the three groups of Koreans. Further, sociodemographic factors, such as mothers' education levels or whether participants lived with their grandparents, had a more significant effect on their home values across all four groups. For example, respondents from three-generation households demonstrated higher collectivistic values than those from two-generation households. Respondents whose maternal education was higher showed greater individualism than those with lower maternal education. In the analysis of results for Korean

migrants in the United States, this study supports the claim that adaptation of a new culture occurs distinctively in various contexts.

Furthermore, 'culture' is a term that is often defined and used differently by various research participants. Through a triangulation of collected data, including interactional data via recordings, ethnographic data via interviews, questionnaires and researchers' notes, and samples of written data via emails and protocols, Schnurr and Zayts (2017) discovered discrepancies in ways that the culture was conceptualised and defined by each participant.

Since this thesis explores the possible impact of culture on healthcare via the interpreter's role in interactions between patients and healthcare professionals who do not share the same language and culture, it adopts a definition of the multidimensional and dynamic nature of culture that is interpreted as part of action and interaction based on context. Such a dynamic definition of culture in social interaction emphasises diversity and plurality, which means that the context of communication and the circumstances of the interlocutors are paramount to understanding healthcare interpreters' challenges rather than the fixed knowledge of a nation-based cultural understanding.

2.2.3 Cross-cultural communication vs. intercultural communication

Hall (1959) was one of the first anthropologists to explore the concept of 'intercultural communication'. Although not all researchers agree on one definition, the most widely accepted among cultural anthropologists is that intercultural communication refers to interactions among interlocutors from different national or ethnic groups, whereas cross-cultural communication is used to "refer to comparative data, in other words, to data obtained independently from two different cultural groups" (Spencer-Oatey, 2000, p. 6). Scollon and Scollon (2001) identified the differences:

Although there is no widespread agreement on this, we take 'intercultural communication' to signal the study of distinct national or ethnic groups in interaction with each other. That is to say, the comparative analysis of the groups or synthesis between them arises in this framework as part of the interaction of members of different groups with each other, and the analyst's role is to stand outside of the interaction and to provide an analysis of how the participants negotiate their cultural or other differences. As with cross-cultural analysis, the groups under study are often presupposed. (p. 539)

Piller (2011, p. 70) further explained that intercultural communication refers to any communication between two or more people who do not share the same language or ethnic culture. By adopting the variable and dynamic nature of culture explored above, Piller (2011) argues that intercultural communication cannot be limited to native versus non-native speakers of the language of the host country but must be extended to any communication between two or more people in any setting. Thus, a pragmatic approach is adopted to understand and interpret the communicative problems in observed linguistic data from an interactional-sociolinguistic perspective (Hale, 2007; Sarangi, 1994)

There have been inconsistencies in the use of the terms 'intercultural communication' and 'cross-cultural communication' in interpreting studies and bilingual healthcare studies. According to Hsieh (2016, p. 7), in the medical field, the term 'cross-cultural care' is traditionally used when medical providers and patients do not share the same ethnic backgrounds. Despite the existing confusion between the terms *intercultural communication* and *cross-cultural communication*, 'intercultural communication' is the most appropriate term to use in the context of interpreting studies, as interpreters translate interactions among interlocutors who do not share the same ethnic or linguistic culture. To maintain consistency

with other fields and disciplines, such as anthropology (e.g., Gudykunst, 2003), applied linguistics (e.g., Scollon & Scollon, 2001; Spencer-Oatey, 2000; Verschueren, 2008), and management or business communication studies (e.g., Jandt, 2004; Schnurr & Zayts, 2017), in this thesis, *intercultural communication* is used for interpreter-mediated healthcare encounters.

2.3 Culture and health

Intercultural communication is an important component of multicultural healthcare provision. While the goal of the healthcare system is to provide optimal care for all patients (Galanti, 2015, p. 1), such a goal can be difficult to achieve, or even unattainable, in a situation where communication is influenced by varied cultural beliefs among participants, especially in a multicultural society like Australia. For that reason, healthcare professionals have examined how health and illness are shaped, experienced, and understood within diverse cultural worlds. Since the 1990s, there has been an increasing amount of literature on the relationship between patients' ethnic backgrounds and medical communication between patients and healthcare professionals (Souza, 2016). This is because language barriers and cultural differences can be primary reasons for inadequate communication and poor patient-doctor relationships in healthcare settings (Cerimagic, 2013). Galanti (2015) argues that there are three necessary phases for healthcare professionals to be able to achieve the ultimate goal of the healthcare system (providing optimal care for all) in a multicultural society: (1) to understand one's own culture and biases, then become sensitive to other cultures; (2) to acquire knowledge and understand other cultures; and (3) to apply that knowledge to practice (p. 2). In doing so, better health outcomes can be achieved, including greater patient satisfaction, improved clinical outcomes, and greater cost efficiency. To understand one's

own culture and other cultures, a generalisation of cultural trends of certain groups is commonly used. For example, health-related values and beliefs of diverse cultural groups are provided by Australian governments to educate healthcare professionals so that they can provide culturally sensitive care (Abbato, 2011; Queensland Health, 2013). The most commonly adopted approach is to promote cultural sensitivity from an ethnic or national perspective, in which cultural profiles of people from various countries are provided by either government departments or healthcare providers in the areas of communication, health status, health beliefs and practices, and social determinants of health (Abbato, 2011; Galanti, 2015). However, the authors clearly highlight the dissimilarity between generalisation and stereotype:

> The difference lies not in the context, but in the usage of the information. A generalisation is a beginning point … . It indicates common trends, but further information is needed to ascertain whether the statement is appropriate to a particular individual … it [generalisation] can help us understand and anticipate behaviour (Galanti, 2015, p. 11).

Therefore, providing cultural profiles of people who originate from various countries can also be useful for both healthcare professionals and healthcare interpreters to become culturally competent, even though cultural competence will never be achieved by memorising lists of cultural profiles, since such information may or may not apply to a particular individual.

2.3.1 Cultural profile: Koreans as an ethnic community

As explained above, in order to become aware of other cultures' characteristics and be culturally sensitive, it is important to mention some cultural patterns described in the

literature as a starting point. Cultural profiles of Koreans, both in Korea and in the diaspora, will be reviewed in this section, since this thesis will examine the intercultural challenges between Korean-speaking patients and English-speaking healthcare professionals. In most documentation on cultural profiles provided for healthcare professionals by government departments or healthcare providers (Abbato, 2011; Galanti, 2015; Queensland Health, 2013), the cultural profiles of Koreans are generally included in the broader category of Asian migrants. Most of the distinctive cultural traits of Koreans, as outlined in these studies and government documents, will be explored in this section, including their attitudes towards patient autonomy; the tradition of filial piety; and health beliefs, especially around pregnancy and birth.

As explained in Section 2.2.1, Korean culture is described as collectivist; therefore, harmony is highly valued, and conflicts are to be avoided among groups (Hofstede, 1980, 2001). Although North Korea clings to its unique state ideology, and it is difficult to acquire accurate cultural profiles of North Koreans due to the state's secrecy, communism encourages collective behaviour and cooperation in general (Hassig & Oh, 2008). However, as researchers on North Korea, Hassig and Oh (2008) argue, "North Korea is undergoing a stealthy change in its culture" (p. 68). That is to say, traditional values of culture in Korea, both North and South, are reshaping over time. For this reason, making healthcare decisions after getting family members' opinions rather than relying on patient autonomy is regarded as a norm in Korean culture. In the field of medical studies and based on quantitative surveys (Blackhall et al., 1995; Frank et al., 1998), differences in the attitudes of ethnic groups towards patient autonomy were explored. In both studies, Korean Americans were least likely to believe that a patient with a life-threatening illness should be informed of their diagnosis and prognosis. For example, only 35% of Korean Americans believed that a patient should

be informed of a terminal prognosis, whereas 48% of Mexican Americans, 63% of African Americans, and 69% of European Americans believed so (Blackhall et al., 1995, p. 821).

However, it appears from the literature that the cultural beliefs of Koreans towards patient autonomy have changed over time. As described in the literature, more than 20 years ago, the traditional beliefs among Koreans, both in Korea and in the diaspora, did not emphasise patient autonomy in end-of-life decision-making. Therefore, based on the traditional culture of Korea, Koreans tended to believe that negative diagnoses were to be withheld from the patient, and the role of the family members' opinions was regarded as more important than the patient's right to know (Frank et al., 1998). In contrast, recent studies have shown some drastic changes in attitudes towards patient autonomy and the role of the family (S. Kim, 2015; Mo et al., 2012; Morita et al., 2015). Based on a survey using structured questionnaires, S. Kim (2015, p. 229) demonstrated that demand among Koreans for patient autonomy in end-of-life decision-making is increasing. Of the 390 survey participants in that study, 70% were terminally ill cancer patients and insisted that they wanted to be actively involved in decision-making about their prognoses and treatment options. Further, 62% of respondents answered that the patient is the most appropriate person for end-of-life decision-making. Similarly, in another survey of 93 terminal cancer patients in Korea, Mo et al. (2012) found that there is a significant minority of patients (6.5%) in Korea who prefer not to be involved in decision-making, and more than 70% of their 93 survey respondents, who were cancer patients in the 46–72 age range, expressed a strong preference for patient autonomy in decision-making.

A similar pattern emerges in studies of attitudes towards patient autonomy among healthcare professionals in Korea. A team of healthcare researchers in East Asian countries (Morita et al., 2015) conducted a survey of palliative care physicians' perceptions of patient

autonomy and what constitutes a good death. Out of cohorts of 505 Japanese, 207 Taiwanese, and 211 Korean physicians, a greater proportion of Japanese (82%) and Taiwanese (93%) physicians than Korean physicians (74%) agreed that the patient should be the first person to be informed of a terminal illness. However, this still implies that most Korean physicians agreed with the idea of patient autonomy, rather than a family-centred approach. Thus, the traditional cultural beliefs of Eastern medical culture regarding decision-making in end-of-life situations, which are more family centred than autonomous, have been changing over time. Thus, S. Kim (2015) suggests that healthcare professionals should be aware of the possibility of conflict of interest between the patient's wishes and the physician's recommendation, and various dynamics in terms of the decision-making process, as both patient autonomy and the traditional family-centred approach currently coexist in Korean society.

Along the same vein, family is regarded as the primary unit when making treatment decisions and looking after patients, which was indicated to be influenced by patriarchal and hierarchical cultural values (H. Kim, 2017). One such example is filial piety, which means that children have a responsibility to obey their elders and to take care of their parents and grandparents (H. Kim, 2017, p. 11), and this responsibility becomes more important when their parents are old and ill. However, the concept of filial piety is a complex ideal and more than just a traditional Confucian notion of "respect-the-old" and "care-for-one's-parents" (Sung, 1995, p. 240). To explore various measures and dimensions of filial piety, Sung (1995) conducted a questionnaire with 1,227 adult children and students residing in Korea. The findings indicated that the tradition of filial piety persists in Korean culture and can be seen as the provision for the integration of the elderly with their family and society (p. 246). Having said that, ideas of adult children's responsibility for the care of their elderly parents

have gradually evolved in modern Korean society. Furthermore, the ageing population as well as the changes in filial piety in Korean society lead to challenges in the healthcare system (H.-J. Park, 2015). Thus, in 2007, the Korean government passed a controversial law on filial piety, which was to "encourage the practice of filial duties and responsibilities within the family unit, the community, and the wider society" (H.-J. Park, 2015, p. 281). The Korean filial piety law does not obligate adult children to support their parents in an explicit way, but "requires the state and local governments to provide adult children with support and encouragement" (H.-J. Park, 2015, p. 288). Legislating for filial piety can provide a unique example in which the traditional Korean culture is conceptualised and supported by law, while cultural beliefs evolve over time in a modern society.

Another cultural trait some authors have observed relates to Korean traditional health beliefs in pregnancy and birth. There are many studies, conducted by professional anthropologists, midwives, doctors and nurses, that explore the pregnancy and childbirth process around the globe, and some in which the customs of Koreans have been described (Ahn, 2009; Galanti, 2015). For example, according to Galanti (2015), in Korean culture, new mothers may want to drink warm liquids rather than iced water because of the belief of maintaining a hot/cold balance in their body, and bathing is avoided for three weeks after giving birth and the postpartum lying-in period is also three weeks (Galanti, 2015). According to Ahn (2009), special care for postpartum recovery is still very common in Korean society, and it can be at the new mother's home, her mother's home, or in a special care place. However, these days, prioritising personal hygiene, including having a hot water shower after giving birth, is allowed, although it is still considered that "cold air can make the women's body cold which might generate an illness in their later life" (p. 81). The aforementioned cultural practices surrounding pregnancy and childbirth cannot be

generalised since both sources (Ahn, 2009; Galanti, 2015), though written by healthcare professionals, are based on personal experiences and anecdotal evidence, and the question of cultural practices regarding certain medical encounters would be best addressed using empirical data to improve the objectivity and validity of the data. However, as stated above, these studies are still worth mentioning in order to understand one of the most significant components of the cultural profile of Koreans in Korea. As explained in 2.3, for healthcare professionals to achieve successful intercultural communication, one has to understand one's own culture and be sensitive to, and understand, other cultures. Only then can one apply such understanding and knowledge to practice. To become culturally competent, two different aspects of culture, which can have an influence on healthcare communication, should be acknowledged and understood by healthcare professionals.

2.3.2 Linguistic aspects in intercultural communication

Aspects of culture that have an influence upon healthcare communication are generally classified into two types: linguistic aspects and cultural beliefs in relation to health (Crezee, 2013; Galanti, 2015). According to Crezee (2013), linguistic aspects consist of two categories: language issues—communication style, such as directness of speech or manner of delivery—and non-verbal communication, including eye contact, touching, or use of personal space. As an example of language issues, Lee (2009b) points out four interlinguistic differences between English and Korean that result from linguistic features of the Korean language: the absence of strict grammatical marking of singularity and plurality, number, person, and gender.

Non-verbal communication, including eye contact, physical contact and personal space, and paralinguistic aspects of communication, including tone, volume, rhythm, and

speed of delivery, are also significantly influenced by cultural norms (Crezee, 2013; Galanti, 2015; Hale, 2013b). One of the most frequently discussed aspects is eye contact. According to cultural profiles provided by Australian government departments (Abbato, 2011; Queensland Health, 2013) and medical anthropologists (Galanti, 2015), in some Asian cultures, including Chinese, Japanese, and Korean, it is considered disrespectful to look someone directly in the eye, especially if the other party holds a superior position.

However, language-related communication issues should be able to be overcome by expert interpreters. Using the distinction between pragmalinguistic and sociopragmatic failures advanced by Thomas (1983), Hale (2013b) argues that well-trained professional interpreters should be able to avoid pragmalinguistic failure if they interpret accurately at the discourse pragmatic level. That is, linguistic features of the Korean language, such as the absence of strict marking of singularity and plurality, number, person, and gender can be interpreted at the pragmatic level based on the context. For example, a greeting in Korean such as 'Jal Jinaesseo-yo [Well have been]?' can be interpreted into 'Have you been well?' in English, with the grammatical subject being suggested by the context. In this sentence, the subject 'you' in Korean is not required as well as a grammatical marker of singularity and plurality. This greeting in Korean can be accurately interpreted into English at the discourse pragmatic level by a competent interpreter. On the other hand, sociopragmatic differences are more difficult for the interpreter to deal with because they go beyond the linguistic level. For example, when Koreans avoid eye contact, it can be interpreted as a sign of respect according to the Korean cultural norm or as the suspicious behaviour of an individual trying to hide their feelings in the Anglo-Saxon tradition.

2.3.3 Cultural beliefs in relation to health

Unlike linguistic aspects, which can be expressed and observed in an explicit manner, cultural beliefs in relation to health are not easily detected unless all participants become culturally aware and sensitive, since beliefs go beyond language issues. In relation to the cultural beliefs relating to health, there are frequently quoted examples: the impact of religious practices and spiritual beliefs, and that of the role of the family; expression of, or attitude towards, pain; attitude towards pregnancy and childbirth; attitude towards revealing/withholding a negative diagnosis/prognosis; the stigma of mental illness; belief in traditional remedies; gender issues; and time orientation. However, this section will be limited to three main categories: the role of the family in decision-making; attitudes to pregnancy and birth; and managing end-of-life situations, including revealing/withholding a negative diagnosis/prognosis. These are the most frequently emerging topics of cultural challenges in medical anthropology—a field that studies the ways that health and illness are shaped, experienced, and understood within diverse cultural worlds (Goldstein et al., 2002; Kagawa-Singer & Blackhall, 2001).

In her comprehensive analysis of 300 case studies with healthcare providers in the US, Galanti (2015) reports that most nurses in her study responded that the most challenging experience with non-English speaking ethnic groups was their families. One aspect can be reflected in the cultural difference in family relationships. For example, in some Asian cultures, the eldest son generally lives with his parents until they die, rather than that they live on their own (p. 118). Even though such traditional cultural norms of an adult son living with his parents have mostly disappeared in contemporary Korean society, some Korean migrants in Australia still adhere to the traditional Korean cultural norms. Based on a research

project conducted by the City of Sydney in partnership with the Korean Women's Association, Korean migrants in Australia tended to maintain traditional Korean cultural values due to lack of opportunities to experience different cultures, including Australian, mainly due to linguistic barriers (Ng & Shim, 2011). Thus, for the reason of filial piety, traditionally, elderly parents live with their adult children and are looked after by them, rather than being moved to nursing homes or palliative care facilities. Based on two case studies of patients with terminal illnesses, Kagawa-Singer and Blackhall (2001) illustrate the reluctance of a Chinese–American family who lived in Hawaii to send the elderly patient to hospice care due to issues of filial responsibility; there was an expectation that adult children, especially male children, must care for their parents (p. 2998). The authors argue that this antipathy towards hospice care facilities demonstrated in the Chinese–American group can be observed more often in collectivist cultures in which judgement from outsiders and saving face are paramount, which is in line with Hofstede's view on cultural dimensions. However, as explored in Section 2.2.2, Hofstede's cultural dimensions are outdated, and attitudes towards filial piety evolve in a modern society. Another aspect can relate to the role of the family in decision-making, which then can be relevant to the issue of protective families who try to withhold negative diagnoses from the patient, as will be discussed below in the end-of-life situation section. In some cultures, including Asian, males are traditionally the authority figures who have the decision-making role in terms of treatment options for the patient. In such cultures, age also plays an important role in allocating the main decision-maker in a family. However, most importantly, some cultures see the family, rather than the individual, as the primary unit, and family interdependence is held in higher regard than independence of the individual (Galanti, 2015, p. 111). This means that some families can only make medical decisions after an extensive consultation among family members. Similarly, the so-

called Western medical culture has been gradually changing, especially in terms of patient autonomy. Even though providing all the necessary information to the patients and giving the patient the right to make decisions about treatment are considered morally and legally obligatory in modern medical ethics, the way of engaging patients in the healthcare decision-making process has been slowly changing from one of sole patient autonomy to shared decision-making in many Western countries, including Australia (Butow et al., 1997, p. 325). When reviewing physicians' perceptions of ethical aspects of truth telling, Gold (2004) explains the changes in modern Western medical culture as follows:

> One hundred years ago, treatment options were limited and the physician exercised his judgement to determine which course of action would be likely to produce the best outcome for the individual. … Medical information has become increasingly complex and specialists draw on a vast amount of training and experience to arrive at a decision or recommendation. Clearly, it is impossible to provide the patient/relative with knowledge equivalent to that of the doctor, and in many cases this would be incomprehensible. Thus, some guidance is necessary. … Indeed, some might argue that leaving complex decision-making entirely in the hands of the patient is an abdication of the doctors' responsibilities. (Gold, 2004, pp. 578–579)

This view reflects a fundamental shift from an assumption of patients' autonomous clinical decision-making in Western medical cultures compared to the one of family-oriented decision-making in Eastern medical cultures, to a shared decision-making among patients, family members and healthcare professionals regardless of cultural background. Moreover, considering that subcultures must be taken into consideration when investigating the relationship between language and culture in the workplace, the above remarks by Gold (2004) are worth referring to since the medical culture also contributes to the interactions in

the health setting, as well as patients' cultures and healthcare professionals' individual cultures.

The second category of cultural beliefs in relation to health reviewed in this section is traditional attitudes to pregnancy and birth, including diverse beliefs regarding the so-called pregnancy taboos. They include what to do and not to do during pregnancy, and what to eat and not to eat. Lay people from many Asian cultures such as Chinese, Japanese, and Korean believe that the cause of sickness is related to a balance between the hot and cold systems (Abbato, 2011; Galanti, 2015). Since pregnancy is generally considered a 'hot' condition, pregnant women are traditionally encouraged to have 'cold' foods, whereas they are to have 'hot' foods, such as soups and teas, after giving birth (Galanti, 2015). The traditional practice of the postpartum lying-in period is another example. In some Asian cultures, after a woman gives birth she is encouraged to avoid both showers and exercise for a certain period. This can vary in duration; however, this traditional practice often causes trouble in the Western healthcare system in which exercise and showers for new mothers are promoted for reasons of health and hygiene (Abbato, 2011; Crezee, 2013; Galanti, 2015; Queensland Health, 2013). As an example from anecdotal accounts, a new mother, who has emigrated from Korea and given birth in Australia, may refuse to have a shower, and a nurse may have difficulties understanding such a situation without an explanation. The traditional practice of the postpartum lying-in period is, however, less problematic today than it might have been in the past, since younger generations vary in their adherence to such customs.

Among all the aspects of cultural beliefs in relation to health mentioned above, end-of-life situations can be the most complicated and challenging since cultural traditions can vary significantly on various issues. The most frequent topic of discussion in a cancer-related or any other terminal illness–related situation is whether to reveal or to withhold from

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patients, a negative diagnosis and prognosis, which also relates to the topic of patient autonomy. Based on two case studies of patients with terminal illnesses, Kagawa-Singer and Blackhall (2001) reviewed intercultural challenges in end-of-life situations, specifically an African-American elderly couple in the United States, and Chinese American elderly parents with terminal illnesses and their adult children in Hawaii. In this study, in the case of the Chinese American patients, an adult daughter of parents with extended illnesses was interviewed after both her parents had passed away. Even though the interviewee and both parents were born and raised in Hawaii, she expressed her firm belief that she needed to withhold information about the diagnosis and prognosis of terminal illnesses from her parents. The reasoning for this belief was that truth-telling would make her parents lose hope and suffer emotional distress (p. 2997). She also believed that her involvement in decision-making as part of her parents' medical process was a way to express her love and support by taking the decision-making burden upon herself. In terms of the filial responsibility, she considered that sending her parents to a hospice where care is provided by outsiders would dishonour the parents by sending the message to the relatives and the community that she had failed in her role as the caretaker and was unable to provide adequate care (Kagawa-Singer & Blackhall, 2001, p. 2999). Although these findings were from an interview with only one participant, it can be argued that they represent some of the cultural challenges of end-of-life situations. A similar pattern emerges in studies of the healthcare professionals' communicative patterns. For example, Parsons et al. (2007) identified differences between US and Japanese healthcare professionals' communicative patterns regarding cancer diagnoses in children. Although medical practices in both the US and Japan are based on a Western-style practice, and the rationale behind telling or not telling the children about their illness would be different than that of telling or not telling adult and elderly patients, only

9.5% of Japanese physicians reported that they always tell children about their cancer diagnoses, while 65% of US physicians reported the same (p. 63). Cho (2021, p. 60) argues that how to communicate in end-of-life situations is seen to be "predominantly a doctor's decision". Based on interviews with 50 professional interpreters in Australia and 55 interpreters from other countries, Cho asserts that, within the power structures between migrant patients and healthcare professionals in medical settings, in some cases, doctors can be sensitive and willing to accommodate the specific needs of patients. However, in others, doctors "believe in the benefit of telling the truth as it is and require strict accuracy from interpreters" (Cho, 2021, p. 60). Although we need to acknowledge the existence of migrant cultures, it is also worth noting that the extent of cultural adaptation by migrants in the mainstream culture can vary depending on factors such as years of residence in the mainstream country and degree of exposure to the mainstream culture.

Various cultural beliefs and their influence on communication in healthcare provision have been explored so far. However, as we can see from the literature, such cultural beliefs are slowly changing, and not all members of the same culture would make the same choices. For example, people from any culture, including Anglo-American or Anglo-Australian, may choose not to know the negative diagnosis. Goldstein et al. (2002) conducted focus group discussions and individual face-to-face interviews with first-generation Greek migrants residing in Australia to identify the perceptions of Greek migrant cancer patients. Out of a total of 58 participants, half were over and half under the age of 60 years, and most participants had lived in Australia for more than 20 years. Many participants believed that cancer is an incurable disease that unvaryingly leads to death. This concept of the incurability of cancer was found in all participants and did not appear to be influenced by the gender, age, or acculturation level of the participants. This shared concept was reported by the participants

to be linked to the stigma attached to a cancer diagnosis in the Greek-Australian community, so they avoided telling others their cancer diagnoses. However, inconsistencies emerged in the attitudes of the participants towards their desire to know the diagnosis and prognosis of their cancer. Greek-Australian cancer patients showed inconsistencies in how they accept a cancer diagnosis and whether they would like to be informed about their cancer diagnosis and the prognosis. Some believed that patients should be informed about their cancer diagnosis and prognosis so that they can make medical decisions independently. Others considered that information about a poor prognosis will worsen the patients' condition (Goldstein et al., 2002, p. 292).

Having discussed the literature about how communication is influenced by varied cultural beliefs among participants in healthcare settings, the next section of this chapter addresses the challenges of healthcare interpreters in these contexts, their strategies in dealing with such challenges, users' perceptions on the interpreters' strategies, and their role in intercultural communication.

2.4 Interpreters' challenges in intercultural communication and strategies to overcome them

As explored above, when patients and healthcare professionals have different cultural backgrounds, communication in medical encounters may encounter challenges and even communication breakdown, and the ultimate medical goal may not be achieved. Although linguistic barriers can be accurately dealt with, competent interpreters still face challenges due to cultural differences and ethical dilemmas. Challenges can be exacerbated when family members or other participants are present during interpreter-mediated interactions. The presence of family members or other participants can cause a constant change in the

participants' dynamics, and there can be direct communications either with healthcare professionals in English or with patients in languages other than English (LOTE) (Hsieh, 2016). If there is no pre-arranged mutual agreement among all participants, interpreters are faced with finding the most appropriate way to manage such situations. Interpreters' behaviours and strategies when facing challenges in healthcare interpreting have been observed in previous interpreting studies (Angelelli, 2004; Hsieh, 2016) and will be discussed in the next section.

2.4.1 The role of interpreter in intercultural communication

The notion of 'role' in general has been defined by Pöchhacker (2004, p. 147) as "a relational concept defined by sociologists as a set of more or less normative behavioural expectations associated with a social position". Thus, it is crucial to understand the role of interpreters as professionals in community-based settings, including healthcare encounters, to understand a set of normative behavioural expectations of interpreters and to explore intercultural communication in healthcare settings. In community interpreting studies, the interpreter's role is one of the most researched areas, and there has been a debate about what constitutes the interpreter's role, including whether interpreters should act as helpers, advisors, cultural brokers, or fulfil other functions as part of their professional role. The issue of dealing with intercultural differences in community interpreting was one of the main topics in the first Critical Link conference in Toronto in 1995, which was the first international conference on community interpreting (Carr et al., 1997). In Canada, community interpreting was labelled 'cultural interpreting', and explaining cultural differences and misunderstandings to the other parties is described as the roles and responsibilities of the 'cultural interpreter' (Carr et al., 1997, p. 26). As the professionalisation of interpreting

became a research interest in the course of the twentieth century, the issue of the interpreter's role became an integral part of studies on dialogue interpreting (Pöchhacker, 2004), in which interpreters are actively involved in the interaction (Roy, 1993) and relay and coordinate turns at talking in a social context (Wadensjö, 1993).

Roy (2002) examines the history of the changing descriptions of the interpreter's role. Although the review is mostly based on sign language interpreting, it is equally applicable to spoken-language interpreting. Roy's four main metaphorical descriptions range from an extreme personal involvement to a not-so-extreme, non-involvement of the interpreter: interpreters as helpers; professionalism and the emergence of the conduit description; interpreters as communication-facilitators; and interpreters as bilingual, bicultural specialists. Before the 1960s, there was no distinction between a helper and an interpreter since family members and friends interpreted for people who could not communicate in the majority language (Roy, 2002, p. 349). For that reason, they were free to give advice and make decisions for others. Roy asserts that the professionalisation of the interpreting profession led to the conduit metaphor, since the conduit idea was useful for a disassociation from the helper view. Subsequently, however, conflicts arose with the extreme conduit view, and a less radical description of the role of the interpreter was proposed, which was that of the role of a communication facilitator: "Based on theoretical notions provided by the field of communication … [the interpreter] now became a language and communication-mode expert" (Roy, 2002, p. 350).

One of the most important discussions on intercultural communication in community interpreting includes whether the interpreter plays the role of cultural broker or not. Such discussion has revealed dissenting views, and various further descriptions of the role of the interpreter have been developed. Opposing views on the role of the healthcare interpreter as

a cultural broker are presented in extreme comparisons: machine versus human (Spencer-Oatey & Xing, 2007), visible versus invisible (Angelelli, 2004), or emotionless and uncaring conduit versus overt advocate (Dysart-Gale, 2005; Hsieh, 2008). However, Hale (2007) argues that "dichotomies such as 'visible' versus 'invisible', 'machine' versus 'human' or 'involved' versus 'uninvolved' do not adequately capture the complexity of the interpreter's tasks" (p. 41). Bolden (2000) identifies two distinct types of interpreter interaction—one is the 'directly interpreted interaction', and the other is the 'mediated interaction':

> In the first situation, the interpreter directly interprets what has been said in the previous turn by one of the participants. The doctor and the patient primarily address each other rather than the interpreter. Second, the interaction may take the shape of two interweaving but separate conversations, one between the doctor and patient, and the other between the interpreter and the patient. In this case, the interpreter acts as an independent participant in each interaction, mediating the conversation instead of directly translating what has been said. As a result, rather than communicating directly with each other, the doctor and the patient interact mainly with the interpreter. (Bolden, 2000, p. 391)

Researchers who favour the mediated approach argue that the interpreter is an active contributor to the communication process who is given responsibility in identifying cultural barriers and the resolution of cultural differences (Kaufert & Koolage, 1984). In particular, some argue that objectivity or impartiality is not desirable for healthcare interpreters (Angelelli, 2004).

The healthcare interpreter's visibility was explored by Angelelli (2004) with an ethnographic study of over 300 observations, as well as interviews with interpreters. She asserts that the interpreters become visible co-participants when bridging cultural gaps.

Interviews have shown that when participants in her study were asked to describe the role of the healthcare interpreter, it was defined as that of "detectives" who go in search of an answer and help the patient discover it (p. 129), "multi-purpose bridges" to navigate both cultural perspectives (p. 130), "diamond connoisseurs" to know how to tell the diamonds from the ordinary stones in the same bag, and "diggers" to dig and extract the necessary information (p. 131). Angelelli argues that the role of the healthcare interpreter needs to be examined differently from conference, court, or other community interpreters, since the nature and the goals of the interaction are contextualised by the setting. Conversely, Angelelli admits that the interpreters in her study impeded the participants in building a trusting relationship between patients and healthcare professionals by deliberately changing, omitting, or adding to the original utterances of either patients or healthcare professionals. For example, one interpreter always added closing lines expressing solidarity to patients by wishing them good health; it was done in order to adhere to cultural norms in closings of meetings by being polite to patients who might otherwise feel offended due to Hispanic cultural norms: "hope you have a good day; hope everything is fine; hope you get better; good luck to you" (Angelelli, 2004, p. 83). Such additions in the interpretation were not given by the doctors but were created by the interpreter based on their assumptions and their impression of the patient during the consultation. The same interpreter claimed, during the post-encounter interview, that such behaviour was meant to bridge the cultural gap. However, the patient's culture could not be assumed to be the same as the interpreter's individual culture. Similarly, in another example in Angelelli's (2004) study, one interpreter deliberately omitted the patient's story, which the interpreter believed was irrelevant to the consultation, to save the doctor's time. The reason behind this behaviour was that, according to the interpreter, contextual information tends to be explained before a straight answer for a question in the patient's

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culture, and the interpreter decided which information was relevant. The behaviours of the interpreters in Angelelli's study resemble the behaviours of the early helpers who acted as ad hoc interpreters, as described by Roy (2002). It is also important to note that the interpreters in Angelelli's study had not received any interpreting training. Commenting on Angelelli's visible interpreter's role in healthcare settings, Hale (2007) points out that the interpreters in Angelelli's study did not show any evidence of "communicating cultural gaps, affect nuances, establishing trust between parties, facilitating mutual respect, putting the parties at ease or creating more balance in the interaction" (p. 49). As discussed in 2.4.2, examples from Angelelli's study showed interpreters' ethical challenges rather than cultural ones, and others showed interpreters' strategies to deal with cultural challenges, but their understanding of culture is based on generalised views of nation-based culture, which is not valid in interpreting studies (see 2.4.2 for more detail).

Some researchers suggest a comprehensive approach to the interpreter's role, where the role of the interpreter lies on a continuum from 'language interpreter' to 'advocate' (Avery, 2001; Kaufert & Koolage, 1984). In response to the emerging debate on the role of the healthcare interpreter, the National Council on Interpretation in Health Care (NCIHC) was established in 1998 in the United States and Canada. The Council held six working group meetings between 1994 and 2001 and published a working paper titled *The role of the health care interpreter* (Avery, 2001). Rather than adopting the early dichotomy of neutral interpretation roles versus varied responsibilities in healthcare settings, a continuum from conduit to community embeddedness (p. 5) was introduced. The 'cultural broker' was defined as a role whereby "the interpreter provides a necessary cultural framework for understanding the message being interpreted", and the 'patient advocate' was defined as a role in which "the interpreter acts outside the bounds of an interpreted interview on behalf of

the patient" (p. 9). Regarding the role of the healthcare interpreter as cultural broker, the working group agreed that "there are times when, because of the cultural distance between the parties, the interpreter may have to serve as a cultural bridge" (p. 12). However, they argue that debate continues over "what are the ethical implications when the mandate for completeness conflicts with deeply held cultural values and beliefs of the patients" (p. 13). It may not be possible for interpreters to know exactly what the cultural differences are between patients and healthcare professionals, and interpreters' cultural understanding of each participant can still be subjective (Crezee, 2013; Katan & Taibi, 2021). For healthcare professionals to be aware of possible cultural differences, Tebble (1998) suggests that healthcare professionals need to have a briefing to discuss cultural issues with interpreters.

Although the role of the healthcare interpreter has been a central topic since community interpreting attracted academic attention, little is said about the consequences of each role described above (Hale, 2007, p. 43). Hsieh (2007) is one exception. In her major study, she discusses the consequences of the interpreters' behaviours during healthcare encounters, while defining various roles of the healthcare interpreters. Through participant observations with two Mandarin interpreters in 12 medical encounters and interviews with 26 interpreters of 16 languages conducted in the United States, Hsieh (2007) describes the interpreters' role as a 'co-diagnostician'. Hsieh identifies five behaviours of interpreters as co-diagnosticians:

1. assuming the provider's communicative goals (e.g., the interpreter initiates information re-seeking on behalf of the provider when the patient's answer is deemed incomplete);
2. editorialising information for medical emphasis, in which interpreters decide whether certain information provided by patients has medical value or not;

3. initiating information-seeking behaviours (e.g., in one case in the study, the interpreter initiates a question to obtain more detailed information for diagnostic purposes);

4. participating in diagnostic tasks (e.g., in one case, the interpreter points out a symptomatic area—rash on the knees— hat the provider failed to comment on);

5. volunteering medical information to the patients and providing emotional support outside the medical encounter, even though the interpreter understands such behaviours are not expected from their code of ethics (p. 926).

The researcher observed that the different roles led to ethical breaches and negative consequences; for example, interpreters displayed co-diagnostician behaviours outside as well as during medical encounters. One interpreter provided extra information and advice that had not been given by the healthcare professional during the medical encounter (p. 934). The interpreter from the example introduced a new treatment option that was not mentioned by the provider. The interpreter later clarified during an interview with the researcher that the interpreter independently provided, verified, and confirmed information for the patient to save the provider's time. However, the author expresses her concerns that these co-diagnostician behaviours can be risky, as interpreters are not medical experts, and patients do not have the ability to evaluate the quality of the information provided by interpreters. This can have a disruptive influence on the patient–doctor relationship (Hsieh, 2008, p. 1382). Similarly, Tebble (2012) also argues that the interpreter can interfere rather than facilitate communication by summing up, offering advice, doing any of the work of the medical nursing staff, speaking on behalf of the patient, or talking about either client during the consultation without letting them know immediately what was said about them (p. 37).

Moreover, some researchers (Felberg & Skaaden, 2012; Hale, 2013) disagree with those who ascribe any communication problem to culture. They argue that cultural differences are often blamed for any institutional complications or incompetence of the interpreter, or for interpreters' unjustified interferences (Felberg & Skaaden, 2012). Felberg and Skaaden argue that this approach may lead to the 'othering' of minority patients instead of improving doctor–patient relationships (p. 97). According to them, discussing the cultural variability of the patients, without taking into consideration the cultural variability of the interpreters or healthcare professionals, would carry the implicit assumption that minority patients are the only carriers of culture.

As seen above, combined roles and more mediated views of the roles of the healthcare interpreters are detected more often in the literature of the United States and Canada (e.g., Angelelli, 2004; Avery, 2001; Hsieh, 2007; Kaufert & Koolage, 1984) compared to the discussion of the roles of the healthcare interpreter in Australia where it is described in guidelines as presented in Section 2.5.

2.4.2 Interpreters' strategies to deal with cultural challenges

As discussed in Section 1.3.2, healthcare interpreters may encounter ethical dilemmas resulting from cultural differences between patients and healthcare professionals in intercultural communication. Interpreters who participated in previous studies (Angelelli, 2004; Cho, 2021; Hsieh, 2016) adopted various strategies to deal with these challenges: providing additional information, initiating the information-seeking process, deciding on relevant and crucial information and omitting other, and reminding and prompting patients to discuss certain issues. Examples of each behaviour and the interpreters' explanations for their behaviours will be explored in detail.

First, interpreters added pieces of information, mostly when interpreting utterances from healthcare professionals. For example, one interpreter from Angelelli's (2004) study constantly added closing remarks in Spanish for patients by wishing them well. During the post-observation interview, this interpreter argued that patients might feel offended without such closing remarks since greetings and closings are in the norms of their culture (Angelelli, 2004, p. 83). In another case from the same study, the doctor simply asked if the patient had had TB tests before a different interpreter explained what the TB test is (p. 88). The interpreter later claimed that she added the explanation because she assumed that the patient did not understand the medical terminology. She referred "to the patient's level of education, saying that she could tell from the way they speak" (p. 89). Regarding the reason for providing additional information, another interpreter stated that he did this to save time for the healthcare professionals, using medical information from the "experience he gained while working in the paediatric unit and from his experience as a father of three" (p. 91). All three interpreters from the above examples claimed that they faced intercultural communication challenges and their behaviour was based on their understanding of culturally appropriate practices. However, they all made assumptions about the patients' culture based on them sharing the same ethnic background. A general understanding of such assumptions involves a dichotomous national view of culture, as discussed in Section 2.2.1, and subcultures are not taken into consideration.

Secondly, studies show that interpreters at times initiate an information-seeking process to gain health information without being asked by healthcare providers or even without the presence of the provider. For example, one interpreter from Hsieh's (2016) study asked parents additional questions when the doctor was seeking information about their baby's sleeping patterns (p. 257). When a patient said that the baby was awake for one hour

for feeding at night, the interpreter asked a follow-up question–"Once every … . How many times is she awake?"–instead of interpreting the patient's utterance. Another interpreter from the same study initiated a conversation with the patient to find out more information when the doctor left the room (p. 259). The interpreter asked the patient for symptoms and the official diagnosis, which looked like a medical history-taking session that would have happened between a doctor and a patient. The author argues that the interpreter's actions can be explained as purposeful behaviours to facilitate later interpretation. When interpreters seek information from the patient without the presence of the healthcare professional, the author argues that it can help "accomplish the communicative goals of having more background knowledge about the medical encounter" (Hsieh, 2016, p. 260). That being said, the author also argues that it would be unethical for interpreters to use information acquired from a private conversation with a patient to add such information during the interpreting. Similarly, it would also be unethical for interpreters to initiate information-seeking without being asked by healthcare providers and to have direct conversations with a patient without interpreting. While the interpreters from Hsieh's (2016) study did not explain why they initiated direct conversation to seek healthcare information, the author justified the interpreters' actions by the interpreters' feeling part of a medical team and acting in order to better control the interpreting sessions.

