A Case Study of MIC Kanagawa: 
The Medical Interpreter as the Community Interpreter

Gilles-Abuloph Nicolas Frew

Summary:

This paper discusses how MIC Kanagawa, the medical interpreters' association in Kanagawa Prefecture was started. Discussing the collaborative efforts between the local government and the local nonprofits, the paper argues how such collaboration was made possible by the bond of individual 'actors.' The unique style of Japan allowing full-time public officials to be engaged in nonprofit organizations as board members also helps government-sponsored nonprofits start up with very little funding. In conclusion, the paper argues that the medical interpreter is more of an interactive participant in the patient’s story-telling than he/she is an organizational gatekeeper.

1. Medical interpreter as community interpreter

According to Roberts (1994), community interpreting is 'to enable people who are not fluent speakers of the official language(s) of the country to communicate with the providers of public services so as to facilitate full and equal access to legal, health, education, government, and social services' (p. 127). In many cases, the clients for community interpreters are immigrants and refugees, both adults and children. While the adults often work in difficult conditions, their children may face problems of acculturation. The settings can be hospitals, doctor’s offices, schools police stations and various offices which handle immigrant matters relating to housing and social security.

Compared to conference interpreting, the range of languages needed is enormous
and the language levels quite different and diverse. Instead of well-educated clients, the clients of community interpreters may have regional dialects and they may be illiterate. Faced with life-threatening or legal issues and placed in strange surroundings, they may be worried and afraid. Moreover, the organizational professionals, i.e., doctors, nurses, police officers, or social workers are usually in a hurry and may feel pressure to complete their own tasks within a limited timeframe. In these difficult circumstances, community interpreters must be skillful in their interactions with both clients and service providers, utilizing not only their language expertise, but also their cultural knowledge and interpreting know-how.

In the case of medical interpreters, they sometimes must convey messages involving terminal illness and are expected by medical professionals to give patients emotional support.

Most community interpreters in Japan are volunteers, not paid employees of companies or organizations, making their professionalization difficult. In the 1980’s faced with a rapid increase of foreign workers, Japan’s lawmakers in a Lower House judicial-affairs meeting\(^1\), discussed implementing a law governing the services of medical interpretation that, by implication, would have acknowledged the rights of illegal residents’ to be provided with medical treatments. Although such a law was not enacted, in that meeting, medical professionals were re-assured that they could attend to patients, irrespective of their visa status. In that Diet meeting, there was also official recognition of the necessity of providing medical interpreters services for immigrants and refugees, and recognition of the rights of medical interpreters to protect the patient’s privacy and if needed, not to report to the police about the visa status of the patients since many overstayed immigrants whose visas expire could not go see doctors for fear of being arrested, which can deprive of their basic human rights to get medical assistance.\(^2\)

However, in Japan there is no mandate that forces medical institutions to hire

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1 Parliament Standing Committee on Justice answer in November, 1989

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interpreters. Nor is there usually a budget set aside for this purpose. Although many medical institutions face communication problems when treating foreign patients, they do not have licensed medical interpreters on staff.

The startup members of MIC Kanagawa were trying to solve these issues, with the objective of instituting a national licensing program for medical interpreters. In this paper, I am going to discuss how MIC Kanagawa began as a collaborative effort between the local government officials, leaders of grassroots nonprofits and a medical clinic.

2. MIC Kanagawa and its background

The 1990s in Japan was the decade of 'New Comers' as an unprecedented flood of immigrants came from South America (i.e. Nikkei) to work in labor-shortage sectors of Japan. Unlike the 'Old Comers' who were mostly from Korea or China and who had settled before the WWII, the ‘New Comers’ had little knowledge of the Japanese language or Japanese customs. When the central government was slow to recognize the situation, several local governments started to address the problem.

For example, Oizumi town in Gunma Prefecture attracted large numbers of Brazilian factory workers, so officials began to translate official documents into Portuguese. Many sign boards were also written bilingually or trilingually. In similar fashion, the forward-looking Kawasaki City government launched an advisory board of foreign nationals to help understand their needs and problems. The advisory board noted, for example, that while foreign nationals were paying taxes to the government, they were often unaware of social and administrative services available to them.