Like the second of the strategies explored above—that of independent information-seeking—the third strategy adopted by the interpreters in these studies was to editorialise and only deliver information that they believed to be relevant to the medical situation (Angelelli, 2004; Hsieh, 2016). In Angelleli's (2004) study, one interpreter managed the interaction by interrupting the patient and asking the patient to answer the question instead of telling the story (p. 87). The interpreter claimed ownership of the text by saying, "She is not answering

my question, Doctor". The author asserts that the interpreter exercised her power to control the communication by focusing on the medical information, ignoring the story, reprimanding the patient, and instructing the patient to answer the question directly. The author added that overlapping speech is common in Spanish-speaking interactions, and telling the story instead of providing direct answers to questions is common among Spanish patients. Such generalised views of nation-based culture can be too static and inaccurate in the context of interpreting studies, as discussed in Section 2.2.2. In fact, the behaviours of the interpreters from the above-mentioned examples need to be explained by ethical challenges, and not cultural ones.

Lastly, interpreters at times remind patients and prompt them to initiate a discussion with healthcare professionals. In Hsieh's (2016) study, one interpreter reminded the patient to ask the doctor a certain question based on information acquired from a previous conversation with a nurse, not the current provider (p. 246). During interviews from the same study, several interpreters noted that they direct the question to the patient first instead of asking questions of the healthcare professionals on behalf of the patient; they explain it by wanting to empower the patient by providing them control over the doctor-patient interactions. The interpreters point to cultural difference to justify their behaviours: "Patients from a different culture and/or society may not be familiar with the kinds of services available, their rights as patients, or the appropriate norms of provider-patient interaction" (Hsieh, 2016, p. 248). However, interpreters should also bear in mind that their understanding of patients' cultures may also be subjective (Katan & Taibi, 2021, p. 358) and that the patient does not necessarily share the same culture as the interpreter or others from the same ethnic background (Crezee, 2013). Interpreters in these studies seem to base their judgements on

the assumptions they make about the patients' culture and seem to ignore the interpreters' professional ethical principles.

With reference to interpreters' professional ethics, the aforementioned examples show that interpreters' interventions in the healthcare-professional/patient interaction were not at all times consistent with the interpreter's role; their actions were not always appropriate and were likely to have had a disruptive influence on the interpreter-mediated medical encounters even though their original intention was to help healthcare professionals by saving time or to help patients by empowering them. Furthermore, in most cases, the challenges were related to the interpreter's role and professional ethics and were not of a cultural nature. However, in cases where challenges were cultural in origin, the authors and the interpreters from these studies seem to have adopted a generalised, monolithic, and static definition of nation-based culture (see 2.2.1 for more detail). That is, interpreters from the literature (Angelelli, 2004; Hsieh, 2016) have form a subjective and generalised understanding of patients' cultures. In fact, interpreting service users from Hsieh's study (2016) expressed their concerns about interpreters' behaviours in dealing with intercultural communication challenges, which will be explored in the next section.

2.4.3 Interpretation users' perceptions of how interpreters deal with challenges

To gain the perceptions of service providers and LOTE patients of how community interpreters deal with intercultural challenges, interviews and surveys have been used by various researchers in the interpreting field (Crezee, 2003; Hale, 2013; Kelly, 1998; Lee, 2009a; Mesa, 1998; Pöchhacker, 1998) and the medical field (Butow et al., 2012; Drennan & Swartz, 1999).

A general tendency for including cultural brokerage in the role of community interpreters among interpreters and service providers varies across countries and settings. In the US (Kelly, 1998), Canada (Mesa, 1998), and Europe (Pöchhacker, 1998), more interpreters than service providers regard the provision of cultural information as part of the interpreter's role. A survey was conducted by Kelly (1998) among various legal professionals, including legal interpreters and trainers, judges, prosecutors, defence attorneys, and legislators from Massachusetts and court administrators across the US. The focus of Kelly's questionnaire was to identify the perceptions of each professional group of the interpreters' roles regarding intercultural challenges in the courtroom. Categorisations of intercultural differences included gestures, customs, and socio-economic differences and factors, such as auditory misperception or differences of cultural concepts dealing with time, age, or dates (Kelly, 1998, p. 142). Further explanations or definitions for each categorisation were not provided. An interesting finding from Kelly's (1998) survey was that more than half (57%) of the interpreters considered it was within their role to explain the meaning of culture-specific gestures. On the other hand, legal professionals, including judges and prosecutors, seemed to express some hesitancy about non-verbal communication being conveyed as part of the interpreter's role, and over one-third of judges (35%) and prosecutors (33%) expected that the culturally different meaning of gestures should be included in the interpretation. Although legal professionals agreed on "the possibilities of various gestures to which other cultures assign conflicting meanings" (Kelly, 1998, p. 142), how and when the interpreter should convey the cultural differences of a gesture was not suggested in this survey. None of the legal professionals from her study thought that court interpreters should explain the cultural meaning of gestures.

Pöchhacker's (2000) study was based on quantitative analysis of a survey of 600 service providers in Viennese hospitals, including doctors, nurses, therapists, social workers, and healthcare interpreters. The survey showed that 81% of spoken-language interpreters and 80% of signed-language interpreters agreed that healthcare interpreters should "explain foreign cultural references and meanings", whereas 62% of service providers agreed with such a view. From a survey of almost 500 service users in Canada, including clients, healthcare workers and interpreters, 73% of interpreters believed that explanations about the patient's culture were very important, whereas 61% of healthcare professionals agreed with such a view (Mesa, 1998). The above studies (Kelly, 1998; Mesa, 1998; Pöchhacker, 1998) show that service providers are less amenable to allowing interpreters to explain cultural issues than the interpreters themselves are to providing cultural information, whereas it seems to be the opposite case in Australia (Hale, 2013; Lee, 2009a). A comparison of the above findings with Lee's (2009a) survey results indicates that Australian court interpreters are more reluctant to provide an explanation of the cultural differences than their counterparts in the United States and New Zealand. In a study on court interpreters' roles and quality of interpreting (Lee, 2009a), almost one-third (28%) of legal professionals believed that the cultural meaning of gestures should be explained by legal interpreters. However, only three interpreters (8%) agreed that they should add an explanation to the cultural meaning of gestures.

In another study (Hale, 2013), out of 148 judicial officers and tribunal members, and 138 interpreters, more service providers (87%) than interpreters (55%) considered intervening or alerting the other parties to potential intercultural differences to be part of the role of the interpreter. Based on an online questionnaire, as part of a larger project on intercultural differences in court interpreting in Australia, Hale (2013) asked 138 interpreters

whether they were willing to alert the court or tribunal to potential intercultural misunderstandings and asked 148 judicial officers/tribunal members whether they expected interpreters to alert the court or tribunal to potential intercultural misunderstandings. Just over half of the interpreters (55%) said that they would alert the court or tribunal to potential intercultural misunderstandings, although when and how to alert the court or why they would do so was expressed differently in their comments. On the other hand, most of the legal professionals (87% out of 148 judicial officers and tribunal members) in her study said that they expected interpreters to alert the court or tribunal to potential intercultural misunderstandings.

On the other hand, several healthcare professionals from Hsieh's (2016) study expressed concerns about interpreters' behaviours, including initiating conversation, modifying narratives, or omitting information from either party, believing that such behaviours might infringe upon healthcare professionals' control over the medical dialogue, infringe on patient autonomy, and affect quality and equality of care in the long run, which is in contrast to what interpreters from a different study said: The professional interpreters of 17 languages from Hsieh's study (2008) justify their communicative behaviours by claiming various roles, from conduit, advocate and manager to professional, and state that they manage both the content and the flow of information as communicative strategies (Hsieh, 2008). The author also states that "Although [interpreters] acting on behalf of the patient without the patient's or provider's explicit consent may be efficient in meeting the patient's needs, such strategies may blur the lines between the patient's and the interpreter's agendas and communicative goals" (p. 249). Although some interpreters from the same study justified their enactment of various and shifting roles as maintaining the interactions during the medical encounters, other interpreters expressed concerns about their active involvement in

medical encounters and were hesitant to bridge cultural differences to empower patients. For example, during the observations, some interpreters initiated the conversation and prompted patients about topics to discuss with healthcare professionals, believing that they provided a means of self-advocacy to patients. During the post-observation interview, interpreters argued that their behaviours were shaped by the assumption that patients from a different culture may not be familiar with their rights as patients or the appropriate norms of doctor-patient interaction. However, interpreters also voiced their concerns as to whether their behaviours allowed patients to have full control over the medical encounters or infringed on patient autonomy by not providing patients opportunities to express their own opinions or to initiate conversation. As explored in Section 2.2.1, a general understanding of cultural profiles can be a starting point to understanding other cultures and applying that knowledge to practice in intercultural communication. However, a cultural stereotype based on a nation-based approach developed by interpreters and shaped by their own experiences should be avoided when dealing with cultural challenges between patients and healthcare professionals. In this light, it is now necessary to explore the role of interpreter in intercultural communication.

2.5 Australian standards and guidelines on intercultural healthcare communication

While healthcare interpreters and professionals are expected to follow ethical and professional standards and guidelines, very little guidance exists on how to deal with intercultural differences, including whether the interpreter is expected to alert the other parties to potential cultural differences, such as the role of the family in decision-making; matters of pregnancy and birth; and end-of-life situations, including revealing/withholding a negative diagnosis/prognosis; and how or when to provide explanations on such intercultural

differences (Hale, 2013). In this section, various standards and guidelines on intercultural healthcare communication are reviewed in two different sub-sections: guidelines for healthcare professionals on culturally appropriate practice, and guidelines and policies for healthcare interpreters on intercultural challenges. For the purpose of this thesis, the reviewed literature focuses on Australian settings.

2.5.1 Guidelines for healthcare professionals working with interpreters

In 2007, AUSIT developed guidelines for healthcare professionals working with interpreters to enhance communication with patients (AUSIT, 2007). When explaining the role of healthcare interpreters, the guidelines suggest that healthcare professionals should not ask interpreters to provide information about the patient's culture. They propose that the importance of culture may be over-emphasised at the expense of taking note of the individual characteristics of each patient. When possible, the patient's direct involvement and a further discussion with the appropriate multicultural health unit are further proposed. According to the policy regarding standard procedures for working with healthcare interpreters published by the NSW Health Department (NSW Health, 2017), healthcare professionals are expected to direct culture-related enquiries to patients and their family members. However, this policy requires interpreters to possess a thorough understanding of the cultural differences between patients and healthcare professionals.

Different views about whether interpreters should be seen as a source of information about cultural issues have been explicitly acknowledged in the guidelines developed by the Victorian Transcultural Psychiatry Unit (Minas et al., 2001); however, they highlight the fact that "interpreters are not trained to interpret behaviour although they may be able to comment

on cultural practices" (p. 11). NSW Health (2017) also explains that healthcare professionals should try to avoid cultural stereotyping.

Through clinical practice guidelines for healthcare professionals in Australia for communicating prognoses and on end-of-life issues, healthcare professionals suggest that patients should not be assumed to not want to discuss these topics due to their cultural background (Clayton et al., 2007). Healthcare professionals should give the patient the options of whether or not, and when and how, to discuss the issue (p. S87). The same guidelines suggest that healthcare professionals should be aware of cultural differences, clarifying them with the patient and family members and should not make assumptions about the patient's culture (p. S90). This is in line with the more recent holistic approach of modern Western medical culture discussed in Section 2.2.2.

Stressing the importance of 'cultural competence' in healthcare systems in general, the National Health and Medical Research Council (NHMRC) advises, in the paper-published guide book for policy, partnerships, and participation, that providing culturally appropriate healthcare services to CALD communities is a shared responsibility at a systemic, organisational, professional, and individual level (NHMRC, 2005). The term 'cultural competence' is defined in the guidelines as "much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services" (p. 7). The Australian Psychological Society (2013) also states in its guidelines that to successfully provide culturally appropriate healthcare services, a holistic approach that includes interpreting services is essential. The NHMRC and the Australian Psychological Society both assert that intercultural training for healthcare professionals is needed for cultural competence and culturally safe practices.

Based on research conducted through the Centre for Research and Development in Interpreting and Translating at Deakin University in conjunction with the Monash Medical Centre and the Southern Healthcare Network of Victoria, Tebble (1998) published a book titled *Medical Interpreting – Improving communication with your patients* along with a videotape as a resource for the professional development of healthcare professionals so that healthcare professionals can improve their communication skills with non-English speaking patients when working with healthcare interpreters. Effective strategies for healthcare professionals to adopt at each stage of the encounter, from briefing sessions, greetings, through consultations, to summing up and debriefing sessions, are offered in detail. According to Tebble, healthcare interpreters are better briefed prior to a consultation so that they can make necessary preparations. In the same manner, a debriefing session can be arranged with the interpreter after an interpreted medical consultation either "to seek clarification on any social, cultural religious, historical, political, medical, bureaucratic, financial, language aspects or other points that would enhance your [healthcare professionals] understanding of the consultation and of your patient(s) for future reference" or "to advise the interpreter to seek his or her own debriefing with the hospital counsellors if the interpreted consultation was particularly traumatic" (Tebble, 1998, p. 55). One very important stage that Tebble introduces is called the 'contract', which is a term borrowed from psychology, where healthcare interpreters can explain the ethical boundaries of the interpreter to healthcare professionals, patients, and any others present (Tebble, 1998, p. 27). While highlighting the importance of the contract, Tebble describes that people may have different expectations of the role of the healthcare interpreter even though interpreters in Australia are not expected to be patient advocates. Regarding the way interpreters can deal with cultural differences in healthcare settings, Tebble suggests that healthcare professionals can seek cultural

information from healthcare interpreters during the briefing session before the consultation or the debriefing session after the consultation. She argues that healthcare professionals can "check with the qualified medical interpreter who is a bilingual and bicultural interpreter" (Tebble, 1998, p. 43). Similarly, the guidelines developed by Queensland Health Interpreter Service and AUSIT also recommend using pre-session briefing and after-session debriefing to discuss any intercultural issues with the interpreter (AUSIT, 2007; Queensland Health Interpreter Service, 2007). However, unlike Tebble's early suggestion, these guidelines are more cautious, stating that "interpreters are not cultural experts or cultural brokers" (Queensland Health Interpreter Service, 2007, p. 14) and "all patients have different personalities, temperaments and life experience, and may vary considerably in the way they manifest their cultural background" (AUSIT, 2007, p. 6).

Likewise, in the Competency Standards Framework for Clinicians, published in January 2019 (Migrant and Refugee Women's Health Partnership, 2019), clinicians are advised to acknowledge and understand the diversity between and within cultures, and to be sensitive of the impact of their own cultural values and beliefs on healthcare services. A possible risk of making cultural assumptions and stereotyping the patients' cultures, and relevant negative outcomes, is also emphasised. This standards framework, most importantly, highlights individual values, beliefs, and behaviours so that patients are encouraged to achieve an informed and shared decision-making. In Section 2.4.1, the interpreter's role is clearly stated in line with above guidelines, and being bicultural and acting as a health advocate should not be expected by clinicians (Migrant and Refugee Women's Health Partnership, 2019, p. 12).

2.5.2 Guidelines for healthcare professionals and interpreters to deal with cultural issues

In Australia, professional healthcare interpreters are expected to adhere to the Code of Ethics that was established in the early 1990s by AUSIT in conjunction with NAATI for practising interpreters and translators in all settings; over the years it underwent several revisions, with the current version developed in 2012 (AUSIT, 2012). The Code of Ethics has been "generally upheld by professional associations, employing agencies, institutions requiring the services of interpreters and by practising interpreters themselves as the standard to which interpreters should aspire" (Hale, 2007, p. 103). The general principles of the AUSIT Code of Ethics are professional conduct, confidentiality, competence, impartiality, accuracy, clarity of role boundaries, maintaining professional relationships, professional development, and professional solidarity.

In the 2012 AUSIT Code of Ethics, the terms 'culture' or 'cultural' are only mentioned twice:

Professional conduct: Interpreters are committed to providing quality service in a respectful and culturally sensitive manner. (AUSIT, 2012, p. 4)

Professional development: "Interpreters and Translators maintain proficiency in the languages and familiarity with the cultures for which they offer professional interpreting and translation services… . They continually upgrade their language and transfer skills and their contextual and cultural understanding. (AUSIT, 2012, p. 6)

Therefore, only two of the articles in the Code of Ethics make reference to cultural elements, albeit without a detailed description of what 'culture' means in the context. Apart from the articles where the cultural element is explicitly mentioned, in the revised 2012 Code

of Ethics the role boundaries have been clearly provided, stating that 'practitioners do not, in the course of their interpreting or translation duties, engage in other tasks such as advocacy, guidance or advice' (p. 6). According to this principle, the role of cultural informants, cultural mediators, or co-diagnosticians for healthcare interpreters are not acceptable in Australia.

Other organisations have developed their own Codes of Ethics. The NSW HCIS developed guidelines in 1998 to assist healthcare interpreters in making ethical decisions in challenging situations. These guidelines were later revised in 2014. In an explanation of interpreters' challenges during the interpreting assignment, the topic of providing cultural information is discussed in these guidelines, and possible strategies to overcome such challenges are proposed (NSW HCIS PDC, 2014). Although offering insights into cultural aspects is regarded as part of healthcare interpreters' roles, limitations are explicitly outlined. Consistent with the AUSIT Code of Ethics, the role of cultural broker is not considered to be within the scope of that of healthcare interpreter. Healthcare interpreters are asked to offer cultural information at the request of healthcare professionals or when facing communication breakdown due to such cultural differences. Further, the guidelines emphasise the possibilities of variations in cultural practices within subgroups. A suggested phrase that healthcare interpreters can use when requested to provide cultural information is "it is possible that some people who come from this country may have these beliefs … ", rather than "In my culture …" (NSW HCIS PDC, 2014, p. 19). This seems to be cautious and practical advice, considering the complex nature of cultural traits, which also recognises that interpreters cannot assume that they share the same culture as patients or fully understand a patient's individual culture.

In a similar way, in the guidelines for the healthcare professionals as described in 2.5.1, the guidelines for healthcare interpreters also highlight that interpreters are not

expected to bridge cultures, and that healthcare professionals should be cautious and avoid stereotyping about the patient's culture. Healthcare professionals are "encouraged to ask patients direct questions regarding any matters that they view as needing clarification, thus enabling patients to provide the information relevant to them as unique individuals" (NSW HCIS PDC, 2014, p. 18). According to these guidelines, the healthcare interpreters are the ones who empower the patients rather than just act on behalf of the patients, thus "healthcare interpreters are aware of the importance of patient-centred care, enabling the primary parties to communicate directly and to develop rapport" (NSW HCIS PDC, 2014, p. 17). In sum, the healthcare professionals direct any questions to their patients and patients supply their answers, with the interpreter interpreting for both.

Interestingly, however, in the guidelines provided for healthcare interpreters in the 1990s, healthcare interpreters were asked to play a more active role in intercultural situations, which included: providing information to clients about the healthcare system; providing health-related cultural information to healthcare professionals; and helping clients to reduce fears, anxieties, and concerns that may impede effective communication (The Health Care Interpreter Service, 1994). That is to say, interpreters who have practiced for more than 20 years, having entered the profession in the 1990s or earlier, and mostly untrained, were introduced to the guidelines suggesting that interpreters become helpers as part of their role as interpreters. They may also have traditional views of nation-based culture; thus, they would be likely to assume that they share the same culture with patients that have the same ethnic background.

2.6 Conclusion

As mentioned earlier, the main question addressed in this thesis is whether intercultural issues cause interpreting challenges in medical encounters; if so, what constitutes intercultural communication challenges, and how do interpreters deal with them? While research has been conducted on intercultural communication in healthcare settings, the meaning of the multifaceted term 'culture' has been defined, described, and explained differently by different authors, organisations, interpreters, patients, and healthcare professionals. As shown in this chapter, there are discrepancies in the ways scholars, professionals, and lay people conceptualise and use the term 'culture'. Traditional approaches to the notion of culture were developed by Hall (1959, 1976); later Hofstede (1980, 2001) focused on a relatively static and restrictive nature of nation-based dimensions. This static conceptualisation of the term 'culture' and this generalised view of defining culture has been criticised, especially in the fields of sociolinguistics and applied linguistics (Piller, 2011; Spencer-Oatey, 2000), even though Hall's and Hofstede's studies are still used in international business studies where a comparison of more than two different cultures is the main point. In contrast, in more recent studies, researchers focused on a dynamic process and the specific context in which an interaction takes place. A diversity and complexity of the definitions of culture, including a change of cultures over time in one group, within-group variations, and individual traits, started to be taken into consideration, especially in interpreting studies.

It has been shown in more recent works (Butow et al., 2012; Butow, Sze, et al., 2013; Crezee, 2003, 2013; Kagawa-Singer & Blackhall, 2001) that culture has a significant influence on one's attitude to health, which then affects patients' communication with

healthcare professionals. It has been recognised that the ultimate goal of providing optimal care for all patients can be negatively affected by cultural differences between patients and healthcare professionals (Butow et al., 2011; Butow et al., 2012). A growing awareness of intercultural communication challenges in healthcare settings has come both from the perspectives of medical anthropology and of interpreting studies. Since the 1990s when researchers started showing interest in the relationship between patients' ethnic background and medical communication (Souza, 2016), studies have investigated the impact of culture on the behaviours of patients or on the interactions between patients and healthcare professionals so that medical outcomes and the wellbeing of patients can be improved (Angelelli, 2004; Hsieh, 2016). So far, however, researchers have focused predominantly on the diversity of patients' ethnic backgrounds and their perceptions of medical communication. In response to the need for healthcare professionals to become culturally competent, cultural profiles of the patients have been provided by government departments and organisations (Abbato, 2011; Galanti, 2015; Queensland Health, 2013). However, such cultural profiles should not be used as a stereotype, but rather as a starting point to the understanding of other cultures. It is also worthwhile noting that some aspects in the cultural profiles are gradually changing, as reviewed in Section 2.2.2. To achieve better healthcare outcomes, healthcare professionals must become informed in cultural aspects so that they can become culturally competent and sensitive and achieve better outcomes.

When the communication breakdown occurs in medical encounters between patients and healthcare professionals because of cultural differences, interpreters can face challenges in making a professional judgement. While the challenges may be of a cultural nature, several studies (Angelelli, 2004; Cho, 2021; Hsieh, 2016) show that interpreters adopt various strategies that are related to professional ethics: they provide additional information, initiate

an information-seeking process, decide what information is relevant and crucial and omit what is not, and remind and prompt patients to discuss certain issues—these strategies show that interpreters go beyond their interpreting role. Most interpreters from the aforementioned studies are shown to have assumed the patients' cultures based on a generalised, monolithic, and static definition of nation-based culture. Furthermore, in some cases, interpreters have demonstrated unprofessional and unethical behaviours as strategies to deal with cultural differences, real or perceived, including adding or omitting information, initiating conversations with the patient, and acting on behalf of the patients or doctors (Angelelli, 2004; Hsieh, 2016). Ultimately, interpreters' interventions are not always appropriate and have a disruptive influence on the interpreter-mediated medical encounters even though their original intention was to help healthcare professionals by saving them time or to help patients by empowering them. Some interpreters and healthcare professionals, however, expressed concerns about such interventions and strategies adopted by interpreters in dealing with cultural challenges (Hsieh, 2016). Interpreters and healthcare professionals from Hsieh's study voiced concerns that such behaviours of interpreters might infringe on healthcare professionals' control over the medical dialogue, infringe on patient autonomy, and negatively affect the quality and equality of care in the long run.

In Australia, as of 2021, healthcare professionals are provided with standards and guidelines on how to work with interpreters and how to communicate with CALD patients. However, there remains little guidance on how to deal with cross-cultural differences. The importance of 'cultural competence' within healthcare systems and 'cultural awareness and sensitivity' of healthcare professionals has been acknowledged in the standards and guidelines for healthcare professionals (Abbato, 2011; Australian Psychological Society, 2013; Migrant and Refugee Women's Health Partnership, 2019; NHMRC, 2005). In

addition, healthcare professionals are encouraged to clarify cross-cultural differences with the patient rather than to ask interpreters to provide information on the patient's culture. Likewise, guidelines and policies, including the AUSIT Code of Ethics (2012) and NSW HCIS Guidelines for interpreters (2014), have been available for healthcare interpreters to inform their professional judgement on what to do when facing cultural difficulties. The AUSIT Code of Ethics has a limited mention of 'culture' and 'cultural differences', and to function as advocate or advisor is not acceptable for healthcare interpreters in Australia. Almost all guidelines and standards in Australia clearly show the importance of the cultural awareness and sensitivity that healthcare professionals must have, and the possible risks for medical outcomes if healthcare professionals carry cultural stereotypes of patients.

Even though guidelines and standards are readily available, and qualification systems for healthcare interpreters are relatively comprehensive in Australia, international debates on the cultural role of healthcare interpreters are ongoing (Angelelli, 2004; Cho, 2021; Dysart-Gale, 2005; Hsieh, 2016; Souza, 2016). How interpreters define the notion of culture and how interpreters perceive their roles varies considerably (Section 2.4.2). The existing studies rely on the self-reported beliefs and practices of interpreters and service providers without verifying whether what they believe to be an actual cross-cultural communication barrier is correct or whether it is related to another issue, such as institutional requirements or interpreter incompetence. Thus, more research is needed to clearly identify and examine cultural challenges faced by interpreters in healthcare settings.

In this light, this thesis aims to fill a gap in the literature—namely, what constitutes cross-cultural differences in healthcare settings and how interpreters approach them in order to interpret faithfully and act ethically. As explained in Section 2.4, previous studies have categorised some themes as intercultural challenges in healthcare settings: communication

issues, including cross-linguistic issues, communication style, and non-verbal communication; and cultural beliefs in relation to health, including family, pregnancy and birth, end-of-life situations, and mental health. However, culture is not a static concept, but changes over time and varies within a group and depending on the context (see Section 2.2.2). Furthermore, previous studies reviewed in this chapter show that interpreters often go against the AUSIT Code of Ethics. Thus, this thesis aims to explore whether in Australian medical encounters, too, intercultural communication issues create significant interpreting challenges and, if so, how interpreters attempt to solve them within the framework of professional ethics.

Another gap in the literature that this thesis addresses relates to methodological limitations. In terms of the interpreter's role in intercultural communication, most studies, especially in Australian settings, are based on interviews with small numbers of interpreters or anecdotal evidence. Since the role of the interpreter needs to be explored in interactions where the interpreted exchange takes place, the research question about intercultural communication and interpreters' challenges would be best addressed using empirical data based on observations, and the triangulation in the data collection and analysis can be employed to improve the objectivity and validity of the data. As Pöchhacker (2004) argues, to assert that communication challenges in healthcare settings are of an intercultural nature, with current conflicting views about the role of the interpreter as broker, detailed descriptions of interpreters' actual performances as empirical evidence are needed.

Using a representative sample of Korean patients in their interpreted interactions with English-speaking doctors, this thesis aims to explore whether communication challenges are intercultural, establish how frequent intercultural communication challenges are, and to describe what they are. The study further aims to explore Korean healthcare interpreters' practices and perceptions of their role as an interpreter, whether there is an agreement among

Korean interpreters on what constitutes cross-cultural differences, whether they need to broker them, and how. Furthermore, the consequences of the interpreter's behaviours in interculturally challenging communication in which Korean patients are involved are also investigated. To answer my research questions, in this thesis, I have used an ethnographic, qualitative methodology as well as a survey, which will be outlined in the next chapter. Based on the results of this study, practical benefits will include a set of recommendations for practical strategies for healthcare interpreters on how to identify cross-cultural issues and how to deal with them to ensure accurate and ethical interpreting.

Chapter 3 Research Methodology

3.1 Introduction

This thesis aims to address two main research questions in healthcare interpreting. The first explores whether intercultural issues are a significant reason for interpreting challenges in interpreter-mediated encounters between Korean-speaking patients and English-speaking healthcare professionals in an Australian setting. The study investigates circumstances where cultural differences challenge healthcare interpreters' compliance with their code of ethics or institutional guidelines. The first part of the thesis thus aims to address the following sub-questions:

- Do intercultural issues pose significant challenges for community interpreters?

- What other challenges are faced by community interpreters?

- How do interpreters act when they face intercultural and other challenges in interpreter-mediated encounters?

The second research question explores the perceptions of interpreters, in other languages as well as Korean, of their roles in bridging gaps in intercultural communication. This includes the interpreters' perceptions of the definition of intercultural communication and cultural differences, of their roles in such situations, and of what strategies to adopt to address intercultural communication difficulties, if any. The second part of the thesis thus aims to address the following relevant sub-questions:

1. How do healthcare interpreters identify and address communication challenges in interpreter-mediated medical encounters?

2. Is there a consensus among interpreters within the same language group on what constitutes intercultural communication challenges?

3. What are their strategies to overcome such challenges, if any?

To answer the above research questions, a mixed methods approach was chosen using both qualitative and quantitative methods to collect and analyse data. Dörnyei (2007) identified several advantages of mixed research methods: increasing the strengths while eliminating the weaknesses, multi-level analysis of complex issues, improved validity, reaching multiple audiences (p. 46), and corroborating findings through 'triangulation'(p. 165). For these reasons, a mixed research methods approach has been widely used in empirical studies of interpreting activity in healthcare settings (e.g., Angelelli, 2004; Hsieh, 2016).

Specifically, this study consists of two components: an ethnographic component, involving participant observations of authentic interpreter-mediated healthcare encounters and post-observation interviews with interpreters (Phases One and Two) and a questionnaire component using an online survey of healthcare interpreters working in Australian settings (Phase Three). Phases One, Two, and Three will be discussed in more detail in Section 3.6.

3.2 Research hypothesis

This research study hypothesises that intercultural communication challenges frequently occur during interpreter-mediated healthcare encounters between Korean-speaking patients and English-speaking healthcare professionals, and that there is a consensus among interpreters with the same language combination on what constitutes intercultural communication challenges. Each chapter in this thesis addresses different research questions as described above, all related to these central issues. Broadly, it is

hypothesised, based on the literature described in Chapter 2, that Korean language interpreters will often face intercultural communication challenges due to cultural differences between Asian cultures and Western cultures.

3.3 Research site

Westmead Hospital was chosen as the setting for Phases One and Two of this study because it is one of the major hospitals in Sydney, and it serves a large population of Korean immigrants. Westmead Hospital is one of the facilities where the Western Sydney Local Health District (WSLHD) provides a range of health services. Health services of WSLHD also cover Auburn, Blacktown, The Hills Shire, Holroyd, and Parramatta Local Government Areas, and the Greater Western Region. According to the 2016 Census (Australian Bureau of Statistics, 2019), 49.5% of the District's residents were born overseas, compared to 27.6% in all NSW, and 52% of the residents spoke a language other than English at home, compared to 25.1% in all of NSW. Between 2011 and 2016 in the City of Parramatta area, where Westmead Hospital is located, people who speak Korean was the second-largest emerging group after the Mandarin-speaking group (Australian Bureau of Statistics, 2019, p. 24).

For Phase Three of this study, an online questionnaire was conducted to gain various perspectives from a wider interpreter population in different languages using the KeySurvey software, a platform hosted by the University of New South Wales (UNSW). That is to say, the observations and the interviews were conducted at Westmead Hospital, and the rest was done online using the UNSW KeySurvey software.

3.4 Ethics approval

The study required ethics approval from two human ethics committees: the University of New South Wales and the hospital ethics committees. The National Ethics Application Form (NEAF) was submitted to the Western Sydney Local Health District Human Research Ethics Committee (WSLHD HREC) along with a master Participant Information and Consent Form (PI&CF) obtained from the NHMRC website. The master PI&CF was without a local institutional letterhead, site investigator's name, or site contact and complaint details. Each site adapted the approved master template for their site,—adding the local letterhead, site investigator's name, and site contact and complaint details—after the HREC final approval had been obtained. The version numbers of master/local document and the dates were inserted into the footer, so that the ethics committee could check whether the approved version of the PI&CF was used for the study.

There were four major steps that had to be undertaken before I could observe medical consultations at Westmead Hospital as an external research student. Firstly, the Scientific Advisory Committee (SAC) had to approve any study for it to be recommended as scientifically sound. Secondly, the approval for the entire multicentre study had to be granted by WSLHD HREC. Thirdly, a separate approval from the Research Governance/Site Specific Assessment (SSA) was needed. Finally, I had to submit an external researcher application to the Research Governance Officer of Westmead Hospital with an intent to conduct a research project at Westmead Hospital. It took approximately three months for each step to be completed, which meant the complete process of getting ethics approval took approximately thirteen months. Another reason for this slow process was my PhD enrolment status being part-time.

Firstly, a staff member of Westmead Hospital needed to be designated to act as a principal investigator for Phase One of the study, before preparing the ethics application, since I was an external student. This principal investigator had to be someone other than myself or either of my UNSW supervisors. I contacted the Department Head of the HCIS to seek advice on finding a principal investigator from the HCIS, who was employed by the Local Health District (LHD). A principal investigator for medical research should be a senior clinician with research experience. However, a senior clinician was not eligible to be a principal investigator for this study since this was not medical research. The role of the principal investigator in this study was to liaise between WSLHD and me, and to facilitate access to the research sites. With the help of the Department Head of the HCIS and the senior ethics officer at WSLHD Research and Education Network Research Office, the Translation Service Manager agreed to be the principal investigator for Phase One of this study. The HREC ethics application was submitted on the NHMRC website, along with PI&CFs, online questionnaires, and the research proposal. According to the guidelines, all documents had to be submitted in hard-copy format. Twenty-one copies of each document were printed, signed, and submitted to the HREC.

After receiving the ethics approval from WSLHD HREC for a multicentre study, a separate process of Research Governance/SSA clearance was commenced. Four different types of PI&CFs for the participants of observations were used, including for Korean-speaking patients (one in English and the other in Korean), English-speaking healthcare professionals, and interpreters. As a NAATI-accredited translator between English and Korean, I translated the PI&CF into Korean for the patients or family members of patients who could not speak English.

To conduct this study at Westmead Hospital as an external research student, I had to submit an application form to become a casual member of the hospital staff. This process was rather complex, since supporting documents included an identification checklist, a vaccination record, serology test results, a TB screening test, and a police criminal record check. It took approximately three months to complete this process.

As mentioned earlier, the overall duration for obtaining the ethics approval was approximately thirteen months. Based on the recommendation of the National Statement to avoid duplication of ethics review, the UNSW Ethics Committee granted ethics clearance based on the ethics approval reviewed by WSLHD HREC.

3.5 Participants

Three participant groups—healthcare professionals, Korean-speaking patients and their accompanying family members, and healthcare interpreters—were involved in Phases One and Two of this study (the observations of the interpreted consultations and the follow-up semi-structured interviews with interpreters). Although three out of 20 cases were conducted with sessional interpreters and one case with one full-time interpreter, most of the cases in the observation phase involved two full-time interpreters who normally practice at Westmead Hospital. Five interpreters agreed to participate in Phases One and Two of this study. Almost all the observation cases took place in different clinics at Westmead Hospital.

In the following section, the characteristics of the healthcare professionals, patients, and interpreters who participated in this phase of the study will be described.

3.5.1 Healthcare professionals

The inclusion of the healthcare professionals in the study depended on the pre-existing bookings for the interpreters who had agreed to participate. Thus, there were no sampling criteria of this participant group for this study. The only requirement was that they had to have agreed to participate in the study prior to the consultations. A total of 19 healthcare professionals participated in 20 observations, and one of them was involved in two different cases. The healthcare areas varied, and professionals included oncologists, a geriatrician, a gynaecologist, dentists, radiologists, nurses, midwives, and a medical student. Demographic characteristics of the participating healthcare professionals were not collected for this study, as no such information is available in the hospital. However, according to the Australian Institute of Health and Welfare (2018), the number of healthcare professionals born overseas who work in Australia has increased in recent years. Based on the 2016 Census data provided by the Australian Bureau of Statistics, a substantial part of the healthcare workforce in Australia is formed of migrant and/or overseas-trained health workers. For example, "in 2016, 33% of healthcare professionals employed in Australia received their initial qualification overseas" (p. 3).

Even though the demographic characteristics of the participating healthcare professionals were not collected in this study, the diversity of their ethnic backgrounds observed throughout the data collection process was in line with the census statistics, and many spoke with different non Anglo-Australian accents. In nine out of 20 cases, healthcare professionals seemed to have Asian backgrounds and spoke with some degree of a foreign accent.

3.5.2 Patients

The relevant characteristics of this participant group is that they were Korean patients who needed interpreters for the benefit of communication with healthcare professionals during the medical consultations. The inclusion of patients, in the same manner as for healthcare professionals, depended on the bookings that had been made for the interpreters who had agreed to participate in this study. Thus, there were no sampling criteria for this participant group either. The only requirement was that the patients had to agree to participate in the study prior to the consultations. Of the 20 observations, three cases included patients under the age of 18, and both parents of each of those patients attended the clinic with them. In addition to these three cases, ten cases included other family members, who were involved in the consultation in many ways. The categories of the family members included the patients' adult children, a daughter-in-law, and a spouse. Demographic characteristics of the participating patients were not collected for this study. In five out of 20 cases, elderly patients attended on their own or with their adult children.

3.5.3 Healthcare interpreters

The criteria for the selection of interpreters were that they needed to be Korean language interpreters who work in the healthcare setting, specifically in the WSLHD where the research site was located. Since I am a native Korean speaker and a Korean translator and interpreter, I can understand both English and Korean and can take notes for the purpose of collection and analysis of the data. Recordings of the consultations were not permitted.

The WSLHD HCIS had six full-time and 11 sessional interpreters in the Korean language group at the time of data collection; they worked at different sites, including Auburn

Hospital, Cumberland Hospital, Blacktown/Mount Druitt Hospital, and Westmead Hospital. Although the two full-time Korean interpreters mainly practice at Westmead Hospital, other full-time interpreters or sessional interpreters attend when needed. A total of five interpreters (three full-time and two sessional) agreed to participate in a semi-structured interview about their experiences in healthcare interpreting. They were all born in South Korea and are native Korean speakers. Only one sessional interpreter had studied interpreting at university level and had a master's degree, while the three full-time interpreters and one sessional interpreter had completed a short course of one semester at TAFE and had a diploma. All three full-time interpreters had more than thirty years of residence in Australia, and between 16 and 25 years of practice as interpreters. All five participants were female and had NAATI accreditation at Paraprofessional level[2] (for a full description of the NAATI accreditation levels and a certification system change, see Chapter 1) in interpreting in both language directions. Demographic characteristics of the participating interpreters can be found in Table 3-1 below.

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[2] Paraprofessional Interpreter (formerly known as Level 2): Prior to 2018, this represented a level of competence in interpreting for the purpose of general conversations. Paraprofessional interpreters generally undertook the interpretation of non-specialist dialogues with short utterances (up to 21 words). Practitioners at this level were encouraged to obtain Professional Level accreditation.

Table 3-1

Demographic Characteristics of the Participating Interpreters

Number	Status	Gender	Years of residence in Australia	Years of practice	Education level	NAATI level
1	Full-time staff	Female	> 30	16	TAFE Diploma	Para-professional
2	Full-time staff	Female	35	25	TAFE Diploma	Para-professional
3	Full-time staff	Female	32	16	TAFE Diploma	Para-professional
4	Casual staff	Female	20	4	TAFE Diploma	Para-professional
5	Casual staff	Female	18	15	MA	Para-professional

According to a comprehensive outline of the different levels of NAATI accreditation (National Accreditation Authority for Translators and Interpreters, 2010), Professional level[3] is the minimum level which is recommended by NAATI for work in healthcare settings, and Paraprofessional interpreters were encouraged to obtain Professional Interpreter level accreditation. However, all three full-time interpreters participating in my study had been practising in the healthcare setting for more than 16 years with their Paraprofessional interpreter accreditation at the time of data collection.

For a detailed description of the participants, see Chapter 4 for the healthcare professionals and Korean patients, Chapter 5 for the Korean/English interpreters of the follow-up interviews, and Chapter 6 for the interpreters in different languages of the online questionnaire.

3.6 Data collection

3.6.1 Recruitment of participants

Once ethics approval was granted, I arranged an initial meeting with the translation service manager and three coordinators who arranged the schedules of the healthcare interpreters at HCIS. During this meeting on 6 November 2014, I gave a presentation about

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[3] Professional Interpreter (formerly known as Level 3): This used to represent the minimum level of competence for professional interpreting and was the minimum level recommended by NAATI for work in most community settings, including banking, law, health, as well as social and community services. Interpreters accredited at Professional Interpreter level were expected to be capable of interpreting across a wide range of semi-specialised situations and could use the consecutive mode of interpreting speeches or presentations.

the research and the data collection process to the coordinating managers of the healthcare interpreters in a conference room located at the Cumberland campus building of Westmead Hospital.