The Kanagawa prefectural government also decided to launch a governor’s advisory

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2 International Medical Interpreters Association (IMIA) which was started in 1987 states this clearly in their code of ethics. See the website: http://www.imiaweb.org/code/default.asp
4 The background and history of this advisory board is stated in Kanagawa prefectural government home page: http://www.kisc.meiji.ac.jp/~yamawaki/kyosei/gaikokujinkaigi.htm
board, selecting 24 members to represent immigrants. Launched in 1998, the board continues to this day, with membership renewed every year.

Upon advice of the board, the Kanagawa prefectural government decided to set up two nonprofits, the Sumai Support Center, an agency which helps foreign residents find rental properties and jobs and MIC Kanagawa, a multilingual medical interpretation service. The latter organization was formed in 2001 in response to a ‘problem’ noted by the board: when immigrant workers had to go to a doctor, they frequently asked their children to take a day off from school to accompany them as ‘interpreters.’ This meant their children were forced to miss school; moreover their translations were often inadequate for medical treatment.

Today, however, MIC Kanagawa (Multi-Language Information Center Kanagawa) can dispatch spoken-language medical interpreters to medical institutions such as the hospitals and clinics in Kanagawa Prefecture for the patients with LJP (limited Japanese proficiency).

3. The NGOs and collaborative support of the local government

MIC Kanagawa was a brainchild of both the local government and a network of local NGOs which assists foreign residents in Kanagawa prefecture in some aspects. Seed money was given by the local government and the adviser of the board, Akio Nishimura was sent from the prefectural government. Nishimura was a local government employee who had conducted preliminary research by visiting several existing nonprofit medical interpreters’ services.

Nishimura believed there should be a system of national licensing of medical interpreters is mentioned there and the prefecture immediately responded by starting medical interpreters start-up committee in 2001. http://www.pref.kanagawa.jp/uploaded/attachment/574172.pdf
interpreters. “In order to do this, we have to collaborate with organizations which are commercial-based,” he said. In his view, alliances with for-profit and fee-based interpreters’ associations would make their collective voices “heard” by the government. However, critics of licensing felt such a system would lead to developing a system of high-paid interpreters who serve only well-to do foreigners who come to Japan to get a top medical treatment.

According to Nishimura, “some former left-wingers who worked with us did not like this idea (of professionalization) since their motto was to help destitute people who need public support and that is why we were working hard developing a training program by scraping up limited resources,’ (Nishimura, May 2010 interview).

Hiroshi Hayakawa was one of those who questioned Nishimura’s licensing plans, the founder of Minatomachi Medical Center in Yokohama City. Minatomachi Medical Center was one of the first medical institutions to serve foreign residents in Kanagawa Prefecture. Minatomachi Medical Center had initiated a medical insurance system called ‘MF-MASH’, which provided affordable healthcare insurance to the indigent. Hayakawa’s medical center already had ties to a number of organizations which were providing medical interpretation services on a volunteer basis. These included: TELL (Inochi-no-Denwa, established in 1971), AMDA (Association of Medical Doctors of Asia, established in 1984), AWC (Asian Women & Children’s Network, established in 1996) and ANY (AIDS Network Yokohama, established in 1993).

Hayakawa believed that the need for medical interpreters could be met by mobilizing non-profit resources and that an alliance with for-profit organizations was not necessary.

6 In MIC Kanagawa, medical interpretation services are available in ten languages, i.e. Cambodian, Chinese, English, Korean, Laotian, Portuguese, Spanish, Tagalog, Thai, and Vietnamese. Except for a few languages including English, most of these languages are not commercially viable and, therefore, not offered by fee-based organizations.
7 http://www.find-j.jp/zenkoku.html
8 http://www.amdainternational.com
9 http://www.awcnetwork.org/
10 http://www.netpro.ne.jp/~any/
“We launched a mutual aid program to support foreign workers ineligible for Japanese national health insurance. The member of MF-MASH (Minatomachi Foreign Migrant Workers’ Mutual Aid for Health), will pay ¥2,000 a month for medical services. In exchange, their medical bill at Minatomachi Medical Center will be met at 30 percent of actual cost. The insured foreign workers can get full medical cover.” (Dr. Yoshiomi Tenmyo, Minatomachi Medical Center, 2013, May interview).

The medical center was originally established in 1979 by contributions from local dock workers at the Port of Yokohama. But as the handling of cargos in the Port decreased after the late 1980s, the number of foreign workers who worked as day laborers in Kanagawa-based small factories and construction companies started to increase. When injured or falling ill, they came to the clinic for treatment, referred there by Kanagawa-based support groups of foreign workers. In 1987, the clinic formally started treating foreign patients with the support of multi-lingual medical interpretation service.