I subsequently sent an invitation letter, which included information about the participants, aims of the research, participant eligibility criteria, possible benefits or risks of participation, contact details, and the complaints procedure for the Korean interpreters, to 17 Korean healthcare interpreters (see Appendix 1). Three full-time interpreters and two sessional interpreters agreed to participate in the observation and interviews comprising the study. Since two of the full-time interpreters were based at Westmead Hospital, where most of the consultations requiring Korean interpreting took place, the coordinators of the healthcare interpreters had to work together to reschedule the arrangements of interpreters, so that different interpreters could be observed and interviewed for the study. All five interpreters who had agreed to participate in the study were given the PI&CFs prior to the observations. It was clearly stated in the forms that participation in the study was voluntary, and participants could withdraw at any time without prejudice.

To obtain consent from both healthcare professionals and patients for the observations, I was given an initial schedule of Korean interpreters' assignment bookings. When an interpreting service was needed, a nurse in the clinic would make a booking for an interpreter for the required language. The person who made the booking was not always able to confirm which healthcare professional would be attending the consultation until the day of the appointment. It was almost impossible, therefore, to directly contact the healthcare professional prior to the consultation, to get informed consent for them to participate in the study. Some healthcare professionals did not agree to participate, so I was not able to observe a case because prior notification had only been sent to the Nursing Unit Manager and not

directly to the healthcare professionals. In one case, the patient's daughter was resistant to participation and questioned the procedure for getting consent from the patient, but she agreed after receiving detailed information about the research from the researcher while in the waiting area. Printed copies of the information and consent forms for the patients were prepared and distributed to patients and their family members in the waiting area before the session.

When a participant agreed to participate, he or she completed two copies of the consent form, of which he or she kept one in hand and handed the other back to the researcher at the time of the observation. All participants were informed that they were free to withdraw from the study at any time. It was also clearly stated that no individual would be identified in any publication of the results although anonymised quotes or transcribed examples of comments might be used. When consent from the participants was gathered, consent from individual participants for the use of their stored data/samples for this research project was also obtained.

For Phase Three, between May and August 2016, the online questionnaire (see Appendix 5) was conducted using KeySurvey, a website hosted by UNSW at the time of the data collection for this study. First, an email invitation for the online survey (see Appendix 4) was sent out with the assistance of AUSIT, NAATI, HCIS, and other interpreting-related online forums. Ninety-nine valid responses were received. As this invitation was only sent via email, interpreters who did not indicate their email addresses on the online directories were excluded from this study. Since the total number of interpreters who were contacted is difficult to determine, it is not possible to calculate the exact response rate. That being said, AUSIT had approximately 900 members at the time of the data collection.

For Phase Three, the online questionnaire, participants gave their consent to participate in the study by completing the survey.

3.6.2 Phase One: observations

Since I was a participant observer, I had to be present in the setting of medical consultations with other participants. I tried to minimise intrusion during the data collection process so that the participants would be able to act as naturally as possible.

The data sources from Phase One were field notes from observations of medical consultations. During the consultations, I observed the interactions from a distance, while sitting to the side, and made notes on the number and position of the participants, the description of the event, intercultural issues that arose, and any other features of the interaction considered to be relevant to this study (the observation sheet template appears as Appendix 2). Notes were taken during the observations; the consultations were not audio-recorded because permission to do so was not granted by the ethics committee. This, however, did not prejudice the study, since the focus of the study was on participant interactions and sociopragmatic challenges, rather than on the usage of the language interpretation.

Twenty interpreter-mediated medical encounters held at Westmead Hospital in New South Wales, Australia, over approximately six months in 2015, form the data for Phase One of this study.

3.6.3 Phase Two: follow-up interviews

To triangulate the observation notes from the observations, semi-structured follow-up interviews with five Korean interpreters were conducted after each observation. Follow-

up interviews with interpreters were conducted once with each interpreter after their first case of the observations. Interviews were carried out in a quiet place, such as interpreters' offices for permanent staff and interpreters' waiting areas for casual staff, so that they could be audio-recorded. All interviews were conducted in Korean, as all the interpreters felt more comfortable expressing themselves in their native language. Firstly, participants were asked to answer a series of structured demographic questions, including questions about their years of residence in Australia, years of practice as an interpreter, and educational background. Prepared questions that were related to the research questions (see Appendix 3) were asked as well as follow-up questions about some of their behaviours during the observations. For example, when an interpreter had asked questions on behalf of the patient during the consultation, they were asked the reason for this behaviour. A series of predetermined but open-ended questions allowing participants the freedom to express their views in their own terms is defined as a 'semi-structured interview', and it has been the most common interview type conducted in applied linguistic research (Dörnyei, 2007, p. 136). As Dörnyei (2007) explains, pre-prepared guiding questions are developed by the researcher based on the literature review and an overview of the phenomenon in question. At the same time, a format of open-ended and follow-up questions allows the researcher to deepen the respondent's story (Dörnyei, 2007, p. 136). Interviews were audio-recorded using an iPhone app, iTalk. Each interview took between twenty and thirty minutes, not including the time taken to write up field notes from side conversations in waiting areas or to move to another appointment. There were also other opportunities for me to have an informal conversation with two full-time interpreters who worked at Westmead Hospital all day, almost daily. Again, the interpreters were given the right to withdraw at any time without prejudice. However, all five interpreters completed the interviews. The data sources from Phase Two comprised audio-recordings and

field notes from the interviews. Any participant information was accessed only by me to ensure the confidentiality of the data. Electronically recorded data and a scanned copy of the field notes are securely stored on a password-protected laptop and hard copies of PI&CFs are kept in a lock-up cabinet in my home office.

3.6.4 Phase Three: online questionnaire

After finalising the ethnographic study at Westmead Hospital, an online questionnaire was conducted to gain various perspectives from a wider interpreter population in different languages. The online questionnaire was designed to address the same research questions as the in-depth interviews but with interpreters from different language groups, rather than just Korean, and working around Australia, rather than just NSW. The survey was aimed at all interpreters working as healthcare interpreters in Australia. The results of the online questionnaire were triangulated with the results of the in-depth interviews with Korean interpreters.

3.7 Data analysis

An ethnographic approach was adopted for the analysis of all data collected in this study. During the participant observations, I took notes of whether intercultural issues posed significant challenges for interpreters, what other challenges interpreters faced, and how the practitioners practised interpreting when dealing with intercultural communication challenges. The notes were then qualitatively and quantitatively analysed. Likewise, the results of the online questionnaire were quantitatively analysed to gain an understanding of the perceptions of interpreters with the same language combination about their definition of cultural challenges in intercultural communication and whether they agree on what

constitutes intercultural differences in healthcare settings. The open-ended questions were qualitatively analysed.

Interviews were recorded so that during the interview I could focus on the conversations with the interpreters and accurately record their answers. Audio files were later transcribed into Korean by the researcher and coded for themes. The coding process was based on the findings that emerged from the data.

Once the handwritten field notes were digitised and the interview data were transcribed, I explored themes that emerged from the data. This process was done using the data management software tool NVivo, which helped me to tag data and to categorise them. I firstly coded data to identify the major emergent themes, and these were then organised into categories and scrutinised for any connections or patterns in order to reorganise the information into revised themes. Through the first coding process, I tried to identify intercultural communication challenges based on the themes explored in the literature; these were gradually replaced or supplemented by other challenges. When I moved on to the next sets of data, from the follow-up interviews and the online questionnaire, emergent patterns appeared and some initial themes were recoded. As Dörnyei (2007) explains, qualitative research analysis is an iterative process where "we move back and forth between data collection, data analysis and data interpretation depending on the emergent results" (p. 243). In this way, categories for the data collected were set in the initial stage, then refined, deleted, or added throughout the observations, or even through the next phases of interviews and online questionnaire.

Descriptive statistics and the report function of the KeySurvey software were used to analyse the results of the questionnaire. For the qualitative data generated from the open-ended narrative comments, the NVivo program was also used to identify emerging themes

and categories. The survey results were triangulated with the results from the ethnographic study to determine whether interpreters of the same language group agreed on what constitutes intercultural communication challenges in healthcare settings and if there was any difference in their perceptions of the role of the interpreter.

3.8 Conclusion

In this chapter, I have described the research project as an ethnographic study of observations, interviews, and online questionnaire. The methods selected for this study favour a multi-method approach. By collecting data from multiple sources, I have strengthened the validity and reliability of the study via triangulation (Hale & Napier, 2013). In the following chapters (Chapter 4, Chapter 5, and Chapter 6), the results of the participant observations, semi-structured interviews, and the online questionnaire will be reported and discussed. A detailed description of each case of the observations of the interpreter-mediated healthcare encounters, of the semi-structured interviews with Korean interpreters, and of the online questionnaire results from healthcare interpreters of various language combinations will be included.

Chapter 4 Exploring interpreter-mediated healthcare consultations: observations

4.1 Introduction

As discussed in Chapter 2, when patients go to a hospital, they are in a vulnerable position and can face unexpected challenges no matter the reason for their visit or whether the setting is monolingual or multilingual. Ferguson and Candib (2002) argue that one of the greatest sources of communication challenges in healthcare settings resides in the language barrier (see Section 2.3.2 in Chapter 2). However, other studies have shown that some challenges in intercultural communication remain, even with the presence of healthcare interpreters whose task is to remove the language barrier (see Section 2.3.3 in Chapter 2). For example, CALD patients still report high unmet needs in terms of being given insufficient information, insufficient consultation time, or unsatisfactory treatment by healthcare professionals, all of which may lead to patient anxiety, depression, lower satisfaction levels, and even poorer outcomes of treatment (Butow, Bell, et al., 2013). Thus, as discussed in Section 2.3 (Chapter 2), both healthcare professionals and healthcare interpreters are trained to understand cultural aspects so that they can become culturally sensitive and competent, yet little is known about what intercultural communication challenges in interpreter-mediated medical encounters can arise, if any, and what healthcare interpreters actually do when facing intercultural challenges.

In Australia, standards and guidelines on how to work with interpreters and how to communicate with CALD patients were produced for healthcare professionals (AUSIT, 2007; NSW Health, 2017). Healthcare interpreters are also provided with guidelines and

policies to help them make professional judgements in medical interpreting settings (AUSIT, 2012; NSW HCIS PDC, 2014). However, there is very little guidance on how to identify intercultural differences and how to deal with them when they arise (see Section 2.5 in Chapter 2).

To fill the gap in the literature as discussed in Chapter 2, namely on what constitutes intercultural differences in healthcare settings, I undertook observations of twenty interpreter-mediated healthcare consultations in 2015. In this chapter, I describe what I witnessed during the observations, aiming to address the following questions:

- Do intercultural issues pose significant challenges for community interpreters?

- What other challenges are faced by community interpreters?

- How do interpreters act when they face challenges in interpreter-mediated encounters?

4.2 The study

4.2.1 Data collection

The observations consisted of 20 interpreter-mediated medical consultations with Korean patients at Westmead Hospital in the State of New South Wales, Australia, over a period of six months in 2015. As an observer, I was present in the settings with the participants during the entire consultation period. I did not interact with the study participants during the consultation to minimise the potential for researcher intrusion in the data collection process, so that the participants would be able to act as naturally as possible. The participants were asked not to do anything differently from what they would normally do at a similar consultation. I attended 32 consultations, but I was only able to observe 20 due to various

reasons including: a participant who refused the interpreting service, a patient who did not turn up, a healthcare professional who was able to speak some Korean, and a consultation which was rescheduled without my being informed.

During the consultations, I sat in the back or to the side of the room, observed the interaction and took notes using an observation template (see Appendix 2). The notes included information on the number and position of the participants, a description of the event, any instance of intercultural issues, and any other features of the interactions between the participants that I considered to be relevant for my study, such as linguistic issues, non-verbal communication issues, or any other challenges that interpreters faced. I was not granted permission to audio-record the consultations, which, however, did not compromise my data collection, since it does not consist of discourse analysis of communication but focuses on the interactional behaviours of the healthcare interpreters. Even though the conversation was not recorded, I was able to take the relevant notes in detail, as I am a certified consecutive interpreter who was professionally trained in note-taking skills through a master's degree in translation and interpreting studies in Sydney.

After the observations were finished, I converted the handwritten notes for each observation into a word document and coded them for themes using NVivo 12. The codes of the themes were categorised based on the findings that emerged from the data as explained in Section 3.7 of Chapter 3. Since this observation was part of my mixed method study, and an early phase of an ethnographic study, I started analysing data at an early stage to identify research directions. As explained in the methodology chapter (see Chapter 3), I used a grounded theory approach, in which the data helped me identify the themes in the analysis. Just as Dörnyei (2007) described, the process of data collection and data analysis overlapped

during my observations due to the emerging nature of the qualitative research process (p. 124).

4.2.2 Data description

As seen in Table 4-1, I observed four cases in the cancer care clinic, four cases in the outpatient clinic, five cases in the women's clinic, four cases in the dental clinic, two cases in the private consulting rooms, and one case in the transplant department.

The interpreter booking time for each consultation ranged from 30 to 90 minutes, as shown in Table 4-1. The actual time interpreters spent in the consultation was between 15 and 45 minutes in 18 out of 20 cases. There was one case that took 60 minutes at the dental restoration centre and another case, 95 minutes at the women's clinic. The former was an information session where treatment options and information regarding the surgical process were provided to the patient. The latter case was the initial consultation of a pregnant woman with a midwife during which the patient expressed deep anxiety about her personal life, which needed to be dealt with by another specialist; this additional consultation was not expected or predicted prior to the consultation. In the other two cases, 4 and 19 (see Table 4-1), interpreters had bookings for another session only 10 minutes after the start of the previous ones. Table 4-1 provides an overview of the cases, and a discussion of my observations will be presented in the following section.

Table 4-1

Overview of the Consultations

No	Name of the clinic	Duration	Participants	Type of consultation
1	Cancer clinic	40 mins	HP* Patient FM* (husband) Interpreter1	Standard consultation (CT scan results discussion)
2	Outpatient clinic	40 mins	HP Patient FM (daughter) Interpreter3	Long consultation (cognitive assessment)
3	Women's clinic	30 mins	HP Patient FM (husband) Interpreter4	Midwife appointment (34-week check-up)
4	Cancer (Breast)	15 mins	HP Patient FM (husband) Interpreter5	Standard consultation (post radiation therapy)
5	Dental (Paediatric)	15 mins	HP1 HP2 Patient (baby) FM1 (mother) FM2 (father) Interpreter5	Standard consultation (breastfeeding problems with a newborn baby)
6	Women's (Fertility)	30 mins	HP Patient Interpreter2	Long consultation (pre-interview for IVF procedure)
7	Private consulting	15 mins	HP1 HP2 Patient FM (son) Interpreter2	Standard consultation (regular check-up after surgery)
8	Renal transplant	30 mins	HP1 HP2 Patient FM (daughter-in-law) Interpreter2	Long consultation (check-up for benign prostatic hyperplasia)
9	Dental (Restoration)	60 mins	HP Patient FM1 FM2 Interpreter1	Long consultation (scan: view results and discussion about surgery options)
10	Cancer (Breast)	15 mins	HP Patient FM1 (baby) FM2 (toddler) Interpreter1	Standard consultation (biopsy results discussion)
11	Private consulting	20 mins	HP Patient Interpreter2	Standard consultation (general check-up after injection)

No	Name of the clinic	Duration	Participants	Type of consultation
12	Outpatient clinic	35 mins	HP Patient Interpreter1	Standard consultation (chronic lower back pain)
13	Dental (Paediatric)	35 mins	HP1 HP2 Patient (child) FM (mother) Interpreter1	Standard consultation (discussion about orthodontic treatment options)
14	Cancer clinic	45 mins	HP1 HP2 Patient FM (son) Interpreter2	Long consultation (discussion about the process of radiation therapy followed by chemotherapy)
15	Outpatient clinic	40 mins	HP Patient Interpreter2	Standard consultation (check-up, blood test results)
16	Women's clinic	95 mins	HP1 HP2 Patient Interpreter2	Long consultation (First midwife appointment; Pregnancy with depression and anxiety)
17	Women's clinic	35 mins	HP1 Patient FM (husband) Interpreter1	Standard consultation (last midwife appointment before the scheduled date of induction)
18	Outpatient clinic	20 mins	HP Patient Interpreter2	Standard consultation (check-up, blood test results)
19	Dental	25 mins	HP1 HP2 Patient Interpreter2	Dental surgery
20	Women's clinic	25 mins	HP Patient FM (father) Interpreter2	Standard consultation (discussion about laparoscopic surgery options)

* HP: Healthcare professional, FM: Family member

4.3 Results

This section describes what I observed during the interpreter-mediated medical consultations in the order of occurrence during my observations. A complete description of what occurred prior to the consultation, during the consultation, and after the consultation will be provided.

4.3.1 Prior to the consultation

When an outpatient with no or limited English skills makes an appointment with a healthcare professional in hospital, an interpreting service can be booked either by the patient or the healthcare professional. A family member with no or limited English skills can also request an interpreting service even when the patient can speak and understand English. A person in charge of each hospital clinic or department contacts an interpreting service coordinator, who in turn contacts an interpreter in the appropriate language combination. In this section, I describe the booking procedure and what happens to the interpreters after their arrival and prior to the consultation.

4.3.1.1. The booking procedure

In my experience as an observer, the interpreter booking procedure was standard. When healthcare interpreting coordinators in the WSLHD were contacted by clinics or departments, they first arranged the schedules with the full-time staff interpreter. If the full-time staff interpreters were unavailable, coordinators usually contacted the casual staff interpreters to check their availability. After the allocation of the interpreters had been finalised, coordinators provided the same information to me, the researcher, as they did to the interpreters after they had allocated their assignments.

Full-time staff interpreters can see their allocated assignments, as part of their daily schedule, on the screen of their individual desktop in the office when they log into the system each morning, whereas casual staff interpreters receive a telephone call from one of the healthcare interpreting coordinators prior to the consultation. As a casual staff interpreter would, I received a telephone call from one of the healthcare interpreting coordinators to

advise me about the consultation one or two weeks before the date at the earliest and two or three days before the date at the latest. Interpreters can request a written confirmation with the details of the consultations from the coordinators via text messages or emails. After the appointment had been arranged with the interpreters, the coordinators provided the information to me via email so that I could prepare my observation of the consultations.

Based on my observation, when interpreting services were requested by a clinic, the information with which the interpreter was provided prior to the consultation was limited. It included the date and time of the appointment, the clinic, the name of the patient, the name of the healthcare professional, and the nursing staff who booked the interpreting service. No other information, such as the reason for the consultation, the patient's condition, or who would be attending, was provided to the interpreters or the researcher before or during the consultations. When, in some cases, the honorific or title of the healthcare professional was not given, or 'doctor on duty' was the only information that was provided to the interpreter, the interpreters were not advised whether the healthcare professional who attended the consultation was a doctor, a nurse, a midwife, or any other type of healthcare professional.

4.3.1.2. Observations in the waiting room or area

In cancer care clinics, university clinics, dental clinics, and private consulting rooms, there were no separate waiting areas for the interpreters. However, there were two clinics where a separate waiting area for interpreters was provided. In the first, when the interpreters arrived at the women's clinic, they notified the receptionist of their arrival and went to their assigned waiting area where interpreters can have a rest, have a cup of tea or coffee, or talk to other interpreters, until they are called for their assignments. The second was a dental

general practice unit, where there were separate areas for the interpreters to wait until they were called.

In total, I observed seven out of 20 cases where interpreters sat with the patients and/or the patients' family member(s) in the waiting rooms of clinics in which there were no separate areas for the interpreters. In the other 13 cases, interpreters met the patients and/or the patients' family member(s) only when they were called into the consulting rooms, either because interpreters or patients arrived late for the consultations or because there were separate waiting rooms or areas for interpreters to wait in prior to the consultations.

For the seven cases where the interpreters sat with the patients and/or the family member(s) of the patients in the waiting room, I explained the research project to the patients and/or the family member(s) and obtained written consent from the patients and the family member(s) if they were present. As for the other 13 cases where the interpreters met the patients in the consulting rooms, I introduced myself to both healthcare professionals and patients, briefly explained the research study, and obtained consent before the consultation started. The waiting time varied from five minutes to 40 minutes depending on the clinics. During this time, interpreters always had conversations with the patients and/or the family member(s) of the patients. The topics of the conversations varied from private conversations to explaining their role of interpreter. The dominant topics of the conversations in the waiting room or area will be discussed in the following section under four different categories: (i) interpreter building a relationship with the patient, (ii) interpreter establishing the background of the consultations, (iii) interpreter educating the patient on the role of the interpreter, and (iv) interpreters playing a role outside their professional role as an interpreter. Even though topics in the waiting room or area were divided into four different categories, I observed various topics being discussed in each case. That is to say, during those seven cases in which

the interpreters and the patients or their family members conducted small talk prior to the consultation, topics in more than one category were covered.

I observed five out of seven cases where interpreters tried to build a friendly and personal relationship with the patients and their family members in the waiting room prior to the consultation. Interpreters started conversations with greetings and by asking questions ranging from issues relating to the patient's personal life to their general health. When the waiting period became prolonged, the conversation extended to religion, experiences of either the patient or the interpreter in hospital, life in Australia, membership in any other Korean community groups, or even an art exhibition that the patient had recently been to. Talking about the children or grandchildren of the patient or the interpreter was also observed in three cases. Four out of a total of five interpreters who participated in my study (see Table 3-1 in Chapter 3) had a conversation with the patients or their family members within this category at least once.

In cases 1 and 13 (see Table 4-1), Interpreter 1 used the waiting period to establish the background to, and context of, the consultation. As discussed in 4.3.1.1, since information provided for the interpreters prior to the consultation was limited and a briefing session with the healthcare professional never took place, some interpreters tried to gather background information about the consultation from the patient while they were waiting for the consultation to begin. To obtain the context of the consultation from the patients, interpreters asked the patients about their symptoms and the aims of the consultation. In case 13 (see Table 4-1), Interpreter 1 also asked the patient and the family members whether they had any questions they wanted to ask the healthcare professionals. I observed two cases, with two different interpreters, in which the interpreters initiated a conversation with the patient by

asking about the symptoms and the questions that the patients could have. Neither, however, took notes during the waiting room conversations.

Before or after the consultations, five out of 20 patients asked the interpreters questions about general health issues, institutional issues, hospital processes, the healthcare system in Australia, or any additional question that emerged from the previous consultations. Four out of five interpreters answered those questions based on their knowledge or their experience or said that they were not sure. Unlike these four interpreters, Interpreter 2 (see Table 3-1 in Chapter 3) tried to educate the patient on the role of the interpreter when asked questions by the patient about any of the issues mentioned above. She explained to the patient how to work with interpreters, what interpreters can and cannot do, and how interpreters should abide by the AUSIT Code of Ethics, such as by following the articles on accuracy, confidentiality, and impartiality.

In one case, Interpreter 2 and the patient had a conversation in the waiting area before the patient's name was called. The patient asked the interpreter why she had to have so many blood tests, and the interpreter advised the patient to address questions directly to a healthcare professional during the consultation. Then the interpreter tried to educate the patient on the role of the interpreter. The interpreter explained the interpreter's role and referred to the code of ethics that she should abide by, as the reason the interpreter could not ask questions on the patient's behalf.

In terms of the topics discussed in the waiting room, one last category I observed was where interpreters went beyond their interpreter's role and played the role of assistants to a medical team. In three cases, interpreters were asked to help the patient to fill in the form before the consultation started, which is a task beyond the interpreter's role—although interpreting the questions on the form and writing the answers in English can be part of what

interpreters do. In three of the 20 cases, interpreters acted voluntarily without being asked by the healthcare professionals. For example, one interpreter explained the healthcare system and the hierarchy of healthcare professionals in Australia.

4.3.1.3. Briefing and information provided to interpreters prior to the consultation

Out of twenty observations, there was no case where either briefing or debriefing sessions were conducted for the interpreters with the healthcare professionals, or any case where an interpreter asked for a briefing or debriefing during my observations. A lack of information given to the interpreter prior to the consultation as well as the absence of any briefing sometimes led to confusion for interpreters. For example, Clinic C is the outpatient clinic in the university clinic area, and there are ten or more consulting rooms within it, which makes it difficult for interpreters to find the right consulting room, especially when they are not provided with the name of the healthcare professional. Further, in some cases, different doctors or specialists share the rooms, using them on different days or at different times. For example, the same room at the women's health clinic can be used for an appointment with a midwife, a technician, a specialist, a doctor, or a nurse.

More importantly, since the interpreters were not provided with any briefing about the case, they were clearly unprepared for the subject matter and had to ask for clarification from the healthcare professionals in order to convey correct messages as shown in Example 4-1.

Example 4-1

Healthcare professional: One of the options that you could think of would be an implant.

Interpreter: 한 가지 옵션으로 생각해 보실 수 있는 것이, 임플란트 … 그러니까 …
        (*One of the options you can think about is a hmmm … implant of … hmmm …*
)

        [to the healthcare professional in English] Excuse me, can I ask for clarification about what you meant by the implant?

In Example 4-1, the interpreter had been asked to go to the oral restoration clinic for the assignment (Case 9 from Table 4-1). Since the interpreter had not received any information regarding the topic of the consultation or the status of the patient prior to the consultation, it was assumed that the consultation would be related to 'oral' restoration. In this case, the information about the healthcare professional provided to the interpreter prior to the consultation was 'doctor on duty'. Thus, given the circumstances, the interpreter could not prepare or conduct any relevant research on what could be discussed during the consultation. After the consultation had started, the healthcare professional introduced a surgery process as a possible treatment option that the patient could consider. However, the healthcare professional simply used the term 'implant' without any further information. The term 'implant' can be used for various medical procedures, including dental implants, cochlear implants, hip implants, and breast implants to name a few. Dental implants are the most widely known medical implants among Koreans, and in this case, being unprepared, the interpreter had to ask for clarification of what was specifically meant by implant.

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Another example of the lack of information provided prior to consultations, which can lead to confusion among interpreters was regarding the level of English of the patients and/or the patients' family members. In case 2 (see Table 4-1) at the outpatient clinic, both the elderly patient and his adult daughter could speak English. The patient could speak some English and was able to actively engage in a brief conversation with the doctor, whereas his daughter could communicate fluently in English with the doctor without any difficulty. The interpreter had been arranged by the doctor for a specific cognitive assessment since more precise and clearer results were needed for a regular check-up of the stroke patient. There were four participants in this case; however, there was no mutual agreement on whether the interpreter was to interpret the whole discourse, and when and how the interpreter was to intervene to start interpreting in a case where only part of the communication needed to be interpreted. Due to this uncertainty of each participant's expectation about the interpreter's role, the interpreter did not interpret at all when the patient and his daughter answered the doctor directly in English. Furthermore, direct conversations between the doctor and the patient's daughter in English was never interpreted into Korean for the patient. After the consultation started, the interpreter interpreted or summarised what others had said only if the other participant looked at the interpreter, which could be assumed by the interpreter as a communication breakdown that required his or her intervention.

4.3.2 During the consultation

In this section, I describe the following aspects of the consultation in which interpreters were involved: introductions and greetings; seating arrangements; communication issues, including the direct/indirect interpreting approach with reference to patients; situations when patients could speak English, and non-verbal communication

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among parties; and family involvement and patient autonomy in the medical decision-making process.

4.3.2.1. Introduction and greetings

Healthcare professionals mostly started the consultation without appropriate introductions or greetings to either the patient or the interpreter. In seven of the 20 observations, healthcare professionals introduced themselves with their names and titles to the patient in English, and the interpreter interpreted this into Korean. In four of these seven cases, the healthcare professionals asked the interpreters to introduce me as the researcher and to explain the research to get consent from the patients. In one case, the interpreter started the consultation by explaining the presence of the researcher without introducing herself or the healthcare professional to the patient. In the remaining 12 cases, there was no introduction by either the healthcare professional or the interpreter, and the healthcare professionals started the consultation by immediately asking about the patients' symptoms or test results. There was no case I witnessed as a researcher in which the interpreter introduced themselves and explained their role to the healthcare professional or to the patient at the start of the consultation; following an interpreting protocol where the interpreters did do this would facilitate effective communication.

In nine cases where the interpreters had not received information about the healthcare professionals and the healthcare professionals did not introduce themselves, the interpreters were not able to recognise the healthcare professionals' positions or roles—namely whether they were doctors, nurses, medical specialists, medical technicians, or other healthcare professionals. Even though the names or the positions of the healthcare professionals had been provided to the interpreters and the researcher in each of these nine cases, it was hard

to tell whether the healthcare professional who conducted the consultation was the same person as that listed in the booking since they did not introduce themselves to the interpreters at the start of the consultations. There were only two cases for which the names and the positions of the healthcare professionals had been provided, and they introduced themselves at the start of the consultation. The lack of introductions posed challenges and led to confusion for the interpreters in some cases. For example, in case 20 (see Table 4-1), the role and the name of the healthcare professional for the consultation that had been provided to the interpreter was Dr T[4]. All the participants started using the first-person pronoun at the start of the consultation. When the healthcare professional said, "Dr T will be your surgeon" during the consultation and the interpreter interpreted this sentence, the patient became confused and asked if this healthcare professional was not Dr T. The healthcare professional had to explain that she was Dr T's assistant and was in charge of providing information about a surgical procedure, but the appointment had been made under the surgeon's name. This lack of earlier communication from the healthcare professional was not related to the fact that the consultation was interpreted, but it obscured the clarity of communication and added frustration for all involved.

In six of the 20 cases, the healthcare professionals started the conversation with a short greeting addressed to the patient, immediately beginning to talk about the symptoms, medical history, or test results. There were two cases in which healthcare professionals started the conversation with small talk and made jokes with a family member who could

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[4] Not the doctor's real name, as the participants had to be de-identified.

speak English. In case 2 (see Table 4-1), the adult daughter of the elderly patient started a conversation with a specialist by talking about Chinese New Year and how they had been since their last consultation.

4.3.2.2. Seating arrangements

Seating arrangements were always initiated by healthcare professionals, and all three parties sat in a triangle so that they were at an equal distance from each other and could have a direct line of vision to each other. When there were more than three parties—for example, family member(s) or more than one healthcare professional—the patient, health professional, and interpreter sat in a triangle, and the family member(s) or second healthcare professional sat between them or behind the patient. In the dental clinic, the patient lay on the dental chair, and all the others present stood around the chair.

4.3.2.3. Linguistic aspects of interpreter-mediated medical encounters

4.3.2.3.1. Direct/indirect interpreting approach with reference to patients

In five of the 20 cases, rather than speaking in the first person, which is the norm of professional practice, the healthcare professionals and the patients used the third-person pronoun when referring to each other, thus, in fact speaking to the interpreter. In those five cases, the healthcare professionals typically asked, "Does he know when the last time was he had a blood test?", "Did she agree?", or "Is she allergic to anything?" During these consultations, interpreters shadowed the speakers and used the third-person pronoun mixed with the first-person pronoun while interpreting. This confusion became worse when there were other family members in the room. While some healthcare professionals used the third-

person pronoun throughout the consultations when referring to the patients, interpreters started with the first-person pronoun but switched to the third-person pronoun towards the end of the consultation since the healthcare professionals addressed the interpreter rather than the patient. As a result, this change triggered the patient to make more direct eye contact with the interpreters rather than the healthcare professionals. No interpreter asked for clarification from either party about who they were referring to, or invited them to use the first-person pronoun, when they were referring to each other. There was one case where the interpreter switched her role from language transfer to trying to assist, unprompted, by engaging with the patient and then reporting this exchange to the doctor using the third-person pronoun (see Example 4-2).

Example 4-2

Doctor: Do **you** have any sleep problems at the moment?

Interpreter: 주무시는 데는 문제 없으세요 ? (*Do **you** have any sleep problem?*)

Patient: 아유 못 자지. 못 자고 자꾸 깨고 하는데 그냥 화장실 자주 가니까 또 깨고. 요기가 아프기도 하고, 근데 그냥 자꾸 소변 보니까 못 자는 거야. (*I can't sleep well. I wake up too often, and I need to go to the toilet. <u>Sometimes I have pain here</u>. I just can't sleep because I have to urinate too often.*)

Interpreter: I cannot sleep well. I wake up frequently because I have to go to the toilet. Yes ... um … I cannot sleep through the night because of frequent urination.

Doctor: How many times do **you** have to wake up?

Interpreter: 몇 번이나 깨시는데요? (*How many times do **you** wake up?*)

Patient: 뭐 자주 깨지. 서너번 깨나? (*Very often. Three or four times?*)

Interpreter: Frequently. Maybe three or four?

Doctor: Okay.

Interpreter: [to the patient, in Korean] 근데 아까 어디가 아프다 그러셨지? 의사 선생님한테 한번 이렇게 가리켜 보실래요? (*By the way, where did **you** say **you** have pain? Can **you** show the doctor where you had pain?*)

Patient: [pointing at his bottom] 요기 요기가 아퍼. 여기 방광 있는데 … (*Right here. Near the bladder*)

Interpreter: [to the patient's daughter-in-law, in Korean] 방광이라 그러시는데 가리키기는 엉덩이를 가리키시네. (***He said the bladder but pointed at his bottom. Yeah?***)

[to the doctor, in English] Actually, **he** said **he** had pain in his bladder, but **he** was pointing at his bottom while **he** was saying that.

In this example above, both the doctor and the patient began by using the first-person pronoun when referring to each other and had a direct conversation through the interpretation. However, as seen in Example 4-2 above, the interpreter did not interpret one part of the patient's remark ("I have pain here"). After relating more turns between the doctor and the patient, the interpreter came back to the patient's utterance that had not been delivered to the doctor and initiated a conversation with the patient to confirm where he had pain. Then she used the third-person pronoun to relate this to the doctor. The interpreter initiated the examination without being asked by the doctor, then the patient pointed out the area where he had pain to the interpreter, not the doctor. Furthermore, the interpreter made a comment

regarding the patient's information and had a side conversation with the family member in Korean. Although this side conversation was not interpreted into English, the doctor did not ask the interpreter to do so. The patient and the family member both used third-person pronouns when referring to the doctor afterwards and engaged in more direct eye contact with the interpreter. As a result of engaging in asides with the patient and then the doctor, the interpreter in this example referred to both as 'he'. (This example can also be regarded as the interpreter switching her role, which will be further explored in Section 4.4.3.2.)

4.3.2.3.2. Situations when patients could speak English

In nine of the 20 cases, the patients could speak English as assessed on a scale from basic to fluent. There were two cases where the patients were school-aged children, and the interpreters were booked for their parents. In those two cases, the healthcare professionals had direct conversations in English with the patients unless the parents of the patients asked questions of the healthcare professionals in Korean, which were interpreted into English for the healthcare professionals. None of the direct conversations in English between the healthcare professionals and the patients, though, was interpreted into Korean for the parents of the patients. The patients could speak some English enabling basic communication in the other seven cases. When the patients could understand English, they answered either in Korean or English without being interpreted. However, when the patients could not fully understand what the healthcare professionals had said in English, they looked at the interpreter and then the interpreter started interpreting. In these cases, eye contact among parties played a role in triggering the interpreting when patients could speak some English; this will be discussed further in the following section (see Section 4.3.2.3.3). This trend was consistent in all nine cases even though there was no case where a mutual agreement was

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made among all parties about how and when the interpreter needed to interpret or not in situations where the patient could speak some English.

Another tendency observed in situations where the patient could speak English was when the patients answered the healthcare professionals' questions directly, even after a confirmation and a reminder from both healthcare professionals and interpreters about the use of the interpreting service for a more accurate communication. In three out of nine cases in which patients could understand and speak English, the patients frequently answered the healthcare professionals' questions in English without waiting for the interpreter's interpretation, even though the healthcare professionals and the interpreters reminded them to wait until the interpreters interpreted into Korean what the healthcare professionals had said and to answer in Korean so that the interpreter could interpret more accurately.

4.3.2.3.3. Non-verbal communication among parties

As discussed in Section 2.3.2 (Chapter 2), research supports the premise that it is common in Asian cultures, including Chinese, Japanese, Korean, Hmong, and Vietnamese, to follow the tendency of avoiding direct eye contact in order to show respect, especially to a person in a superior position (Abbato, 2011; Galanti, 2015; Queensland Health, 2013). However, my observations did not support this claim: in 16 of the 20 cases for this study, patients and healthcare professionals made direct eye contact while talking to each other, and each party turned to the other party to signal the end of their utterance and an invitation for the interpreters to take their turns. On the contrary, in case 12 (see Table 4-1), the doctor, who described himself as Irish, looked at the computer screen and did not turn or make eye contact to look at the interpreter or the patient, even when he made a joke. Three other cases were also observed where nurses or midwives—not limited to those of Asian appearance—

consistently looked at the computer screen while continuing to speak to the patients. Except for these four cases, 19 out of 23 healthcare professionals typically looked directly at the patients throughout their consultations, especially when talking about their illnesses, including diagnoses and prognoses.

Many healthcare professionals of Asian appearance followed this trend. All 20 Korean-speaking patients directly looked at the healthcare professionals, except for one case, in which a pregnant woman with symptoms of depression showed shyness and passivity throughout the consultation. The patients' age group, sex, or period of residence in Australia did not seem to have any effect on whether they preferred to have or avoid direct eye contact with healthcare professionals.

As explored in 4.3.2.3.2, the patients who could understand and speak some English tended to turn to the interpreter when they did not understand what the healthcare professional had said and interpreting was needed. That is to say, the patient usually looked directly at the healthcare professional except for when the patient wanted the interpreter to interpret. I observed a situation where the healthcare professional and the patient looked at each other when the consultation started, but the situation changed into a case where both parties looked at the interpreter more than each other after the interpreter had asked for clarification and repetition from the healthcare professional more than three times. This change of communication pattern also led to a frequent use of the third-person pronoun in both parties when addressing each other (see Section 4.3.2.3.1).

4.3.2.4. Family involvement and patient autonomy in the medical decision-making process

As described in Section 3.5.2 in Chapter 3, one or more of the patient's family members attended their consultations in more than half of the cases (13 out of 20). During the consultations, in ten out of 20 cases, they were actively involved in the conversation and the medical decision-making process. In most cases, family members generally did not answer questions, on behalf of the patient, that the healthcare professionals had asked the patient directly. Conversely, they asked questions on the patients' behalf on many occasions, either in Korean or in English. Even though the questions asked in Korean by the family members were interpreted into English for the benefit of the healthcare professionals, direct questions by the family members in English were not interpreted into Korean for the patients in any case. None of the interpreters in this study interpreted the direct conversations in English between the healthcare professionals and the family members to the patient in Korean. The situations in which patients were excluded when there were family members present will be discussed further in Section 4.3.4.1.

Despite family members' active involvement in consultations and the medical decision-making process, the patients always actively participated in the medical decision-making process in 18 of the 20 observations; the only two exceptions were when the patients were a newborn baby and a school-aged child.

In one interesting case (Case 9 from Table 4-1), the patient had undertaken extensive research on possible treatment options and asked the doctor for confirmation about the information he had found. After being provided with detailed information and considering advantages and disadvantages for the three different treatment options the doctor offered, the

patient rephrased all the details as he understood them. While explaining the complicated surgery options, the doctor had to use a diagram to help the patient understand it fully. The interpreter, therefore, had to interpret the complicated process, pointing at the diagram the doctor had drawn. In the end, the patient actively suggested that he would try the first option for a while and come back to see the doctor in a few weeks' time to have a further discussion. The whole process of medical decision-making in this particular case took place with the full involvement of the patient, who had actively prepared and analysed the information and determined exactly what he wished to be done regarding treatment options and future plans. In this case, the patient was the most active participant and the decision-maker, despite the presence of the other family members, and the interpreter focused on interpreting the conversation between the patient and the healthcare professional.