Dr. Tenmyo adds, “Many illegally working foreigners who are suffering from illness hesitate to see doctors because they fear they may be deported if they go to hospitals. And there were few hospitals that accepted them in those days.\textsuperscript{11}”

MF-MASH started in November, 1991 officially. Within three months, it gained a membership of over 200 people who came from 20 countries.\textsuperscript{12} As it continued to grow, in 1994, the total number of the members in MS-MASH was 3542 (409 female) from 55 countries (MF-MASH News No. 8, June, 1994).

In Yokohama City (in Kanagawa Prefecture), there was another group of people working on creating a medical support system for the foreign residents, which eventually

\textsuperscript{11} ‘Yokohama clinic comes up with scheme to fund health care for foreign workers,’ The Japan Times, February 22, 1991.
\textsuperscript{12} ‘Over 249 members already,’ MF-MASH News First Issue, February, 1992.
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became the ‘Gaikokujin Iryo to Kotoba no Mondai wo Kangaeru-Kai or the Meeting for the Medical Care for the Foreign Residents and Languages.’

The first meeting was held on February 22, 1999, sponsored by Kanagawa Prefecture Council of Social Welfare Volunteer Center. The hosting members of the meeting were from the Minatomachi Medical Clinic in Yokohama, Saiseikai Kanagawa Hospital, Katorikku Yokohama Kyoku Tainichi Gaikokujin To Rentaisuru Kai or Diocese of Yokohama Catholic Church Meeting for the Fellowship of the Foreign Residents and Japanese.

The Yokohama Association for International Communications and Exchanges also invited medical personnel from hospitals and clinics, including personnel from city associations and town “lounges” of international communications and exchange. Administrative personnel from Kanagawa Prefectural Government and Yokohama City Government also joined the meeting.

Hiroshi Hayakawa, Chief of Medical Secretariat at Minantomachi Medical Center and Vice Chief Director of MIC Kanagawa, recalls.

“It was almost a miracle that all the members from different fields could get together and share what we all were feeling for and thinking about the foreign residents’ medical care. I didn’t know what was going to happen at first then, of course, but as time went by, we recognized that all of our thoughts were mutual and we all wanted to establish the system, which should be supported by the medical professionals, government, and language interpreter organizations. As my hospital alone could not take care of all the patients who should be hospitalized, had to have special examinations, or needed surgical operations. Then I could ask Katsumi Matsuno, director at Medical Social Worker at Saiseikai Kanagawa Hospital to allow some patients to be treated in his hospital. It was hard in those days but we worked together. Incidentally, Mr. Matsuno is currently serving as Chief Director at MIC Kanagawa.”

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13 Interview with Mr. Hiroshi Hayakawa, May, 2013.
In those days, most medical institutions refused to provide medical services to foreign patients, claiming that the patients and the medical staff could not communicate because of the language barrier, according to Hayakawa. The partnership between Hayakawa and Matsuno had a significant impact amongst the foreign residents in Kanagawa Prefecture.

After the first meeting of February 1999, they began holding the meeting regularly, involving more people and more nonprofits. The list of the members of the first Medical Interpretation System Review Committee counted 28 in 2001 August 1, with 27 supporting organizations.

“Fortunately we found there was a special fund we could receive from the government at the time. That was set aside for the 2002 FIFA World Cup in Yokohama City. It was a real trigger for establishing MIC Kanagawa.”

“The 2002 FIFA World Cup gave MIC Kanagawa a chance to organize the project with a modest fund. We started the activities, making non-official volunteer organizations and the local governmental organizations working together. In April 2002, thanks to these activities, MIC Kanagawa officially started its activities as “Medical interpreting service for foreign residents in Kanagawa Prefecture Support Model Project.”

Akio Nishimura has been a public official working for Kanagawa prefectural government for more than 30 years. When the prefectural government decided to start up a nonprofit called MIC Kanagawa in 2002, he was sent to the board as Chief Director. Nishimura, having worked as one of the coordinators for the advisory council of Foreign Residents in Kanagawa Prefecture, took strong interest in the discussions. He went and studied the system at several volunteer groups which were dispatching medical interpreters. After serving the MIC Kanagawa as a board member for three years, he was transferred to another section in the prefectural government. Yet his informal assistance to MIC Kanagawa continues to this day.