4.3.3 Post-consultation

The usual procedure to end consultations included closing remarks by the healthcare professionals, and the interpreters' marking their attendance by putting a sticker with their personal identification codes on the patients' charts. While the patients and their family members left the consulting rooms before the interpreters and no further conversation took place in most cases, there were six cases where the patients and/or family members continued conversations outside the doctor's office with the interpreters after the consultations. Although the conversations were mostly casual and involved expressions of gratitude to the interpreters, in two particular cases the interpreters played additional roles to what the they would generally be expected of them. For example, in case 13 (see Table 4-1), the family member of the patient asked the interpreter, after they had both left the consulting room, where they should go to make the next appointment with another specialist and to pay the

consultation fee for that day. The interpreter explained where to go and what to do to the family member. Since the cashier was on the way from the consulting room to the healthcare interpreter service office, the interpreter guided her to find the cashier, explained how to pay the fee, and then where to go to make another appointment. In another case (Case 16 in Table 4-1), the patient was asked by the midwife to collect a midstream urine sample at the end of the consultation. The patient did not ask questions about how to do it properly or what the term midstream urine sample meant. The interpreter simply interpreted the phrase into an equivalent Korean term. Even though the patient did not ask any further questions' and the midwife did not provide any further information, after they had left the consulting room, the interpreter started explaining in Korean what a midstream urine sample is and how the patient should collect the midstream urine sample correctly. As will be explored in 4.3.4.2, this interpreter switched her role from that of interpreter to being a part of the healthcare team, helping and giving advice on medical procedures without indicating her role boundaries as an interpreter.

Although 18 of the 20 cases were completed with interpretation, there were two cases in which the interpreters had to wait for as long as 30 to 40 minutes before the consultation, and then because of this delay, had to leave five or ten minutes after the consultation started, to be on time for the next assignment. As a result, there was no time for briefings or introductions before the consultation, or for staying until the consultations were finished. For example, in case 19 (see Table 4-1), the interpreter had to leave ten minutes after the start of the appointment for another appointment at a different clinic. The patient, who was an elderly woman, was expected to have dental surgery and could not speak any English at all. The dentist quickly went through the surgical procedure and the possible risks with the interpreter, and this information was summarised and explained in Korean to the patient by the

interpreter. The interpreter did not take notes while listening to the dentist, so she fully relied on her memory for the technical explanation. The dentist gave the consent form to the interpreter and asked her to get it signed by the patient. The interpreter explained the content of the consent form, which, again, was not sight translated but rather presented as a summary of the content, and the form was signed by both the interpreter and the patient. The interpreter had to explain to the patients that she, the interpreter, had another appointment, so the surgery procedure would be completed without the interpreter's assistance. After the consent form had been obtained, the interpreter left the room. In this case, the interpreter had acted as a healthcare team member rather than a communication facilitator since the interpreter created her own discourse based on her understanding of what the healthcare professional had said to her.

4.3.4 Interpreters' challenges in intercultural communication

As explained in 4.1, the original intention of my observation was to examine what cultural difficulties healthcare interpreters could face, and not to assess or judge whether the healthcare interpreters act professionally and follow their code of ethics. The most frequently emerging topics of cultural challenges in medical anthropology include family and the decision-making process; pregnancy and birth; end-of-life situations and revealing/withholding a negative diagnosis/prognosis (Goldstein et al., 2002; Kagawa-Singer & Blackhall, 2001); non-verbal communication, including eye contact; and paralinguistic aspects of communication (Crezee, 2013; Hale, 2013). However, I did not observe any case where interpreters had to provide cultural information or the communication broke down due to cultural differences. Even though, in some cases, I encountered a situation of the aforementioned cultural challenges, such as family involvement and issues relating to

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decision-making, end-of-life situations, or non-verbal communication, the patients from my observation did not act as described for Korean patients according to the literature (Abbato, 2011; Galanti, 2015; Queensland Health, 2013). For example, the elderly patient with a terminal illness from Case 1 (see Table 4-1) wanted to know the diagnosis and the prognosis of her illness and actively asked questions directly of the doctor, despite the presence of her husband. On the contrary, the middle-aged woman with a breast cancer from Case 4 (see Table 4-1) did not ask any questions of the doctor while her husband asked all the questions about her post radiation therapy care. Korean culture is often described as a collectivist culture in which healthcare decisions are made after getting family members' opinions rather than relying on patient autonomy or in which males have the decision-making role for the patient (Blackhall et al., 1995; Frank et al., 1998). However, the findings of the current study differ on what is described as an aspect of the cultural differences in family relationships. Every patient from my observations, except for the two minors—a newborn baby and a school-aged boy—actively participated in the decision-making process, although there were one or more family members present in 13 of the 20 cases. Similarly, direct eye contact is often regarded as an example of cultural differences, as it is considered disrespectful to look someone directly in the eye if the other party is in a superior position, especially in some Asian cultures (Abbato, 2011; Queensland Health, 2013). However, patients from 16 of the 20 cases from my observations had direct eye contact with the healthcare professionals, whereas some healthcare professionals (4 out of 19), regardless of their ethnicity, avoided eye contact or looked at the computer screen while talking to the patients.

Instead of finding instances of intercultural communication challenges, as I mentioned in the above sections, in my observations I came across many instances of interpreters facing ethical challenges, not cultural challenges or breaching their code of

ethics. Therefore, such behaviours unexpectedly became a major part of the collected data. As a result, I analysed the observations and found two common types/patterns of interpreters' unethical behaviours: (1) violating the principle of accuracy by conducting side conversations—either in Korean or in English, among any participants, whether or not they were private conversations or they were still relevant to the patients—that were not interpreted into the language so that all the participants were informed; and (2) interpreters switched their roles from facilitating communication to assuming other roles, for example, providing help or advice as part of a healthcare team without indicating their role boundaries as an interpreter.

4.3.4.1. Violating the principle of accuracy: Side conversations and exclusion of patients

One of the most common phenomena observed (in at least 12 cases) was the exclusion of the patients from the conversations. One example was when the healthcare professionals, interpreters, or other family members conducted side conversations in English, and they were not interpreted into Korean (in 10 out of 20 cases). Similarly, in two cases, side conversations in Korean between the patient and other family members were not interpreted at all into English for the healthcare professionals.

According to the principle of accuracy and completeness in the Code of Ethics (AUSIT, 2012), interpreters should interpret everything that is said by all participants even if it is a side conversation made by any of the parties when there are more than three participants. Regarding conduct issues specific to interpreters, the AUSIT Code of Ethics provides full details of completeness in interpreting, relations with other parties and the interpreting role in dialogue situations, and specific institutional settings of interpreting work:

"Interpreters keep the participants informed of any side comments made by any of the parties or of their attempts to engage the interpreter in a private or any other conversation" (AUSIT, 2012, p. 15).

The case of side conversations in English not being interpreted into Korean for the patients happened more often in ten cases. In case 8 (see Table 4-1), the elderly male patient was accompanied by his daughter-in-law, who could communicate in English. Although the patient answered all the questions from the doctor through the interpreter, the daughter-in-law stopped the patient when he started to change topics. When the daughter-in-law tried to stop the patient, this conversation between the patient and his daughter-in-law was conducted in Korean and not interpreted into English for the doctor. At the end of the consultation, after a physical examination and a scan had been completed, the doctor gave the daughter-in-law a few options for treatment and explained what would be best for the patient. This information was not interpreted into Korean for the patient but summarised into Korean by the interpreter for the daughter-in-law, to ensure her understanding. The doctor did not ensure that this information was interpreted into Korean for the patient. However, the exclusion of the patient in the conversation did not only happen with elderly patients. In cases 3, 4, and 17 (see Table 4-1), young female patients, whose English was very limited, were accompanied by their husbands who could speak some English. Direct conversations in English between the husbands and the healthcare professionals were not interpreted into Korean for the patients, and direct conversations in Korean between the husbands and the patients were also not interpreted into English for the healthcare professionals.

In case 2 (see Table 4-1 above), both the elderly patient and his daughter could speak English. Even though the patient actively participated in the conversation, his daughter answered some of the questions, including those about changes in the patient's medical

history and the names of his medications. In this case, none of the direct conversations in English between the healthcare professional and the family member was interpreted into Korean for the patient. The interpreter did not play any further role while there were direct conversations in English, although there had been no mutual agreement among all the parties as to whether interpretation for such conversations was needed. The doctor had direct conversations with the daughter during the process of collecting the patient's medical history. The patient had had a stroke a few years before, so the main purpose of the consultation was to conduct a cognitive assessment test. Also, the interpreter was booked to ensure accurate results were communicated, even though both the patient and his daughter were capable of basic communication in English. When the memory test for the cognitive assessment process began, the doctor asked the daughter to leave the consulting room so as to achieve an accurate result without any interruption or aid from her. An adequate explanation was given for this request, and the daughter of the patient agreed.

In another case (Case 16 in Table 4-1), there were several conversations among different parties, including the midwife, the interpreter, and the mental health nurse. They included different conversation modes among various parties, such as whispering, a private dialogue, and a telephone conversation. However, none of these conversations in English was interpreted into Korean for the patient. The patient was in an early stage of pregnancy and had not expected to see a mental health nurse, as this was an initial assessment session intended to collect basic information and the previous medical history of the patient. When the patient had completed a questionnaire about her mental health status, the midwife recognised that she suffered from anxiety and depression. After the patient had revealed her suicidal thoughts, the midwife decided to ask for help from a mental health nurse. The midwife stopped the session and made a phone call to a mental health clinic from the

consulting room. The midwife did not explain to the patient what she was doing. Furthermore, the telephone conversation between the midwife and the mental health clinic nurse was informal and was not interpreted into Korean for the patient; thus, the patient was not informed about anything and might have been unclear about the situation. For about five minutes, until a mental health nurse came to the consulting room, no explanation was provided to the patient, although the midwife offered tissues so that the patient could wipe her tears. After the mental health nurse introduced herself, the midwife provided the mental health nurse with an explanation of the reason for this unexpected consultation on the patient's mental health. The interpreter then interpreted this into Korean for the patient. The interpreter also initiated a side conversation with the midwife by providing additional information about a telephone interpreting service to the midwife without being asked. This was not immediately interpreted into Korean for the patient; however, she later added this information while interpreting into Korean what the midwife had said to the patient.

In cases 8 and 17, the patients and the family members had side conversations in Korean that they did not interpret into English for the healthcare professionals. No interpreter from my observations switched interpreting modes from consecutive to simultaneous, which would be more appropriate when interpreting side conversations. Another finding was that no interpreter from my observations took notes during the consultations. Although most of the dialogues were not too long so that the interpreters were able to deliver the main messages, in some cases (cases 8 and 19 in Table 4-1), the interpreters summarised the medical information when interpreting into Korean for the patients without taking notes.

4.3.4.2. Violating the principle of impartiality: Interpreters switching roles

According to the AUSIT Code of Ethics, impartiality also means that interpreters should maintain clear role boundaries separating their main role of facilitating communication and additional tasks that might have to be undertaken when necessary (AUSIT, 2012, p. 6). Additional tasks may include advocacy, guidance, or advice. It is the responsibility of the interpreter to provide an explanation of their role to the participants when necessary. The interpreters should inform all participants when they need to switch their roles. In eight of the 20 cases, the interpreters provided additional information, from general to detailed, to the patients, which included information about the Australian healthcare system and an explanation of the hierarchy of healthcare professionals in Australia. Furthermore, in some cases, the interpreters provided unsolicited advice, including how to interact with healthcare professionals, what to do in healthcare encounters, how to collect midstream urine samples, and how to use a telephone interpreting service while interpreting during consultations. In terms of the role boundaries of interpreters, the AUSIT Code of Ethics states "practitioners do not, in the course of their interpreting or translation duties, engage in other tasks such as advocacy, guidance or advice" (AUSIT, 2012, p. 6). In addition to the AUSIT Code of Ethics, NSW HCIS provide guidance to healthcare interpreters on how to offer cultural information at the request of healthcare professionals or when facing communication breakdowns due to such cultural differences (NSW HCIS PDC, 2014). A suggested phrase that healthcare interpreters can use when requested to provide cultural information is 'it is possible that some people who come from this country may have these beliefs … ' rather than stating 'in my culture … ' (NSW HCIS PDC, 2014, p. 19). However, from my observations, when the interpreters provided additional information or advice, there

was no case of a request from healthcare professionals for cultural information or any indication of communication breakdown. Interpreters added unsolicited advice while conveying the source messages, without informing the speaker of the original messages, or they did so when the healthcare professionals left the consulting rooms for various reasons, such as calling other departments, getting information booklets, or getting necessary forms to be filled in.

Such behaviours of interpreters have also been observed in previous studies (Angelelli, 2004; Hsieh, 2016) where interpreters acted as if they worked as healthcare professionals. In cases 14 and 16 (see Table 4-1), the interpreters helped the patients to fill out the medical form, without being asked to do so by either party. In none of the cases above, did the interpreters indicate when they switched their roles from facilitating communication to any other institutional role due to specific circumstances. According to the guidelines for healthcare interpreters provided by WSLHD HCIS, healthcare interpreters should not fill out forms on behalf of a patient, explain medical terms to clients, or provide emotional support to patients.

However, in eight of the 20 cases, interpreters asked questions on behalf of the patients during the consultations based on their own understanding or assumptions without being asked by the patients. The contents of the questions included requests for extra information about what the patients should do after the consultations, reaffirmation of the healthcare professionals' questions or instructions, and additional information about the healthcare professionals' questions. By doing this, interpreters became the owners of the speech rather than the facilitators of communication in healthcare encounters.

4.4 Discussion

This study began with the widely accepted assumption that cultural diversity and intercultural challenges directly challenge communication in medical consultations. This chapter has described interpreter-mediated medical consultations through participant observations, in which the issues of cultural differences and intercultural communication challenges that have been discussed in the literature were not observed on most occasions. Interpreting studies, especially in community interpreting such as healthcare interpreting or legal interpreting, have so far regarded the notion of culture as being embedded in the practices of particular national or language groups (see Section 2.2.1 in Chapter 2) and have focused mainly on the linguistic challenges (see Section 2.3.2 in Chapter 2). However, as discussed in Section 2.2.2 in Chapter 2, dichotomous thinking about stereotypical ideas used in comparing two mainstream cultures from which the parties originate is not appropriate. This is especially true in interpreting studies since the context of communication and the circumstances of the interlocutors are crucial to understanding healthcare interpreters' challenges rather than the fixed knowledge of a nation-based cultural understanding. Interestingly, there were no significant examples of Korean patients acting the same way in similar situations, challenging the view that there is a distinctive Korean culture that interpreters should be familiar with.

Common examples from previous studies about intercultural communication challenges that healthcare interpreters face, include nonverbal communication, cultural beliefs about cancer and terminal illnesses, patient autonomy and medical decision-making, and family involvement (see Section 2.4 in Chapter 2). As described in Section 4.3.4, in the situations I encountered in my observations, such as family involvement in decision-making,

end-of-life situations, or non-verbal communication, the patients did not act according to the cultural descriptions of Korean patients in the literature (Abbato, 2011; Galanti, 2015; Queensland Health, 2013). In the 20 cases I observed, no case clearly showed an instance of intercultural differences between the healthcare professionals and the Korean patients. Attitudes towards end-of-life situations have been regarded as the most challenging and complicated cultural aspects when it comes to cultural beliefs in health. The most frequent discussion in a cancer-related or any other terminal illness–related situation is whether to reveal or to withhold a negative diagnosis and prognosis to/from the patient, which also relates to the topic of patient autonomy. Patients of an Asian background are, as a whole, often believed to be reluctant to receive a diagnosis and prognosis of their terminal illnesses and would prefer not to be informed (Cho, 2022; Kagawa-Singer & Blackhall, 2001; Parsons et al., 2007), and the family members of the patients get involved in medical decisions, as family interdependence is held in higher regard than independence of the individual (Galanti, 2015). However, in my study, Korean patients and their family members behaved in various ways when discussing terminal illnesses. For example, in one case, an elderly patient actively asked questions about the diagnosis and prognosis of her terminal illness, whereas in another case, a young female patient did not ask any questions at all about her cancer, while her husband asked all the questions about the care plan on her behalf.

The extent of family involvement varied in each case, regardless of age group or level of English. In more than half of the cases (13 out of 20), family members attended the consultations with the patients, and in 10 of the 20 cases, family members were actively involved in the conversation and the decision-making process. However, the patients actively participated in the decision-making process in 18 of the 20 observations; the only exceptions were where the patients were a newborn baby and a school-aged child. Similarly, eye contact,

which is regarded as a good example of non-verbal communication significantly influenced by cultural norms (Crezee, 2013), was observed in a discordant manner among all participants. For example, all Korean patients, except for the cases where the patients were a newborn baby and a school-aged child, made direct eye -contact with the healthcare professionals while some healthcare professionals looked at the computer screen when talking to the patients, regardless of their ethnicity.

Instead of finding instances of intercultural communication challenges, as I mentioned in the above sections, in my observations I came across many instances of interpreters facing ethical challenges, not cultural, or breaching some of the articles of their code of ethics. Although a pattern of family involvement and patient autonomy emerged in various forms among Korean patients and their family members, one of the most common phenomena observed was the exclusion of the patients from the conversations in which side conversations were not interpreted. Based on the article accuracy of the AUSIT Code of Ethics (2012, p. 15), any side conversation or comment made by any of the parties should be accurately interpreted into the other language so that all parties can be kept informed, regardless of whether this side conversation or comment was a private conversation among parties or was an attempt to engage the interpreter in a private conversation with either party. As explained in 4.3.4.1, in 12 of the 20 cases, side conversations between participants, either in Korean or in English, were not interpreted at all into the other language, thus breaching the Code of Ethics.

Another finding from my observations in terms of the ethical challenges faced by interpreters was that interpreters often switched their roles and provided medical information or unsolicited advice to the patients, thus violating the article, impartiality. According to the guidelines (AUSIT, 2012; NSW HCIS PDC, 2014), interpreters should not act as advisors or

provide unsolicited additional medical information unless there has been a request from other parties or communication breakdown occurs. However, from my observation, there was no such case of either a request from healthcare professionals for medical information or of any communication breakdown when the interpreters provided medical information or unsolicited advice. By doing this, interpreters became the owners of the speech rather than the facilitators of communication in healthcare encounters. It is noteworthy that some interpreting service users express their concerns about such behaviour of interpreters (Hsieh, 2016). For example, through post-observation interviews, several healthcare professionals from Hsieh's (2016) study argued that "although [interpreters] acting on behalf of the patient without the patient's or provider's explicit consent may be efficient in meeting the patient's needs, such strategies may blur the lines between the patient's and the interpreter's agendas and communicative goals" (p. 249).

It is also interesting to note that in some cases, the interpreters from my observations acted as if they were part of the medical team and helped the patients to fill out the forms or to provide medical information with or without a request by either the patients or the healthcare professionals. In previous studies, healthcare professionals expressed concerns about interpreters' active involvement in medical encounters, arguing that interpreters acting as a part of the medical team might also have negative impacts on the patient-doctor relationship (Hsieh, 2016). It is interesting to note that in the now outdated guidelines provided by the NSW Health for healthcare interpreters in the 1990s (The Health Care Interpreter Service, 1994), healthcare interpreters were asked to play a more active role in intercultural situations, such as providing information to clients about the healthcare system; providing health-related cultural information to healthcare professionals; and helping clients to reduce fears, anxieties, and concerns that may impede effective communication.

Considering that four of five interpreters who participated in my observations were accredited in the 1980s or 1990s, they would have received the former guidelines suggesting that interpreters can be helpers as part of their role as interpreters. Furthermore, all five had more than 20 years of residence in Australia, which suggests that they might also have traditional views of Korean culture, as described in Section 2.2.1. At the time of the collection of the data for this study, a university-level education was not necessary to become a healthcare interpreter (see Chapter 1), and four of the five interpreters who participated in this study did not have university-level education. Moreover, despite the existence of the guidelines and policies developed by government agencies or interpreting organisations, how much they are adopted by interpreters in real-life situations is unknown. Thus, the question is then whether the interpreters keep up with the changes in the theory and the industry as part of their professional development.

In addition to the ethical challenges, the working conditions of the healthcare interpreters also posed significant challenges to interpreters. Out of twenty observations, there was no case where either briefing or debriefing sessions were provided for the interpreters by the healthcare professionals, or any case where an interpreter asked for a briefing or debriefing during my observations. A lack of information given to the interpreter prior to the consultation as well as the absence of any briefing sometimes led to confusion for interpreters. The AUSIT Code of Ethics clearly describes an appropriate briefing as important for secure satisfactory working conditions (2012, p. 6). According to Tebble (1998, p. 19), the list of participants, the venue, the estimated time of the consultations, the patient's condition, the intention of the consultations, the patient's' linguistic and cultural background, and the interpreting modes could be discussed during the briefing session. Both the AUSIT Code of Ethics and HCIS Guidelines for interpreters direct interpreters to "request and access

reference material and background information before their work commences" (AUSIT, 2012, p. 23; NSW Health Care Interpreter Services (NSW HCIS), 2014, p. 18). HCIS also states that briefing with the healthcare professional prior to the consultation can prevent many possible challenges that healthcare interpreters may face. HCIS guidelines for healthcare interpreters (2014) clearly state that "interpreters can take a proactive approach and ask that the healthcare provider brief them" (p. 16). However, even though guidelines for both interpreters and healthcare professionals exist, and training for both interpreters and healthcare professionals have been consistently provided, there was no case where either briefing or debriefing sessions were conducted for the interpreters with the healthcare professionals, or any case where an interpreter asked for a briefing or debriefing during my observations.

As described in Section 2.5.1, Tebble's (1998) important concept of a 'contract' requires healthcare interpreters to explain the ethical boundaries of the interpreter to healthcare professionals, patients, and others present (p. 27). When interpreting service users have different expectations of the role of the healthcare interpreter, briefing sessions and the contract stage can also be very important in dealing with cultural differences in healthcare settings. For example, from my observations, when the patient could speak some English, he or she had direct conversations with the healthcare professional in English without interpretation. Also, the patients were excluded when the family member and the healthcare professional had direct conversations in English that were not interpreted into Korean. The briefing session between the healthcare professional and the interpreter could have been used as an opportunity to discuss the level of English ability of the patients and family members, helping to clarify the interpreter's role in cases where the needs and expectations of the healthcare professional diverged from the actual role of the interpreter. Since no briefing was

requested by the interpreter or provided by the healthcare professional, the interpreter could have declared his or her role as an interpreter and any ethical obligations before the consultations started. As Tebble (1998) asserts, this stage allows the interpreters to draw attention to their ethical boundaries among all participants present. However, during my observations, no interpreter started the medical consultations with the introduction of their role. In 12 of the 20 cases, there was no introduction by either the healthcare professional or the interpreter, and the healthcare professionals started the consultation by immediately asking about the patients' symptoms or test results. As a result, a lack of information given to the interpreter prior to the consultation, as well as the absence of any briefing, sometimes led to confusion for interpreters. Although the contract is generally declared after the introduction and greetings and is expected to be invited by the healthcare professionals, interpreters may use the waiting room conversation as an opportunity to declare the contract. However, I observed only one interpreter (Interpreter 1, see Table 3-1 in Chapter 3) attempt to use the waiting room talk to establish the context of the consultations and another interpreter (Interpreter 2, see Table 3-1 in Chapter3) who tried to educate the patient on the role of the interpreter. These two interpreters, both permanent staff interpreters with Paraprofessional accreditation and a TAFE diploma, each had more than 30 years of residence in Australia and more than 16 years of practice as an interpreter at the time of the data collection.

One interesting phenomenon observed during the consultations, when there was no briefing or background information provided or asked for by the interpreter, was the transition of the use of the first-person pronoun into the third-person pronoun from both the healthcare professionals and the interpreters as the consultations progressed (see Section 4.3.2.3.1). For example, in cases 9 and 13, all participants used the first-person pronoun when

addressing each other, as if they were having a direct conversation without an interpreter present. As the consultation went on, however, the interpreter asked for clarification of what had been said, possibly due to a lack of background information being provided to the interpreter prior to the consultation. The numerous turns of the interpreter's request for clarification led the healthcare professional and the interpreter to start using the third-person pronoun when addressing the patients, making the interpreter a more obvious primary participant in the encounter. As a result, direct conversations took place more often between the healthcare professional and the interpreter or the patient and the interpreter than between the healthcare professional and the patient. According to the guidelines for healthcare interpreters (NSW HCIS PDC, 2014), interpreters should interpret in the first person using a direct speech style to minimise confusion as well as to reinforce the role of the interpreter as a neutral facilitator of communication (p. 17). However, as in the cases observed above, at times interpreters became the owners of the speech rather than the facilitators of communication in healthcare encounters by using the third person pronoun to refer to the speakers.

4.5 Conclusion

This chapter presented the results of the analysis of the interpreter-mediated medical encounters between Korean-speaking patients and English-speaking healthcare professionals through 20 participant observations. Contrary to expectations based on the literature about the prominence of intercultural issues in healthcare interpreting, this study did not find any evidence of such issues in the observed interpreted interactions. Previous researchers in interpreting studies (Angelelli, 2004; Cho, 2022; Hsieh, 2016; Souza, 2016), argued that communication breakdown can occur in medical encounters due to cultural differences,

necessitating the intervention of interpreters to bridge cultural gaps, even at the expense of the interpreters overstepping their role, as stipulated by their code of ethics. However, the findings of the current study do not support the above argument. The issues of cultural differences and the intercultural communication challenges that have been discussed in the literature were not observed in the 20 interpreted interactions that form part of this study. Instead of finding instances of intercultural communication challenges in my observations, I came across numerous instances of interpreters facing ethical rather than cultural challenges as well as being in breach of their code of ethics. These ethical breaches were unrelated to any cultural difference or intercultural communication issues, and mostly affected the principles of accuracy, impartiality, and clarity of role boundaries.

This chapter reported the results of my observations, which did not support the assumption that cultural differences produce significant challenges for Korean/English healthcare interpreters. The next chapter will report the results of my interviews with the participating interpreters about their perceptions of intercultural communication challenges and intercultural issues, and the way they address them when and if they face such challenges in medical encounters.

Chapter 5 Interviews: Interpreters' voices

5.1 Introduction

As explained in Chapter 2, language barriers and cultural differences can be obstructive factors for both healthcare professionals and interpreters in providing optimal care for CALD patients. Unlike linguistic issues, which can be explicitly observed by all parties during medical encounters, cultural differences may not be easily detected (see Section 2.3.2 in Chapter 2). By understanding one's own culture and other cultures, and applying that knowledge to practice, better health outcomes can be achieved in a multicultural society like Australia. There is still no consensus, however, about what constitutes intercultural communication challenges in healthcare settings (Butow et al., 2012; Crezee, 2003; Drennan & Swartz, 1999; Souza, 2016). Furthermore, at the time of writing this thesis, no study has been conducted on the communication challenges faced by Korean interpreters in an Australian setting.

To fill the gap in the knowledge, as discussed in Chapter 2, namely, whether a group of Korean interpreters agree on what constitutes intercultural differences in healthcare settings and when to offer cultural brokerage, I observed interpreted interactions between healthcare professionals and patients (see Chapter 4), and conducted follow-up interviews with five interpreters in 2015. During my observations, I noted how interpreters interact during consultations between healthcare professionals and CALD patients. In contrast to earlier findings, however, the issues of cultural differences and the intercultural communication challenges that have been discussed in the literature were not observed (see Chapter 4). Instead, I came across many instances of interpreters facing ethical challenges,

rather than cultural challenges or breaching their code of ethics. In the follow-up interviews, I examined the interpreters' perceptions about intercultural communication and intercultural differences between Korean patients and non-Korean healthcare professionals. The aim of this chapter is to triangulate the data presented in Chapter 4 on observations. In this chapter, I describe the data gathered during the interviews and present the results of my analysis. The chapter aims to address the following questions:

- How do healthcare interpreters identify and address communication challenges in interpreter-mediated medical encounters?

- Is there a consensus among Korean interpreters on what constitutes intercultural communication challenges?

- What are the interpreters' strategies to overcome such challenges, if any?

5.2 Data description

After each observation of healthcare professional consultations with a Korean patient, the interpreters who interpreted during my observations were invited to participate in semi-structured interviews to canvas their views on communication challenges that may have occurred and explain their strategies to overcome these challenges, if any. Appendix 3 shows the indicative interview guide. The interpreters also built on their anecdotes, stories, and examples from their broader experience.

The WSLHD HCIS had six full-time and 11 sessional interpreters in the Korean language group at the time of the data collection; they worked at different sites, including Auburn, Cumberland, Blacktown/Mount Druitt, and Westmead Hospitals. The two full-time Korean interpreters mainly practised in Westmead Hospital, and other full-time interpreters or sessional interpreters were asked to come to Westmead Hospital when needed. Five

Korean interpreters responded to the call for participation (see Chapter 3) and volunteered for the study. They were all born in South Korea and were native Korean speakers. Only one sessional interpreter had studied interpreting at university level, and had a master's degree, while the three full-time interpreters and one other sessional interpreter had completed a short course at TAFE over one semester and had a Diploma of Interpreting. All three full-time interpreters had more than thirty years of residence in Australia and between 16 and 25 years of practice as interpreters. All five interpreter participants were female and had Paraprofessional level NAATI accreditation (see Table 1-1 in Chapter 1) in interpreting in both language directions. Demographic characteristics of the participating interpreters can be found in Table 3-1.

According to a comprehensive outline of the different levels of NAATI accreditation (National Accreditation Authority for Translators and Interpreters, 2010), Professional Interpreter level (see Table 1-1 in Chapter 1) is the minimum level recommended by NAATI for work in healthcare settings. However, all five interpreter interview participants, including the interpreter with the master's degree, had only Paraprofessional-level NAATI accreditation (see Table 1-1 in Chapter 1) in interpreting in both language directions.

All five interviewees classified themselves as native Korean speakers with advanced English skills and chose Korean as the language of the interview. Interviews were recorded so that during the interview I could focus on the conversations with the interpreters and accurately record their answers. Audio files were later transcribed into Korean by the researcher and coded for themes. As an accredited translator, I translated Korean quotes into English to be used in this chapter.

5.3 Results

This section describes what I found from the follow-up interviews with the five Korean interpreters who participated in the observations (see Chapter 4). The results of the follow-up interviews will be triangulated with the findings of the observations in the discussion section to account for the behaviours of the interpreters. However, with a small sample size, caution must be applied, as the findings might not be transferable to all Korean interpreters or all healthcare interpreters in Australia. Notwithstanding, these responses may help us to understand the healthcare interpreters' perceptions of what constitute the intercultural communication challenges they face.

5.3.1 Interpreters' perceptions of the definition of intercultural communication

In the first part of the interview, I asked the interpreters to define the term 'intercultural communication' and to provide examples of possible cultural differences in healthcare settings involving Korean patients and English-speaking healthcare professionals. I did not provide definitions of the terms 'intercultural communication' or 'culture' before the interviews to avoid influencing the way in which participants took up the issues.

The question on the definition of intercultural communication was as below:

> Q1: Can you tell me about your perception of any intercultural issues in healthcare settings involving Korean patients and English-speaking medical practitioners?

Four out of five interpreters said that they do not encounter any cultural difficulties in interpreter-mediated healthcare settings. As for the reasons behind this, Interpreters 1 and

4 explained that in recent years Korea has been influenced by the Western world, particularly the United States, so Koreans are Westernised (Quote 5.1). Interpreter 3 believed that any differences between patients and healthcare professionals are individual differences rather than cultural differences. She believed that each individual has a different culture based on their background and experiences.

Quote 5.1: "글쎄요. 저는 사실 문화적 차이 이런걸로 트러블이 있을 이유가 없어요 거의. 뭐 개인마다 다 서로 다를 수 있는거고. 글쎄요. 그리고 뭐 워낙에 요새 한국 분들이 다 서양화되어 있어서 뭐 부끄러워서 의사 선생님에게 말을 못한다거나 질문을 못 한다거나 눈을 못 마주친다거나 뭐 이런거도 없고요. 전에는 뭐 애기 낳고 미역국도 많이 먹고 그랬는데 요샌 그런 일도 잘 없고요. 그런 일로 통역사가 뭐 문제될 만한 일도 잘 없어요".

"Well … I don't think I have problems with cultural differences. I mean each individual is different, anyway. Also, these days Koreans are very much Westernised so that they are not too shy to ask questions or to have direct eye contact with doctors at all. For example, new mothers used to have seaweed soup only at hospital after the baby's birth rather than foods given by the hospital, but it happens very rarely these days. Also, this didn't even cause any problem to interpreters anyway". (Interpreter 1)

The interpreter from the above quote mentioned some examples, including nonverbal communication differences and the views regarding postpartum care. For example, some Koreans used to avoid direct eye contact with doctors, were too shy to ask questions of doctors, and ate seaweed soup rather than food provided by hospitals after the childbirth. However, she stated that such traditional Korean cultural beliefs evolve over time in a modern society.

Interpreter 2 was the only one who said that she always encountered intercultural communication challenges, and in the first instance she pointed out the Korean patients'

reluctance to ask questions of medical professionals. She explained that Korean patients have the attitude that they can get all the right answers from healthcare professionals, and healthcare professionals should always take the lead. However, the other four interpreters disagreed on this matter, as will be discussed in Section 5.3.3.

Interpreters 1 and 2 both stated that one of the characteristics of Korean patients is that, in the interpreters' views, Korean patients do not answer directly to questions by healthcare professionals: they provide incoherent replies or irrelevant answers and background information. Interestingly, in Angelelli's (2004) study, the author argues that telling the story instead of providing direct answers is common in Spanish patients, indicating that this is not a Korean-only cultural trait. The interpreters in Angelelli's study managed the interaction by stopping the patient and asking the patient to answer the question instead of telling the story (p. 87), clearly breaching the interpreter's role according to the Code of Ethics. Consistent with the AUSIT Code of Ethics, the interpreters from my study argued that the interpreter's role is limited to acting as what they describe as a 'language tool' so that healthcare professionals can ultimately make their judgement and/or decision based on accurate interpretation, as expressed in Quote 5.2 below.

Quote 5.2: "우리는 언어 도구에요. 우리에게 결정권은 없으니까 양쪽의 이야기를 전달만 해 주는거죠. 우리가 뭐 의사에게 환자를 이렇게 해주세요 하지 말게 해 주세요 할 수도 없고. 환자에게 이렇게 하라고 권장할 수가 없기 때문에 우리는 그냥 정확한 통역, 정확한 언어 전달만 하는 거죠" .

"We [Interpreters] are language tools. We don't have the right to make decisions but [have to] deliver messages from both sides. We can't ask doctors to do something for patients, and we can't give advice to patients either. All we have to do is to interpret. In other words, we deliver messages from one language to another language". (Interpreter 2)

According to Interpreters 1 and 2, therefore, interpreters should only deliver messages accurately even though they are aware of intercultural differences with Korean patients. This view is in line with the position that the interaction be interpreted directly as described in Hale (2007), whereby healthcare professionals and patients primarily address each other, and interpreters interpret directly what has been said in the previous utterance by one of the participants. This direct approach (see Bolden, 2000) is also consistent with the Code of Conduct, specific to interpreters, of the AUSIT Code of Ethics (AUSIT, 2012, p. 14).

In contrast, Interpreter 3 reported that interpersonal skills are needed for healthcare interpreters in particular. She argued that interpreters have to comfort patients and soften the atmosphere with added expressions of comfort, a soft tone, and a gentle voice, as expressed in Quote 5.3.

Quote 5.3: "한 번 이런 일이 있었던 게 생각이 나요. 한 번 상담을 하던 중에 간호사가 무슨 폼을 작성하고 있었거든요. 그런데 환자분이 저한테 귓속말로 간호사가 너무 무서워보인다고 그래서 좀 겁이 난다고 그러는거에요. 그래서 제가 환자분한테 그랬죠. 제가 그 간호사분이랑 오랫동안 같이 일했었는데 좋으신 분이라고. 단지 좀 말투가 차갑고 딱딱하다고요. 환자분이 간호사를 믿을 수 있게끔 제가 해 드린 거죠. 물론 이 얘기를 영어로 통역하지는 않았죠. 그치만 그게 뭐 거짓말한 것도 아니고 뭐 없는 얘기를 한 것도 아니고 뭐 그렇잖아요. 그냥 제가 환자분을 안심시켜드릴 책임이 있고 또 환자분이 편안하게 느끼시게 해 드려야 하잖아요".

"Once the nurse was writing a form during the consultation, the patient whispered in Korean that the nurse looked scary, and the patient felt intimidated. I just told her that I had worked with the nurse for a long time, but she is a nice person but with a cold and dry tone. I assured the patient that she could trust the nurse. I didn't interpret this conversation into English, of course. But I don't

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> think it was a lie or an insertion or anything like that. I have some sort of responsibility to reassure the patient and make them feel comfortable". (Interpreter 3)

This view reflects a mediated approach as described by Hale (2007) and adopting Bolden's (2000) definition. With this approach, the interpreter is an active contributor to the communication process, and the interpreter is responsible for identifying communication barriers rather than being objective or impartial (Angelelli, 2004; Kaufert & Koolage, 1984). However, one can argue that in this instance the interpreter tried to look after the patient for the wellbeing of the patient, which motivated her actions. As explored in Section 2.5.2 in Chapter 2, in the guidelines provided for healthcare interpreters in the 1990s in Australia, healthcare interpreters had been asked to play a broader and more active role in intercultural situations, such as providing information to clients about the healthcare system; providing health-related cultural information to healthcare professionals; and helping clients to reduce fears, anxieties, and concerns that may impede effective communication (The Health Care Interpreter Service, 1994). Considering that four out of five interpreters who participated in my interview were accredited in the 1980s or 1990s, they would have followed the former guidelines suggesting that interpreters can be helpers as part of their role as interpreters. Another important aspect highlighted here is that the exchanges between the interpreter and the patient from the above quote were not shared with the nurse. When the interpreter began to act as a helper and tried to look after the patient, the nurse was excluded from this conversation, which is in violation of the principles of accuracy and impartiality of the AUSIT Code of Ethics. It should be noted that the example provided in Quote 5.3 had no

relationship to any intercultural differences between the Korean-speaking patient and the English-speaking nurse.

When asked to provide examples of possible cultural differences between Korean-speaking patients and English-speaking healthcare professionals, Interpreters 1 and 5 pointed out that differences between healthcare systems in Korea and Australia can be considered as cultural differences (Quote 5.4).

Quote 5.4: "이게 문화적인건지는 잘 모르겠는데 시스템 차이 때문에 어려울 때도 있어요. 호주 병원 시스템이 한국이랑 다르잖아요. 그러니까 뭐 호주 병원은 뭐가 이렇게 복잡해… 이런다던가. 아니면 뭐 메디케어 같은거, 그 다음에 뭐 일반의 있고 전문의 있고 이러잖아요. 그리고 또 산과 같은 경우에는 사립 병원이랑 공립 병원이랑 좀 다르고 미드와이프가 애를 받는 것도 좀 낯설고. 그런 시스템 차이를 모르는 분들이 좀 있으면 그게 이제 좀 우리가 설명을 해 드려야죠. 그런 것도 문화적 차이죠 뭐".

"I'm not sure whether it's a cultural difficulty or not, but the different healthcare systems between the two countries [Australia and Korea] can cause difficulties. Hospital systems in Australia are different from the ones in Korea, of course. So, patients often complain that hospital systems in Australia are more complicated. Or they are not sure about Medicare or the difference between GPs and specialists. When it comes to obstetrics, patients often don't know much about differences between public and private hospitals, or about the role of midwives. When patients are not sure about these differences in healthcare system, we [interpreters] have to explain. I think that's cultural difficulties". (Interpreter 1)

This view corroborates the existing findings (Kaufert & Koolage, 1984; Souza, 2016) in which interpreters define their role of 'cultural broker' as someone who explains the healthcare system or medical culture to a patient. However, the interpreter from the above quote did not explain when and how to provide the patients with this information about the

healthcare systems, and on what basis—for example whether it be based on the latest accurate information obtained from healthcare professionals or based on the interpreters' personal experience and understanding. It could be argued that lack of familiarity with the health system in NSW could be experienced by anybody who needs health services in the system for the first time, regardless of the language spoken or of their need for an interpreter.

5.3.1.1. Intercultural challenges that arise during home visits

When asked for examples of cultural differences between Korean-speaking patients and English-speaking healthcare professionals, all five interpreters answered that they face intercultural issues more often during home visits than at hospitals. One example mentioned was when healthcare professionals are asked to respect the Korean rules of the house by taking their shoes off (quotes 5.5 and 5.6). Most healthcare professionals accede to this request; however, some do not remove their shoes but put covers or plastic bags over them.

Quote 5.5: "가정 방문을 해 보면 한국분들 집에 가면 신발 벗어놓고 들어가야 되고. 그런데 의료 전문가들은 절대 신발 벗지 말라고 그래요. 위생이나 안전 뭐 이런 거 때문에 차라리 그냥 커버를 씌워서 들어가요. 그래서 그거를 제가 설명한 적이 있어요. 이런게 한국 문화라고. 한국 문화상 이렇게 하는거라고 얘기를 했죠".