“Kanagawa has been favored by foreign people to settle down in Japan since its

14 Interview with Mr. H. H, May, 2013.
15 Interview with Mr. H. H, May, 2013.
capital city of Yokohama opened the first international port in 1859. We also had the resettlement Promotion Center for Indo-Chinese refugees in 1980s through the 1990s in Yamato City (west of Yokohama City). So it was natural for the local government to do something about problems involving the foreign residents. To receive a proper medical treatment came as one of the priorities in the list.”

Nishimura recognized the need among the foreign residents to have access to the medical institution, particularly after the 1990s, when the number of Asian workers and South American Nikkeis increased in the prefecture.

4. Government Official as an aggressive coordinator

Generally speaking, in order to prevent conflicts of interest, the U.S. and western European governments do not allow their full-time officials to sit on the boards of directors of corporations or nonprofit organizations to which they have ties or regulatory authority. On the other hand, it is not unusual in Japan, for a government official to be a board member of a nonprofit. In the case of MIC Kanagawa, the collaborative efforts involving the local government, local nonprofits and medical institutions worked

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16 In the U.S. for example, the government officials cannot sit in the executive board of any nonprofit since the government is not supposed to intrude in the nonprofit sector.
particularly well because the system connected individuals of those organizations to each other and to government officials.

As a government official, Akio Nishimura understood how ‘social capital’ can foster trust in the government. According to Bourdieu (1986), social capital is the ‘aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition’ (p.248).

In this sense, “Japanese tend to trust the government, so even though the Kanagawa government cannot provide a big financial backing, the trust makes organizations and people work. I could invite representatives of medical institutions and ask them to trust the medical interpreters MIC Kanagawa sends. We issued a formal identification card which is hung around the neck of each interpreter in the hospital so that his/her status is obvious and respected. Being a public official, I could discuss the financial issue with lots of public funders. I also knew that the hospitals would trust MIC if the prefectural government openly supports this. The government has a limited funding but it has an enormous impact in society and it can instantly create credibility towards other public institutions.” (Akio Nishimura 2010 May).

Establishment of a national license for medical interpreters is essential to secure stable income for medical interpreters, according to Nishimura. Unlike some countries such as the U.S.A., the U.K., Canada, and Australia, medical interpreters in Japan do not earn enough money to make a living since there is no legal requirement for hospitals and clinics to provide medical interpretation services. In order to establish this system, a law requiring medical interpretation services would be needed along with a national licensing system to support it, Nishimura believed.

“As a first step, it was necessary for the medical institutions to feel the need to use medical interpreters and make them pay for this service. In the beginning, the Kanagawa prefectural government gave a subsidy to pay the interpreter 2,000 yen per visit. But that was supposed to be over soon. We had to make a sustainable system, so we offered our
services for ‘free’ in the beginning. This worked. All of the hospitals and clinics felt the
service quite useful and very soon they agreed to pay 1,000 yen per visit from their own
pocket. Luckily, we were able to receive another 1,000 yen from the local government
(Nishimura 2010, May).

The Birth of the Medical Interpreter Dispatching System

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<th>April, 2002</th>
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<td>Establishment of MIC Kanagawa</td>
<td>Medical Interpreting Service for Foreign Residents in Kanagawa Prefecture Support Model Project</td>
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The above is a simple chart of the history of MIC Kanagawa taken from handout
“Kanagawaken ni okeru iyou-tsuyaku hakenjigyo ni tsuite by tokuhi, tagengo-shakai
risosu Kanagawa (MIC Kanagawa) at Medical Interpreters Forum 2013 in Kanagawa.”
5. Special skill training programs funded by the local government

Volunteer interpreters should not be considered as amateurs,\textsuperscript{17} but some may lack strong medical language translation and/or interpretation skills. Accordingly, the Kanagawa Prefectural Government and professional medical care givers conduct training programs and holds study meetings for MIC’s medical interpreters four times a year. In addition, each language group holds monthly or bi-monthly study sessions, inviting professionals in the fields of linguistics, medicine, laws, etc. to make presentations.

The Medical Interpreter Dispatching System of MIC Kanagawa

[Diagram of the Medical Interpreter Dispatching System]

Adapted from MIC Kanagawa Homepage, http://www.mickanagawa.web.fc2.com/

6. Medical interpreters as ‘volunteers’ or as ‘professionals’?

In this paper, I have discussed the importance of the collaboration between local government and grassroots nonprofit organizations, which were created out of the needs of the community. The interviews of Mr. Hayakawa and Mr. Nishimura illustrate the success of MIC Kanagawa in getting several ‘actors’ involved as volunteers. Those actors who took advantage of the existing network were also sharers of ‘core values,’ one of the

\textsuperscript{17} Nishimura Akio 2009 Solution Guide to Communicate Better with Your Foreign Patients. Tokyo: Medical View.
essential factors in developing social capital. Their network, which has been constantly renewed over decades, closes the organizational gap between government, hospitals, and the civic organizations. It is also important to note that Akio Nishimura’s insistence to make the medical interpreter as professionals needs to be examined at the end of this paper. While professionalization is essential in improving the quality of medical interpretation, there are also serious issues to be considered before trying to ‘standardize’ translation ‘skills’ through national exams.

It is important to consider that in institutional cross-cultural encounters, the interpreter becomes the point of negotiation and exchange between the social “frameworks” inhabited by the physician and by the patient. In hospital-based cross-linguistic, medical interviews, interpreters are not acting simply as “neutral machines of semantic conversation” but are also active participants in the process of diagnosis.

Davidson, following the discourse analysis of medical interpreting done by Angelelli (2004) and Wadensjö (1998), calls the medical interpreter the ‘institutional gatekeeper’ (Davidson 2000). Bolden (2000) also disagrees with the concept of a medical interpreter being just ‘a voice box’, since mere translation does not fully describe the interaction between the patient, the translator and the physician. Bolden’s discourse analysis uncovers what actually takes place in interpreter-mediated encounters between professionals and their clients (or patients) who do not speak the same language. It reveals the interpreter as an interactive participant in cross-cultural communication.

The concept that a medical interpreter is a mediator between two cultures and not just a translator of words, suggests to me that Mr. Nishimura’s goal of licensing medical interpreters would be difficult if licensing is based solely on a national exam system. How, for instance, can we “measure” through testing the “mediating” or “gatekeeping” skills of an interpreter. Under the national exam-based license, it is difficult to assess the cultural interpretation in a systematic way.
During medical interpretation, mistakes in the use of words are bound to happen particularly when the interpreter and the patient are using a second common language such as English. In some studies, even when the interpreter spoke the mother tongue of the patient, there were frequent misinterpretations caused either side: both by the interpreter and patients, who cannot find accurate medical terms. Sometimes, the interpreters face serious time constraint (Becker 2011).

However, in my opinion, some mistakes can be positively valued, since they are often caused by the interpreter in order to achieve a ‘common goal’, i.e. the treatment of the patient. In the dialogue between the interpreter and the patient, the trained medical interpreters try to aim at achieving some communicative or social goal that needs to be met. Through their actions, the speakers first try to negotiate and then to achieve their goals for the speech in question. Once the goals are determined, for each conversational participant, it is easier to understand the context of the speaker. In other words, the interpreter tries to make the socio-cultural background of the patient who appeals the symptom be understood by the doctor, while the interpreter also tries to make the patient understand the institutional background of the doctor/nurse who undertake the medical treatment. What interpreters are mediating in hospital discourse is not only the diagnosis and care of patients, but a form of cross-cultural encounter between the patient and agents of the institution.

Socio-historical facts surrounding the patients may often influence the interpreter's choices of words which influence the resulting outcomes of the interaction between the patients and the medical professionals. It may be difficult to assess such complicated interactions in a national exam.

Diagnosis is an ‘interpretive process’ (Angelelli 2004) in which the patient's physical and verbal data is passed. While interpreting as a medical interpreter, I often feel it is necessary for patients to ‘construct the story of the disease’ (Foucalt 1973), even if it may lead to a delay in my interpretation or slight difference in the choice of words I convey to the doctor.
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As a professional, I try my best to make my interpretation accurate. On the other hand, I often choose to interpret the patients’ narratives as ‘stories’.

Establishing a national license system may secure the socio-economic position of medical interpreters, but ‘standardizing’ how interpreters ‘tell a story’ may actually inhibit the accuracy of the ‘story.’

In order to achieve a common goal, the story should involve all the three actors, i.e., medical professionals, patients, and medical interpreters. In another paper, I would like to discuss how discourse analysis helps medical interpreters improve their skill as the interpreters of culture.

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