"When you go on home visits to Korean homes, you should take your shoes off. But some healthcare professionals never want to do so because of hygiene or safety issues. They rather put some covers on their shoes. So, I used to explain to healthcare professionals that this [taking shoes off] is part of the Korean tradition and culture". (Interpreter 1)

Quote 5.6: "가정 방문을 하면 이제 문화적 차이라는 것은 이제 신발을 벗어야 되니까. 신발 벗는데 이제 병원 규정 자체가 의료 전문인이 신발을 벗지 못하게 되어 있어요. 그래서 예를 들어 그 수술실에서 쓰는 그 신발 커버를 가지고 다니면서 그거를 신는 분도 계세요. 근데 뭐 가끔 커버가 없으신 분들 있으면 한국 분들이 그냥 신발 신고 들어오세요 하는 경우도 있고. 아니면 거꾸로 그런 거를 이해하시고 알아서 신발을 벗는 의료 전문인도 있으시고요. 전부다 사람 나름이에요".

"I think the cultural difference when you go on home visits is when you are asked to take your shoes off. According to hospital regulations, healthcare professionals are not allowed to take their shoes off. So, some professionals bring their own covers, like the ones they use in operating theatres. But when they don't have any covers, Korean patients sometimes let them come in their houses with the shoes on. And of course, sometimes healthcare professionals understand and take their shoes off without any trouble. Everyone's different and every situation is different anyway". (Interpreter 3)

As seen in quotes 5.5 and 5.6, all five interpreters in my study held the general view that Koreans take their shoes off in their homes and English-speaking healthcare professionals will not, whether they understand and exercise such practices or not. Galanti (2015, p. 10) questioned whether such a practice is a cultural trait or a personal idiosyncrasy. Then, the interpreter explains, "Today, many Anglo Americans trying to be 'green' will also remove their shoes".

Another example provided was when, also according to the Korean tradition of hospitality, healthcare professionals are offered food and drink by Korean patients during home visits, sometimes excessively, even after the visitors kindly refuse (Quote 5.7). All five interpreters reported that this is based on Korean culture and tradition, so they always explain that to healthcare professionals. Interpreter 2 clarified that she also explains to Korean

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patients that healthcare professionals refuse the food or drink because of cultural differences, and not because they are rude, to make sure that Korean patients do not feel offended (Quote 5.7).

Quote 5.7: "가정 방문을 하면 완전 문화 차이를 느끼는데, 많은 한국분들이 뭐 커피 한잔 하세요 뭐 드세요 이래요. 그런데 의료 전문인들은 다 노 땡큐. 딱 싫다고 안 마셔요. 그런데 또 한국 할머니들은 그냥 막 가져와서 앞에서 딱 강제로 놓고 마시라고. 물론 좋은 마음인데 강제로 먹으라고. 그게 굉장히 한국적인 거거든요. 그러면 이제 제가 굉장히 유머감각을 가지고 한국분들 속상하거나 상처입지 않게 설명을 잘 하면서 양해를 구하죠".

"You can notice cultural differences very often during home visits. For example, many Korean patients always offer food and beverage like coffee to healthcare professionals and interpreters. Even if healthcare professionals say, "No thank you", Korean patients, especially elderly people, still bring some food and drink and almost force them to eat or drink. Of course, being gracious is a good thing and it's from their good hearts and kindness, but it's very Korean. Then I try to help Korean patients understand that healthcare professionals might not want to eat or drink not because they are rude, but they are not hungry or thirsty. I need a sense of humour so that I don't hurt the feelings of Korean patients". (Interpreter 2)

All the above examples in this section also illustrate the way Korean interpreters involve themselves by providing an explanation to either healthcare professionals or patients. All five interpreters suggested that they face intercultural communication challenges more often during home visits, and they all admitted that they intervened more often to provide an explanation during home visits than at hospitals. However, what they described as Korean culture was mostly based on the traditional nation-based views as explained in Section 2.2.1 in Chapter 2. This can lead to a situation where interpreters have only a subjective understanding of patients' culture so fail to bridge culture between two parties. Furthermore,

interpreting-service users often have different expectations of the role of the healthcare interpreter, which can pose challenges to healthcare interpreters.

5.3.1.2. Users' expectations of the role of healthcare interpreters

Users' expectations of the role of community interpreters usually do not coincide with interpreters' perceptions (see Section 2.4.2 in Chapter 2). This has been witnessed during my observations as well. In one case the interpreter was asked by the nurse to help the patient to fill out a form prior to the consultation, and in other cases the patients asked the interpreters to help them with administration issues after the consultation had finished (see Section 4.3.4.2 in Chapter 4).

Interpreter 3 pointed out users' unrealistic expectations of the role of healthcare interpreters when asked for examples of intercultural communication challenges (Quote 5.8).

Quote 5.8: "한 번은 환자분이 저한테 돈을 어떻게 내야 하냐고 물어보시더라고요. 그리고 또 한 번은 뭐 메디케어에 청구해야 하냐 아니면 개인 보험에 청구해야 하냐 이런거도 물어보시고. 한번은 환자분이 무슨 비자를 신청했는데 그 기관에서 편지를 받았다고 하시면서 그 편지를 보여주시더라고요. 그런데 편지를 읽어보니까 병원에서 무슨 증명서를 떼서 제출하라고 써있더라고요. 근데 환자분이 어떻게 해야할지 모르겠다고. 그 때 마침 제가 시간도 좀 있고, 내용도 아는거여서 제가 병원 창구에 모시고 가서 증명서 떼는걸 도와드렸어요. 보통 이런 일이 생기면 제가 시간이 있는한 도와드리는 편이에요. 환자분들이 이제 이런 것도 제가 하는 일이라고 생각을 하시는 거 같아요. 그러니까 이제 병원에서 제가 환자를 도울 수 있는 사람이 되기를 원하시는거죠".

"There was a case where a patient asked me what to do with the payment and another case where a patient asked me whether she could claim on Medicare or private health insurance. A patient came to me once and said he had applied for a visa and received a letter from a department. He showed me the letter, and it said he had to submit a certain type of certificate from the hospital. He said he didn't know what to do. I had some time and knew what he had to do, so I took him to the

> right counter and helped him to get the certificate. I normally help them with these things if I have time. It seems like patients believe that it is part of our job. They all expect us to be a helper at hospital". (Interpreter 3)

The interpreter from the above example has acted in accordance with the now outdated guidelines suggesting that healthcare interpreters become helpers as part of their role as interpreters. Furthermore, this view is in accordance with the description of the interpreter's role before the 1960s when there was no distinction between a helper and an interpreter who was, in most cases, a family member or a friend of the patient (see Section 2.5 in Chapter 2).

It is apparent that all five interpreters could not provide a clear definition of intercultural communication and had only a vague understanding of the cultural differences they could face during medical encounters. When asked to define the term 'intercultural communication' and to provide examples of possible cultural differences between Korean-speaking patients and English-speaking healthcare professionals without being given any further explanation or examples of intercultural communication, except for Interpreter 2 who said she encounters intercultural communication difficulties all the time, the other four interpreters said they do not have difficulties because of cultural differences. However, when I moved on to the next questions, which required some more detailed explanations, interpreters provided illustrations of cultural challenges with examples and anecdotes.

5.3.2 Korean family dynamics in medical consultations

In medical anthropology, the most frequently emerging topics of cultural challenges with CALD patients have been the facing of end-of-life situations with family members and

decision making (see Section 2.3.3 in Chapter 2). In her comprehensive analysis of 300 case studies with healthcare providers in the US, Galanti (2015) also reports that one of the most challenging experiences for healthcare professionals dealing with CALD patients is when patients are with their family members. This includes issues of family relationships and involvement, which can raise the question of patient autonomy.

The question on family dynamics across different cultures was as below:

Q3: Do you think patients across different cultures have different views on the issue of patient autonomy in regard to telling the truth to the patient about their diagnosis or prognosis (end-of-life situation, in particular)?

When asked whether patients across different cultures have different views on the issue of patient autonomy and family involvement, three interpreters answered that there are not many differences between Korean-speaking patients and English-speaking healthcare professionals, especially in recent years. Regarding the end-of-life situations and family involvement in decision-making, Interpreter 3 argued that there used to be cases where family members, especially adult children, asked doctors not to tell the truth about their condition or use the term 'cancer' to the patients. However, she had not experienced such cases for a long time. She explained that this situation very rarely happens these days.

Interpreter 2 said that some family members, before the consultation starts and in the absence of the patients, ask the healthcare professionals in Korean not to say the word 'cancer' in front of the patients. She then interprets everything into English and gives healthcare professionals the right to decide whether to do so (Quote 5.9).

Quote 5.9: "그런 경우 많지요. 가족분들은 어머님이나 아버님이 그런 사실을 알게 되면 더 빨리 악화된다는 그 생각으로 의사 선생님에게 아무 말도 하지 말아 주세요 라고 미리 부탁을 해요. 미리 부탁을 할 경우에는 우리가 미리 의사나 간호사나 또 전문가에게 알려 줘요. 가족이 원하지 않는다고 이야기를 했습니다 라고 해서 그 결정권은 전문가가 가지게끔 하는 거지요. 그렇지만 환자 앞에서 가족분들이 영어로 부탁을 하는 것은 저희가 어쩔 수가 없습니다. 저는 그냥 가만히 있는 거지요. 그리고 역시 의료 전문가가 결정을 하게 되는 거지요".

"Yes, it [family involvement in decision-making] happens a lot. Family members, especially adult children, usually believe that elderly patients' health will deteriorate when they find out about their terminal illnesses, so family members, before the consultation starts, ask healthcare professionals not to say anything about the terminal cancer diagnosis to patients. In this situation, interpreters have to deliver this message to nurses, doctors, or other professionals so that healthcare professionals will have a right to make a professional judgement. However, when family members directly ask doctors in English not to reveal terminal illnesses to patients, there's nothing I can do about it. I don't do anything. Then again, the healthcare professional makes a judgement". (Interpreter 2)

This is in accordance with the guidelines and policies (see Section 2.5.1 in Chapter 2) where healthcare professionals are expected to direct culture-related enquiries to patients and their family members. However, it is noteworthy that the interpreter from the above quote said that she cannot do anything when family members directly ask doctors in English not to reveal terminal illnesses to patients. This means that this dialogue between the family members and the doctors is not interpreted into Korean for the benefit of the patients. According to the AUSIT Code of Ethics, in the article accuracy (2012, p. 15), every side conversation or comment made by any of the parties should be accurately interpreted into the other language so that all parties can be kept informed, regardless of whether a side

conversation or comment was a private conversation among parties, or an attempt to engage the interpreter in a private conversation with either party. From my observations (see Chapter 4), in most cases, side conversations between participants, either in Korean or in English, were not interpreted at all into the other language, thus breaching Article 5, accuracy, of the Code of Ethics. The question is whether the interpreters from my observations and interviews were aware of the requirements of the Code about side conversations. It can only be surmised that Interpreter 2 from my interview did not know about this aspect of the Code regarding side conversations because she stated that there was nothing she could do about side conversations between the family members and the doctors.

Interpreter 1 explained that adult children of elderly patients are often deeply involved in healthcare communication. She asserted that an active involvement of adult children is based on the Korean culture, since children in Korea tend to take the responsibility of looking after their ill parents and make decisions on behalf of their parents, which they believe is a reflection of filial piety; although it can be argued that this is universal practice and not exclusive to Koreans. Furthermore, when adult children can directly communicate with healthcare professionals in English, they occasionally interpret for their parents without the assistance of interpreters. According to Interpreter 1, family members who can speak English tend to answer questions from healthcare professionals on behalf of their parents, and they sometimes interpret what healthcare professionals say in English into Korean for the patients. Interpreter 1 said that she generally waits until any party asks her to help by interpreting, and sometimes she asks them if they need a professional interpreter or not (Quote 5.10).

> Quote 5.10: "한국 자녀분들은 끼어들어요. 본인들이 막 통역을 해요. 그런데 가족들은 필터를 많이 하니까. 그리고 환자의 의견보다도 가족의 의견을 의사한테 얘기해버리니까.

그리고 뭘 지시를 해도 그냥 간단하게만 해주고 하니까. 특히 환자가 암이다 뭐 중병이다 그러면 환자도 알아야 되는데 가족이 안 알려줄 수도 있기 때문에. 그래서 사실 전문 통역사가 해야되는건데. 본인들이 끼어들면 저희도 어쩔 수가 없어요".

"Adult children of Korean patients usually cut in before interpreters interpret and they interpret for patients. But family members usually filter and summarise doctors' messages. And they directly deliver their opinions rather than the patients'. Also, they can edit doctors' instructions. For example, if patients are diagnosed with cancer or any other serious illnesses, family members often hide the diagnosis from patients. That's why they need professional interpreters, but interpreters can't do anything when they cut in". (Interpreter 1)

The situation above arises when family members of patients can speak English fluently. From this quote, similar to what Interpreter 2 explained above (see Quote 5.9), the healthcare professional had direct conversations in English with the family members, and the interpreter did not interpret their conversations into Korean for the patient. These two interpreters justified their behaviour on the grounds that family involvement is part of Korean culture, and there is nothing for them to do as an interpreter. However, it can be surmised that these interpreters do not seem to have the necessary tools to make a professional judgement and to behave ethically, regardless of whether there are intercultural differences. They can establish the contract at the start of the consultation, or they can switch to simultaneous interpreting when needed, which was never witnessed in my observations.

When asked about their perceptions on the issue of patient autonomy, other findings emerged in regard to doctor/patient rapport and communication: one with the theme of decision-making and the other with that of trust/lack of trust.

Two interpreters agreed that Korean patients tend to leave all the decision-making to healthcare professionals even after they have been given all the relevant information and

treatment options. As for the reason behind this view, Interpreter 3 mentioned that Korean patients are not familiar with the informed decision-making process, which she believes is more common in Western cultures. However, the other three interpreters disagreed on this matter. Interpreter 5 explained her opinion as below (Quote 5.11):

Quote 5.11: "글쎄 두 가지 경우가 다 있는 것 같아요. 보통 한국분들이 대부분 의사한테 맡기는 편이긴 한데, 또 그렇다고 다 무조건 하라는 대로 하는 건 아닌 것 같고. 한 번은 이런 적이 있었어요. 이건 완전히 한국 환자라고 할 수는 없겠지만. 예방주사를 맞히라고 하는데 아빠는 호주분이고 엄마는 한국분이어서 의사가 예방주사 맞히라고 하니까 엄마는 그냥 맞히려고 했는데 아빠가 반대해서 못 맞힌 경우가 있었어요. 아빠가 그 백신 안전에 대해서 걱정이 있었나 그래서. 근데 뭐 그게 꼭 한국 사람이고 호주 사람이고 그런거보다는 개인적으로 생각하는게 다르니까".

"I think it's yes and no [to the question of whether Korean patients leave decision-making to healthcare professionals]. I mean Korean patients usually leave all the decision-making to doctors, but not necessarily every patient does that. I remember one case where a Korean mother and an Australian father came with their baby. A doctor told them to get their baby immunised and the Korean mother just said yes, but the Australian father rejected vaccines because the father was worried about the safety of vaccinations. But still, that was not because the mother was Korean and the father was Australian, but it was more of a personal belief, I think". (Interpreter 5)

According to the above quote, the Korean mother followed the doctor's advice on immunisation, and the Australian father rejected vaccines because of his own beliefs. However, the interpreter from the above quote wanted to make it clear that this medical decision was more of a personal belief whether it be held by a person from a Korean culture, Australian culture, or Western culture. As explored in Section 2.3.1 in Chapter 2, the cultural beliefs of Koreans towards patient autonomy have changed over time although Korean

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culture was traditionally regarded as collectivist whereby harmony is highly valued and conflicts are to be avoided among groups, especially with authority figures (S. Kim, 2015; Mo et al., 2012; Morita et al., 2015). Similarly, the Western medical culture has been gradually changing, especially in terms of patient autonomy, from one of sole patient autonomy to that of shared decision-making (Butow et al., 1997, p. 325). Furthermore, public opinions about vaccination vary depending on diverse cultural beliefs, including individual stances towards vaccination, religious standpoints, and suspicion and mistrust of vaccines (The College of Physicians of Philadelphia, 2021). However, as the interpreter from the above quote argued, beliefs about vaccination cannot be limited to nation-based generalised views.

Interpreters 1 and 3 pointed out that Korean patients prefer older/experienced male doctors, and they tend not to trust young female doctors, especially when patients have to have major surgery. In this situation, Interpreter 1 said she provides any objective information that she is aware of to the Korean patients, such as how long a particular doctor had been practising or how many patients she had witnessed the doctor operate on. However, she did not explain when and how she provides such information nor the source of the information about the doctor. In contrast, when patients ask for an older male doctor, Interpreter 3 explained that she interprets what patients say into English so that the message is delivered to the healthcare professionals. She perceived that this preference is based on the Confucian hierarchical culture and can happen more often among patients of the older generation and those with less education. She explained that she can assume the patients' level of education by the way they speak, which can be assessed during the conversation in the waiting room. What is discussed during the waiting room conversation and how interpreters use this information during the medical encounters will be discussed in more detail in Section 5.3.4.1.

5.3.3 Speaking on behalf of any party

From my observations, in eight of the 20 cases, interpreters asked questions on behalf of the patients during the consultations based on their understanding or assumptions without being asked to do so by the patients. However, some interpreting-service users express their concerns about such behaviours of interpreters (Hsieh, 2016), arguing that they "may blur the lines between the patient's and the interpreter's agendas and communicative goals" (p. 249). To gain the interpreters' perceptions of Korean cultural values of hierarchy and the patients' hesitation in asking questions of healthcare professionals, the following question was asked:

> Q5: Do you think that patients from some cultures tend not to ask questions to people of authority, for example, elders, professors, or physicians?

Four out of five interpreters stated that Korean patients do not necessarily refrain from asking questions due to the hierarchical cultural values of Koreans. Interpreter 2 was the only one who argued that Korean patients are usually reluctant to ask questions of medical professionals. She asserted that Korean patients have the attitude that they can get all the right answers from healthcare professionals, and healthcare professionals should always take the lead (Quote 5:12).

> Quote 5.12: "문화적 차이...음...일단 한국분들은 그 질문하는 거가 훈련이 안 되어 있어요. 그 질문을 해서 대답을 받고 가는 그런 훈련이 되어 있지 않아서 그냥 그러니까 쉽게 말하면 사과나무 밑에서 입 벌리고 있는 식. 의사 선생님들이 다 대답해주고 알아서 해 주는걸 바라는 그런 마음가짐. 그래서 그렇게 좀 질문하고 내가 질문해서 알아야 될 권리를 좀

훈련해서 적어가지고 메모 식으로 적어서 확실하게 질문하고 내가 질문할 수 있다라는 거 확신을 가지시고 자신감으로 답을 얻어서 항상 시원한 마음으로 나가는 그런 거를 좀 가졌으면 너무 좋겠어요".

"Cultural differences … hmmm … first of all, Koreans are not trained to ask questions. They are not trained to ask questions to seek answers. I mean, it's like they're all opening their mouths under the apple tree. They just expect doctors to give answers to them. So, I wish Korean patients had been trained to prepare questions, write them down on a notepad prior to the consultation, and then come to see doctors with the confidence of being able to achieve what they want from doctors". (Interpreter 2)

From Quote 5.12, it is apparent that this interpreter seems to have the traditional views of Korean culture as described in Section 2.2.1. It can be surmised that the interpreter still has an understanding of Korean culture as it was in the 1970s, when she left Korea, since she had been living in Australia for more than 35 years at the time of the data collection.

On the other hand, all the other four interpreters disagreed on this matter. Interpreter 3 stated that it depends on the individual. However, she noticed some Korean patients, or their family members, were hesitant to ask questions, and she could detect this hesitancy based on the waiting room conversation. Interpreter 3 uses the waiting time to collect some background information about patients. She generally asks patients about their symptoms, the reason for their visit, whether they have any concerns or questions, and about any previous conditions (Quote 5.13).

Quote 5.13: "저는 이제 시작 전에 시간이 좀 있으면 항상 미리 얘기를 좀 해요. 물어보고. 특히 뭐 어디가 딱히 아픈지, 오늘 뭐 무슨 일로 왔는지, 특별히 뭐 물어보고 싶은건 없는지. 그래서 오늘도 아까 대기실에서 분명히 환자가 배가 아프다고 했는데, 딱 들어가서 의사가

'How are you?'하니까 그냥 괜찮다고 하잖아요. 그래서 이제 내가 환자분한테 '아까 아프다고 그랬잖아요'하고 이렇게 얘기를 해 주면 더 쉽죠".

"Before the consultation starts, I usually talk to patients and ask questions, such as what their symptoms are, what brings them to the clinics, and whether they have any specific questions they would like to ask the doctor. Today, before the consultation, I also had a conversation with the patient in the waiting room, right? She said she had pain in the stomach. But when the consultation started and the doctor asked her, 'How are you?', she said, 'all right'. So, I reminded her that 'You said you had pain before'. Then it's a lot easier for everyone". (Interpreter 3)

Despite the fact that the interpreter tried to collect background information about the patient while in the waiting room to help facilitate communication during the consultation, in the above quote (Quote 5.13), Interpreter 3 assumed that the doctor's message was to identify the patient's symptoms rather than to build rapport with the patient, which cannot be confirmed. As a result, the doctor might have lost a chance to build rapport with the patient even though the interpreter believed the communication proceeded much more easily for everyone involved because of her intervention. In this case, the interpreter also justified her behaviour saying that such issues are intercultural communication rather than ethical decision-making challenges. This interpreter possibly misread the doctor's behaviour and attributed the patient's reply to a cultural difference. Then she went beyond her role and breached the Code of Ethics in order to overcome what she believed was an intercultural challenge.

5.3.4 Interpreters' decisions about how to deal with intercultural communication challenges

Finally, I asked the interpreters how they manage a situation where they face difficulties arising from what they believe to be cultural differences between a medical professional and a patient. In previous studies (Angelelli, 2004; Hsieh, 2016), interpreters adopted various strategies to deal with cultural and ethical challenges: providing additional information, initiating an information-seeking process, deciding what is relevant and crucial information and omitting what they consider irrelevant, and reminding and prompting patients to discuss certain issues. The question on the interpreters' strategies to deal with intercultural communication challenges was as below:

Q8: How do you manage a situation where you face difficulties arising from cultural differences between a medical practitioner and a patient?

Interpreters 1 and 3 reported that they usually explain to healthcare professionals what they believe Korean culture is, although they did not say when and how they do so. Both interpreters believe their decisions and behaviours are based on common sense and professional judgement, which they learned from their work experience (Quote 5.14).

Quote 5.14: "그냥 뭐 일반 상식으로 하는 거죠. 문화라는 게 뭐 공부해서 다 배울 수 있는 것도 아니고 일을 하다보면 상식 선에서 결정하는 거죠. 그런데 경험 같은거는 하루 이틀에 되는게 아니니까 시간을 길게 두고 배워가야죠".

"I think we decide what to do based on our sensible common sense. Culture is something that you cannot study to learn everything, but it's something you acquire through experience. You just make

decisions based on common sense while working. But common sense and experience cannot be gained in one or two days. It takes a long time to learn culture through work experience". (Interpreter 3)

Interpreters 1 and 3 answered that they always provide additional information to healthcare professionals regarding patients' cultures mainly during the consultations, whereas Interpreter 2 stated that she uses the waiting room conversation to educate patients about how to communicate through interpreters and what to expect from interpreters, and the debriefing session to provide information to healthcare professionals. Interpreter 2 argued that the role of healthcare interpreters is to convey the message from one language to another. That is why she reported that she does not add any information, cultural or otherwise, during the conversation but tries to educate patients on what patients should do and what interpreters can do, and to debrief healthcare professionals about cultural differences between Korean patients and English-speaking healthcare professionals. Indeed, I observed cases of her acting as an educator in the waiting room and teaching patients how to work with interpreters. However, I did not observe any case where she had, or asked for, a debriefing session with healthcare professionals after the medical encounters. Further, what she did during the medical encounters was different from what she reported. For example, in Case 16 (see Table 4-1 in Chapter 4), Interpreter 2 initiated a side conversation with the midwife in English when providing additional information about a telephone interpreting service without being asked, and this conversation was not interpreted into Korean for the patient. Also, Interpreter 2 asked unsolicited questions on the patient's behalf on many occasions.

Interpreter 5 argued that it would be better for interpreters to share their intercultural communication challenges through workshops or seminars as part of their professional development. However, she added that it is not easy for sessional interpreters who are not able to receive regular interpreting jobs and often receive relatively urgent jobs in various places, to attend workshops or seminars during working hours. Furthermore, she asserted that some sessional interpreters cannot afford to attend those workshops or seminars even if they would like to do so. Interpreter 5 was the only one who appreciated the importance of training as well as work experience, and she was the only one who had completed a master's degree in translation and interpreting studies. Despite this, she was not aware of the current professional development programs or various online platforms that any interpreter could access. None of the interpreters who participated in this interview was an AUSIT member or had actively participated in online platforms or other channels where interpreters can share their questions and look for possible solutions. We can speculate that their isolation from other interpreting professionals could be contributing to their answers.

5.3.4.1. Use of conversations in the waiting room

Each interpreter had different perceptions of what occurs during the interactions between interpreters and patients in the waiting room. However, all availed themselves of this time with the patient to build a rapport with the patient, to establish the background of the consultation, or to educate the patient on the role of the interpreter (see Section 4.3.1.2 in Chapter 4). Interpreter 5 was the only one who said she always tries not to be left alone with patients in the waiting room/area so that she can keep a distance from patients and be objective. While waiting with patients, Interpreter 2 said that she generally educates Korean patients about how to prepare and make a list of their questions before the consultation and

get the answers to all the questions they might have in mind. She also explains to patients that interpreters can only convey messages that have been uttered, so patients should directly ask questions of the healthcare professionals. She then informs patients that it will break the principle of accuracy of the Code of Ethics if the interpreters ask questions on behalf of the patients. She repeatedly emphasises the requirement of accuracy that interpreters should abide by, and she explains the role of the interpreter and the Code of Ethics to patients and their family members whenever possible (Quote 5.15).

Quote 5.15: "한국분들은 궁금한 게 있어도 질문을 잘 하지 않고 의사 선생님이 다 알아서 해주길 바래요. 그래서 좀 질문할 것을 미리 좀 메모 식으로 적어서 확실하게 질문하고 답을 얻어서 가시라고 제가 항상 이야기를 하곤 해요. 그래서 이제 기다리는 동안에 같이 있으면 질문사항을 미리 준비해서 들어가시고 또 그 질문에 대한 대답만 하세요 하고 미리 교육을 시켜요. 통역사는 이제 권장을 할 수도 없고 하니까. 의사 선생님 앞에서 얘기를 하시면 무조건 통역을 해야 한다 뭐 이런 얘기도 하고요".

"Korean patients usually don't ask any questions even if they have something to ask and expect doctors to do everything for them. So, I always tell Korean patients to prepare a list of questions beforehand so that all the questions can be answered during the consultation. While waiting for the consultation, I usually train them to prepare a list of questions and also ask them to answer doctors' questions directly. I also educate them that interpreters cannot provide advice, and we are supposed to interpret everything they say in front of doctors". (Interpreter 2)

According to Quote 5.15, Interpreter 2, on the one hand, actively refers to the essential principles of the AUSIT Code of Ethics. On the other hand, she undertakes different roles, such as doctor's assistant and educator, which contradicts the principle of role boundaries in the AUSIT Code of Ethics. By making assumptions that she believes are of an intercultural

nature, as mentioned in Quote 5.15, she may be in breach of the Code of Ethics without realising it.

Interpreter 3 reported that she uses the waiting time to collect some background information about patients. She generally asks patients about their symptoms, the reason for their visit, any concerns or questions, and previous conditions. Interpreter 4 stated that she uses the waiting time to build a relationship with patients by asking personal questions. She mentioned that after the consultation, some patients ask questions or for advice, which may not directly be related to the consultation, or they ask for her contact details. Interpreter 4 gave out her telephone number and once received a call from a patient asking her to do another interpreting job on a personal matter. By doing so, she violated the principle of role boundaries in the Code of Ethics and Code of Conduct, which advise that "interpreters take care that conversations that may arise during periods of waiting remain courteous but do not become personal" (AUSIT, 2012, p. 15).

5.3.4.2. Use of debriefing sessions

Interpreters 1 and 2 reported that they often add their own explanations of an intercultural nature to the healthcare professional after the consultation finishes, and some healthcare professionals are glad to learn about cultural differences (quotes 5.16 and 5.17). One example Interpreter 2 cited was that, among in-patients, some have beliefs that the patients have to keep warm and eat warm foods because the imbalance of hot and cold is the cause of disease. In that case, after the consultation, she explained this cultural belief to the healthcare professionals and described it as an example of Korean cultural beliefs.

Quote 5.16: "한국 사람은 아프면 잘 먹어야되고, 마사지하고, 또 다른 사람이 떠먹여 주고 뭐 이런거 있잖아요. 또 따뜻하게 해야 하고. 그래서 막 병실에서 더운데도 옷 껴입고 그러는거. 이제 그러면 그게 오해가 생길 수 있고, 오진을 할 수도 있기 때문에 저는 끝나고 나서 설명을 해 줘요. 이게 한국 문화고 그런 어떤 믿음이 있어서 그런다라고 제가 설명을 해 주죠. 그럼 'That's good to know'이러죠. 어떤 경우에는 끝나고 전문의가 저에게 물어보는 경우도 간혹 있어요. 내가 조금 이상하게 느끼는 것이 혹시 culturally appropriate 하냐 하고요. 그러면 이제 제가 설명을 해 주는 경우도 있죠".

"Korean patients believe that they have to eat well, get a massage, and be fed by someone else when they are unwell. Also, they tend to cover patients in warm blankets and layers even in warm hospital rooms. This can cause misunderstandings and even misdiagnosis. So, I always explain this to doctors after the consultation. All these behaviours are based on Korean culture and their beliefs. Then doctors often say, 'That's good to know'. Sometimes professionals ask me, after the consultation, whether their behaviour or feeling was culturally appropriate. Then again, I explain this Korean culture to them". (Interpreter 2)

Quote 5.17: "한국 분들은 또 껴입어요. 입원실이 더워도 그렇게 껴입고 있어요. 특히 산모나 애기들. 너무 덥지 않냐고 간호사가 그래도 할머니가 애를 아주 뜨뜻하게 입혀서 세겹 네겹 이렇게 입혀서 있어요. 이제 그러면 제가 나중에 간호사한테 설명을 하죠. 한국 문화가 이렇다고 특히 신생아를 뜨뜻하게 해놓고 산모도 뜨뜻하게 입어야 된다. 양말 신어야 되고, 찬물도 마시면 안되고, 절대 차게 하면 안된다. 찬 바람도 쐬면 안된다. 이렇게 한국 문화다 이렇게요".

"Koreans tend to wear layers of clothes even if hospital rooms are warm—newborn babies and new mothers, in particular. Nurses sometimes say that it will be too hot, but grandmothers usually put three or four layers on newborn babies. Then after the session, I have to explain to nurses that this is Korean culture. In Korean culture, newborn babies and new mothers have to stay warm. New mothers must wear socks all the time, must not drink cold beverages, must avoid cold wind, and stay warm all the time. That is Korean culture and tradition". (Interpreter 1)

Interpreter 3 argued that it would be beneficial if interpreters can have a chance to have a brief conversation or explanation before the consultation starts, which rarely happens. She stated that interpreters only obtain patients' names and names of clinics just before the consultation. A lack of background information makes interpreting more challenging, especially in mental health clinics (Quote 5.18).

Quote 5.18: "사실 우리가 일을 하면서 5 분 정도 debrief 같은거 하면 환자에 대해서 우리가 background 를 알면 우리가 통역하기가 훨씬 쉬워요. 그리고 또 우리 마음의 준비도 할 수 있고. 근데 그런 케이스가 그렇게 많지 않아요. 그냥 환자 이름만 받아가지고 그냥 들어가는 거죠. 근데 이제 그런 것이 특히 정신과 병동 같은데 그런데 이제 들어가면 굉장히 따라가기가 힘들어요. 통역하면서 동시에 무슨 일인가 이런거를 빠르게 catch up 하고 배워야 돼요. 이런게 안 되면 통역이 자연스럽게 안되는 경우가 많죠".

"Actually, if we can have a debriefing session, maybe around five minutes, before the consultation, interpreting will be much easier. We can be prepared. But such a case is very rare. We usually go into the consulting room only with the patients' names. When it is in mental healthcare settings, in particular, it's a lot harder for us to manage. We have to grasp what is going on and catch the flow of the consultation while interpreting on the spot. If you can't, our interpreting will often be awkward". (Interpreter 3)

It is worth noting that this participant uses the word 'debriefing' where she clearly means 'briefing', and that this last comment refers to interpreters' working conditions, and not intercultural matters.

5.4 Discussion

My interviews have led me to conclude that all five interpreters have only a vague understanding of the definition of intercultural communication challenges, and they erroneously describe some ethical/professional challenges as cultural ones. Moreover, they generally do not agree on what can be described as Korean culture, and much of what they attribute to Korean culture could be perceived as the universal practices and beliefs of an older generation. This has been regarded as the biggest obstacle in understanding intercultural communication challenges in interpreting studies since the term 'culture' is likely to be perceived differently by different interpreters even among those with the same language combination (Hale, 2013).

The literature (See Chapter 2) shows a common tendency among interpreters and healthcare professionals to generalise the cultural trends of certain groups when healthcare professionals are being trained (Abbato, 2011; Galanti, 2015). However, it is important to clarify the distinction between generalisation and stereotype. That is to say, both healthcare professionals and interpreters need to be culturally competent by understanding the cultural profiles of people from various countries; however, such information may or may not apply to a particular individual and to a certain context. In my study, however, all five interpreters had stereotypical views about what Korean culture is. For example, they believe that Koreans all take their shoes off in their homes, and they offer food and drink to their visitors as part of their tradition of hospitality. Furthermore, each interpreter's views on Korean culture contradicted other interpreters' understandings in most cases. For example, five interpreters expressed contradicting views on whether Koreans regard family involvement and patient

autonomy differently than do English-speaking patients, whether Koreans are reluctant to ask questions of healthcare professionals, or whether Koreans prefer older male doctors.

As explored in Chapter 2, Korean culture is regarded as a collectivist culture in which family members' opinions are important in decision-making and respect is shown for the elderly—attitudes that have been influenced by patriarchal and hierarchical cultural values (Abbato, 2011; Galanti, 2015; H. Kim, 2017). However, recent studies have shown drastic changes in attitudes towards such cultural norms, and both patient autonomy and the traditional family-centred approach currently coexist in modern Korean society (see Section 2.3.1 in Chapter 2). In terms of family involvement and patient autonomy, which have been the most frequently discussed topic in previous studies (Goldstein, et al., 2002; Kagawa-Singer & Blackhall, 2001), all interpreters in my study agreed on the fact that in Korean culture, family members, and not the patient, used to be the main decision-makers, especially in the case of elderly patients with adult children who also attend the consultation. Some interpreters described this tendency as a disappearing one in modern Korean culture, whereas one interpreter claimed that it still exists among Korean patients. From my observations, in almost all cases, except for two cases in which the patients were children, the patients actively participated in the decision-making process; however, family members were also actively involved in the consultations (see Section 4.3.2.4 in Chapter 4). Furthermore, even in modern Western countries like Australia, the healthcare decision-making process has moved from a sole patient autonomy to a shared decision-making situation (Butow et al., 1997). As explored in Section 2.3.3 in Chapter 2, cultural beliefs about truth-telling in end-of-life situations are changing in all cultures, and not all members of the same culture would make the same choices. Inconsistencies in the attitudes of the patients towards their desire to know about their terminal illnesses and in how they accept a cancer diagnosis have been found in

my observations (see Section 4.3.4 in Chapter 4), which was consistent with previous studies (Goldstein et al., 2002; Kaufert, 1999). Similarly, during the follow-up interviews, interpreters showed mixed perceptions of traditional Korean culture and modern Korean culture.

During my observations, except for Interpreter 5, all the other four interpreters had waiting room conversations with patients. During the interviews, the interpreters explained how they use their conversations in the waiting room. Interpreter 2 said that while waiting with patients before the consultation starts, she educates patients on how to work with interpreters, and Interpreter 3 stated that she collects background information from patients since the chance to have briefing sessions and information provided prior to consultations is limited. However, interpreters commonly adopt additional roles during the waiting room conversation such as that of an educator or a doctor's or nurse's assistant. By doing so and by making their conversation personal, they unwittingly violate the Code of Ethics. Furthermore, they all explained their behaviours as intercultural communication strategies.

Another interesting finding, which supports previous studies, was the contradiction between what the interpreters believe they do and what they actually do. Thus, Interpreter 2 was the one who argued that she always educates patients on the role of the interpreter and the AUSIT Code of Ethics, including accuracy and impartiality. Contrary to her own argument, however, during my observations, she often initiated side conversations and asked questions of healthcare professionals on behalf of patients without being asked, and she provided additional information about the Australian healthcare system or other unsolicited extra medical information to patients (see Section 4.3 in Chapter 4). This interpreter, in particular, showed noticeable inconsistency between her accounts during the interview and her practices during the consultations observed. Although such inconsistency needs to be

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carefully analysed and cannot be extrapolated to all interpreters, as I only observed one instance of such inconsistencies, it may help us to understand the possibilities of inconsistency between how interpreters believe they behave and how they actually behave in real situations. This finding is consistent with the existing findings (Angelelli, 2004; Xu, 2019) where what interpreters do in actual practice is different from what they report in interviews. It is also worth noting that Interpreter 2 was the one who had worked longest as a healthcare interpreter, with 25 years' experience, and also had resided longest in Australia—35 years at the time of the data collection. She might still have an understanding of Korean culture as collectivist, whereby harmony is highly valued and conflicts are to be avoided among groups (see Section 2.3.1 in Chapter 2). Also, since she started working as a healthcare interpreter in the late 1970s, she would have been trained with the former guidelines that suggest that interpreters act as helpers as part of their role as interpreters. However, the findings of my study, from observations and interviews, show that whenever there is a situation that interpreters consider to be 'cultural', they act in ways that go against some of the articles of the Code of Ethics, mainly accuracy, impartiality, and role boundaries.

As I mentioned in the previous chapters (Chapters 2 and 4), despite all the existing guidelines and recommendations on briefing and debriefing sessions being essential (AUSIT, 2007; NSW HCIS PDC, 2014; Tebble, 1998), out of twenty consultations that I have observed, I have not observed any cases where either briefing or debriefing sessions were conducted, or where any interpreter asked for briefing or debriefing sessions. During my interviews, all five interpreters reported being aware of the need for briefing and debriefing sessions and complained that they do not have them very often. However, none mentioned that interpreters have the right to ask for briefing and debriefing sessions. Under the principle of maintaining professional relationships (AUSIT, 2012, p. 6), interpreters are responsible

for the quality of their work and should endeavour to secure satisfactory working conditions, which includes asking for appropriate briefing.

All five interpreters I interviewed in this study reported that they provide unsolicited cultural information to healthcare professionals either during or after the consultation based on their common sense and without being asked by healthcare professionals. However, these five Korean interpreters did not share their understanding of what common sense is and what constitutes Korean culture, hence healthcare professionals will receive inconsistent information from different interpreters regarding Korean cultures. The interpreters seemed to provide information about a patient's culture to healthcare professionals based on their individual beliefs and assumptions, and not supported by any studies or other information. This observation is consistent with some studies that found healthcare interpreters' behaviours playing various roles: from language interpreter to cultural broker, through to advocate (Angelelli, 2004; Kaufert & Koolage, 1984). However, one of the major concerns about these studies is that all the participating interpreters had no training or credentials. In Australia, professionally accredited or certified interpreters are expected to work in healthcare settings, at least with the mainstream languages, including Korean (see Chapter 1). At the time of the collection of the data for this study, university-level (or any other) education was not necessary to become a healthcare interpreter (see Chapter 1); however, four out of five interpreters who participated in this study had TAFE-level training, and one had a university-level translating and interpreting education. Moreover, there are guidelines and policies for both healthcare professionals and interpreters developed by government agencies or interpreting organisations. According to most of these guidelines and policies, healthcare professionals and interpreters are required to avoid cultural stereotyping and to direct any culture-related enquiries to patients and their family members instead of asking

interpreters to provide information about the patient's culture (AUSIT, 2007; Migrant and Refugee Women's Health Partnership, 2019; NSW Health, 2017; NSW HCIS PDC, 2014). However, how much these policy documents are adhered to by interpreters in real-life situations is unknown. My study shows that interpreters do not necessarily use any professional platforms or channels to update their skills and understanding of the more up-to-date professional Code of Ethics. Also, interpreters who had been in practice for more than 20 years, were more likely to act on the belief that they should play a more active role in intercultural situations than described in current guidelines.

The main finding in this section of my study is that what interpreters perceive as cultural challenges are often related to ethical or other professional challenges, and suggestions on how to deal with communication challenges is informed by their ethical decisions and even the breach of established professional ethical principles. Some interpreters justified their behaviours in violation of the Code of Ethics as inevitable actions in their roles as cultural brokers. When they tried to act more like a 'helper', allegedly for the patients' wellbeing, they were more likely to violate the principles of the Code of Ethics unwittingly. These findings support the criticisms of this approach by some researchers (Felberg & Skaaden, 2012; Hale, 2013) who argue that culture is often misused to explain communication breakdowns that are actually caused by other factors, such as poor working conditions, interpreters' ethical breaches or even incompetence.

Chapter 6 More voices from healthcare interpreters in Australia: online survey

6.1 Introduction

In intercultural communication studies (Schnurr & Zayts, 2017) and interpreting studies (Felberg & Skaaden, 2012; Hale, 2013b), researchers have found inconsistencies in the ways the notion of 'culture' has been defined and understood by individuals and in various contexts. Furthermore, participants from the above studies frequently mention the term 'culture' in various ways to express their frustrations in multicultural contexts or their challenges in intercultural communication. In the previous chapter, I presented a qualitative analysis of the data gathered during the post-observation interviews and discovered that all five Korean interpreters had divided views on the definition of Korean culture. They also mistakenly identified some of their ethical/professional challenges or interprofessional challenges as being cultural challenges. In addition, I witnessed a direct correlation between healthcare interpreters' communication challenges and unsatisfactory working conditions, including lack of briefing and debriefing sessions, lack of information about the case received before the consultations, and users' unrealistic expectations of the role of the healthcare interpreters. I also observed the interpreters' mixed understanding of their role boundaries and inconsistent professional behaviours.

As briefly mentioned above, from the data gathered during the post-observation interviews with Korean interpreters, there was no consensus on what constitutes communication challenges associated with Korean culture; they all had stereotypical views of Korean culture and provided unsolicited cultural information to healthcare professionals

based on their individual beliefs and assumptions, which is not supported by any studies or other information. However, the interview results are only part of the bigger picture since only five interpreters participated in the interviews, and the working language of the interpreters was also limited to Korean. Therefore, to broaden my study and gain perceptions from more interpreters with diverse language combinations and from different ethnic backgrounds, I also conducted an online survey that involved interpreters of other languages.

This chapter presents and analyses the results of the survey about intercultural communication challenges relating to healthcare interpreters' practices. While analysing the data from the survey, I also triangulated the survey results by comparing them with the findings from the data presented in the previous chapters on the observations and the interviews. This chapter aims to address the following questions:

1. How do Australian healthcare interpreters in different languages define intercultural communication and cultural differences?

2. How do healthcare interpreters identify and address intercultural communication challenges in interpreter-mediated medical encounters?

3. Is there a consensus among interpreters of the same language group, in addition to Korean, on what constitutes intercultural communication challenges?

4. What strategies do interpreters use to overcome such challenges, if any?

5. How do working conditions impact on the intercultural communication challenges?

6.2 The study

6.2.1 The questionnaire design

The questionnaire was designed to explore intercultural communication challenges of healthcare interpreters with diverse language groups in interpreter-mediated medical encounters. It was informed by the results of my observations and post-observation interviews with Korean interpreters. All the participating interpreters for the observations and interviews (see chapters 4 and 5) were Korean-English interpreters, whereas the target population for the questionnaire was Australian healthcare interpreters who work in any language combination. Therefore, a much bigger audience of interpreters was reached through the online questionnaire. The questionnaire (see Appendix 5) consisted of 29 questions, comprising closed questions and open-ended questions, with the last question asking for any additional comments. The questionnaire was divided into four parts. First, in Part 1, the demographic information of the respondents, including gender and age, first language and working language combinations, years of residence in Australia and years of practice as an interpreter, academic qualifications in interpreting, and NAATI accreditation level, were collected. In Part 2, the views of practising interpreters about intercultural communication challenges were investigated, including interpreters' understanding of intercultural communication and perceptions about patients' reactions to receiving a terminal illness diagnosis, patients' views about the decision-making process and patient autonomy, patients' involvement during the consultations, and interpreters' strategies in dealing with intercultural communication challenges. In Part 3, the perceptions of practising interpreters about the interpreter's role were elicited, including their functions of a cultural broker and/or helper. Interpreters' personal profiles were used for comparing their comments on their views

on intercultural communication challenges and the role of the interpreter. Lastly, in Part 4, the healthcare interpreters' views about their working conditions were asked, such as the provision of information before the consultations, briefing/debriefing sessions, and the way of explaining their role to the patients at the beginning of the consultations.

6.2.2 Data collection and analysis

In an attempt to canvass broader views and perceptions of healthcare interpreters working in Australia, regardless of their language combination, a questionnaire was conducted online between May and August 2016. Email invitations to participate in the online questionnaire (see Appendix 4) were sent to interpreting practitioners—who were at the time listed on the NAATI or AUSIT websites—via email, and also distributed through various online platforms, blogs, and newsletters, for interpreters whose names were not listed on either NAATI or AUSIT directories or who were not NAATI-accredited and were not AUSIT members. The online questionnaire was open for four months. The total number of interpreters who were contacted is difficult to determine since the participants were recruited through the snowball sampling method (Dörnyei, 2007; Sadler et al., 2010) whereby interpreters were contacted directly and asked to pass on the call for participants to others. I received 99 responses from interpreting practitioners, with various language combinations, who worked in Australia, whereas I observed and interviewed five Korean interpreters who worked in Westmead Hospital. The survey data were analysed quantitatively and qualitatively. For the qualitative analysis, themes and emerging patterns were identified (see Chapter 3).

6.3 Results

In this section, I present the findings from the online questionnaire, divided into four sub-sections: the demographic information of the respondents, the interpreters' perceptions of intercultural communication challenges, the interpreter's perceptions of their role in healthcare settings, and the interpreters' perceptions of their working conditions.

6.3.1 Respondents' demographic information

6.3.1.1. Gender and age

The gender and age distributions show a similar pattern as previous similar studies (Ozolins, 2004; Xu, 2019): more than 70% of respondents were female (72% female, N = 70 and 28% male, N = 27) and the majority older than 30 years (only 3% were younger than 30 years old).

Table 6.1

The Respondents' Age Group (n= 99)

Age group	Responses (%)	No. Responses
18–21	0	0
22–29	3.03	3
30–39	19.19	19
40–49	22.22	22
50–59	29.29	29
Over 60	26.26	26

Although it is commonly known that community interpreting is a profession with a preponderance of women, what is interesting in the table above is that an overwhelmingly older cohort showed more interest in the study. A similar pattern was also shown in my observations, where all five interpreting participants were female and over the age of 50.

6.3.1.2. First language and working languages

The questions had multiple-choice options, and the languages were grouped and classified based on the Australian Bureau of Statistics (2017) classification of languages. When asked about their first language and their working languages, more than a third of the respondents chose English as their first language (36.08%, N = 35) and slightly less than a third chose Australian Sign Language (Auslan) as their working language other than English (29.29%, N = 29). Among those 35 respondents who chose English as their first language, six declared that their working languages are spoken languages, such as Southern European languages, Southeast Asian languages, and Eastern Asian languages. Even though this is a relatively small proportion of the total number of respondents, it must be noted that not all healthcare interpreters in spoken languages are migrants or hail from the same ethnic community as the patients for whom they interpret. There was no respondent whose first language was an Australian indigenous language.

Table 6.2

The Respondents' First Language (N = 99)

First language	Response (%)	Response total
English	36.08	35
Eastern Asian languages (e.g., Chinese, Japanese, Korean)	15.49	16
Southern European languages (e.g., French, Greek, Italian, Maltese, Spanish)	12.37	12
Southwest and Central Asian languages (e.g., Arabic, Iranian, Turkish)	13.40	13
Eastern European languages (e.g., Baltic, Bulgarian, Hungarian, Polish, Romanian, Russian)	10.31	10
Auslan	7.22	7
Southern Asian languages (e.g., Hindi, Punjabi, Tamil)	7.22	7
Southeast Asian languages	3.12	4

First language	Response (%)	Response total
(e.g., Burmese, Filipino, Indonesian, Khmer, Malay, Thai, Vietnamese)		
Northern European languages (e.g., Celtic, German, Dutch, Scandinavian, Finnish)	0	0
Australian Indigenous languages	0	0

6.3.1.3. Years of residence in Australia and years of practice as interpreter

More than a quarter of the respondents (26.04%, N = 25) were born in Australia, and 76 out of 99 respondents stated that they had resided in Australia for more than 20 years. However, relatively few had worked for a long period as an interpreter. Over a third indicated they had been working as an interpreter for fewer than ten years (15% for fewer than five years and 21% for between 5 and 10 years), while a further 25% had been working for between 11 and 20 years. A little less than 40% (N = 38) had worked more than 20 years. It is apparent that more than half (N = 63) had practical experience of more than 10 years.

6.3.1.4. Academic qualifications in interpreting and NAATI accreditation

When asked to indicate their academic qualifications in interpreting, more than three quarters of respondents (76%) reported that they had some tertiary education in interpreting studies, such as a TAFE diploma (32%), undergraduate degree (13%), or postgraduate degree (27%). Only 24% of the respondents reported no education or training background in interpreting. This corroborates the findings of previous studies (Hale, 2007; Ozolins, 2004;

Xu, 2019), which could indicate that educated interpreters are more likely to participate in research. The respondents with no academic background in interpreting indicated interpreting experience ranging from fewer than 5 years to more than 20 years. Among those 24 respondents with no academic background, the most notable were five respondents with fewer than 5 years of practice from various language groups, including South-East Asian, Southern and Central Asian, Southern and Eastern European, and Southwest and Central Asian. Although the importance of interpreting education and training has been emphasised and promoted by researchers (Hale, 2007), there are still many in the field who practice without any formal training.

Most of the respondents (98%) were NAATI accredited[5]. Out of 99 respondents, 45 were accredited at Professional Interpreter level, 43 at Paraprofessional Interpreter level, four at Conference Interpreter level and 4 were Recognised Interpreters[6]. The Korean interpreters I observed and interviewed (Chapters 4 and 5) were all Paraprofessional Interpreters with some training, ranging from a TAFE diploma to a master's degree, which supports the results of the survey. In a national survey of interpreting practitioners in 2003, Ozolins (2004) found

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[5] At the time of data collection, the NAATI certification system had not been introduced. Thus, the term 'accreditation' is used throughout this thesis.

[6] Recognised Interpreter: This credential is an acknowledgement that at the time of the award the applicant has had recent and regular work experience as an interpreter but no level of proficiency is specified. In order to be granted NAATI Recognition, the applicant must provide proof of English proficiency and complete an introductory NAATI workshop or related activity. There is no NAATI testing of a Recognition applicant. Recognised interpreters are encouraged to obtain accreditation as it becomes available (Slatyer, 2015, p. 27).

that more Professional interpreters had completed postgraduate studies than Paraprofessional interpreters. Such a trend was also shown in my survey data in which all four Conference interpreters had undertaken postgraduate studies, and 15 out of 42 Professional interpreters and four out of 43 Paraprofessional interpreters had completed postgraduate studies. Two respondents stated that they did not have NAATI accreditation. One respondent did not have NAATI accreditation in interpreting but only in translation and still had work experience as a healthcare interpreter.

6.3.2 Intercultural communication challenges

This section reports on the results of questions relating to the key aspects of the thesis, which focus on the intercultural communication challenges that healthcare interpreters can face. I first asked the respondents if they had ever experienced challenges due to cultural differences in healthcare interpreting. I did not provide a definition of the term 'intercultural communication' in the questionnaire to avoid influencing the respondents' answers. Then they were asked to provide examples of intercultural communication challenges and their strategies for dealing with them.

6.3.2.1. Perceptions of the definition of intercultural communication

This section of the questionnaire started with an open-ended question to allow the respondents the freedom to answer in their own words rather than limiting their responses to a set of choices. First, the respondents were asked whether they had experienced challenges due to cultural differences in healthcare interpreting. If they responded 'yes', they were asked to provide examples. Interestingly, several respondents stated that they could only answer

this question if the definition of intercultural communication was adequately provided (see Quote 6.1):

Quote 6.1

"Too many things get thrown into the basket of 'cultural differences' when they are not cultural, they are a lack of knowledge, a lack of information, inherently poor communicators, a failure of an interpreter to verbalise non-verbal components of information when needed (ask Auslan practitioners about this one), or interpreter lack of objectivity, skill, knowledge or experience, or a combination of same". (Respondent No. 23)[7]

The respondent from the above quote added that we need to define 'cultural difference' before she can answer this question. As Hale (2013b) points out, the biggest obstacle in understanding intercultural issues is that "the term 'culture' or the phrase 'cross-cultural differences' remain vague and elusive and are likely to elicit very different responses from different interpreters" (p. 2). The respondent from the above quote also claimed that culture is often mistakenly blamed for unethical and incompetent interpreters.

When asked if they had experienced challenges due to cultural differences in healthcare interpreting, 61 out of 99 respondents replied 'yes', 15 said 'no', and 23 did not answer the question. Although almost two-thirds of the respondents (61.6%) said that they

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[7] I have not edited the statements in the survey and have reproduced them as they are.

had experienced intercultural communication difficulties, almost a quarter of the respondents (23.2%) did not respond to this question.

The respondents who reported 'no' or did not answer the above question might not have been entirely sure what the term 'intercultural communication' implies, since ten of them added some examples of intercultural and/or interlinguistic challenges in the comments. One respondent stated that "Due to being very familiar with my culture, I have not faced major challenges during my assignments as an interpreter" (Respondent No. 96). This respondent apparently has stereotypical views of the patient's culture being the same as the interpreter's because they came from the same country or the same ethnic group. This interpreter was a Paraprofessional Interpreter with fewer than five years of practice as an interpreter and no academic background in interpreting.

In the next sub-sections, I examine interpreters' responses in relation to several themes that arose from the survey: family involvement and patients' being informed of a terminal illness, patients' reluctance to ask questions, cultural beliefs in relation to health, and communication challenges.

6.3.2.2. Family involvement and being informed of a terminal illness

It has been claimed that one of the most challenging experiences for healthcare professionals dealing with CALD patients occurs when patients are with their family members and the patients are in end-of-life situations (Galanti, 2015; Kagawa-Singer & Blackhall, 2001). Galanti's (2015) argument concerning healthcare professionals' challenging experiences with family members is based on her comprehensive analysis of 300 case studies with healthcare providers in the US about cultural differences in the role of family members when someone is ill (See Chapter 2, Section 2.3.3). Examples relating

challenging experiences with family members include whether a patient or a family is to be regarded as the decision-maker, who can be the authority figure in a family, and situations when family members are too protective of the patient or too demanding. When asked about the respondents' understanding of patient autonomy in terms of being informed of a terminal illness, the results of my survey showed that more than half of the interpreter respondents (58.3%) disagreed that patients they interpret for prefer not to be informed of a terminal illness, and fewer than 10 percent of the respondents agreed. One third of the respondents (32.3%) chose 'neutral' as their response. The respondents who agreed with this statement added comments expressing a view that family members' active involvement, or even interference, and their concealment of a negative diagnosis or prognosis from patients are cultural traits of people from their language background. There was no marked difference between the language groups, but respondents from some language groups showed contradicting views within the same language group. For example, only 1 out of 18 respondents in the Southern European language group agreed that the patients from the same language group prefer not to be informed of a terminal illness whereas five out of 18 strongly disagreed with such a view. Of course, many languages fall within the category of Southern European languages, and those languages are spoken in many countries around the globe. Another interesting point from this language group is that all six respondents who claimed their first language to be English selected 'neutral' for this question. Similarly, out of 7 respondents in the Eastern European language group, one respondent strongly agreed and three strongly disagreed that the patients from the same language group prefer withholding information about a terminal illness. These data must be interpreted with caution because of the variety of languages within one category. However, a very small number or none of the respondents from all the Asian language or Auslan groups believe that the CALD patients

they interpret for prefer not to be informed of a terminal illness, which contradicts what has been described in the literature (Abbato, 2011). The diverse opinions across the different language combinations can be seen in Figure 6.1.

Figure 6-1

Respondents' Perceptions of Whether CALD Patients Prefer Not to be Informed of a Terminal Illness
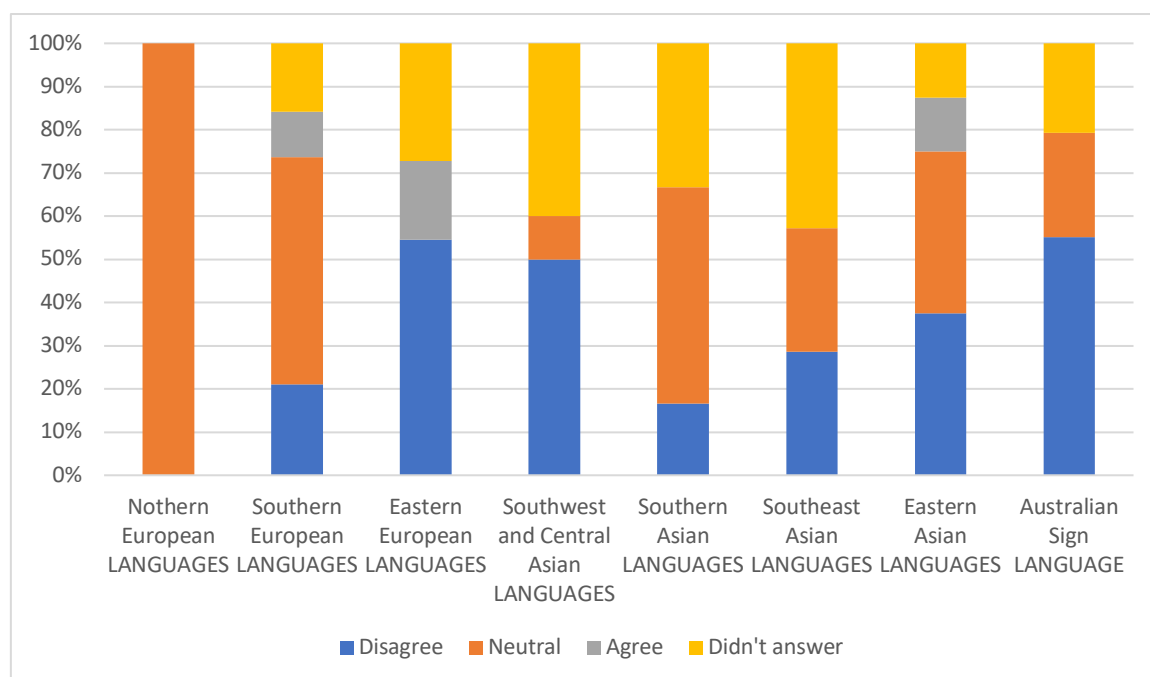
One respondent added comments indicating that, in her view, family members often intervene in the discussion between patients and healthcare professionals, dominate and control the consultation, or withhold a negative diagnosis or prognosis from patients (see Quote 6.2):

However, two other respondents from the same language group as the above

respondent did not agree with such views. Although they did not make any further comments,

those two respondents chose 'neutral' for the question of whether the CALD patients for

whom they interpret prefer not to be informed of a terminal illness. It is important to bear in

mind that the view from the respondent in Quote 6.2 cannot be generalised since it is only

that of one respondent. What is interesting in this data is that there is no consensus among

the respondents of the same group of languages on what constitutes a cultural norm in terms

of patient autonomy and family involvement. One respondent added that the degree of family

involvement can differ between demographic groups:

comes to treatment. Uneducated people are very passive, don't provide much information to doctors and expect their doctor to decide for them". (Respondent No. 93)

From this respondent's perspective, age groups and education levels of patients can also exert an influence on the degree of family involvement and the patient's preference as to whether they want to be informed of a terminal illness or not. Although, again, this view cannot be generalised since it was mentioned by only one respondent, it is still interesting to note a disagreement among respondents of the same language group.

6.3.2.3. Patients' reluctance to ask questions

Effective doctor-patient communication can improve the quality of healthcare outcomes, such as patient satisfaction, patient adherence to treatment, and health outcomes (Felberg & Skaaden, 2012). Although there has been a shift in doctor-patient communication towards patient-centred care through enabling patients to actively participate in their own medical care, patients in monolingual medical encounters may still feel reluctant to ask questions of their healthcare professionals (Katz et al., 2007). One of the reasons behind this reluctance to ask questions is when patients view the healthcare professional as the decision-maker and patients do not hold a belief in his or her capacity to execute one's own behaviour (Street et al., 2005). Similarly, patients in bilingual or multilingual medical encounters can also have a certain reluctance to ask questions for the same reasons. Based on an analysis of 279 doctor-patient interactions from three different clinical sites in America, Street et al. (2005) found that non-White, working class, and less educated patients are less active participants than their counterparts. That is to say, even patients from non-English speaking

cultures may be more reluctant to ask questions in medical settings despite the existence of interpreters. For this reason, through clinical practice guidelines for healthcare professionals in Australia for communicating the prognosis and end-of-life issues, healthcare professionals are recommended to "encourage the patient or caregiver to ask questions and revisit the topic in the future when they want further information" (Clayton et al., 2007, p. S91).

In my survey, when asked if they thought the patients from their language group are reluctant to ask questions during medical consultations even if they do not understand what the healthcare professionals said or disagreed with them, more than half of the respondents (53.6%) either strongly or somewhat agreed with the question. Nine out of 99 respondents indicated neutral/do not know, and more than a third of the respondents (37.1%) either strongly or somewhat disagreed with the question. Again, there was no marked difference between the language groups, and each language group showed contradicting views and similar percentages of agreement and disagreement were found from all the respondents. There was only one language group that showed a marked tendency (25 out of 28 respondents) to agree that the patients from their language group were reluctant to ask questions, which was the Auslan group; this is consistent with previous research findings (Mindess, 1999). Also, a similar belief can be seen in the comments among respondents from some Asian language groups. One respondent from the Southeast Asian and another from the Southern Asian language group commented that "patients are a bit shy and some of them are reluctant to give details when it comes to personal, sensitive issues" (Respondent No. 57). Furthermore, two respondents from the Southern European language group commented that "Doctors are seen as God, so patients do not dare ask questions or clarifications, contradict the doctor, or defend him/herself if the doctor is rude or patronising" (Respondent No. 3).

However, with only a small number of respondents who made such statements, caution must be applied, as their views might not be generalisable to others in their language groups.

6.3.2.4. Additional comments

At the end of this section of the questionnaire, there was a question for optional free-text comments so that the respondents could add their own examples of intercultural communication challenges not listed in the previous questions. Two main themes emerged from the respondents' comments: cultural beliefs in relation to health, and communication challenges. Since these themes emerged from the respondents' free-text comments and mostly from a small number of respondents, they cannot be extrapolated to all interpreters in the same language group, and it is important to bear in mind the possible bias in these responses. However, these responses may help us to understand the healthcare interpreters' perceptions of what constitutes the intercultural communication challenges that they face.

6.3.2.4.1. Cultural beliefs in relation to health

Regarding cultural beliefs in relation to health, three main themes emerged from the respondents' comments: the stigma of mental illness, the issue of the gender of the interpreter, and the patients' discourse practices where listeners should have knowledge of a particular situation to understand what words mean. Additionally, some Auslan interpreters commented on Deaf culture.

Firstly, with regards to beliefs about mental illness, three respondents—one from the Southern European language group and the other two from the Southwest and Central Asian language group—reported that there is a stigma attached to mental illness in the culture of their language community. Respondent No. 3 stated that "some patients experience fear of

and resistance toward psychologists and psychiatrists". Respondent No. 70 also commented that "interpreting in medical appointments regarding mental health issues can also be challenging due to cultural stigmas attached to it".

Secondly, with regards to the gender of the interpreter, a total of seven respondents from various language groups reported that the gender of the interpreter is a cultural issue for some patients (see Quote 6.4). Two of them were from the Southern European language group, two were from the Southwest and Central Asian language group, another two were from the Southern Asian language group, and one from the Eastern Asian language group.

Quote 6. 4

"Sometimes there are difficulties with gender differences within certain cultures. I think the gender of the interpreter needs to be considered more carefully on a case-by-case basis". (Respondent No. 49)

There are similarities between the attitude expressed in the above quote and those described by Crezee (2013). In a small pilot survey conducted among healthcare interpreters in Auckland, New Zealand, in 2001, Crezee (2013) found some issues to do with female interpreters interpreting for male clients, or vice versa. In their surveys, respondents from some languages (e.g., African or Pacific Islands languages) reported that the gender of the interpreter was more likely to be an issue than did respondents from other languages (e.g., Chinese languages) (p. 256).

The third aspect related to patients' cultural beliefs was about the discourse practices of the patients who give excessive information rather than a direct answer to the doctor's questions (see quotes 6.5 and 6.6).

Quote 6.5

"When a question requires a specific answer, but the person goes into the whole story". (Respondent No. 30)

Quote 6.6

"Deaf people will often tell the entire story of how they acquired the health condition. Health professionals often want short answers to their questions due to time constraints". (Respondent No. 45)

Both respondents from the above quotes are Auslan interpreters and report that providing excessive background information before a direct answer to the questions is a type of discourse practice and a cultural trait of deaf people. These responses, however, need to be interpreted with caution since only two respondents mentioned such behaviour. These data do not provide patterns that can be generalised to the perceptions of all Auslan interpreters, but they can provide illustrative examples. It is known from the literature that some languages are contextual languages or topic-comment languages where sentences describe a contextual background first (Mindess, 1999). In an ethnographic study on intercultural communication conducted in the US by Angelelli (2004), a Spanish interpreter also asserted that in the

interpreter's culture, contextual information tends to be explained before a straight answer for a question is provided. The interpreter from her study deliberately omitted the patient's story, which the interpreter believed was irrelevant to the consultation, to save the doctor's time (see Section 2.5.1 in Chapter 2). Also, as mentioned in Section 2.2.1, Chapter 2, Hall classified Asian, African-American, and Native American cultures as high-context cultures, and North American, German, and Scandinavian cultures as low-context cultures (1976, p. 91). However, some Auslan interpreters' commented that Deaf patients often tell the entire story instead of giving short answers to the healthcare professionals' questions, which corroborates the ideas of Mindess et al., (2006) who found the concept of high- and low-context cultures can be used to describe certain groups or specific settings and is not limited to nationalities or regional communities. In this case, Deaf culture can be classified as one distinct cultural group regardless of their country of birth. On the other hand, it can also be suggested that such comments as made in quotes 6.5 and 6.6 can be expressed by any language group; thus, it is not necessarily a cultural issue but a universal issue relating to the patient or the less powerful participant, or to less educated people. Looking at a link between social class and the successful outcome of a trial in the courtroom, Conley and O'Barr (1990) found that a powerless speech style, or relational orientated speech in which witnesses rambled and went off on tangents in telling their full story, tended to belong predominantly to a lower social class, minorities, the poor, and the uneducated.

6.3.2.4.2. Linguistic challenges and non-verbal aspects of communication

Along with cultural beliefs in relation to health, linguistic challenges and non-verbal aspects of communication are aspects of culture that can influence healthcare communication, including manner of delivery, pragmatics, and non-verbal aspects of

communication (see Section 2.3.2. in Chapter 2). Some respondents added comments regarding communication challenges in different areas seemingly unrelated to intercultural matters: interlinguistic differences, including false cognates when similar-sounding words have different meanings in different languages; turn-taking in conversation; healthcare professionals' use of the third-person pronoun when referring to the patients; and non-verbal communication differences.

Firstly, two respondents expressed the belief that linguistic difficulties can be regarded as intercultural communication challenges. One respondent asserted that "the entire challenge being dealt with in interpreting is a cultural difference between the two interlocutors: they can't speak the same language" (Respondent No. 2). However, it seems that this respondent did not understand the fact that even if the two interlocutors speak the same language, they do not necessarily share the one definite culture. Another respondent included a specific example of cross-linguistic differences:

Quote 6.7

"Gender neutral language: sometimes, the syntax of certain sentences in South Asian languages is gender neutral. However, while interpreting into English, I need to use the pronoun he or she. Therefore, every time, I would need to say, 'he or she' or I use the pronoun 'that one'". (Respondent No. 37)

The issue of gender-neutral language as in the above quote has also been discussed in Lee's (2009b) study. Based on the discourse of Korean-English interpreting in Australian courtrooms, she found that interpreters can face difficulties due to differences between the

lexico-grammatical systems of Korean and English. She pointed out that interlinguistic differences between Korean and English resulting from linguistic features of the Korean language—such as the absence of strict marking of singularity and plurality, number, person, and gender—can pose challenges for interpreters. Although the interpreter from Quote 6.7 is not from the same language group as Korean, it can be assumed that the same interlinguistic features can be shared with interpreters from different language groups. Hale (2013b) argues that well-trained and competent professional interpreters should be able to interpret accurately at the discourse pragmatic level. That is to say, interpreters should have a thorough knowledge of the two languages involved and understand the text as discourse rather than as words or sentences strung together (Hale, 2007, p. 23) even though it still may be impossible to interpret accurately without additional information about gender or number.

A second aspect of the communication challenges that emerged from the respondents' comments was when a word or term that has an equivalent in the other language has different shades of meanings in different languages. There were two examples in this category from the respondents' comments (quotes 6.8 and 6.9), both from the Southern European language group.

Quote 6.8

"Case in point—a patient is told not to drink too much tea because of its effect on the bladder. An English-speaking patient will understand tea to mean black tea (tea leaves), whereas a patient from my cultural background will understand tea to mean herbal tea, which has no impact on the bladder and indeed is seen as beneficial to the health. It would be good to let both parties know that there is a difference to how they each understand the word 'tea', otherwise they're not on the same page". (Respondent No. 29)

Quote 6.9

"In Latin America, seasons change on the 21st rather than the first day of the month,

e.g., Spring starts on 21 September. One of the questions in the mental health

assessments is 'what season are we in now'. Some patients would mention the wrong

season and that can be taken as mental health deficiency". (Respondent No. 59)

To someone unfamiliar with the patients' cultures from the above quotes, it would be difficult to understand the possibilities of miscommunication due to different meanings of the same word or term in different languages. Although interpreters can understand this interlinguistic difference, it would be equally important not to ascribe patients' individual cultural traits or beliefs to their national culture. It is known from the literature (Ferguson & Candib, 2002; Lee, 2009b, 2010) that such cross-linguistic challenges could affect interpreting performance. Analysing approximately 80 hours of audio-recorded interpreter-mediated courtroom examinations in Australia, Lee (2009c) found a case where the interpreter used various words inconsistently, as there was no equivalent concept of the term in Korean. Lee argues that such inconsistency in the interpretation of the same terms might have serious implications for the results of the case; thus, court interpreters should alert the court to the difficulties of accurate translation and endeavour to clarify interlinguistic differences. Having said that, it is worth pointing out that both interpreters who made the above comments seem to display stereotypical views of how the patients from their cultural backgrounds understand such terms. Also, while looking at the different meanings of the

same words or terms, some respondents make an assumption about the medical benefits of what healthcare professionals suggested (see the example of the term 'tea' in Quote 6.8). Even though such understanding is based on what they believe is common sense, it can still be risky to assume the intention of the healthcare professionals as interpreters are not professionally trained healthcare staff.

Thirdly, respondents mentioned turn-taking in conversation as another source of communication challenges for healthcare interpreters. One respondent commented in relation to telephone interpreting, as explained in Quote 6.10 below:

Quote 6.10

"Problems in phone interpreting with non-native English speakers of English (Chinese, Indian, etc.) who do not have a heightened sense of turn-taking when it comes to speaking. They will interrupt as often as the Greek speaker will interrupt. I label this linguistic/cultural as it may be deemed appropriate in other cultures to interrupt dialogue without concern". (Respondent No. 7)

Telephone interpreting deprives interpreters of visual cues and poses more challenges in managing the communication process. However, the interpreter from the above quote emphasises the fact that turn management raises more issues with non-native English-speaking healthcare professionals. Two interpreters from the Southern European language group claimed that they face intercultural communication challenges more with non-native English-speaking doctors, especially Asian doctors. Respondent No 7, who commented above, reported that his first language was English even though he was born in North-West Europe. One Auslan interpreter whose first language was English also commented that she

faced intercultural communication challenges with non-native English-speaking healthcare professionals. As explored in the literature review chapter (Chapter 2), most of the previous studies on the issue of intercultural communication focused on the diverse cultures of the patients, not the healthcare professionals or interpreters. As witnessed in the data above, based on their cultural diversity and personal experiences, interpreters can experience diverse intercultural challenges from various standpoints. Not all interpreters from the same language background agreed on what the cultures of patients are, but neither did they agree on what the cultures of healthcare professionals from different language backgrounds are.

A fourth aspect of the communication challenges that emerged from the respondents' comments was a use of the third-person pronoun by the healthcare professionals when referring to the patients. Two Auslan interpreters complained that healthcare professionals rarely address the patients directly and often speak about them to interpreters in the third person, for example, "Can you tell them…?" Healthcare interpreters are guided and trained to interpret in the first person "to minimise confusion, enhance accuracy in form and content as well as reinforce the role of the interpreter as a neutral facilitator of communication" (NSW HCIS PDC, 2014, p. 17). However, it is not known whether those respondents in the survey had invited both the healthcare professionals and the patients to use the first-person pronoun, nor whether they had set the ground rules before the consultations and properly explained to the healthcare professionals and the patients how to work with interpreters before the consultation started.

Lastly, six respondents from various language groups, including Southern European, Southern Asian, Eastern Asian, and Auslan, regarded non-verbal communication issues as examples of intercultural communication challenges. Examples include avoidance of eye contact from patients and less overt body language. It is known from the literature that

cultural values can have a significant influence on non-verbal communication, including eye contact, physical contact, and personal space (Crezee, 2013; Galanti, 2015; Hale, 2013b). In the documents on cultural profiles provided for healthcare professionals (Abbato, 2011; Galanti, 2015; Queensland Health, 2013), it is stated that it is common in Asian cultures, including Chinese, Japanese, Korean, Hmong, and Vietnamese, to follow the tendency of avoiding direct eye contact in order to show respect, especially to a person in a superior position. However, in my survey, respondents from various language groups reported that some medical professionals do not make eye contact with patients. The Auslan language group had the greatest number of respondents who added comments about non-verbal communication as intercultural communication challenges. Six out of 29 Auslan interpreters complained that healthcare professionals do not make direct eye contact with patients and look at the interpreters instead. They all strongly contended that there is a need for educating healthcare professionals in how to deal with deaf patients and that more specific and visual explanations should be provided for Auslan interpreters. One respondent from the Eastern Asian language group commented that "I have also experienced challenges because body language in the LOTE in which I work is less overt than Australian" (Respondent No. 23). Another interesting comment, similar to the issue of turn management, was from one respondent from the Southern European language group who complained that "Asian doctors do not look at patients directly and address interpreters instead. Asian doctors ignore cultural issues and refuse to ask interpreter's advice" (Respondent No.73). This interpreter not only expressed a stereotypical view of Asian doctors but also showed a misconception of the interpreter's role. As explained both in the AUSIT Code of Ethics and HCIS guidelines for healthcare interpreters, interpreters should not engage in advocacy, guidance, or advice (AUSIT, 2012; NSW HCIS PDC, 2014). However, this interpreter claimed that doctors who

refuse to ask interpreters for advice are ignoring cultural differences. Even though it is known that there is a greater tradition of interpreter involvement and functioning as part of a professional team, the Code of Ethics for Auslan interpreters also make it clear that "they [practitioners] will not counsel, advise, or interject personal opinions" (ASLIA, 2007, p. 4).

6.3.2.5. Interpreters' strategies in dealing with intercultural communication challenges

The survey responses about interpreters' strategies in dealing with intercultural communication challenges, if encountered, were also diverse. Almost half of the respondents (48.35%) chose 'It depends on the situation', and more than a third of the respondents (34.1%) added some comments with examples. Among them, 25 respondents stated that they would explain any intercultural communication challenges to both parties (see quotes 6.11 and 6.12).

Quote 6.11

"I will let the professionals know and they will explain". (Respondent No. 9)

Quote 6.12

"I explain to the clinician what the differences are, without criticising either approach. I also tell the patient what I've explained to the clinician". (Respondent No. 29)

These two quotations reflect the main attitudes expressed by the respondents who added comments regarding their strategies of dealing with intercultural communication challenges. It seems that most of them adopted a relatively conservative approach and to let healthcare professionals and patients be the decision-makers even though interpreters still provide cultural information. After openly discussing any issues with both parties present, the interpreters then leave it to the clients to decide what to do. One Auslan interpreter (Respondent No. 19) stated that "explaining the differences and giving clients the opportunity to speak up or act differently are the roles of the interpreter as a communication facilitator", which—she claims—remains within the role boundary. This is consistent with the Code of Ethics (AUSIT, 2012, p. 5).

In terms of when to provide cultural information, none of the respondents reported at what stage of the consultation they do so or whether they provide cultural information during the briefing or debriefing sessions. This may be because, as explained in Section 6.3.4.2, they rarely or never have opportunities to have briefing or debriefing sessions.

Regarding the way of revealing any intercultural communication issues to both parties, one respondent added further comments as below (Quote 6.13):

Quote 6.13

"I feel that an interpreter should try to keep a cordial and friendly approach to both patient and doctor in order to make everyone feel at ease. The appointment should be close to when you speak to a doctor whom you trust and whose help is really being sought. I say this because I do not believe that interpreting can be just cold and surgically accurate, but rather carry the whole meaning of what is being said".

(Respondent No. 40)

This respondent (No. 40) has been practising as an interpreter in Australia for more than 20 years. The comment from the above respondent shows a traditional approach where interpreters should facilitate access for patients "to reduce fears, anxieties and concerns that may impede effective communication" (The Health Care Interpreter Service, 1994, p. 3). However, professional interpreters practising in Australia need to comply with the current AUSIT Code of Ethics, including its articles on accuracy and impartiality. Unlike previous studies in healthcare interpreting with ad hoc interpreters (Angelelli, 2004; Davidson, 2000), nationally accredited professional interpreters who work in healthcare settings commit themselves to abiding by the code of conduct. A description of the principle of accuracy states that:

> Interpreters and translators provide accurate renditions of the source utterance or text in the target language. Accurate is defined for this purpose as optimal and complete, without distortion or omission and preserving the content and intent of the source message or text. Interpreters and translators are able to provide an accurate and complete rendition of the source message using the skills and understanding they have acquired through their training and education. (AUSIT, 2012, p. 10)

The problem is, however, as Hale (2007) pointed out, that some interpreters understand 'interpreting accurately' as meaning 'literal translation'. Hale (2007) argues that formal training is needed for interpreters to achieve a correct interpretation and application of the code. In my survey, when describing their role, some respondents stated that healthcare interpreters should adopt a cordial approach while interpreting rather than a cold and surgically accurate one. Although there was no further comment or explanation from the

respondents about their understanding of the meaning of accuracy in the Code of Ethics, it is possible to hypothesise based on such comments that these respondents wrongly interpret the code. There seems to be no clear pattern in the academic background of the respondents who showed an incorrect interpretation of the code; however, most of them have been working as interpreters for more than 20 years. It is probable, therefore, that these respondents are less likely to continue professional development and acquire the latest information about the current Code of Ethics.

In addition to the cautious approach to how to discuss intercultural communication issues with both parties, one respondent also added that careful consideration is required regarding when and how interpreters provide cultural information (Quote 6.14):

Quote 6.14

"There should be some room for qualifying when interpreters may need to intervene and how they make the decision. Otherwise, interpreters answering that they intervene may create the impression that they do as they see fit without any ethical considerations. From my experience interpreters will intervene, if there is miscommunication particularly if it can have a negative impact on the health outcome". (Respondent No. 81)

Such reservations as explained in the above quote are consistent with the guidelines for healthcare interpreters (NSW HCIS PDC, 2014). The limitations and careful consideration provided in the guidelines state that "they [healthcare interpreters] generally provide cultural information at the healthcare provider's request or when the cultural gap is affecting communication during an interpreting assignment" (NSW HCIS PDC, 2014, p. 18).

Some respondents from my survey commented that interpreters should be more cautious when it comes to culture and avoid generalisations, and that handling cultural communication challenges is best addressed by the healthcare professional (see quotes 6.15 and 6.16):

Quote 6.15

"I do not believe all patients I interpret for shared any one definite cultural expectation for the issues asked in the questions. I do not think that the culture that the interpreter identifies with is necessarily the typical or the prescriptive culture of anyone else let alone any entire culture group. I think it would be dangerous to assume there would be one definite culture in existence that is shared by all people who speak the same language or who seek assistance of interpreters in a health setting". (Respondent No. 28)

Quote 6.16

"It is extremely risky to express an opinion based on assumptions as to the patients' background, particularly those coming from a country that has hundreds of local dialects and socio-economic environments, due to having been invaded from all sides and by incredibly different cultures. It is much better if the doctor asks specific cultural questions to the patient, which are then interpreted". (Respondent No.3)

These comments from the above quotes corroborate the ideas of Hsieh (2016), who suggests that interpreters' behaviours, including initiating conversations, modifying

narratives, or omitting information from either party, may be efficient in meeting the patient's needs; however, such strategies may infringe on healthcare professionals' control over the medical dialogue, infringe on patient autonomy, and affect quality and equality of care in the long run. In fact, some healthcare professionals from her study expressed concerns about such interpreter behaviours occurring without the patient's or provider's explicit consent. Furthermore, these comments from the above quotes are consistent with those of other researchers who suggest that interpreters' understanding of patients' cultures may also be subjective (Katan & Taibi, 2021) and that the patient does not necessarily share the same culture as others or the interpreter from the same ethnic background (Crezee, 2013).

6.3.3 Interpreters' perceptions of their role

I asked the survey respondents to indicate their levels of agreement on the interpreter's role boundaries. Firstly, respondents were asked whether healthcare interpreters should intervene and explain cultural differences to healthcare professionals and patients when they are asked by either client to provide cultural information and when they are not. When they are asked to provide cultural information by either the healthcare professional or the patient, almost three quarters of the respondents (72.73%, N = 72) replied either 'agree' or 'totally agree'. On the contrary, when they are not asked to provide cultural information by anyone, considerably fewer (35.35%, N = 35) responded 'agree' or 'totally agree', whereas almost half (47.47%, N = 47) chose 'neutral' or 'somewhat agree'. From the comments provided after these questions, two distinct descriptions of perceptions of the interpreter's role emerged from the respondents' answers: helper and cultural mediator.

6.3.3.1. Interpreter as helper

Three respondents added comments indicating that helping patients should be within the role boundaries of interpreters and that "advocating for a patient is different from helping them" (Respondent No. 14). One respondent provided an example of helping patients without breaching the Code of Ethics (Quote 6.17).

Quote 6.17

"Helping patients for example, sometimes they need assistance, as where to have their blood tests, scans, etc. Many elderlies live on their own or do not expect their children to attend appointments with them. It does not harm as to direct them which way to go for their tests immediately after the appointment, particularly when the interpreter has the time to do it. It is a duty of care". (Respondent No. 93)

From the literature in interpreting studies, we can witness that users' expectations of the community interpreter's role usually do not coincide with interpreters' perceptions (Kelly, 1998; Mesa, 1998; Pöchhacker, 1998). As for the notion of 'helper' (see Section 6.3.4.2), one respondent stated that "sometimes the patient is anxious that the details of the illness might be divulged in other places as our community is very small" (Respondent No. 83). However, healthcare interpreters are bound by the AUSIT Code of Ethics, in the article Confidentiality, and should not divulge information gained in the course of assignments to a third party (AUSIT, 2012). Also, healthcare interpreters are guided and trained to introduce and educate clients on the role of the interpreter before the interpreting assignment, including interpreter ethics—in particular, confidentiality and accuracy (NSW HCIS PDC, 2014, p.

15). The question is then whether this interpreter is aware of such guidelines and if she explained the role of the healthcare interpreter to the clients in line with these ethical principles.

Even though the guidelines specify that "the duty of care for the clinical outcome lies primarily with the treating professional, and interpreters do not take responsibility for the health and wellbeing of the clients they interpret for" (NSW HCIS PDC, 2014, p. 12), the respondent from Quote 6.17 believes that looking after the patient is part of the interpreter's duty of care. Similarly, one respondent commented that "there should be a distinction between the role of interpreter in medical encounters and other various social or legal encounters" (Respondent No. 17). On the contrary, a more conservative view of interpreter as helper can be seen in another comment (see Quote 6.18):

Quote 6.18

"It is NEVER the job of an interpreter to offer their opinion as to the medical

conditions or otherwise. We, as interpreters, are not medically qualified to offer our

opinions. Our job is ONLY to accurately render what the patient has said. If the

medical practitioner needs further explanation, they have to rephrase their question

until they get the answer they can work with. There is a misconception in the

community that interpreters are helpers. We are only a conduit in communication … . It

is totally inappropriate for medical practitioners to seek explanations from the

interpreters, they do not ask for explanations from English speakers. Again, if the

interpreter has accurately interpreted what the patient has said then the medical

professional has to form their own opinion based on this information". (Respondent No.

66)

This respondent strongly supports the AUSIT Code of Ethics and believes that "there is a misconception in the community that interpreters are helpers". She also added that "it is totally inappropriate for healthcare professionals to seek explanations from the interpreters, they do not ask for explanations from English speakers". However, the same respondent also adopted the metaphor of the interpreter as an inanimate object—a conduit, which was not as described in the AUSIT Code of Ethics. Thus, it can be argued that there was confusion about how to interpret the codes among interpreters.

One interesting response from the Southern-European language group was that interpreters can be viewed with suspicion by patients, especially in smaller communities; however, at the same time, they are often expected to be an ally, and patients have unrealistic expectations of interpreters, as explained in the comment below (Quote 6.19):

Quote 6.19

"Some patients do not believe the interpreter is assisting and they see him/her as a spy; that is why they want to use relatives to interpret. The doctor needs to explain that the interpreter is a professional and has the same secrecy obligations as a doctor. On the other hand, because the interpreter speaks the patient's language, the patient may think of the interpreter as an ally or a distant relative and have unethical expectations (that gifting will produce a better outcome, or that the interpreter should not interpret conversations between the patient and the patient's relatives)". (Respondent No. 79)

What is interesting in this response is that patients' unrealistic expectations and inaccurate perceptions of the interpreters' roles can also pose challenges to interpreters.

6.3.3.2. Interpreter as cultural mediator and advocate

Three respondents used the term 'cultural mediator' to describe their role as healthcare interpreter. One respondent explained that "I usually break out of the interpreter's normative role of accurately rendering the speaker's message and become a cultural mediator if the patient hasn't already done that themselves" (Respondent No. 44). This interpreter gave an example of what cultural differences she is referring to:

Quote 6.20

"Almost every time they will ask the deaf person why they don't have a cochlear implant, a culturally sensitive question because many in the deaf community see these as negative, as cultural genocide, and again it leaves the responsibility for communication on the shoulders of the deaf person". (Respondent No. 44)

In this case, the above respondent would provide cultural information on behalf of the patient without being requested to do so by the healthcare provider and when such cultural gaps did not directly affect communication. The point about the deaf community's reluctance to have cochlear implants is a cultural issue, which can be raised in a briefing. However, if this interpreter switches her role from communication facilitator to cultural mediator based on her assumptions and provides unsolicited cultural information during the consultation, then she goes against the guidelines (ASLIA, 2007; NSW HCIS PDC, 2014). The Auslan language group is traditionally categorised as a collectivist cultural group in which individuals tend to maintain harmony to keep a good relationship with others within a group. Therefore, most of the respondents from the Auslan language group (25 out of 28) either

strongly or somewhat agree that deaf patients are reluctant to ask questions of doctors even if they do not understand what the doctors said or do not agree with the doctors (see Section 6.3.2.3). However, if deaf patients are reluctant to ask questions regardless of their understanding, this could be the same with all powerless participants in similar contexts. Also, whether deaf patients understand what the doctors said or agree with the doctors can only be determined based on interpreters' assumptions. Indeed, healthcare interpreters are guided not to make a judgement about client-related matters (NSW HCIS PDC, 2014, p. 11) and not to assume the intention of patients' behaviours. On a continuum, the views of cultural mediator are located towards the visible and overt advocate. One respondent indeed used the term 'advocate' to describe the role of the interpreter (Quote 6.21).

Quote 6.21

"I do take the side of CALD as I find that most of patients won't be complaining for them even if it's not their fault … I found that the interpreting in healthcare setting involves lots of personal emotions and views from the CALD's cultural background as well as the way of understanding things in their own unique language. Some areas are so obvious that insufficient resources are provided for the particular patient's conditions and treatment. I believe that interpreters should be a resource for this reason in healthcare setting. Because of that, interpreters' neutral but advocate position are so important. If healthcare provider agrees empowering is one of important aspects in patient's treatment and recovery, willingness to understand the CALDs' views may be the first step". (Respondent No. 74)
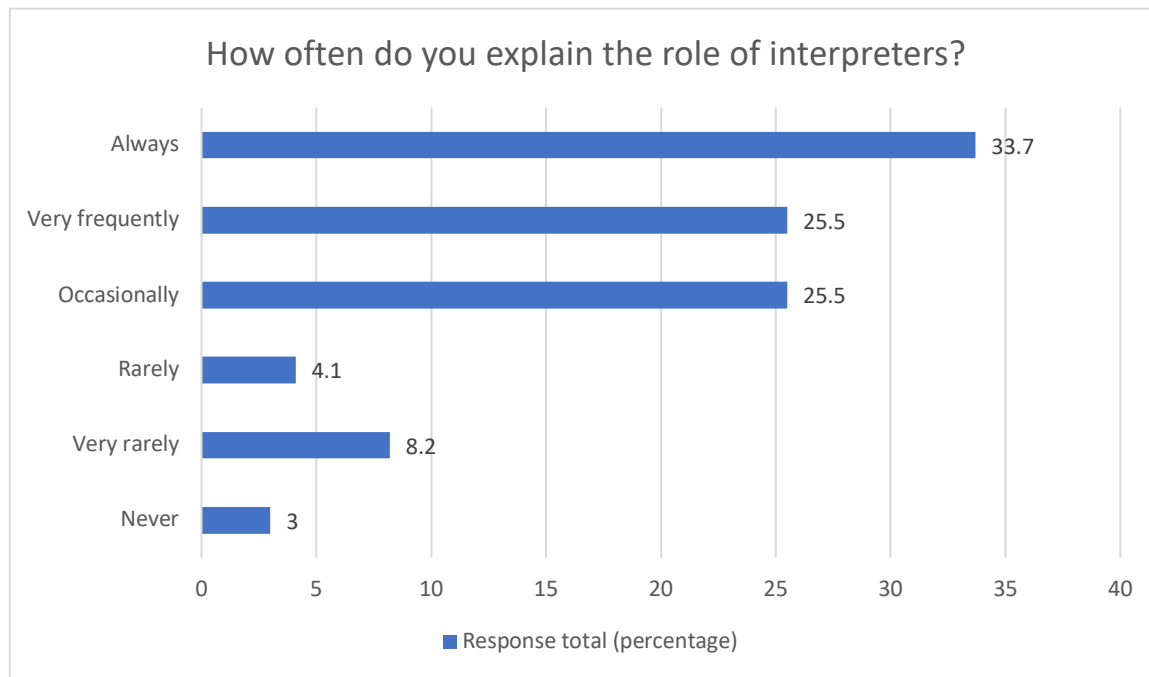

The respondent from the above quote argues that healthcare interpreters can take the side of CALD patients and become advocates in order that CALD patients in vulnerable positions can be empowered. The respondent also argues that, paradoxically, interpreters can maintain both neutrality and advocacy on behalf of patients. However, overstepping the role boundaries of interpreters involves risks in terms of potential adverse health outcomes for the patient and threats to direct communication between the healthcare professionals and the patients (NSW HCIS PDC, 2014, p. 11). That is why healthcare interpreters are guided not to advocate or speak on behalf of any party and cannot be in a neutral but advocate position.

In response to the question of how often the role of the interpreter is explained both to healthcare professionals and patients, over half of those surveyed in this study indicated that the interpreters themselves either always or very frequently explain their role (59.18%) (see Figure 6.2 below). There is no noticeable difference in the tendency to explain their role among interpreters from each language group or between different language groups. Also, there is no noticeable relationship between the academic qualifications of the interpreters and the tendency to explain their role to the healthcare professionals and the patients.

Figure 6-2

The Frequency of Explaining the Role of Interpreters

How often do you explain the role of interpreters?

- Always: 33.7
- Very frequently: 25.5
- Occasionally: 25.5
- Rarely: 4.1
- Very rarely: 8.2
- Never: 3

■ Response total (percentage)

However, from the question and the answers above, it is not possible to determine when and how the interpreters explain their role to healthcare professionals and the patients. It can be surmised that they do so in most cases during the medical consultations since briefing and debriefing sessions are very rarely available, as explained in Section 6.3.4.2 below.

6.3.4 Working conditions

In the second section of the questionnaire, the respondents were asked to provide information regarding their working conditions, including information received before the consultations, and the provision of briefing and debriefing sessions. In my observations and post-observation interviews with the interpreters, I witnessed a relationship between
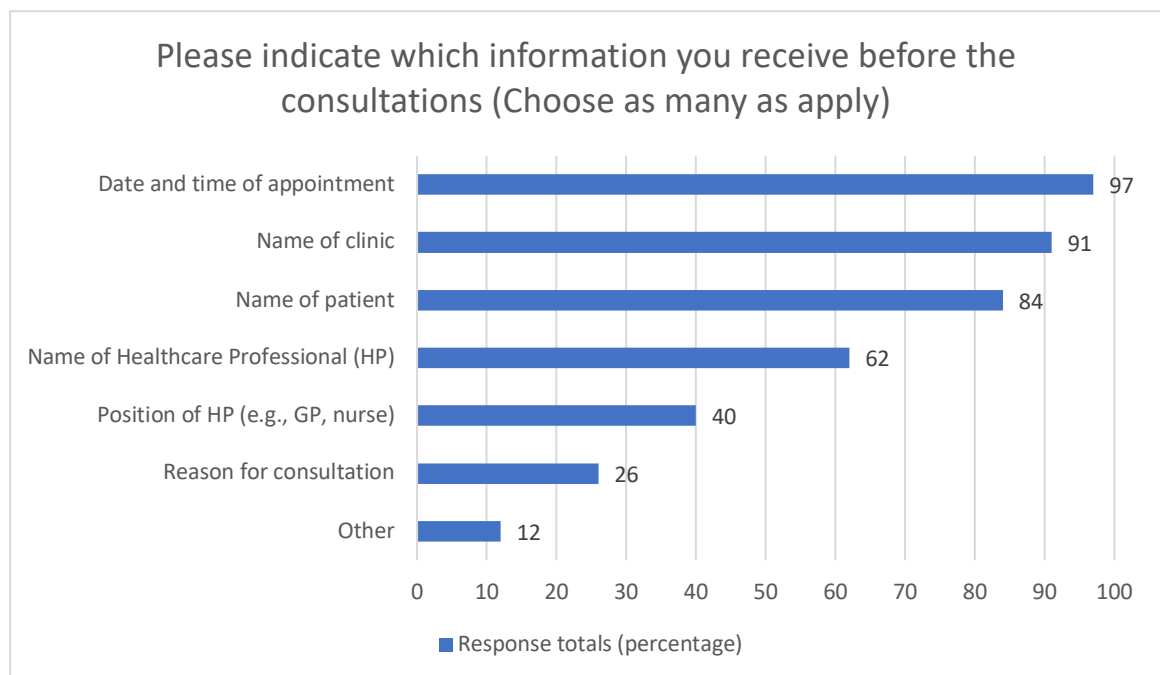
healthcare interpreters' communication challenges and unsatisfactory working conditions, including a lack of briefing and debriefing sessions, and a lack of information received before the consultations. To gain perceptions from more interpreters with diverse language combinations about their working conditions, I asked two questions: 'Which information do healthcare interpreters receive before the consultation?' and 'How often are healthcare interpreters offered briefing/debriefing sessions?'

6.3.4.1. The provision of information before the consultations

To obtain a broader view from interpreters on how much information interpreters receive before the consultations begin, the respondents were asked to choose as many items as applied in multiple-choice questions. They were also able to add comments if needed.

Figure 6-3

Types of Information the Interpreters Receive Before the Consultations

Please indicate which information you receive before the consultations (Choose as many as apply)

Category	Response totals (percentage)
Date and time of appointment	97
Name of clinic	91
Name of patient	84
Name of Healthcare Professional (HP)	62
Position of HP (e.g., GP, nurse)	40
Reason for consultation	26
Other	12

The survey respondents reported a similar trend to the interviewees who participated in my post-observation interviews (see Chapter 5). In the survey, 97 respondents out of 99 reported that they received the date and time of the appointment, 91 reported the name of the clinic, and 84 reported the name of the patient. Less than half of the respondents (40.8%) stated that they received detailed information about the healthcare professionals, and slightly over a quarter of the respondents (26.5%) responded that they received the reason for the consultations. Regarding detailed information about the healthcare professionals and the reason for the consultations, four respondents further added comments on not being able to obtain relevant medical information for preparation in advance. Such a view corroborates previous studies on court interpreters' preparation practices in which court interpreters faced logistical difficulties in receiving background information (Hale, 2013a; Wong, 2020). Most of the respondents in my study who added further comments to this question stated that the information received depends greatly on the language service providers (interpreting agencies) that have booked the interpreter, as exemplified in Quote 6.22 below:

Quote 6.22

"Not necessarily all of these all of the time ... . It also depends on the agency; some provide more information and some far less information". (Respondent No. 63)

As seen in Figure 6.2, detailed information about healthcare professionals or consultations is not always provided. Thus, one respondent added that, when detailed information about a consultation was not provided by the agency, the respondent often

researched the doctor's field of expertise so that he could better prepare for the job (Respondent No. 94).

6.3.4.2. Briefing and debriefing sessions

When asked how often they have briefing sessions before the interpreting assignment and debriefing sessions after the interpreting assignment, almost 80% of the respondents (N = 79) reported they never or rarely have briefing sessions and almost 90% of the respondents (N = 90) reported they never or rarely have debriefing sessions. As seen in Figure 6.4 below, only a very small number of the respondents always have briefing sessions (N = 3) and/or debriefing sessions (N = 1).

Figure 6-4

The Frequency of Briefing/Debriefing Sessions
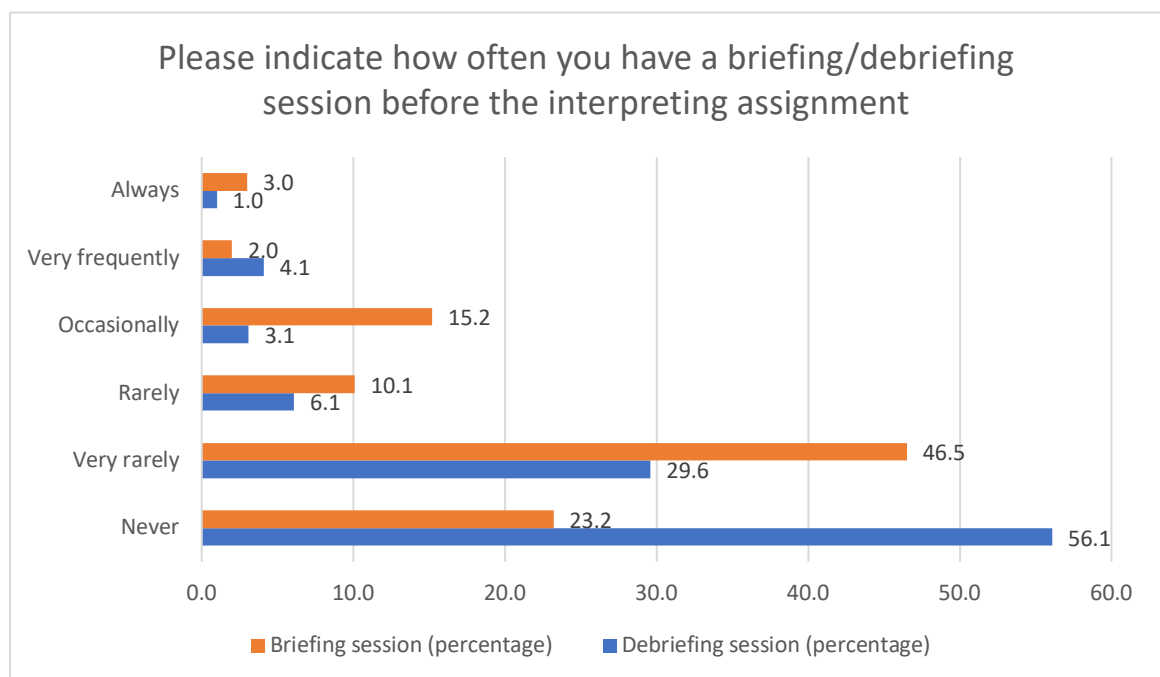
One respondent commented that "Not being briefed ahead of an appointment is an ongoing problem. Usually, we are not even told which branch of medicine or which medical problem will be dealt with" (Respondent No. 6). One interpreter commented that interpreters should also be briefed on patients' behaviour or demeanour, if necessary. She added a comment based on her own experience (Quote 6.23):

Quote 6.23

"Interpreters should be briefed about patients' behaviour/demeanour if this is necessary. I recently had to deal with an aggressive dementia patient—I wasn't told about his aggressive nature before the appointment or when I arrived for the job. I reported the incident to the agency, who in turn reported it to the hospital. This resulted in the hospital agreeing to inform interpreters about those patients who had an aggressive nature and presented a safety risk to interpreters". (Respondent No. 33)

Although the respondent from the above quote did not provide details of the incident during the appointment, it can be assumed to be linked to the aggressive behaviour of the patient. The interpreter insisted that in such cases, interpreters should not only be briefed about the patients' likely behaviour, but also be provided with a safe working environment.

6.4 Discussion

This chapter has aimed to examine how healthcare interpreters define, identify and address intercultural communication challenges in interpreter-mediated medical encounters,

whether there is a consensus among interpreters in the same language group on what constitutes intercultural communication challenges, and how interpreters' working conditions can impact on their intercultural communication challenges. As found in previous studies (Felberg & Skaaden, 2012; Hale, 2013b; Schnurr & Zayts, 2017), the term 'culture' is often conceptualised and defined differently by each individual and in various contexts. Similarly, in the previous chapter, I analysed the data gathered during the post-observation interviews and discovered that the five Korean interpreters did not agree on what constitutes Korean culture. In addition, the interpreters described some of their ethical challenges or interprofessional challenges as cultural ones and claimed that their poor working conditions posed additional challenges. To gain perceptions from more interpreters with diverse language combinations and compare their responses with the findings from the data presented in the previous chapters on the observations and the interviews, I conducted an online survey. The results of this survey are consistent with those of the data from my post-observation interviews and suggest that interpreters have various views on how to define the term 'culture' and how to identify 'intercultural communication' in healthcare interpreting. This survey has also shown that not one language group shared the same view on what constitutes intercultural communication challenges and what to do when facing intercultural communication challenges. In addition to this, the survey respondents also showed diverse perceptions on how to deal with intercultural communication challenges in terms of how and when to provide cultural information, and how to establish their role boundaries. Another important finding was that healthcare interpreters with diverse language groups also face challenges due to poor working conditions, as observed with the Korean interpreters in my observations and post-observation interviews with interpreters (see chapters 4 and 5).

6.4.1 Intercultural communication challenges

My online survey results have led me to conclude that interpreters from various language groups have only a vague understanding of intercultural communication challenges and often have stereotypical views of sharing the one culture with patients from the same language background. The issue of inconsistent understanding of the term 'culture' was also reported in the post-observation interview chapter with the Korean interpreters (see Chapter 5).

When asked to provide their perceptions on the definition of intercultural communication, none of the five interpreters from my interviews could provide a clear definition of intercultural communication and showed a vague understanding of what could be cultural differences they might face during medical encounters. My survey showed a similar pattern; the respondents held contradictory views on what intercultural communication challenges mean and how they perceive what constitutes the culture to which the CALD patients belong. Even though the majority of respondents (61 out of 99) agreed that they had experienced some form of challenges due to cultural differences in healthcare interpreting, the examples of such challenges from each respondent differed. Some respondents showed misconceptions or misunderstandings about what intercultural communication challenges mean in healthcare settings, including all interpreters naturally sharing the same culture with all patients from the same ethnic background or English-speaking healthcare professionals sharing the one same culture. Such a view is consistent with the traditional approach with a static conceptualisation of the term 'culture' (see Section 2.2.1 in Chapter 2). However, it contradicts Spencer-Oatey (2000) who suggests that culture needs to be regarded as a dynamic process and that people behave differently depending on

the context. Interestingly, in my survey, some respondents did not respond to the question of whether they had faced intercultural communication challenges, and they commented that they could only answer this question if the definition of intercultural communication was adequately provided. However, only a small number of respondents indicated that the definition of 'culture' needs to be properly addressed and that culture should not be mistakenly blamed for unethical and incompetent interpreters. On the contrary, the results of the survey indicated that the majority of respondents have various perceptions of the definition of intercultural communication challenges, which is consistent with the results of my post-observation interviews.

6.4.1.1. Family dynamics and the decision-making process in medical consultations

As mentioned in the literature review, medical encounters become more challenging for both healthcare professionals and healthcare interpreters when patients are with their family members and when patients are in end-of-life situations (see Chapter 2). Examples relating communication challenges with family members of the patient include whether a patient or a family member is to be regarded as a decision-maker, who can be the authority figure in a family, and when family members are too protective of the patient or too demanding. During my observations and interviews, I witnessed various instances of family dynamics when family member(s) accompanied patients to medical consultations. Although I did not observe any case where family members tried to withhold a negative diagnosis or prognosis from patients, two interpreters from my post-observation interview related some cases in which family members, especially adult children, had asked doctors not to tell the truth about the patients' conditions or not to use the term 'cancer' with the patients. However, they stated that they had not experienced such cases recently, and they believed that was

because Koreans had been Westernised in recent times (see Chapter 5). The survey results suggest that, just as with Korean interpreters, interpreters from the same language group do not necessarily have the same perception on the degree of family involvement and the patients' preferences as to whether they want to be informed of a terminal illness or not. Also, some respondents stated that they could assume the patients' intentions based on the patients' age group or education levels. The question here is, however, on what basis interpreters determine other factors about the patients, such as age group, education level, religious background, and personal experience, and whether their impressions are accurate. Although some information might transpire during the consultation, these are estimates only.

In terms of the issue of patient autonomy, my survey respondents reported a combination of mixed values and beliefs from patients within the same language groups. There was no marked difference between the language groups, and not one entire language group shared the same view on their perceptions of the patient autonomy of the CALD patients. A possible explanation for this might be that patient autonomy in decision-making and patient-centred care can be an individual belief rather than a shared value within one culture, which corroborates the findings of previous work in the medical anthropology field (S. Kim, 2015; Mo et al., 2012; Morita et al., 2015). Another possible explanation for this is that the so-called Western medical culture has been gradually changing, from one of sole patient autonomy to a shared decision-making process, which is consistent with some previous research in the medical anthropology field (Butow et al., 1997; Gold, 2004).

6.4.1.2. Communication challenges arising in healthcare settings

The survey questions focused on intercultural communication challenges, including the respondents' understanding of intercultural communication, their perceptions about

patients' reactions to receiving notification of a terminal illness, their understandings on patients' views about patient autonomy and the decision-making process, and interpreters' strategies in dealing with intercultural communication challenges. Additionally, I added an open-ended question at the end of the questionnaire to invite additional comments in general. Communication challenges arising in healthcare settings can pose challenges to interpreters and include manner of delivery, pragmatics, and non-verbal aspects of communication. However, these data must be interpreted with caution because these additional comments represent a small number of respondents, and it is possible that the respondents have biased views.

Six survey respondents from various language groups, including Southern European, Southern Asian, Eastern Asian, and Auslan, regarded non-verbal communication problems as examples of intercultural communication challenges. Examples of non-verbal communication from the survey respondents included avoidance of eye contact from patients and less overt body language. Researchers have argued that cultural values can have a significant influence on non-verbal communication, including eye contact, physical contact, and personal space (Crezee, 2013; Galanti, 2015; Hale, 2013b). As outlined earlier, in some cultures, women cannot look a man in the eye, or a younger person cannot look at an older person when talking. Similarly, in some cultures, it is not acceptable to touch the person you are talking to, or it is offensive if the other person moves back when talking (Crezee, 2013, p. 24). The documents on cultural profiles provided for healthcare professionals in Australia (Abbato, 2011; Queensland Health, 2013) state that it is common in Asian cultures, including Chinese, Japanese, Korean, Hmong, and Vietnamese, to follow the tendency of avoidance of direct eye contact in order to show respect, especially to a person in a superior position. However, my observations did not support the claim in these studies: in 16 out of 20 cases,

patients and healthcare professionals made direct eye contact while talking to each other. Many healthcare professionals of Asian or Indian backgrounds in my observations also followed this trend.

6.4.1.3. Cultural beliefs of the participants

Along with communication challenges arising in healthcare settings, the topic of various cultural beliefs of the participants was the most common in the additional comments where the respondents provided examples of intercultural communication challenges. Varied cultural beliefs among participants can influence the medical consultations and make it hard to achieve the goal of the healthcare system, which is to provide optimal care for all patients (Galanti, 2015). Furthermore, cultural beliefs in relation to health are not easily detected unless all participants become culturally aware and sensitive, since they go beyond language issues.

Three survey respondents stated that there is a stigma attached to mental illness in the culture of their language community. Although only a small number of respondents indicated that a general attitude towards mental illness as an intercultural communication challenge, this seems to be consistent with other observations, which showed that the definitions of 'sickness' and 'health' in diverse cultures are different from each other (Crezee, 2013; Galanti, 2015). However, during the observations, I was not able to collect data regarding a stigma attached to mental illness among Korean patients or where any Korean interpreter pointed out such a stigma as an intercultural communication challenge during the post-observation interviews. A general attitude towards mental illness is often explained by a distinction between Western cultures and Asian cultures; however, one survey respondent from the Southern European language group also reported that there is a stigma attached to

mental illnesses in the culture of their language community, and it can be challenging to interpreters. Indeed, one can argue that stigma attached to mental illness continues to be a global public health challenge (Ye et al., 2016) as well as in the Australian mainstream culture. Ye et al. (2016) argue that mental health staff play a crucial role in reducing stigma and discrimination against mentally ill individuals. Mental health professionals and advocacy groups are taking steps to raise awareness of mental health issues and to highlight interprofessional education in order to reduce or eliminate the stigma (Maranzan, 2016). Whether this is also happening in other countries is difficult to say, but it is possible that the migrants among the survey respondents hold antiquated views.

In addition to the patient's attitude towards mental illnesses, seven respondents reported that the gender of the interpreter is a cultural issue in healthcare settings. As to the issue of the gender of the interpreter, it is evident from the respondents' comments that individuals from certain cultures can still have a preference for having an interpreter or healthcare professional of the same sex as the patient. This could be a religious issue; however, I should also point out that sex roles may be changing as younger generations grow up and are educated in other countries. As discussed in Chapter 2, there can be a greater difference regarding the cultural beliefs and values shaping identity between generations than between ethnic groups (Vasta, 2015). The most interesting finding was that the seven respondents who reported the gender of the interpreter as an intercultural communication challenge were from various language groups, including Southern European, Southwest Asian, Central Asian, Southern Asian, and Eastern Asian language groups. The findings of the current study do not support those of a previous study (Crezee, 2013) that showed that the gender of the interpreter was more likely to be an issue for patients from some language

groups, such as African or Pacific Islands languages, than from others, such as Chinese languages.

As explored in Section 2.6 (Chapter 2), not many studies have paid attention to the cultural, ethnic, or linguistic diversity of healthcare professionals or interpreters. However, I observed the diversity of the ethnic backgrounds of the healthcare professionals in my observations (see Chapter 4). Similarly, the survey responses show the diversity of interpreters' cultural profiles and their perceptions of intercultural communication. More than a third of the respondents identified English as their first language, and approximately a third of them identified Auslan as their working language other than English. They indeed provided diverse views on what constitutes intercultural communication challenges from the spoken-language interpreters whose first languages are not English and who also came to Australia as migrants. The respondents whose first language is English reported that they face intercultural communication challenges more often with non-English speaking doctors. Furthermore, Auslan interpreters reported unique deaf cultures and argued that healthcare professionals should be trained to deal with deaf patients and to be culturally sensitive with deaf patients.

6.4.2 Ethical/professional challenges

As reported in the previous chapter, I discovered that all five Korean interpreters often described their ethical/professional challenges as cultural ones. Also, I observed a direct link between healthcare interpreters' communication challenges and poor working conditions, including a lack of briefing and debriefing sessions, a lack of information received before the consultations, and users' unrealistic expectations of the role of the healthcare interpreters.

6.4.2.1. Interpreters' perceptions of their professional role in healthcare settings

As shown in the literature, interpretation users do not share the same expectations as interpreters and often expect interpreters to provide advocacy or advice (Hale, 2013a; Lee, 2009a). Thus, healthcare interpreters are guided to explain the ethical boundaries of the interpreter to healthcare professionals, patients, and any others present (Tebble, 1998). However, during my observations, there was no case where either the healthcare interpreter or the healthcare professional explained the role of the interpreter to the patient. Interestingly, most of the survey respondents reported that interpreters always or very frequently explain their role to patients. However, it is important to bear in mind the possible dissimilarity between what they say in the survey and what they actually do in a real situation. There was no noticeable difference in the tendency to explain their role across language groups, or between different language groups. Also, there was no pattern between the academic qualifications of the interpreters and the tendency to explain their role to the healthcare professionals and the patients.

Previous studies have found that users' expectations of the community interpreter's role usually do not coincide with interpreters' own perceptions of their professional role (Kelly, 1998; Mesa, 1998; Pöchhacker, 1998). Users' different expectations of the interpreter's role has been witnessed during my observations as well. For example, interpreters were asked to help the patient to fill out forms and assist the patient with administration issues (see Chapter 4). Another interpreter from my post-observation interview mentioned that she was often asked to help the patient with administration issues or issues related to the healthcare system in Australia (see Chapter 5). As can be seen from the survey results, the interpreter's role as a helper was generally accepted by some survey

respondents (24 out of 99 respondents); however, their understanding of what a helper can do was divergent. Also, the respondents from the survey expressed some contradictory beliefs about their roles as cultural broker or mediator. For example, some respondents believed that the interpreter should help patients without breaching the Code of Ethics, and others reported that they acted as cultural brokers and switched their roles from communication facilitators to cultural mediators based on their own assumptions about cultural differences.

As explored in Chapter 2 (Section 2.5), the interpreters' behaviours and perceptions of their roles as helpers are reminiscent of the behaviours of the early days of community interpreting in the 1960s when they acted as ad hoc interpreters, as described by Roy (2002), or the early bilingual staff in the 1970s who also acted as ad hoc interpreters in Australia described by Gentile et al. (1996). However, the guidelines (1994) have since evolved, and the more recent guidelines and policies for healthcare interpreters as well as the AUSIT Code of Ethics both indicate that "practitioners do not, in the course of their interpreting or translation duties, engage in other tasks such as advocacy, guidance or advice" (AUSIT, 2012, p. 6).

> The role of the interpreter is to facilitate communication between two parties who do not speak the same language and may represent different cultural backgrounds … . Ultimately, the health providers and patients are responsible for the resolution of the medical encounter (NSW HCIS PDC, 2014, p. 9)

This quote from the guidelines for healthcare interpreters provided by the New South Wales Health Care Interpreter Services (NSW HCIS) in 2014 best summarises the interpreter's role in the medical setting. Based on the current AUSIT Code of Ethics, the roles of healthcare interpreters "do not include: advocate or speak on behalf of any party; provide

advice to clients; or make a judgement or express a personal opinion about client-related matters" (NSW HCIS PDC, 2014, p. 11). Similarly, healthcare interpreters are guided "not to provide emotional support to patients, fill out forms on behalf of a client, or explain medical terms to clients" (NSW HCIS PDC, 2014, p. 11). When interpreters act as helpers by providing opinions or advice during the medical consultations, it constitutes behaviour that goes counter to the guidelines of the Code of Ethics. Researchers explain that untrained and incompetent interpreters may be inclined to assume additional roles, including acting as helpers and advocates for non-English speakers (Hale, 2007; Stern, 2011).

It is interesting to note that some respondents from my post-observation interviews and online survey, who started practising as interpreters in the 1990s, indeed tended to show their beliefs that healthcare interpreters play more active roles, but they are still within the role boundaries of the healthcare interpreters. However, when they tried to act more like a 'helper' for the patients' wellbeing or in the name of duty of care, they were more likely to have unwittingly violated the principles of the Code of Ethics.

6.4.2.2. Link between poor working conditions and intercultural communication challenges

As I explained in the introduction of this chapter, I witnessed a link between healthcare interpreters' communication challenges and poor working conditions, including lack of briefing and debriefing sessions, and lack of information received before the consultations. Interpreters, including those in healthcare settings, can face communication challenges when their working conditions are poor (Hale & Stern, 2011). As Pöchhacker (2004, p. 119) explains, background information plays a crucial role in the interpreter's comprehension process. For example, interpreters can have difficulties understanding the

meaning of ambiguous utterances during interpreting if they have not been provided with the background information or been briefed about the topic in advance. In addition, in a national survey of Australian court interpreters' preparation practices in 2016, Wong (2020) highlighted that "the more *targeted* resources available to court interpreters enables the more *targeted and adequate* preparation to be undertaken" (p. 109). Regarding the working conditions of healthcare interpreters, the survey respondents argued that the information provided for healthcare interpreters is limited, and the lack of briefing/debriefing sessions is an ongoing problem. During my observations, only very brief information was provided for healthcare interpreters, including the date and time of the appointment, the name of the clinic, and the name of the patient. In none of the cases did I witness that the interpreters received the necessary information about the consultation; as a result, in one case, the interpreter struggled with terminology (see 4.3.1.3. in Chapter 4). One survey respondent suggested that healthcare interpreters do some research into a doctor's field of expertise prior to the consultation. This can be one of the strategies that healthcare interpreters can develop when they are not provided with the necessary information to be able to prepare in advance in order to perform adequately during the consultations. However, if the only information about the healthcare professional provided to the interpreter prior to the consultation is 'doctor on duty', such a strategy cannot be implemented.

Both in my observations and interviews, a lack of briefing and debriefing sessions was of serious concern to the interpreters. The results from the survey are consistent with the ethnographic data reported in Chapter 4, which shows that no briefing session and debriefing session was observed. Along with the point that the information interpreters receive before the consultations is relatively limited, interpreters can face challenges more often during their interpreting assignments (see 4.3.1.3. in Chapter 4). Although guidelines and policies for

both healthcare professionals and interpreters suggest that healthcare professionals should provide briefing sessions for interpreters and that interpreters could also ask for briefing sessions if needed, the majority of the survey respondents felt that they do not have enough opportunities to do this. The point arises whether interpreters are aware of their right to ask for briefing sessions as described in the AUSIT Code of Ethics: "Interpreters prepare themselves by obtaining from the initiator/client as much information and briefing as is necessary for the proper execution of their interpreting, and treat such material confidentially or as expressly agreed" (AUSIT, 2012, p. 14).

During my post-observation interviews, two interpreters reported that they often add their own explanations of the intercultural differences to the healthcare professional after the consultation finishes. However, another interpreter complained that the briefing rarely happens, and a lack of background information makes interpreting more challenging, especially in mental health clinics. This interpreter was not aware that interpreters are encouraged to ask for briefing sessions. The survey results are consistent with those of my observations and post-observation interviews, which showed a lack of information provided to interpreters before the consultations and a lack of briefing/debriefing sessions, which led interpreters to challenging situations due to a limited understanding of the patients' medical history and the level of English of the patients (see Chapter 4). What is surprising is that almost 80% of the survey respondents reported they never or rarely have briefing sessions and almost 90% of the respondents reported they never or rarely have debriefing sessions. However, that these survey respondents are aware that they can also ask for briefing and/or debriefing sessions cannot be assumed.

6.4.3 How interpreters deal with intercultural communication challenges

As explained in Chapter 2, while healthcare interpreters and healthcare professionals are expected to follow ethical and professional standards and guidelines, very little guidance exists on how to deal with cross-cultural differences (Hale, 2013b). The guidelines for healthcare professionals (AUSIT, 2007) and for healthcare interpreters (NSW HCIS PDC, 2014) suggest that healthcare professionals should not ask interpreters to provide information about the patient's culture. Healthcare professionals are also advised not to make assumptions about the patient's culture (Clayton et al., 2007). On the other hand, healthcare interpreters are guided to provide cultural background information during the briefing sessions before the assignment, where applicable, and to discuss any cultural differences that may have caused a communication breakdown during the debriefing sessions after the assignment (NSW HCIS PDC, 2014). However, "limitations apply and careful consideration is required in relation to when and how cultural information can be provided. Interpreters do not act as cultural brokers and take great care to avoid stereotyping" (NSW HCIS PDC, 2014, p. 18).

Despite the current guidelines provided to healthcare interpreters, the results from my post-observation interviews and the online survey show that interpreters still have some stereotypical understandings of how to define the patient's culture and provide unsolicited cultural information to the healthcare professionals based on their individual conceptualisation of the patient's culture. The survey responses about interpreters' own strategies in dealing with intercultural communication challenges were also diverse. The problem is, however, whether interpreters are allowed to assume the intention behind patients' behaviours and judge them by the interpreters' understanding of the cultural differences. Crezee (2013) argues that interpreters must bear in mind that "their

understanding of patients' culture can be subjective based on their own life-experiences, personal upbringing and family background, professional development, and time spent in the new country of residence" (p. 25). Researchers (Crezee, 2013; Llewellyn-Jones & Lee, 2014; Slatyer, 2015) suggest that interpreters must be culturally sensitive and be able to make professional judgements while still maintaining appropriate role boundaries dependent on the context in which they work.

Interestingly though, as already mentioned earlier, in the guidelines for both healthcare professionals and healthcare interpreters in the 1990s, when some respondents from my post-observation interviews and survey started working as interpreters, healthcare interpreters were guided to play a more active role as cross-cultural brokers, as illustrated in the quote below:

> Interpreting requires a thorough knowledge of the culture, world views, values and beliefs expressed in the linguistic structure as well as an understanding of the conceptual framework within which the healthcare provider and the patient operate. … Non-English speaking clients are often not familiar with the health system and available services. The Health Care Interpreter provides such information to clients and their families to facilitate access to existing services and to reduce fears, anxieties and concerns that may impede effective communication. … Health Care Interpreters can also provide cultural information relevant to the case, and explain concepts that are unique in other cultures or not easily translatable in English. (The Health Care Interpreter Service, 1994, pp. 2–3)

Three out of five interpreters who participated in my observations and post-observation interviews reported that they always provide cultural information based on their common sense, which they gained from their work experience (see Chapter 5). However,

they had stereotypical views about Korean culture, and each interpreter's views on Korean culture contradicted other interpreters' understandings in most examples. All five Korean interpreters from the post-observation interviews stated that they dealt with intercultural communication challenges and behaved according to common sense and professional judgement, which they had learnt from their work experience (see Chapter 5). However, none of them used any available professional opportunities to update their skills and understanding of the more up-to-date professional Code of Ethics. Similarly, none of the survey respondents added any comments on professional development or ways to share their questions and to look for possible solutions.

According to their website (Last accessed on 22 May 2020, NSW Health Care Interpreter Service), the NSW Health Care Interpreter Service provides a two-day Induction and Orientation program for beginner interpreters and various other programs for current interpreters, including Ethics of the Profession, and various workshops covering Advance Medical Interpreting, Chuchotage in the Medical Setting, Group Interpreting, Phone Interpreting, Note-taking for Phone Interpreting—to name a few. However, if interpreters do not work for the NSW Health Care Interpreter Service, it is difficult, if not impossible, to access such programs. Similarly, AUSIT regularly runs seminars or workshops relevant to healthcare interpreting settings; however, such information may not be easily communicated to interpreters who are not members of AUSIT. This is true of the Korean interpreters from my post-observation interviews, who were not members of AUSIT and not aware of various professional development opportunities. Also, none of them had transitioned to the new NAATI certification system at the time of data collection, which pre-dated the NAATI testing reform; thus, professional development was not compulsory.

6.5 Conclusion

This chapter presented the results of an online survey of healthcare interpreters working in Australia. In this chapter, I embarked on the questions of how healthcare interpreters define, identify, and address intercultural communication challenges in interpreter-mediated medical encounters, and whether there is a consensus among interpreters in the same language group on what constitutes intercultural communication challenges. The survey found that respondents have a vague understanding of the definition of intercultural communication challenges and erroneously ascribe some professional/ethical challenges to intercultural challenges. Also, importantly, not one language group shared the same views on what constitutes intercultural communication—for example, family involvement, managing end-of-life situations, the medical decision-making process, and patients' reluctance to ask questions of doctors. Furthermore, survey respondents often displayed stereotypical views of their culture, which again contradicted those of their peers from the same language group. Recent studies have shown drastic changes in attitudes towards such cultural norms, and various cultural beliefs coexist within one society (H. Kim, 2017; S. Kim, 2015; Mo et al., 2012; Morita et al., 2015). However, it seems that some respondents still understand culture as a static conceptualisation, defined by generalised views (Hall, 1976; Hofstede, 1980, 2001). Such responses are more likely from Paraprofessional interpreters with no educational qualifications or TAFE training, who may not have participated in any type of professional development after they were accredited. This is something that will inevitably change under the new NAATI system of compulsory professional development for re-certification.

As poor working conditions, including a lack of briefing and debriefing sessions and a lack of information received before the consultations, were found to be the common issues from my observations and post-observation interviews with the Korean interpreters, these were also consistent with the survey results. With regards to working conditions, the survey data corroborates the data from my observations and post-observation interviews, which argued that a lack of briefing and debriefing sessions is an ongoing issue, and culture is often misused to explain interpreters' challenges due to poor working conditions. Most respondents reported that they did not receive enough information prior to the consultation, and most of the respondents stated that they never or very rarely had briefing and debriefing sessions. Moreover, they argued that they often face communication challenges because they did not receive enough information and did not have a briefing session prior to the consultation.

There were a number of different ideas presented about the role boundaries of healthcare interpreters—including the belief that they can act as helpers, cultural brokers, or mediators—showing a lack of consensus and a confusion about their role as helpers. Although healthcare interpreters and healthcare professionals are expected to follow ethical and professional standards and guidelines, very little guidance exists on how to deal with cross-cultural differences (Hale, 2013b). The patterns found on the survey regarding role boundaries of interpreters who had practiced for more than 20 years, tended to support the role of helper as part of their role as interpreter. It is difficult to claim, based on my data, that interpreters' understanding of the role boundaries of the role of healthcare interpreter is directly linked to their years of practice, as information regarding whether the interpreters received training or updated their skills and understanding of the more up-to-date professional Code of Ethics was not addressed in the survey questions. What is undisputable,

however, is that professional development for healthcare interpreters is vital in dealing with

intercultural and ethical communication challenges.

Chapter 7 Conclusion

7.1 Introduction

Healthcare interpreters face various challenges due to different reasons. Linguistic challenges are among the main ones (Ferguson & Candib, 2002); however, competent interpreters should be able to overcome them when they accurately interpret both at a pragmatic as well as a sentence and word level (Hale, 2007). In addition to linguistic challenges, there is debate about whether cultural differences constitute a significant challenge for healthcare interpreters and whether interpreters should play the role of cultural brokers or not (Angelelli, 2004; Dysart-Gale, 2005; Hsieh, 2008; Souza, 2016). However, studies on intercultural communication in healthcare interpreting (Angelelli, 2004; Hsieh, 2008) have rarely clearly outlined what is meant by the concept of culture and have provided little evidence for intercultural communication problems in this setting. This thesis critically explores the concept of culture and intercultural communication as the first step to understanding their link to interpreting challenges. The research undertaken in this thesis arose from recurring personal and professional challenges and even frustrations during situations in which a practising interpreter in healthcare settings must make accurate and balanced judgements when faced with ethical and moral dilemmas.

7.2 Summary of main findings

The present study was designed to investigate whether intercultural communication challenges are paramount in healthcare interpreting settings and whether the interpreter is compelled to play the role of a 'cultural broker', which goes counter to their prescribed role

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in the Code of Ethics (AUSIT, 2012). Based on previous studies, common examples of intercultural communication challenges that healthcare interpreters can face include nonverbal communication, cultural beliefs about terminal illnesses, patient autonomy and medical decision-making, and family involvement (Goldstein et al., 2002; Kagawa-Singer & Blackhall, 2001). For example, in some cultures, including Asian, males are traditionally considered to be the authority figures who have the decision-making role in terms of treatment options for the patient, and family members tend to withhold information from the patients about the diagnosis and prognosis of terminal illnesses. Based on authentic data of observations of Korean-English interpreter-mediated medical encounters, the results of this investigation show that none of the cases clearly included any instance of cross-cultural differences between the healthcare professionals and the Korean patients, and Korean patients and their family members each behaved differently when discussing terminal illnesses. The current study provided no evidence for the claim that multicultural issues present a significant challenge for interpreters, and therefore provided no justification for interpreters to take on the role of cultural brokers. Thus, the findings of the current study differ from some published studies (Angelelli, 2004; Hsieh, 2016; Souza, 2016), which argue that communication breakdowns can occur in medical encounters due to cultural differences, necessitating the intervention of interpreters in order to bridge the cultural gaps, even at the expense of overstepping their role as stipulated by their Code of Ethics.

The current study has also endeavoured to explore healthcare interpreters' perceptions on how to identify and address intercultural communication challenges, and whether there is a consensus among interpreters of the same language group on what constitutes intercultural communication challenges. Based on authentic data of post-observation interviews with Korean interpreters and an online survey with interpreters in

various language groups who work in Australia, interpreters' viewpoints on their understanding of intercultural communication challenges were analysed. Previous studies (Furrer, et al., 2000; Hall, 1976; Hofstede, 1980; Jones, 2007; Kubota, 2001) from various disciplines have defined, described, and explained the multifaceted concept of 'culture' in very different ways. The AUSIT Code of Ethics (AUSIT, 2012) includes only two articles that refer to cultural elements, albeit without a detailed description of what 'culture' means in the context. The literature shows a common tendency among interpreters and healthcare professionals to generalise the cultural trends of certain groups, based on their nationalities, to educate healthcare professionals so that they can provide culturally sensitive care (Abbato, 2011; Galanti, 2015). Even though it is important to clarify the distinction between generalisation and stereotype so that interpreters need to be culturally competent by understanding cultural profiles of people from various countries, such information may or may not apply to a particular individual and to a certain context. This study began with the widely accepted assumption that cultural diversity and intercultural challenges directly challenge communication in medical consultations. Interpreting studies, especially in healthcare interpreting, have so far regarded the notion of culture as being embedded in the practices of national or language groups. However, in our rapidly changing world, dichotomous stereotypical ideas used to compare two mainstream cultures have been modified, since the notion of culture is increasingly understood as a much more complex one than previously believed (Schnurr & Zayts, 2017). It cannot be argued, for example, that Australia has one dominant monocultural and monolingual culture. The findings of the study found a lack of clarity from the interpreters about what they understand as constituting intercultural communication challenges. The findings of this study also demonstrated that intercultural misunderstanding was not a critical issue for interpreters and that often culture

is mistakenly blamed for interpreters' incompetent interpreting or unethical behaviour. It was also shown that most of the challenges were not attributable to intercultural issues, but rather to cross-linguistic differences, deficient interpreting skills, ethical dilemmas, poor interprofessional relationships, and inadequate working conditions. Understanding one's own culture and other cultures, and applying that knowledge to practice, can lead to better health outcomes in a multicultural society like Australia (Crezee, 2003, 2013). There is still no consensus, however, about what constitutes intercultural communication challenges for interpreters in healthcare settings (Butow et al., 2012; Crezee, 2003; Hale, 2013). The findings of this study emphasise that interpreters from various language groups have a vague understanding of the definition of intercultural communication challenges and often have stereotypical views about sharing the same culture with patients from the same language background. The most striking result to emerge from the survey data was that not one language group shared the same views on what cultural differences there are between their speech community and the mainstream community. Since cultural differences can lead to communication challenges in medical consultations, healthcare interpreters as well as healthcare professionals should become culturally competent by understanding potential cultural differences. However, it is important for them to clarify the distinction between generalisation and stereotype (Crezee, 2013; Galanti, 2015). Thus, healthcare interpreters must understand that generalised views of one culture may or may not apply to a particular individual and to a certain context. As explored in Section 2.6 (Chapter 2), not many studies have paid attention to the cultural, ethnic, or linguistic diversity of healthcare professionals or interpreters. However, I observed the diversity of the ethnic background of the healthcare professionals in my observations (see Chapter 4). Similarly, the survey responses show the

diversity of interpreters' cultural profiles and their varied perceptions of intercultural communication.

This thesis also aimed to identify and examine the challenges that healthcare interpreters face other than intercultural challenges. The different controversial views among healthcare professionals, LOTE-speaking patients, and interpreters about the role of healthcare interpreters and the ethical judgements that healthcare interpreters are faced with during medical consultations were presented as challenges for healthcare interpreters in the literature (Crezee, 2003; Pöchhacker, 2000). In reviewing the literature, it was found that some interpreters volunteered medical information to the patients to save the healthcare professionals' time and made decisions as to whether certain information provided by patients had medical value or not by assuming what the patients wanted to do or say (Angelelli, 2004; Davidson, 2000). While such a practice can be risky because interpreters are not medical experts, and patients do not have the ability to evaluate the quality of the information provided by interpreters, Angelelli (2004) argues that objectivity and impartiality are not desirable for healthcare interpreters, and the role of the healthcare interpreter needs to be examined differently from that of the interpreter in conference, court, or other community settings, since the nature and the goals of the interaction are contextualised by the setting. However, as Hsieh (2007) argues, interpreters are neither medical nor cultural experts and cannot assume the knowledge of each patient's individual culture. Based on the evidence presented in the current study, one of the most common phenomena observed was the exclusion of the patients from the conversations in which side conversations between a family member and the healthcare professional were not interpreted for the patient. Based on the AUSIT Code of Ethics (AUSIT, 2012, p. 15), any side conversation or comment made by any of the parties should be accurately interpreted into the

other language so that all parties present can be kept informed, regardless of whether this side conversation or comment was a private conversation among parties or an attempt to engage the interpreter in a private conversation with either party. Although the initial research question posed at the beginning of this study was about intercultural communication challenges that healthcare interpreters can face, this study has found that interpreters often face ethical challenges rather than cultural challenges, which mostly affect the principles of accuracy, impartiality, and clarity of role boundaries. This confirmed the concerns of some researchers (Felberg & Skaaden, 2012; Hale, 2013) about ascribing all communication problems to cultural differences. Culture is often blamed or conveniently used to explain away any institutional complications or incompetence or unethical behaviour on the part of the interpreter.

We also see that the poor working conditions, including the absence of briefing and debriefing sessions and a lack of any relevant information provided to interpreters prior to the assignments, posed another challenge for healthcare interpreters. Establishing the context of the medical consultation is important for healthcare interpreters to provide the most effective interpreting services and make the most accurate professional judgements when they face challenges during consultations. As the information provided by healthcare professionals prior to the consultation is limited, interpreters would benefit from being briefed by healthcare professionals. No briefing session and a lack of information provided could eventually influence the quality of interpreting. As Pöchhacker (2004, p. 119) explains, background information plays a crucial role in the interpreter's comprehension process, and without such information interpreters often must guess the intended meaning of ambiguous utterances during interpreting. The results of the current study found no case where either briefing or debriefing sessions were conducted for the interpreters with the healthcare

professionals, or any case where an interpreter asked for a briefing or debriefing, even though the guidelines for healthcare professionals recommend this practice (AUSIT, 2007; NSW HCIS PDC, 2014; Queensland Health Interpreter Service, 2007). The current study showed that the lack of briefing led to the numerous turns of the interpreters' requests for clarification, the transition of the use of the first-person pronoun into the third-person pronoun from both the healthcare professionals and the interpreters, and the interpreters becoming more obvious primary participants in the encounters as a result.

Finally, this thesis has investigated how healthcare interpreters deal with the challenges they face, whether they be cultural or ethical. Interpreters from previous studies (Angelelli, 2004; Hsieh, 2016; Souza, 2016) have been shown to have adopted various strategies to deal with ethical dilemmas resulting from intercultural communication challenges: providing additional information, initiating the information-seeking process, adding what they considered to be crucial information and omitting what they considered to be irrelevant, and reminding and prompting patients to discuss certain issues. However, some healthcare professionals from Hsieh's (2016) study expressed concerns about such interpreter strategies—including initiating conversations, modifying narratives, or omitting information from either party—believing that such behaviours might infringe on the healthcare professional's control over the medical dialogue. The results of post-observation interviews and an online survey of the current study showed that interpreters commonly adopt additional roles during the waiting room conversation such as those of an educator, or a doctor's or nurse's assistant, explaining such behaviours as intercultural communication strategies. Furthermore, whenever a situation arose that the interpreters considered to be a 'cultural' difference, they tended to act in ways that go against some of the articles of the Code of Ethics—mainly accuracy, impartiality, and role boundaries. For example, interpreters stated

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that they often provided unsolicited information to healthcare professionals to help the patients. Moreover, interpreters of the same language group did not share their understanding of the cultural traits of the LOTE patients; hence, healthcare professionals will receive inconsistent information from different interpreters regarding cultural information. Interpreters seemed to provide information about patients' culture to healthcare professionals based on their individual beliefs and assumptions and not supported by any studies. Although healthcare interpreters and healthcare professionals are expected to follow ethical and professional standards and guidelines, very little guidance exists on how to deal with intercultural differences (Hale, 2013). The roles of the healthcare interpreters in Australia described in various guidelines, which were widely adopted at the time of this study, are generally limited to facilitating communication between two parties and to empowering them to make their own decisions (AUSIT, 2012; NSW HCIS PDC, 2014). According to the guidelines for healthcare interpreters, interpreters should not provide advice to clients and only "provide cultural information at the healthcare provider's request or when the cultural gap is affecting communication during an interpreting assignment" (NSW HCIS PDC, 2014, p. 18). Interestingly, however, in the guidelines provided for healthcare professionals and healthcare interpreters in the 1990s, healthcare interpreters were asked to play a more active role in cross-cultural situations, such as providing information to clients about the healthcare system; providing health-related cultural information to healthcare professionals; and helping clients to reduce fears, anxieties, and concerns that may impede effective communication (The Health Care Interpreter Service, 1994). Several respondents from my interviews and the online survey, who started practising as interpreters in the 1990s, indeed tended to believe that healthcare interpreters should play a more active role, at the same time believing that they are not overstepping their role boundaries as healthcare interpreters. The results of the

study suggest that interpreters who were originally provided with the pre-1990s guidelines were more likely to perceive their role as that of a cultural advisor as well as an interpreter. Interpreters who were university trained in subsequent decades did not hold the same perceptions. This finding gives support to NAATI's new system of re-certification after every three years of practice and the requirements of engaging in professional development, including updating of knowledge on the ethics of the profession.

7.3 Significance of the study

The study is significant because it is based on real-life situations in which professional healthcare interpreters were involved, with empirical data collected and analysed. The results contribute to our understanding of interpreted interactions in healthcare settings, including intercultural and other challenges, and interpreters' behaviours. In particular, the study results add to the knowledge of communication challenges in interpreter-mediated encounters between Korean-speaking patients and English-speaking healthcare professionals in Sydney, Australia. Previous research studies on intercultural communication in healthcare interpreting have been predominantly concerned with the English–Spanish (Angelelli, 2004) or English–Chinese (Hlavac & Xu, 2020; Hsieh, 2016) language pairs; therefore, it was unknown whether existing findings were relevant to the English–Korean language pair.

In addition, this thesis has important implications for the professional development of healthcare interpreters. The findings of the study provide support to the need for continuous professional development for healthcare interpreters in dealing with challenges, both intercultural and ethical, that they can face. Interpreters hold contradictory beliefs about their role boundaries, including those of additional roles as helper, cultural broker, or mediator. Their understanding of what a helper can do in healthcare interpreting settings was

inconsistent. As seen in my observations and interviews (see Chapters 4 and 5), some interpreters justified their unethical behaviours as inevitable ethical decisions or decisions based on their intercultural understanding. However, when they tried to act more like a 'helper' for the patients' wellbeing or in the name of duty of care, they were more likely to violate the principles of the Code of Ethics unwittingly and did not achieve their goal of helper. Thus, we need to reconsider the importance of the professional development of interpreters in the healthcare interpreting field. It was also shown that interpreters who had been practising for more than 20 years and were trained under the former guidelines were directed to play a more active role in cross-cultural situations. Therefore, it is important to provide training for healthcare interpreters to update their understanding of the relevant guidelines and their capacity to apply them in practice.

7.4 Limitations of the study

Despite the significance of these findings, the study was limited in several ways. First, the scope of the study was limited to the specific context of healthcare interpreting and only in one language combination, that is, the interpreter-mediated medical encounters of Korean-speaking outpatients. I collected data at Westmead Hospital, which is one of the major hospitals in Sydney and serves a large population of Korean immigrants. That being said, it can be argued that the findings of my study may not be generalisable from this limited context to other settings. Furthermore, the number of interpreters who participated in this study and the total number of observations were relatively small. With a small sample size, caution must be applied, as the findings might not be transferable to other contexts. In addition, it needs to be pointed out that when conducting observations, due to the conditions set out by the ethics committee, I was not allowed to record the interpreter-mediated medical encounters

using any audio or video equipment. My analysis of the observations, therefore, is based on my fieldwork notes. Nevertheless, the findings of the study can be used as a basis for research involving other language pairs and other settings, using larger samples.

7.5 Further research

In contrast to previous studies, no evidence of intercultural communication challenges for healthcare interpreters was found in this study. This can be attributed to the fact that the strict boundaries of the traditional cultural dimensions have been diluted, and traditional values in any culture may be eroded by more recent values due to the globalised world becoming more homogenous. As the present study only explored the Korean<>English language pair, intercultural communication challenges involving other language pairs should be conducted.

Another significant area of future studies would involve the perceptions of healthcare professionals and patients regarding the interpreters' role as cultural broker. The present study has explored the interpreters' intentions behind their behaviours as observed through post-observation interviews and has also found an inconsistency between interpreters' accounts during the interview and their practices during the consultations observed. In the same manner, further studies should be conducted to explore the perceptions of healthcare professionals and patients regarding the interpreters' role as cultural broker.

Also, if the debate is to be moved forward, a better understanding of complex interactions among all parties—including healthcare professionals, interpreters and patients—via video recording, needs to be developed. Empirical research based on real-life situations with professionally accredited/certified interpreters deserves more attention from both healthcare professionals and interpreting researchers.

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Appendix 1 Invitation letter to Korean interpreters

27 November 2014

Dear Interpreters,

Sophia Ra, a PhD candidate at the University of New South Wales is conducting a research study which explores cross-cultural challenges that Korean-English professional interpreters encounter in health care settings. The aim of the study is to investigate the impact of these challenges on the success of the interpreter-mediated consultation and recommend strategies for health care interpreters to overcome the challenges.

This study is being conducted under the supervision of Professor Sandra Hale and Associate Professor Ludmila Stern from the School of Humanities and Languages at the UNSW Australia. Eva Melhem, the Translation Service Manager, is the chief investigator representing WSLHD.

For the purpose of this study, Sophia Ra needs to observe interpreter mediated medical consultation between you and a Korean speaking patient. During the consultation, she might take down some notes. You will not be required to do anything different from what you would normally do in any such consultation.

The aim of the researcher is not to analyse your competence but rather to identify possible cross-cultural differences. Some data may be used for findings but will not include identifying details.

Confidentiality of all participants in this research will be protected at all stages of the research including the dissemination of results.

Should you have any enquiry, please do not hesitate to contact me.

Thank you for your support.

Eva Melhem
Translation Service Manager
Phone: 8838 6210
Email: Eva.Melhem@health.nsw.gov.au

Appendix 2 Participant information and consent form

Participant Information Sheet/Consent Form for medical practitioners / health professionals for observation

Health/Social Science Research - *Adult providing own consent*

Westmead Hospital

Title	Cross-cultural communication challenges: A study of interpreter-mediated encounters between Korean patients and medical practitioners in an Australian setting
Short Title	Cross-cultural issues in health care interpreting
Protocol Number	Research proposal dated 17 February 2014
Project Sponsor	UNSW
Coordinating Principal Investigator/ Principal Investigator	Professor Sandra Hale (UNSW), Associate Professor Ludmila Stern (UNSW), and Translation Service Manager Eva Melhem (WSLHD)
Associate Investigator(s)	Sophia Ra (UNSW PhD candidate)
Location	Westmead Hospital

Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this research project, which is called Cross-cultural communication challenges: A study of interpreter-mediated encounters between Korean patients and medical practitioners in an Australian setting. You have been invited as a medical practitioner or health professional who does not share the same cultural background as Korean patients because you are seeing a Korean speaking patient who will also be invited to participate. Your contact details were provided by WSLHD Health Care Interpreter Service (HCIS).

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved with taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative or friend.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

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• Understand what you have read

• Consent to take part in the research project

• Consent to be involved in the research described

You will be given a copy of this Participant Information and Consent Form to keep.

2   What is the purpose of this research?

The purpose of this study is to identify cross-cultural issues that Korean-English professional interpreters encounter when interpreting in health care settings to explore their impact on the success of the interpreter mediated consultation and recommend strategies to overcome them. Cross-cultural issues in community interpreting have not been studied much and, in particular, need more empirical research. Most recently, researchers have highlighted the importance of guidelines for interpreters on how to deal with cross-cultural differences in health care settings. Based on the findings of the current study, practical guidelines or training schemes for each party (medical professionals, interpreters, and patients) will be able to be developed, and better health outcomes in minority groups will also be able to be achieved.

The results of this research will be used by the researcher, Sophia Ra, to obtain a PhD degree.

This research has been initiated by the researcher, Ms Sophia Ra.

This research has been funded by University of New South Wales.

3   What does participation in this research involve?

If you agree to participate in this study, you will be asked to sign the Consent Form. Your participation will be passive. You will not be required to do anything different from what you would normally do when seeing a Korean patient with an interpreter. The researcher, Sophia Ra, will sit in the back of the consultation room to observe the interpreted interaction between you and your Korean speaking patient. She will take notes during the medical consultation and the consultation will also be audio-recorded to note any cross-cultural communication issues.

This study is a PhD research and it will be reviewed by the UNSW School of Humanities and Languages Postgraduate review panel. The supervisors will also monitor each phase of the research project.

This research project has been designed to make sure the researchers analyse the results in a fair and appropriate way.

There are no costs associated with participating in this research project, nor will you be paid.

4   Other relevant information about the research project

Ten interpreter-mediated medical encounters between Korean patients and medical practitioners in an Australian setting will be observed. This is the second phase of the PhD

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study. Based on the results of the observations, cross-cultural communication challenges for health care interpreters will be classified and analysed with the results of an online questionnaire and a focus group discussion with health care interpreters.

5   Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage.

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with Westmead Hospital or the University of New South Wales.

6   What are the possible benefits of taking part?

We cannot guarantee or promise that you will receive any benefits from this research; however, possible benefits may include the improvement of the quality of health care interpreting services in Australia.

7   What are the possible risks and disadvantages of taking part?

Since you will not be required to do anything different from what you would normally do in any such consultations, the only possible risk is inconvenience due to the presence of the researcher.

8   What if I withdraw from this research project?

If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify the researcher, Sophia Ra, before you withdraw. The researcher will inform you if there are any special requirements linked to withdrawing. If you do withdraw, you will be asked to complete and sign a 'Withdrawal of Consent' form; this will be provided to you by the researcher.

9   What happens when the research project ends?

This study will be conducted over a period of 5 years. If you wish to receive the results of the study, please leave your email address so we can send them to you.

Part 2   How is the research project being conducted?

11   What will happen to information about me?

By signing the consent form you consent to the research team observing and audio recording your consultation. Any information obtained in connection with this research project that can identify you will remain confidential. Any identifiable information that is collected about you for this study will be coded, remain confidential, and be disclosed only with your permission, or except as required by law. Only the researchers named above will have access to the recordings and observation notes which will be stored securely at the University of New South Wales. Your information will only be used for the purpose of this research project and it will only be disclosed with your permission, except as required by law.

The information that the research team collect and use will be in the form of notes taken by the researcher and audio-recordings.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your express permission.

In accordance with relevant Australian and/or NSW privacy and other relevant laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the research team member named at the end of this document if you would like to access your information.

Any identifiable information that is collected about this study will be coded, remain confidential and be disclosed only with your permission, except as required by law. Only researchers named above will have access to the recordings, observation notes and your details and results that will be stored securely at University of New South Wales.

12   Complaints and compensation

If you suffer any distress or psychological injury as a result of this research project, you should contact the research team as soon as possible. You will be assisted with arranging appropriate treatment and support.

13   Who is organising and funding the research?

This research project is being conducted by Sophia Ra, a PhD candidate at the University of New South Wales.

No member of the research team will receive a personal financial benefit from your involvement in this research project (other than their ordinary wages).

14   Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).

The ethical aspects of this research project have been approved by the HREC of WSLHD and UNSW.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

15   Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact the researcher, Sophia Ra (telephone: 0410 229 654 or email: s.ra@student.unsw.edu.au) or any of the following people:

Research contact person

Name	Eva Melhem
Position	Translation Service Manager
Telephone	(61 2) 8838 6210
Email	eva.melhem@health.nsw.gov.au

For matters relating to research at the site at which you are participating, the details of the local site complaints person are:

Complaints contact person

Name	Maggie Piper
Position	The WSLHD Research Governance Officer
Telephone	02 9845 9634
Email	Wslhd-rgo@health.nsw.gov.au

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

Reviewing HREC approving this research and HREC Executive Officer details

Reviewing HREC name	WSLHD Human Research Ethics Committee
HREC Executive Officer	Kellie Hansen
Telephone	02 9845 8183
Email	WSLHD-ResearchOffice@health.nsw.gov.au

Local HREC Office contact

Name	Maggie Piper
Position	RGO officer
Telephone	02 9845 9634
Email	margaret.piper@health.nsw.gov.au

Consent Form - *Adult providing own consent*

Title	Cross-cultural communication challenges: A study of interpreter-mediated encounters between Korean patients and medical practitioners in an Australian setting
Short Title	Cross-cultural issues in health care interpreting
Protocol Number	Research proposal dated 17 February 2014
Project Sponsor	UNSW
Coordinating Principal Investigator/ Principal Investigator	Professor Sandra Hale (UNSW), Associate Professor Ludmila Stern (UNSW), and Translation Service Manager Eva Melhem (WSLHD)
Associate Investigator(s)	Sophia Ra (UNSW PhD candidate)
Location	Westmead Hospital / UNSW

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print) _____
Signature _____ Date _____

I agree to be audio-recorded, for research purposes only. ☐ Agree ☐ Disagree
I agree to be observed and notes taken, for research purposes only, but not audio-recorded.
                                                                                    ☐ Agree ☐ Disagree

If you would like to receive the results of the study, please leave your email address so we can send them to you.
Email address: _____

Declaration by Researcher[†]

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Name of Researcher[†] (please print) _____
Signature _____ Date _____

[†] An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature

Appendix 3 Observation sheet template

Place:

Date:

Time:

People present:

Description of physical setting:

Description of event:

Cross-cultural communication issues:

Reflections:

Reminders (follow-up)

Appendix 4 Interview guide

Sex: Male ☐   Female ☐

Years of residence in Australia:

Place of birth:

Years of practice:

1. Can you tell me about your perception of any cross-cultural issues in health care settings involving Korean patients and English-speaking medical practitioners?

2. Have you noticed any difference in the way the medical practitioners interact with Korean patients based on the medical practitioners' ethnicity? Can you elaborate on this?

3. Do you think that patients across different cultures have different views on the issue of patient autonomy in regard to telling the truth to the patient about their diagnosis or prognosis (end-of-life situation, in particular)?

4. Do you think that patients across different cultures have different views on the issue of the extent of family involvement, hospice, the meaning of silence, or the meaning of smile?

5. Do you think that patients from some cultures tend not to ask questions of people of authority, for example, elders, professors, or physicians?

6. What do you think about this quotation?

   Some interpreters also noted the discomfort some cultural groups experienced in being exposed to the Western style of informed decision making. Such patients expected to be told what to do and were confused, lacking in confidence, and fearful of making the wrong decision. (Butow et al., 2012, p.241)

7. Do you think that an interpreter should add additional information regarding cultural issues, including non-linguistic features, such as eye contact, gestures, greetings, or ways of complimenting, during an interpretation in order to make a patient or a medical practitioner better understand and communicate with each other?

8. How do you manage a situation where you face difficulties arising from cultural differences between a medical practitioner and a patient?

Appendix 5 Email invitations for online questionnaire

Call for participants!

- Are you/Have you ever been working as a health care interpreter?
- Have you ever been asked to provide cultural information by the healthcare providers, and you didn't know what to do?

You can make a difference by participating in the study: "Interpreter-mediated consultation between CALD patients and medical practitioners in an Australian setting"

The survey is being carried out by Sophia Ra (Mobile: 0410 229 654 or email: s.ra@student.unsw.edu.au), a PhD candidate at the University of New South Wales, under the supervision of Professor Sandra Hale and Associate Professor Ludmila Stern.

The aim of this survey is to gather the interpreters' views about the challenges they face in interpreter-mediated consultations between CALD patients and medical practitioners and how to deal with the challenges.

I estimate that your time commitment would be a maximum of 20 minutes. To access the survey, please click the link below:

http://www.surveys.unsw.edu.au/f/162088/171c/

Thank you for your participation!

This project has been approved by the Human Research Ethics Committee of the Western Sydney Local Health District and the University of New South Wales (**HREC HREC/14/WMEAD/109**)

Best regards,

Appendix 6 Online questionnaire

Please tick the following box if you agree:

I understand that when I finish this questionnaire my answers will be used for the "Interpreter-mediated consultation between CALD patients and medical practitioners in an Australian setting" research project. I know that I can contact the researcher if I have any questions (s.ra@student.unsw.edu.au) and that I can withdraw from the research by leaving the questionnaire at any time.

- Agree
- Disagree

A. Please choose the answer that best describes you.

1. What is your gender?
   - Male
   - Female

2. Your age group
   - 18-21
   - 21-29
   - 30-39
   - 40-49
   - 50-59
   - Over 60

3. What is your first language?
   * Based on Australian Bureau of Statistics Classification of Languages
   - Northern European Languages (e.g. Celtic, German, Dutch, Scandinavian, Finnish)
   - Southern European Languages (e.g. French, Greek, Spanish, Italian, Maltese)
   - Eastern European Languages (e.g. Baltic, Hungarian, Russian, Bulgarian, Polish, Romanian)
   - Southwest and Central Asian Languages (e.g. Iranian, Arabic, Turkish)

- Southern Asian Languages (e.g. Tamil, Hindi, Punjabi)

- Southeast Asian Languages (e.g. Burmese, Vietnamese, Khmer, Thai, Indonesian, Malay, Filipino)

- Eastern Asian Languages (e.g. Chinese, Japanese, Korean)

- Australian Indigenous Languages

- Australian Sign Languages

- Other languages

4. What is/are the language(s) that you interpret from and into in healthcare settings (Choose as many as apply)

  * Based on Australian Bureau of Statistics Classification of Languages

  - Northern European Languages (e.g. Celtic, German, Dutch, Scandinavian, Finnish)

  - Southern European Languages (e.g. French, Greek, Spanish, Italian, Maltese)

  - Eastern European Languages (e.g. Baltic, Hungarian, Russian, Bulgarian, Polish, Romanian)

  - Southwest and Central Asian Languages (e.g. Iranian, Arabic, Turkish)

  - Southern Asian Languages (e.g. Tamil, Hindi, Punjabi)

  - Southeast Asian Languages (e.g. Burmese, Vietnamese, Khmer, Thai, Indonesian, Malay, Filipino)

  - Eastern Asian Languages (e.g. Chinese, Japanese, Korean)

  - Australian Indigenous Languages

  - Australian Sign Languages

  - Other languages

5. What is your country of birth?

  * Based on Australian Bureau of Statistics Classification of Countries

  - Oceania and Antarctica

  - North-West Europe

  - Southern and Eastern Europe

  - North Africa and the Middle East

  - South-East Asia

  - North-East Asia

- Southern and Central Asia

- Americas

- Sub-Saharan Africa

- Other

6. Years of residence in Australia

- Less than 5 years

- 6-10 years

- 11-15 years

- 16-20 years

- Over 20 years

7. Years of practice as interpreter

- Less than 5 years

- 6-10 years

- 11-15 years

- 16-20 years

- Over 20 years

8. What academic qualifications in Interpreting do you hold? (Choose as many as apply)

- Nil

- TAFE Diploma/Advanced Diploma

- Undergraduate degree

- Postgraduate degree

- Other

9. What is your NAATI accreditation level as an interpreter?

   - Senior Conference Interpreter

   - Conference Interpreter

   - Interpreter

   - Paraprofessional Interpreter

   - Recognised Interpreter

   - No NAATI accreditation

   - Other

10. How often do you work as a healthcare interpreter?

    - At least once a week

    - At least once a month

    - Less than once a month

    - Never

    - Other

B. Provide your own views about healthcare interpreters' working conditions.
   11. Please indicate which information you receive before the consultations. (Choose as
       many as apply)
       - Date and time of the appointment
       - Name of the clinic
       - Name of the patient
       - Name of the medical professional
       - Position of the medical professional (e.g. GP, nurse, medical student, etc.)

- Reason for the consultation

- Other

12. Please indicate how often you have a <u>briefing session</u> before the interpreting assignment.

  - Never

  - Very rarely

  - Rarely

  - Occasionally

  - Very frequently

  - Always

13. Please indicate how often you have a <u>de-briefing session</u> after the interpreting assignment.

  - Never

  - Very rarely

  - Rarely

  - Occasionally

  - Very frequently

  - Always

14. Please indicate how often a <u>medical professional introduces himself/herself</u> before the consultation.

  - Never

  - Very rarely

  - Rarely

  - Occasionally

  - Very frequently

  - Always

15. Please indicate how often a <u>medical professional explains the role of the interpreter</u> to a patient before the consultation.

  - Never

  - Very rarely

  - Rarely

- Occasionally

- Very frequently

- Always

16. Do you ever <u>introduce yourself, describe your role, and the way you will work</u>?

   - Never

   - Very rarely

   - Rarely

   - Occasionally

   - Very frequently

   - Always

C. Provide your own views about communication challenges due to cultural differences

   17. Have you ever experienced <u>challenges due to cultural differences</u> in healthcare interpreting? If so, can you provide examples?

   18. Do you have <u>your own strategies</u> to deal with the challenges that you mentioned in Question 17?

D. Please indicate your level of agreement with the following statements about the patients who speak a language other than English (LOTE) for whom you interpret, on a scale below.

   19. In my opinion, the CALD patients I interpret express unique views about medicine and medical treatment options.

   1------------2-----------3------------4-------------5

   Disagree   Neutral   Agree

   20. In my opinion, the CALD patients I interpret prefer not to be informed of a terminal illness.

   1------------2-----------3------------4-------------5

   Disagree   Neutral   Agree

   21. In my opinion, the CALD patients I interpret prefer to make medical decisions about future tests or treatments for themselves, not by family members or medical professionals.

   1------------2-----------3------------4-------------5

   Disagree   Neutral   Agree

22. In my opinion, the CALD patients I interpret prefer that medical professionals make medical decisions about future tests or treatments for them.

1------------2-----------3------------4-------------5

Disagree　　　　　　Neutral　　　　　　Agree

23. In my opinion, the CALD patients I interpret prefer that family members make medical decisions about future tests or treatments for them.

1------------2-----------3------------4-------------5

Disagree　　　　　　Neutral　　　　　　Agree

24. In my opinion, the CALD patients I interpret are reluctant to ask questions during medical consultations even if they don't understand what the medical professionals say or disagree with them.

1------------2-----------3------------4-------------5

Disagree　　　　　　Neutral　　　　　　Agree

25. In my opinion, the CALD patients I interpret feel uncomfortable discussing their medical issues with a medical professional who is of a different linguistic background.

1------------2-----------3------------4-------------5

Disagree　　　　　　Neutral　　　　　　Agree

E. Please indicate your level of agreement with the following statements about the interpreter's role on a scale.

26. Healthcare interpreters should intervene and explain cultural differences to both parties, when necessary, <u>even if they are not asked to do so</u>.

1------------2-----------3------------4-------------5

Disagree　　　　　　Neutral　　　　　　Agree

27. Healthcare interpreters should explain cultural differences for both the patients and the medical professionals <u>when they are asked to provide such information</u>.

1------------2-----------3------------4-------------5

Disagree　　　　　　Neutral　　　　　　Agree

28. Healthcare interpreters <u>should *not* limit</u> their role to interpreting only; they <u>should also help the patients</u> in any other way they deem necessary.

1------------2-----------3------------4-------------5

	Disagree	Neutral	Agree

F. Any other comments?

Thank you very much!

If you would like to receive the results of this study, then please provide your email address below:

- Name:
- Contact e-mail: