Positioning of volunteer interpreters in the field of public service interpreting in Spanish hospitals

A Bourdieusian perspective

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Abstract

Positioning of volunteer interpreters in the field of Public Service Interpreting in Spanish hospitals: A Bourdieusian perspective

This thesis sets out to investigate the field of public service interpreting in southern Spain, with a particular emphasis on the position of volunteer interpreters working at two different healthcare institutions. It looks at the power relationships that develop between agents that hold different degrees of control and autonomy, especially in a context where individuals hold different forms and volume of capital in each encounter. Drawing on Bourdieu's Theory of Practice, the study offers an in-depth examination of a group of volunteer interpreters as legitimate agents of the wider field of public service interpreting and the sub-field of healthcare interpreting, while looking at their impact on the structures and ethics of the larger field. This is the first project to employ Bourdieu's theory in a sustained case study of a healthcare context where volunteer interpreters operate as legitimised institutional agents. One of the peculiarities of the two settings under examination is that volunteer interpreters seem to have acquired a high degree of institutionalisation, which provides them with a large volume of symbolic capital and allows them to take part in the field as legitimate members of the healthcare team, often occupying similar positions to those adopted by doctors at the top end of the field hierarchy.

The study adopts an ethnographic approach based on a triangulation of data: participant observation of volunteer interpreters, audio-recorded interpreter-mediated interaction and focus-group interviews with volunteer interpreters. The primary data that informs the thesis consists of four focus groups carried out with volunteer interpreters in two different Spanish hospitals. The additional use of participant observations and audio-recordings make it possible to examine not only interpreters' perceptions but also actual behaviour in authentic encounters, and to compare interpreters' perception of their positioning with the actual positions they often occupy in the field.

Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university of other institute of learning.

Copyright Statement

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Introduction

The number of immigrants arriving in Spain has been growing steadily since the early 1990s. By the end of December 2010, an estimated 4,926,608 foreigners had been granted residence in the country, representing 10.7% of the total population.[1] This section of the population consists of a mixed group of residents who are attracted to Spain by a variety of factors, ranging from better economic conditions to milder weather. Andalucía is the third most popular region among immigrants, attracting 7.7% of foreign residents, due to its geographical position as the closest region to Northern Africa and its mild climate. However, this figure does not reflect the influx of undocumented migrants who make their way to the Southern Coast every year.[2] Additionally, Spain also attracts millions of tourists every year. According to the Ministry of Industry and Tourism, between January and December 2010 52.7 million tourists visited Spain.[3] This means that a very large non-Spanish speaking sector of the population requires access to social services in Spain, including healthcare, and because these individuals do not necessarily speak Spanish they must depend on the mediation of public service interpreters.

Despite these figures and the need to provide fair access to healthcare services for all,[4] hardly any financial assistance is offered to support the provision of interpreting services, and there are no national or regional policies being put in place at the institutions where interpreting is required.[5] Consequently, those in

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[1] See *Anuario de Estadísticas 2010* (Statistical Yearly Report Book 2010) published by the Spanish Ministry of Work and Immigration. Available at http://www.mtin.es/estadisticas/anuario2010/index.htm (last accessed November 2011).

[2] These figures, as estimated by the Spanish Government, only reflect the number of undocumented migrants who are deported to their countries of origin; they do not include migrants who remain irregularly in the country. See *Balance de la lucha contra la inmigración ilegal 2010* (Fight against illegal immigration report 2010) published by the Spanish Home Office. Available at http://www.lamoncloa.gob.es/nr/rdonlyres/98a8e368-cebf-478e-af34-9587bd8cb3af/136523/bal_inm_ilegal_2010_mir.pdf (last accessed November 2011).

[3] See *Balance del Turismo en España, Año 2010* (Evaluation of Tourism in Spain, Year 2010) published by the Spanish Ministry of Industry, Energy and Tourism. Available at http://www.iet.tourspain.es/en-en/paginas/default.aspx (last accessed November 2011).

[4] Tribe and Keefe (2009, p. 43) provide a list of existing legislation that addresses access to healthcare services: European Convention for the Protection of Human Rights and Fundamental Freedoms (1950); the United Nations Convention of the Rights of the Child (1989); Human Rights Act (1998); Race Relations Amendment Act (2000); the Disability Discrimination Act (1995) and the Disability Discrimination Act (2005).

[5] See "Developing a Public Health workforce to address migrant health needs in Europe", funded by the International Organisation for Migration and the European Commission, looks at the situation of migrants in countries of the EU, including Spain, and aims to facilitate their access to healthcare services. In the particular case of Spain, providing access to interpreting services does not seem to be a viable solution; training medical professionals to be aware of linguistic and cultural barriers is considered more realistic. Available at http://www.migrant-health-

charge of healthcare services often do not have access to interpreters (even less so to interpreters who are specialised in healthcare interpreting), and ad hoc (family and friends) or volunteer interpreters generally have to provide the mediation required in these contexts (see Sales Salvador, 2005; Valero Garcés & Cata, 2006). This, together with an already diverse group of patients, creates an environment marked by unbalanced relationships among participants. In Bourdieusian terms, the position of the healthcare interpreter becomes key to understanding the structures of the field[6] of public service interpreting in the Spanish healthcare context (henceforward the sub-field[7] of healthcare interpreting).

The diversity of agents in the sub-field of healthcare interpreting, the complexity of the interaction that takes place between healthcare personnel, patients and their relatives, and the ensuing power relations that emerge in this particular setting all render the analysis of the positioning of interpreters highly complex (Campos López, 2005). The boundaries of the interpreter's position in healthcare settings are constantly (re)shaped through the negotiation of complex issues such as confidentiality, neutrality and the evolving relationships between doctor-interpreters—where interpreters may be seen as institutional agents (Bolden, 2000; Davidson, 2000); and interpreter-patient—where one of the relevant issues is that interpreters are often members of the patients' "guest-culture" (Baraldi & Gavioli, 2008, p. 80) or "embedded in the patient community" (Beltran Avery, 2001, p. 13). This fluidity often means that different agents, including the interpreter him or herself, will envisage different (ideal) positions to be occupied by the interpreter on different occasions, hence placing the interpreter in a liminal space characteristic of "zones of uncertainty" in Bourdieu's terms (Bourdieu, 2000, p. 157; Inghilleri, 2005b, p. 2).[8]

In order to understand and describe the degree of complexity characteristic of these settings, it is necessary to use a flexible theoretical framework that allows all these elements to be taken into consideration in order to offer a more reliable account of the structures and composition of the social activity under

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europe.org/files/capacity%20building%20in%20healthcare_background%20paper(2).pdf (last accessed November 2011).

[6] The concept of 'field' is used throughout this thesis in a Bourdieusian sense, as will be explained in section 2 of Chapter 1 in greater detail.

[7] Bourdieu uses "sub-field" in several publications to refer to a sector of a wider field; in this particular case, I use "sub-field" to refer to the sector of the field of public service interpreting that takes place in healthcare settings (see Bourdieu, 1983, 1985).

[8] "Zones of uncertainty" are social spaces where positions are "ill-defined" and the expectations of the habitus as regards the position it ought to occupy are not met, thus generating a problematic gap that allows agents to bring in their own dispositions and shape the field activity (Bourdieu, 2000, pp. 157-158). This conflicting gap can be a positive experience that will transform the "translatorial habitus" identified by Simeoni (1998, p. 16).

investigation. Scholarly research is increasingly adopting a sociological approach to interpreting, where the position of the interpreter is observed in context and where the social macro-features that influence the position occupied by interpreters are accorded more attention than in the past (see Angelelli, 2004a, 2004b; Díaz Fouces & Monzó, 2010; Gouanvic, 1997, 2005; Gouanvic & Schultz, 2010; Hermans, 1998, 1999; Inghilleri, 2003, 2005a, 2005b, 2006, 2007, 2012; Simeoni, 1998, 2007a, 2007b; Wolf, 2002, 2006b, 2009, 2010; Wolf & Fukari, 2007). In recent years, different scholars have made use of Bourdieu's understanding of social fields in order to examine various aspects of public service interpreting and translation. These researchers have focused on the idea of translation and interpreting as social fields and assumed the existence of a "translatorial habitus" (Inghilleri, 2003; Simeoni, 1998; Wolf, 2007). The three most important publications in this area are *Bourdieu and the Sociology of Translation and Interpreting* (Inghilleri, 2005a), *Constructing a Sociology of Translation* (Wolf & Fukari, 2007) and *Applied Sociology in Translation Studies* (Díaz Fouces & Monzó, 2010). One of the most relevant theories applied has been the Theory of Practice, elaborated by Bourdieu (1977), whose concepts of field, habitus, and capital have been highly influential in Translation Studies and other disciplines, especially newly emerging disciplines. Pierre Bourdieu is one of the leading intellectuals and most influential theorists of the twentieth century. His work has been widely disseminated and applied across disciplines within the social sciences and the arts. His framework is able to address a wide array of issues effectively as a result of its flexibility in explaining social dynamics and different types of interaction within a field. It enables us to look at public service interpreting as a social space in which a certain service is provided by a group of agents who have internalised a series of structures that are unique to them and that allow them to offer specific expertise that no one else can offer. As pointed out by Inghilleri (2005c, p. 135), this is a context in which "socially competent performances are produced as a matter of routine without explicit reference to a body of codified knowledge". Particularly in the sub-field of healthcare interpreting, the range of agents who offer this service is very varied, and different agents will offer and seek different forms of capital. Among the various groups, it is possible to identify paid interpreters, ad hoc interpreters and volunteer interpreters, each of whom bring in and deploy different forms and volumes of capital in exchange for other forms of capital (from economic to cultural and social capital). While paid interpreters may be expected to be aware of certain codified

norms as a result of the training they may have received and their positioning within the professional community, ad hoc and volunteer interpreters may not have that awareness, and expectations about the positions they occupy in the sub-field of healthcare interpreting may therefore shift from one individual encounter to another.[9] It is also important to note that, beyond such distinctions, there is a significant inconsistency in the degree of professional organisation and application of professional ethics in the field at large (Angelelli, 2006; Bancroft, 2005). In this sense, Bourdieu's concepts of field, habitus, and capital can help reconstruct the field structures, existing positions and dynamics and explain how these different elements function to allow interpreters to occupy certain positions. This would then reveal the extent to which we can posit the existence of a field of public service interpreting in healthcare institutions.

One of the pioneers in the application of Bourdieu's theory in Translation Studies is Jean-Marc Gouanvic, who started to apply Bourdieu's concepts of field, habitus, and capital to the study of literary translation in 1994. A few years later, Simeoni published a controversial paper in which he proposed that "subservience" is an essential element of the translator's habitus and described translation as a "pseudo- or would-be field" (Simeoni, 1998, p. 22). This paper generated a series of responses and led some scholars to suggest that it ushered in a sociological turn in Translation Studies (see Heilbron, 1999; Snell-Hornby, 2006; Wolf, 2007). Scholars such as Gouanvic (2002), Hanna (2005, 2009), Heilbron (1999), Meylaerts (2008), Sapiro (2008), and Wolf (2006a) have since widely adopted Bourdieusian concepts to investigate topics in literary translation, with a smaller number of studies investigating commercial translation and the field of publishing. Some studies have also applied Bourdieu to the study of legal translation (see Monzó, 2005, 2009; Vidal Claramonte, 2005). However, despite Bourdieu's increasing popularity among translation scholars, the application of his theory in Interpreting Studies has been very limited, with even fewer scholars applying it to public service interpreting contexts (see Angelelli, 2004a, 2004b; Inghilleri, 2003, 2005b, 2012; Torikai, 2009; Valero Garcés & Gauthier Blasi, 2010). One of the most prolific authors in the area is Moira Inghilleri, who presents Bourdieu's sociology of culture as a model with which to study the social context of community interpreting. Even Inghilleri, however, focuses on very specific settings such as asylum hearings and court interpreting and does not

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[9] This study will not engage in comparing the positions occupied by paid, ad hoc and volunteer interpreters, but will focus instead on the specific positions occupied by the latter group.

engage with the field of public service interpreting at large (see Inghilleri, 2003, 2005b, 2005c, 2007). Furthermore, with very few exceptions, the scholars cited here have not applied Bourdieu's theoretical framework to a body of authentic data in a sustained manner. In terms of the specific sub-field under investigation in the current study, although many scholars such as Angelelli (2004a, 2008), Baraldi (2009), Bolden (2000), Merlini (2009), Merlini and Favaron (2005), Pöchhacker (2000) and Wadensjö (1998) have studied healthcare settings, none have applied Bourdieu's theory in a sustained way in this specific context. There are also no studies that have included volunteer interpreters as legitimate agents of the field of public service interpreting; instead, where volunteer interpreting has been the subject of investigation, it has been examined strictly as a form of activism (see Boéri, 2008, 2010; de Manuel Jerez *et al.*, 2004). Furthermore, the impact of volunteer work on the field of public service interpreting has never been studied. The apparent lack of interest in applying Bourdieu's theory to healthcare settings and the work of volunteer interpreters is surprising, given that the theory allows for the integration of different micro and macro elements and the fluidity of field boundaries, and that public service interpreting has been identified as a zone of uncertainty as mentioned above (Inghilleri, 2005b, p. 2).

This study sets out to investigate the sub-field of healthcare interpreting in southern Spain, with a particular emphasis on the position of volunteer interpreters working in two hospitals and the power relationships that develop among agents with different degrees of institutionalisation[10] and autonomy, especially in a context where individual agents hold different forms of capital in each encounter. Drawing on Bourdieu's Theory of Practice, it offers an in-depth examination of a group of volunteer interpreters as legitimate agents of the sub-field of healthcare interpreting, and examines their impact on the structures and ethics of the larger field of public service interpreting. To the best of my knowledge, this is the first project that applies Bourdieu's theory in a sustained case study in a healthcare context where volunteer interpreters are acknowledged as participants in their own right and are viewed as institutional agents. As will become clear in later chapters, one of the peculiarities of the two settings under examination is that volunteer interpreters seem to have acquired a high degree of

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[10] In this thesis, institutionalisation refers to the degree to which institutional elements [from the healthcare institutions] such as rules, norms, beliefs—which are primarily symbolic in nature—have impacted the social behaviour of public service interpreters, reflected in their professional activities, relations, and resources (Scott, 2008, p. 222). It is understood that "institutions are comprised of regulative, normative, and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life" (Scott, 2008, p. 48). The degree of institutionalisation is related to the professional identity or habitus of the interpreters in this study.

institutionalisation, which provides them with a large volume of symbolic capital that allows them to take part in the sub-field of healthcare interpreting as legitimate members of the healthcare team, working side by side with doctors who occupy the highest positions in the field hierarchy.

The data that informs this thesis was collected in two healthcare institutions in southern Spain over a period of five months of fieldwork. The group of volunteer interpreters observed belongs to the *Asociación de Intérpretes Voluntarios para Enfermos* (Association of Volunteer Interpreters for Patients), an NGO that aims to provide free interpreting services for foreign patients at these two hospitals on the *Costa del Sol* because of the large number of foreign patients who seek treatment in these institutions. The volunteer interpreting group consists of foreign residents who have been living in Spain for a number of years and generally have some linguistic training either in translation or language teaching.

The current study sets out to address the following, overarching research question:

1) To what extent can public service interpreting be considered a field in Bourdieusian terms, with particular reference to volunteer interpreting in healthcare settings in Spanish hospitals?

Answers to this question are pursued by means of a set of more specific questions, as follows:

2) Who are the main agents in the field of public service interpreting in healthcare settings in Spanish hospitals?

3) What positions are available to volunteer interpreters in the field of public service interpreting in healthcare settings in Spanish hospitals?
     a) What positions do volunteer interpreters adopt?
     b) What positions are imposed on volunteer interpreters?

4) To what extent do interpreters' positions acknowledge the doxa in the field as encapsulated by traditional codes of ethics and the expectations of other agents?

In order to address the research questions outlined above, this thesis relies on an ethnographic approach based on a triangulation of data: participant observation of volunteer interpreters, audio-recorded interpreter-mediated interaction and focus-group interviews with volunteer interpreters. The primary

data that informs the thesis consists of four focus groups carried out with volunteer interpreters in two different Spanish hospitals. As will be explained in Chapter 3, focus groups facilitate the collection of a large amount of data in a short period of time, which can be helpful in the context of a PhD thesis, where financial and time constraints limit the length of field trips. In this regard, focus-group interviews have been a successful methodological choice. The data from participant observation and audio-recordings of interpreted encounters, although not included in the initial plan, was secured during the field trip and offered two additional angles for a more in-depth and reliable description of the field under investigation. Participant observation offers access to naturally occurring data, while audio-recordings help the researcher to record naturally occurring data for a more in-depth analysis, as opposed to the researcher-provoked data obtained through focus groups. These two additions to the data collection allowed me to look not only at interpreters' perceptions but also at actual encounters and compare interpreters' perception of their positioning with the actual positions they tended to occupy in the field. All four focus groups and five audio-recordings have been transcribed, coded and analysed using (deductive and inductive) qualitative content analysis, as described in Chapter 3.

This thesis consists of six chapters, in addition to the current Introduction:

Chapter One discusses the main concepts at the basis of Bourdieu's theoretical framework. These concepts are explored and critiqued separately for the sake of systematic discussion while acknowledging that they are interdependent parts of a holistic framework. The chapter starts by analysing the concept of field, followed by capital and habitus, and discusses the shortcomings of these concepts specifically when trying to identify the field boundaries. The concept of attitudinal autonomy is introduced as an alternative to Bourdieu's relative autonomy; it helps shape the field boundaries regardless of the field of economy and politics as claimed by Bourdieu.

Chapter Two offers a description of the field of public service interpreting and the evolution towards more interdisciplinarity in relation to Translation Studies and the Social Sciences. It starts by offering a review of the current state of the art as regards the application of sociological frameworks to the field of public service interpreting in broad terms. It then reconstructs the field of public service interpreting and the different agents, habitus and forms of capital found in

this field, with a particular emphasis on the sub-field of healthcare interpreting in Spain.

Chapter Three outlines the methodology adopted to enable the study to address the individual research questions and explore the existence of a field of public service interpreting in Spanish healthcare settings. It starts by discussing the benefits of data triangulation and describing each type of data used and then explains the process of data collection, with a particular emphasis on focus-group interviews, since this is the primary data that informs the thesis, and how the focus group questions were designed to address the specific research questions posed by the study. Finally, the chapter describes the process of organising, coding and analysing the data.

Chapter Four examines the data in order to identify the external manifestations of the position of volunteer interpreters, such as institutionalisation, legitimisation and bureaucratisation. It starts by offering a detailed description of the context where the data was collected and the profile of each individual agent who took part in the focus groups. It then concentrates on the two traits of institutionalisation found in this context: legitimisation and bureaucratisation, both of which have considerable impact on the positions of volunteer interpreters in the sub-field of healthcare interpreting. Finally, I attempt to establish a link between the external features, discussed in this chapter, and the internal features examined in Chapter 5.

Chapter Five analyses the data in order to identify the internal manifestations of the position of volunteer interpreters, such as alignment and autonomy. It begins by analysing the different forms of alignment found in this context as regards institutional agents and non-institutional agents. It then looks at the different degrees of autonomy that volunteer interpreters possess in different encounters and examines the power relations that influence these different degrees of autonomy, as attested in the data. Autonomy is found to fluctuate constantly and move along a continuum, depending on the features of each language exchange produced in this context.

Chapter Six summarises the conclusions and findings of the study and the impact of these on the field of public service interpreting, specifically for the doxa professional associations and professional ethics. It engages with the limitations of this study, in particular with regard to the size of the data and the combination of data sources in an ethnographic project. It also offers a brief account of issues

that could not be addressed due to space constraints and the implications of this study for further research.

Chapter One

The Attitudinal Autonomy of the Professional Habitus

1   Introduction

Any speech act, including any interpreter–mediated speech act, is always embedded within a social context. The interpreter, the service provider and the service user often come from different social contexts and therefore may exhibit differences in their biological and historical trajectories as social agents. In any interpreter–mediated encounter there are "various agencies and agents involved", and it is essential to understand both agencies and agents if we intend to examine the interaction between the different parties and how this interaction functions (Wolf, 2007, p. 1).

The social context where interpreter–mediated encounters take place has traditionally been approached from a rather rigid perspective. The context has generally been used "as a priori framework which shaped linguistic behaviour" (Pérez González, 2006, p. 39). However, there has recently been a shift toward a more dynamic conceptualisation of context where the social cannot be taken for granted or seen as fixed. This shift calls for a (re)contextualisation of interpreter–mediated encounters to fully understand the interpreter's performance and her/his socio-cultural and interactional contexts (Diriker, 2004; Pérez González, 2006). Accordingly, the position of interpreters is examined both as individuals and as professionals who act within socio-cultural contexts which have an enormous impact on their performance. In this sense, context is seen as "a negotiated social construct produced both by actors and the interpreters of actors' actions" and requires constant (re)contextualisation (Diriker, 2004, p. 2).

Following this trend towards a more dynamic approach to the study of interpreter–mediated interaction, many researchers have turned to social theories for more complex frameworks of research that offer the possibility of studying several variables within social contexts, making it possible to examine interpreter–mediated encounters as socially situated practices (Inghilleri, 2005c). There is now a small yet growing body of scholarly work on a wide range of public service interpreting settings that is informed by sociology. Specifically, this strand of

scholarship observes the role of the interpreter in context by bringing into a sharper focus the influence that social macro-features (i.e. culture, society or politics) have on interpreters (see Hermans, 1999; Inghilleri, 2003, 2005b, 2005c, 2006, 2007; Torikai, 2009; Wadensjö, 1998).

In the present chapter, the main concepts at the basis of Bourdieu's theoretical framework are explored and critiqued in separate sections for the sake of systematic discussion. However, it is important to stress that these concepts (field, habitus, and capital) are interconnected in such a way that it is impossible to articulate the scope of any one of them without making reference to the others. For instance, Bourdieu refers to the mutually dependent relationship between field and habitus as "a relation of conditioning" where "the field structures the habitus" and as "a relation of knowledge of cognitive construction" where "habitus contributes to constituting the field as a meaningful world" (Bourdieu & Wacquant, 1992, p. 127). In this sense, field depends on the existence of habitus for its own existence, while habitus, being the product of field, cannot exist without the structures of the field to internalise.

While the main theoretical framework of this research project is a sociological theory, the goal is to develop the notions of Bourdieu's theory in such a way that they can be usefully applied to the field of interpreting studies. In order to assess the potential applicability of Bourdieu's theories to interpreting studies and, in particular, to public service interpreting, this chapter begins by exploring the key constructs underpinning Bourdieu's Theory of Practice. [11] These constructs are reviewed, setting the stage for an analysis of how they can be used in this particular research context. The concept of field is discussed first, as it is perhaps the most extensive and complex of Bourdieu's constructs, the understanding of which will help clarify the rest of the concepts. Capital is then examined, followed by the concept of habitus. Subsequently, the Theory of Practice is critically reviewed and the main criticisms are outlined. Finally, there is an analysis of models of professionalisation with particular emphasis on the concept of "attitudinal autonomy" whose focus coincides to some extent with Bourdieu's concept of relative autonomy (Forsyth & Danisiewicz, 1985, p. 62). A link between Bourdieu's framework and attitudinal autonomy is then elaborated.

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[11] Also known as Field Theory due to the emphasis on the concept of field, or Reflexive Theory because of the high degree of reflexivity that characterises it. Bourdieu refers to his own theory using different terms, depending on the emphasis of his work (see Bourdieu, 1986a; 1988, among others).

2 Fields of social practice

Field, one of the core concepts in Bourdieu's theoretical framework, is said to exist by virtue of its interaction with habitus and capital—a set of constructs that mutually influence one another and shape each other's structures (Bourdieu, 1977, p. 80). Although habitus and capital will be dealt with later on in this chapter, a short introduction to both concepts is necessary at this stage given the close relationship between all three.

Habitus is an ensemble of dispositions that help individuals feel at ease with the environment around them; this ensemble is developed by internalizing social practices such as norms and conventions in a specific context. Habitus is the result of people living in societies and interacting with one another and learning to respond to social demands. Although habitus is embodied within individuals, it is not entirely an individual property but rather the outcome of the interaction between the individual and her/his environment (see section 2.5 of this chapter).

Capital, on the other hand, designates the various resources and goods available in society, which can range from money to property, from academic qualifications to art. Capital is a valuable asset which can be the centre of social conflict between individual and group (see section 3 of this chapter).

Before moving on to explore the internal features of fields, it is important to examine the larger picture, the social reality where fields exist. Bourdieu uses the term "social space" to refer to the social world (Bourdieu, 1992, p. 242). The social space can be compared to a "geographic space" which consists of different regions, and yet, at the same time, the social space is in constant flux, changing constantly and defying attempts at mapping it (Bourdieu, 1989, p. 16). Society or social space is thus made up of semi-independent fields that are constantly interacting both with each other and with the dominant field of power, i.e. economy and politics. In this sense, social life happens in objective structures called fields (Peillon, 1998, p. 215). These objective structures are understood as the identifiable places [or social structures] where individuals position themselves to carry out their social activity.

Bourdieu's understanding of social space suggests that there are many different fields in any society. For example, in most societies we can identify a wide variety of fields such as the field of healthcare or the field of law. The more technologically advanced a society is, the more fields and sub-fields will coexist

within that particular social space (Bourdieu, 1998, pp. 1-14). Yet fields are semi-independent structures with regard to the field of economy and politics and they can never be fully separated from it or constitute isolated spaces. In Bourdieu's parlance, the field of economy and politics is referred to as the "field of fields" or the "field of power"; it controls social action, the resources available and the value of these resources in every field within the social space that it dominates (Bourdieu & Wacquant, 1992, p. 56). Consequently, fields are always inter-connected with one another and with the field of power, for the field of power extends horizontally across all the social fields, imposing its own rules upon them and organising individuals' positions in hierarchies according to their accumulation of resources (Peillon, 1998). In sum, the field of power is the most dominant of all fields and it is necessary to take into account the influence it exerts upon other fields.

In the Theory of Practice, fields are dynamic structures that help shape individuals' behaviour and their habitus according to the position that individuals occupy in the field – each position is thus associated with a specific habitus (Bourdieu, 1998, pp. 1-14). In this regard, the (re)production of a specific habitus for each social position available in the field is essential: agents whose habitus complies with the specific habitus associated with the field in question will show an interest in the social activity of the field and in the resources available to them in that particular field, while showing less interest in what other fields may offer them (Bourdieu, 1993b, pp. 72-78). A field cannot exist if there are no agents with the appropriate habitus willing to take part in it. The generation of habitus is an endless process, since individuals embody the social conditions of the field, which they can later reproduce when taking part in social activities. By reproducing the characteristics of the field, habitus can comprehend the laws of functioning and acquire specific resources and goods (capital) that constitute a stake in the field and thus allows individuals to take part in the social activity. At the same time, the constant reproduction of the conditions of the field helps to reinforce them.

As will be explained later in this section, fields as dynamic structures are subject to constant change and restructuring. Moreover, habitus and field make sense of social reality together, for neither can exist without the other (Bourdieu, 1989). Reality thus exists twice, in the objective structures of fields (in the tangible reality) and also in the cognitive structures or dispositions of habitus (inside individuals' minds) (Wacquant, 1989).

2.1 Fields as structured spaces of social positions

The structure of a field consists of a series of positions that are occupied by individuals with a broadly shared habitus. Each position can reproduce its own habitus according to the specific social conditions in which it is embedded. Moreover, each position can be defined, horizontally, in opposition to other positions in the same field and vertically, in relation to other positions in the field of power (Bourdieu, 1983, 1989). In this sense, the shorter the distance between any two positions the more characteristics they will share; and the higher up in the hierarchy established by the field of power the more power a position will accrue. For example, in the interpreting field the position of public service interpreters can be defined in opposition to other positions, such as that of conference interpreters, and it can also be defined according to the amount of power they hold as a result of their position as public service interpreters. Consequently, field can be described as a configuration of social relations between positions that exist beyond individuals and their habitus (Wacquant, 1989).

Naturally, any change that occurs in a field will affect all the existing positions. For, in this view of field, even if positions themselves do not suffer any internal modifications, they will change as regards their relation with other existing positions or newly created positions in the field as these positions change or emerge (Bourdieu, 1983). Although this view of field as arenas where individuals exercise their social activity may seem a little simplistic at first glance, fields are never static constructs for there are internal forces operating on individuals who interact within any given field (Bourdieu & Wacquant, 1992, pp. 94-114). This dimension of field is further explained in the next section.

2.2 Fields as arenas of social struggle

Positions are not only affected by changes in the objective structures of the field, but also by the dynamics of internal forces within a field (Bourdieu, 1983). These forces are the struggles between agents who are constantly trying to either maintain or to improve their social position. Fields are thus partly structured in terms of the power relations among agents who are struggling to accumulate valuable resources and goods (capital). Agents interacting in the context of dynamically configured fields seek to achieve maximum power, understood as social status, and dominant positions, and in order to secure these goals, it is

necessary to acquire as much capital as possible (Wacquant, 2008). This struggle for domination and access to capital is the consequence of the unequal distribution of capital within fields (Peillon, 1998). According to Bourdieu (1986b), there are three forms of capital, economic (e.g. money), cultural (e.g. education) and social (e.g. social connections). Each field establishes one specific capital as the most valuable, and this capital (economic, cultural or social) becomes symbolic capital because it provides its holder with a higher status within the field (see section 3.4 of this chapter).

Accordingly, the position of agents within a field will be determined by two factors: the volume of the capital (any capital) they accrue and the composition of such capital (Bourdieu, 1989). For although all forms of capital are available in every field, each particular field values a specific form of capital (Peillon, 1998). For example, economic capital is most valuable in the field of business, whereas cultural capital is of greater importance in the academic field. This view of fields as dynamic configurations allows for changes in the internal structures of the field. Fields thus result from the constant interaction between agents and their respective habitus and the struggle of individuals for the acquisition of capital (Bourdieu, 1993b, pp. 72-78).

The dynamics of fields are the outcomes of the power relations that govern agents' positions and their access to capital. In this regard, power relations can take the form of domination, subordination or equivalence, according to the agents' respective degree of access to the most valued capital in the field (Wacquant, 1989). These power relations will be determined by the position agents occupy, whether it be a dominant or subordinate position, and also by the volume and form of capital attained in each case, as mentioned earlier (Thomson, 2008). According to Bourdieu (1996, p. 234), agents in dominant positions will struggle to maintain their position and capital by using "strategies of conservation" which aim to reproduce the existing structures of the field. Agents in subordinate positions will struggle to change the current structures of the field and the value of the capital at stake, using what Bourdieu describes as "strategies of subversion" that seek to improve their social position within the field (Bourdieu, 1996, p. 234). In this sense, individuals in subordinate positions will challenge the structures of the field and will try to introduce new structures that will allow them to gain access to dominant positions.

This conceptualisation of field in terms of dominant and subordinate positions and as the result of ongoing battles among social agents to occupy top

positions and achieve maximum capital accounts for its hierarchical structure (Giglia, 2003). The hierarchy will be constituted by agents with the largest volume of valued capital occupying dominant positions, and agents with the smallest volume of valued capital occupying subordinate positions.

2.3 Fields and the field of power

Although the hierarchy of social positions within fields is individual to each field and fields differ from each other with regard to the form of capital and positions sought by agents interacting within them, there are some similarities that hold across different fields.

According to Bourdieu (1993b, p. 72), there are "general laws" of fields which are responsible for the functioning of fields.[12] Bourdieu points out that these general laws draw on three principles (Bourdieu & Wacquant, 1992, p. 157). The first principle states that fields inculcate a specific set of dispositions (or habitus) in individuals who enter the field, which demonstrates that fields are active constructs. The second principle pertains to the need to analyse the historical trajectory of fields as sites of struggle that can result in certain aspects of the structure of a field changing or even disappearing, depending on the interest of agents in reproducing the existing structures of the field. As explained earlier, if agents are not willing to participate in a field as currently structured, there are two possibilities: they may either try to change the current structures to accommodate their new positions within the field, or they may move onto another field, thus bringing about the disappearance of the field. History abounds with examples of fields which have disappeared over time, including various professions that have been superseded by technological advances. Finally, the third principle states that the degree of independence (or autonomy) of any field from the field of power will determine the extent to which the field itself can shape its own internal structures and dispositions and differentiate itself from other fields.

In consequence, the field of power, as "the space of relations of force between agents or between institutions having in common the possession of the

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[12] These general laws have important implications for research. According to Bourdieu (1993b, pp. 72-78), these laws allow generalisations across a wide variety of fields with regard to the way fields function and the way social practice is carried out in different fields. In order to study a new field, researchers can always draw on previous studies and build on some of the common variables of fields to identify the specific variables of the field under scrutiny, including the specific habitus of its agents or the value of specific forms of capital available to them.

capital necessary to occupy the dominant positions in different fields", tends to homogenise fields by imposing its own social conditions onto them (Bourdieu, 1996, p. 215). A complete lack of autonomy may condemn the field to being absorbed by the field of power; absorbed fields will simply be ruled by economy and politics and dominant classes will have absolute control over the activity of the field and the individuals who occupy positions within it (Wacquant, 1989). These are the fields that shrink into a "total institution" or an "apparatus" (Bourdieu, 2000, pp. 158-159). To the extent that a field has some degree of autonomy from the field of power, it will be able to establish its own social conditions and the value of the different forms of capital available to its agents.

In order to know precisely where a field is located within society, it is thus necessary to examine the position of a particular field in relation to the field of power (Bourdieu, 1983, p. 319). The position of a field can be determined by its degree of relative autonomy, that is the degree of independence from the field of power to shape its own structures; the more autonomous a field is, the less influenced it will be by the field of power (Bourdieu, 1993a, pp. 161-175). An autonomous field can be described as a field with a high degree of specificity as regards its own history, configuration of agents and capital at stake. Autonomous fields (re)produce their own habitus, have their own social dispositions and beliefs and are marked by sharp boundaries (Peillon, 1998, p. 215). An autonomous field is thus "capable of imposing its own norms on both the production and the consumption of its products" (Bourdieu, 1986a, p. 233).

However, "autonomy is always in danger" since the field of power is constantly trying to exert control over other fields, and fields are constantly trying to liberate themselves from it (Wacquant, 2008, p. 269). This is why Bourdieu (1993a, pp. 161-175) regards fields as relatively autonomous constructs, since every field in the social space will always be somewhat influenced by economy and politics. Consequently, each field is at the same time dominant (in relation to weaker fields) and dominated (by the field of power), and will have both autonomous and heteronomous poles (Bourdieu & Wacquant, 1992, pp. 115-139). The autonomous pole is occupied by dominant positions and the heteronomous pole is occupied by subordinate positions. Fields are therefore not homogeneous, and it is possible to identify parts of a field which are more autonomous than others. For instance, in public service interpreting in legal settings court interpreters tend to occupy more autonomous positions than healthcare interpreters in healthcare settings in many countries (Beltran Avery, 2001),

something which translates into more symbolic capital for those agents working in legal settings, and hence more autonomy, since the autonomy of a field is related to what that field has established as valuable capital. In practice, this means that, relatively speaking, court interpreters are highly regarded practitioners with a higher volume of economic capital. According to Bourdieu (1983), the degree of autonomy of a field can be seen in the capacity of individuals in dominant positions to assign the value of all forms of capital available independently of the field of power. That is to say, in the exchange rate between symbolic capital and economic capital. For example, the degree of autonomy of the field of conference interpreting from the field of power is much higher than the degree of autonomy of the broad field of public service interpreting (Jiang, 2007). This can be observed by looking at the economic remuneration received by those agents working as conference interpreters and the prestige they hold as the elite of the translation and interpreting world. They have relative power to negotiate the value of their symbolic capital, which takes the form of linguistic and cultural capital. In the case of public service interpreting, the degree of autonomy from the field of power is very low in the sense that agents working as public service interpreters receive very little (or no) economic remuneration and they have little power to negotiate the value of their symbolic capital.

2.4 The boundaries of fields

The boundaries of a field are where the field ceases to have an impact on the social activity of the individuals that occupy a position within it (Wacquant, 1989). They are shaped by the struggles between agents to occupy dominant positions and, as a result, they are constantly shifting (Bourdieu, 1993b).

In order to identify the field boundaries one must observe the interaction between individuals and their position within the field (Bourdieu, 1983). In this sense, the boundaries of fields are a product of empirical research. Different researchers who investigate the same field may draw on a different sample of data, and this can lead them to identify different boundaries for the same field, especially since researchers are also constrained by their own point of view (Swartz, 1997, pp. 270-285). Swartz (1997) thus explains that because of the imprecise nature of the boundaries of fields, researchers should not take any boundaries for granted by over-generalizing their results. Researchers must be humble in this sense and acknowledge that their results are somewhat limited to

the aspects they have managed to investigate, and constrained by their own viewpoint. It is also a mistake to assume that if a field has institutionalised points of entry, such as examinations or qualifications, it is easier to identify its boundaries. Bourdieu (1983) stresses that the institutionalised border does not necessarily correspond to the real boundaries of the field, since very often the field extends and exercises its influence beyond the control of institutions. The field of public service interpreting is a case in point, since many interpreters have considerable experience but no qualifications or institutional affiliations.

Since the boundaries of fields can only be identified to a certain extent through empirical research, Bourdieu proposes three operations (Wacquant, 1989, p. 40). In the first place, one must analyse the relationship between the field in question and the field of power, which occupies a dominant position in every social space, in order to ascertain the degree of influence of the field of power over the structure of the field under research. Secondly, it is essential to draw a map of the positions of social agents in the field and the relationships between different positions in their competition for capital. Finally, it is imperative to analyse the habitus of the agents in the field and its strategies of reproduction and subversion. In the field of public service interpreting, although there are codes of ethics for the profession and some training courses at university level, it is not possible to define the boundaries of the interpreting activity by exclusively looking at these aspects. It is necessary to observe the activity of the field and the positions available to agents acting as interpreters in the field, in line with Bourdieu's proposal.

2.4.1 Doxa as the unquestioned boundaries of fields

The concept of doxa appears in most of Bourdieu's scholarly work, and unlike the concepts of field, habitus, and capital, although it has also been (re)appropiated extensively by other scholars, its meaning is generally consistent throughout the literature that draws on a Bourdieusian framework. Bourdieu (1977, pp. 159-179) presents doxa as an essential condition for the existence of fields, since it regulates the limits of fields, the membership of the field and also its conditions of entry. This means that questioning the doxa, or what Bourdieu calls "heterodoxy", can threaten the existence of a field (Bourdieu, 1977, p. 159). According to Bourdieu (2000, pp. 15 & 100), doxa is "a set of fundamental beliefs which does not even need to be asserted in the form of an explicit, self-conscious dogma" and

"whose acceptance is implied in [field] membership itself". In this sense, doxa is the unquestioned belief which is internalised by the habitus in the form of cognitive structures that lead agents to agree with the objective structures of fields as unquestioned truths. Through "doxic experience", agents come to accept a series of arbitary conditions without realising that they are being oppressed and that there may be alternative sets of beliefs (Bourdieu, 1990b, p. 14). Moreover, doxic beliefs are at the root of domination since doxa is a dominant vision that most often has been imposed through struggle between agents in different positions (Bourdieu, 2001). Bourdieu explains doxa in terms of a paradox:

> The fact that the order of the world as we find it, with its one-way streets and its no-entry signs, whether literal or figurative, its obligations and its penalties, is broadly respected; that there are not more transgressions and subversions, contraventions, and follies, [...]; or, still more surprisingly, that the established order, with its relations of domination, its rights and prerogatives, privileges and injustices, ultimately perpetuates itself so easily, [...] and that the most intolerable conditions of existence can so often be perceived as acceptable and even natural. (Bourdieu, 2001, p. 1)

However, in moments of reflection the habitus may become destabilised since the dispositions no longer agree with the objective structures of the field (Bourdieu, 2000, pp. 159-163). In these moments of realisation, agents may develop a heterodoxic discourse whereby they start questioning the doxa and initiate a struggle against domination to change the structures of the field and impose their own dispositions (Bourdieu, 2000). Accordingly, agents in dominant positions who wish to perpetuate the field structures will adopt an orthodoxic discourse in order to conserve the field order.

2.5 The dynamics of fields: agency and structure

The dynamics of the field are shaped by the ontological relationship between agency and structure (Bourdieu, 1989). Agency refers to the ability, whether intentional or unconscious, of agents as individuals to affect the social space around them, which constitutes the structure within which they operate. Agents cannot create the social space from scratch and are constrained by the structures, conventions and norms of the field (Bourdieu, 1998, pp. 1-18). Whereas the

objective structures of fields determine the choices available, agency means that individuals can choose within the available range.

Agency implies that individuals are willing to engage in social situations by choosing strategies available in the field and therefore to reproduce the social structures of that field (Bourdieu, 1998). By exercising their agency, individuals develop a practical sense of social reality. As stated by Swartz (1997, p. 8), this relationship between agency and structure, or subject and object, is dialectical in the sense that agency and structure have traditionally been seen as irreconcilably contradictory concepts.

Social activity has often been explained as either the result of intentional individual choices or as the outcome of externally imposed behaviour. For Bourdieu, social activity is not exclusively a response to external or to internal stimuli, for agency mediates between structure and practice, and structure mediates between agency and practice (Wacquant, 1989). In order to reconcile the two concepts, Bourdieu introduces the notion of habitus, which "incorporates the objective structures of society and the subjective role of agents [agency] within it" (Bourdieu, 1993b, p. 19). External stimuli do not influence agency directly but rather through the arbitration of the field which restructures these stimuli in line with its own internal structure. Depending on the degree of autonomy of a field in relation to the field of power, the need for fields to mediate between agency and external factors will be more or less significant; the more autonomy a field has the more it will have to mediate in order to impose its own structures (Wacquant, 1989). Consequently, agency and structure are intrinsically linked in a two-way relationship: agency exerts an influence on the habitus from within the agent, whereas the structure of the field exerts an influence on the habitus from the outside (Wacquant, 2008).

3 Capital as the field assets

Bourdieu's concept of capital is the basis of domination and must be available within a field in order for the field to function as a meaningful social space for agents, since control over different forms of capital will define the structure and dynamics of the field (Siisiäinen, 2003). A specific capital only makes sense with reference to the particular field that established it [the capital] as its most valuable form of capital, and once a specific capital is transferred to another field it loses its value. Furthermore, the transformation of field-specific capital into

other forms of capital depends on the conditions of the field that established it as such and its relations of domination or subordination with other fields (Bourdieu, 1986b). The value of specific forms of capital is also conditioned by the habitus and the struggle over different forms of capital. In this sense, the value of specific forms of capital is relative and varies historically.

Bourdieu's theoretical approach differs from other sociologists' in that he focuses on changes in social life as the result of the struggle for different forms of capital, although most forms of capital are reducible to economic capital. In the Theory of Practice, capital does not refer solely to material goods, but also to networks or social relations, knowledge, public recognition or authority (Harker *et al.*, 1990). It can be classified into three categories or forms: "economic capital", "cultural capital" and "social capital", each of which can be converted into symbolic capital within a given field (Bourdieu, 1986b).

3.1 *Economic capital*

Economic capital extends beyond money to encompass all forms of economic possessions and is "at the root of all other types of capital" (Bourdieu, 1986b, p. 251). This means, on the one hand, that the value of other forms of capital depends on the conversion rate between a specific form of capital and economic capital; and, on the other hand, that cultural capital and social capital represent different forms of economic capital. Economic capital is the specific capital at stake in the field of power, which means it is ultimately the most valuable form of capital, since the field of power is the field par excellence and controls the social activity of any field, depending on the latter's degree of autonomy (Bourdieu, 1998, pp. 19-34). Therefore, economic capital underpins the value of all other forms of capital, for the exchange rate between economic capital and other forms of capital will be set according to the economic value that individuals in dominant positions attribute to each form of capital. In this respect, individuals in dominant positions are responsible for setting the value of each form of capital with regard to economic capital, since individuals in subordinate positions do not have enough power (or symbolic capital) to influence these matters. For example, in the field of public service interpreting, interpreters are paid according to the value that institutions and authorities attribute to the service they provide. In many, but not all, countries agents acting as interpreters are often volunteers who provide interpreting services without receiving any economic remuneration,

because their field-specific capital, i.e. linguistic capital, is not perceived as valuable (Valero Garcés 2003). In these circumstances, interpreters deploy their linguistic capital in exchange for social capital in the form of social recognition and gratitude.

3.2 Cultural capital

Cultural capital is a broad concept and can encompass a great variety of goods, from art to education and even language. Unlike its economic counterpart, cultural capital is not a stable or universal resource since it is directly associated with individuals and is very often non-transferable from one to another (Swartz, 1997, pp. 65-94). Cultural capital is present in the social space in three different forms: as embodied cultural properties in the form of dispositions of mind within a habitus, such as cultural knowledge or education; as objectified items in the form of cultural goods (e.g. paintings, sculptures or portraits); and as institutionalised objects such as academic qualifications (Bourdieu, 1986b, p. 244). Whereas cultural capital in its objectified form can be transmitted or exchanged, cultural capital in its embodied state cannot. Moreover, cultural capital in its embodied form is very often acquired unconsciously during primary socialisation within one's family, school or group of friends. This kind of cultural capital is what is often known as culture or cultural knowledge. Accordingly, the institutionalised state of cultural capital differs from its other two possible manifestations in that "cultural capital in the form of academic qualifications is one way of neutralizing some of the properties it derives from the fact that being embodied, it has the same biological limits of its bearer" (Bourdieu, 1986b, p. 247).

In this sense, cultural capital in its institutionalised form is an extension of the cultural habitus (or embodied cultural capital) of agents that can be exchanged in the social space for other forms of capital. Academic qualifications provide agents with a valuable resource that can be used to obtain profits, such as a higher salary in the job market. Indeed, academic qualifications play a similar role in acquiring cultural capital as that played by money in attaining economic capital (Bourdieu, 1977, p. 187). Consequently, there is a conversion rate between cultural capital and economic capital: the higher the qualification, the higher the salary. In the case of public service interpreting in some countries such as Spain, the limited opportunities for acquiring a high degree of qualification and training in public service interpreting specifically have a direct

impact on the amount of economic capital available in the field, since there is a lack of cultural capital in its institutionalised form, i.e. professional qualifications in public service interpreting, which is essential in most social fields.

3.2.1 Linguistic capital as a sub-type of cultural capital

Language competence is more than just a tool for communication; it can be considered a form of capital, since those who hold linguistic capital can use it in linguistic exchanges as a means of dominating other individuals in their communicative environment and controlling their capital (Bourdieu, 1992, p. 58). Any communicative act must thus be examined with reference to the inherent power relations between the speaker of the legitimate language and interlocutors who can recognise the speaker's linguistic authority (Bourdieu & Wacquant, 1992, pp. 140-173). Linguistic capital can also provide an opportunity to occupy different positions in a field, since individuals can use their linguistic capital to gain more of other forms of capital, depending on the exchange rate between economic and linguistic capital (Swartz, 1997, pp. 65-94). This in turn allows them to rise in the hierarchy of social positions in the field in question. Bourdieu does not consider linguistic capital as a form of capital in its own right, but rather as a sub-type of cultural capital:

> The laws of transmission of linguistic capital are a particular case of the laws of the legitimate transmission of cultural capital between the generations, and it may therefore be posited that the linguistic competence increased by academic criteria depends, like the other dimensions of cultural capital, on the level of education (measured in terms of qualifications obtained) and on the social trajectory. (Bourdieu, 1992, p. 61)

As stated above, linguistic capital is similar to cultural capital in that it can be viewed as an embodied feature of certain individuals, for example in the form of a mother tongue, or as an institutionalised object, such as a university degree or an official certificate issued by a language school (Garreta i Bochaca & Solé, 2003). Moreover, linguistic capital displays similar characteristics to those of cultural and social capital: it can exist in an embodied or institutionalised state, it can be exchanged or transformed into other forms of capital, and it requires an investment of other resources, except in the case of mother tongues (Garreta i Bochaca & Solé, 2003). In certain fields, where linguistic capital is valued as an

important asset, there exists a conversion rate between linguistic capital and economic capital. For example, in public service interpreting when a non-Spanish speaking agent requires access to healthcare services or the court system, linguistic capital becomes valuable and can often be converted into economic capital. This exchange rate is usually established according to the specifics of each linguistic market and is also dependent on individuals' social relations with other individuals with more or less symbolic capital in a particular field and thus more or less symbolic power (Bourdieu, 1993a, pp. 112-144). For example, in healthcare institutions where service providers may speak a foreign language, generally English, linguistic capital does not become a valuable asset.

3.3 Social capital

Bourdieu defines social capital as "the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalised relationships of mutual acquaintance and recognition" (Bourdieu & Wacquant, 1992, p. 119). Social capital depends not only on the size of the network, but also on the forms and volume of capital possessed by each member of the group, for it is the capital owned by the whole group that attributes more or less symbolic power to each member of the group (Bourdieu, 1986b, p. 249). For instance, in public service interpreting in countries like Spain among others, although it is possible to identify different agents acting as interpreters who possess different forms and volume of capital, it is the capital of the whole group of public service interpreters that is responsible for the low status and prestige of each individual (see Chapter 2, section 3.2.3). Social capital, which can be reduced to what is known as social connections, requires long-term durable relationships that are established either consciously or unconsciously (Bourdieu, 1986b). These social connections, as accumulated social capital, can help individuals to improve their position in a field where these connections are considered valuable, for example by joining trade unions, political parties and other associations (Bourdieu, 1993b, pp. 20-35).

However, in order to acquire social capital two conditions must be met: there must be resources available upon becoming a member of the group, and there must exist mutual recognition among agents with regard to that membership (Siisiäinen, 2003). Social capital is a function of the relationships within a given group of actors, not a quality of the group itself (Bourdieu, 1980).

Its acquisition can help explain the different social positions occupied by individuals who hold similar amounts of economic and cultural capital, under certain circumstances. In certain fields where social connections are essential, "who you know" can take an agent up a step in the social ladder (Siisiäinen, 2003, p. 189). According to Bourdieu (1986b, p. 249), although social capital cannot very often be directly transformed into economic or cultural capital, it can have "a multiplier effect" on the capital possessed by an individual. Finally, unlike cultural capital, social capital can only present itself in two forms: as symbolic exchanges (i.e. friendship) or as institutionalised acts (i.e. group membership).

On the whole, social capital and cultural capital are more closely related to each other than to economic capital. Furthermore, economic capital can be easily transformed into social or cultural capital, but the reverse process is harder (Bourdieu, 1986b). For example, economic capital can be directly transformed into money and institutionalised in the form of property rights; or it can easily be invested in order to acquire an academic qualification or to buy one's way into select social clubs. However, cultural and social capital can be transformed into money only under certain conditions. This question of the convertibility of the different forms of capital is an interesting aspect of Bourdieu's theory since it alerts us to the fact that social agents can use all forms of capital to improve their position or even to change a field.

3.4 Symbolic capital

For Bourdieu (1977, p. 179), symbolic capital is equivalent to power and is "the most valuable form of accumulation in a society" because it can legitimise all other forms of capital possessed by agents as well as the positions that agents occupy within a field.

Symbolic capital is "any property (any form of capital whether economic, cultural or social) when it is perceived by social agents as endowed with categories of perception, which cause them to know it and to recognise it, to give it value" (Bourdieu, 1998, p. 47). It is universal in the sense that it can take other forms of capital and turn them into legitimate goods and therefore into economic capital in any field. Unlike all the other forms of capital, it can neither be embodied into a habitus, nor objectified or institutionalised, except in the form of titles of nobility (Bourdieu, 1998, pp. 92-126). Symbolic capital is realised as prestige, status or consecration, and is based on knowledge and recognition; it is therefore a

cognitive resource that can only exist at an interpersonal level among agents who recognise it as legitimate (Bourdieu, 1998). In this sense, symbolic capital can reproduce itself, since social agents tend to reproduce their own social positions, which means that they maintain the same power relations.

4   Habitus in social practice

The concept of habitus is a cornerstone of Bourdieu's theoretical framework. It is also key to understanding his concept of social spaces. However, it is important to recall at this point that habitus cannot be understood in isolation, but only in relation to two other key Bourdieusian notions: field and capital (see sections 2 and 3 of this chapter respectively). In Bourdieu's framework, field, habitus, and capital are presented as a set of mutually dependent and shaping constructs. Indeed, Bourdieu (1986a, p. 101) contends that social activity is the result of the constant interaction between habitus, capital and field, as illustrated in the following equation:

$$[(habitus)(capital)] + field = practice$$

The Theory of Practice regards habitus as a dynamic and generative principle that links socially regulated activity with individual choices. By incorporating the concept of habitus into his theory, Bourdieu (1990b, pp. 52-65) relates the objective structures of social spaces to subjective constructions (the internalisation of the objective structures of a field), thus overcoming dichotomies such as subject/object and internal/external.[13] Habitus is the concept that helps explain systematic norm-regulated social behaviour while leaving room for individual agency. Bourdieu defines habitus as

> systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles of the objectively "regulated" and "regular" without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an

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[13] During the second decade of the 20th century sociological theorists were divided into two main philosophical waves: the followers of Sartre and his existentialism and those of Levi-Strauss and his structuralism. The sociological scene was divided into a) theories focusing on the societal level and the relationships within (structure), and b) theories focusing on acting individuals (agency) (see Jones, 2003).

express mastery of the operations necessary to attain them and, being all this, collectively orchestrated without being the product of the orchestrating action of a conductor (Bourdieu, 1977, p. 72; emphasis in the original).

This quote can be broken down into several parts in order to understand what Bourdieu means by habitus. We can start by looking at what Bourdieu means by systems of "dispositions" or cognitive structures of the habitus (Bourdieu, 1977, pp. 3-29). Habitus consists of both socially constrained and spontaneous principles which he calls dispositions. These cognitive structures do not exist randomly but are rather grouped systematically following certain social patterns (a pattern in this instance is what we usually identify as a social group). The term disposition refers to individuals' attitude and agency; it is a way of being or a tendency that can be durable in the sense that it lasts over time, an individual's lifetime; and transposable in the sense that it can be transferred from field to field. Individuals carry these dispositions in their own bodies, the dispositions becoming what we recognise as that individual's personality. Therefore, this system of dispositions is relevant to all aspects of social activity, both at personal and professional levels. Accordingly, habitus is acquired over time and is embodied permanently in agents in the form of cognitive structures (Bourdieu, 1998, pp. 35-74). This makes habitus a historical concept that is intrinsically related to each individual's personal trajectory. In Bourdieu's own words, "habitus is history turned into nature"—"structures structured" by individuals' past experiences (Bourdieu, 1977, p. 78). This means that social life is shaped by our personal history, since habitus reproduces the objective social conditions inculcated in us in the form of dispositions. As a result, when we think that we are making unconscious choices, this unconsciousness is the forgotten past embodied within us, a past that reproduces itself into the future by embodying the social objective structures in the form of habitus (Bourdieu, 1998). Habitus is thus a product of previous experiences.

However, habitus is not simply the result of the internalisation of past objective structures; "it is an open system of dispositions that is constantly subjected to experiences, and therefore constantly affected by them in a way that either reinforces or modifies its structures" (Bourdieu & Wacquant, 1992, p. 133). Despite its historical dimension, habitus is not a static or passive concept. Habitus, as structuring structures, is a dynamic concept that shapes agents' thoughts, perceptions, actions and choices more strongly than formal and explicit

rules existing in social fields, whose limits are set by the historical and social conditions that produced the habitus itself (Bourdieu, 1998, pp. 35-74). In this regard, individuals' cognitive structures are constructed through practice, rather than being passively registered. Furthermore, habitus is what helps agents to "cope with unforeseen and ever-changing situations" as well as to establish the activity of a social group and the principles behind choices (Bourdieu, 1977, p. 45). In this sense, habitus mediates one's experiences with the social world, but it does not determine them (Bourdieu & Wacquant, 1992, pp. 115-139).[14]

Understanding habitus as a system of socially structured and structuring principles means that social practice is viewed as the result of neither conscious nor unconscious individual choices. Although habitus predisposes individuals to act according to the rules and conventions of a field, it also gives individuals the opportunity to choose among the possibilities available: "individuals make choices, [...] but they do not choose the principle of these choices" (Wacquant, 1989, p. 45). Habitus is "a sort of spring that needs a trigger and depending upon the stimuli and structure of the field, the very same habitus will generate different, even opposite, outcomes" (Bourdieu & Wacquant, 1992, p. 135). This is why Bourdieu introduces the concept of strategy. Although the usual meaning of strategy suggests prior planning and, hence, consciousness in carrying out certain actions, Bourdieu (1987, p. 5) adopts a view of strategy which does not imply conscious rational calculation. Individual strategies are the result of the interaction between the internalisation of social practice in the form of dispositions and the constraints of social fields. In this sense, strategies orientate individuals towards certain patterns of action. Individuals are strategists that improvise according to the possibilities offered by a particular situation. Therefore, individuals develop a practical sense which is acquired since childhood and which enables them to act within the realm of their social reality.

This practical sense can be better understood by looking at the game metaphor used by Bourdieu. The idea of comparing social fields to games offers an interesting insight into Bourdieu's understanding of social life. Bourdieu often talks about this practical sense in terms of "feel for the game", which is individuals' understanding of social rules, or following the same metaphor, the "rules of the game" (Bourdieu & Wacquant, 1992, p. 23 & 223). This knowledge of the social field and the rules of the game, which are embodied as habitus, guides

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[14] Bourdieu (1990a, p. 87) has often emphasised the "powerfully generative" nature of the habitus, as a response to criticism implying that the Theory of Practice is structuralist in nature.

individuals throughout their lives and helps them to decide on the best strategies for being successful. It allows agents to adapt as their habitus restructures itself according to the structures of the field.

The restructuring of the habitus according to each field in which agents position themselves provides agents with a "taken for granted" world view which is internalised in their bodies and minds (Bourdieu, 1977, p. 85). Taking the world for granted means that we are comfortable with our social reality, we accept it as it is and we do not question it. In addition, since habitus restructures itself according to the conditions of the field, the strategies available also depend on the agent's position within the structure and hierarchy of the field (Bourdieu, 1998, pp. 44-45). In this regard, social practice cannot be exclusively understood by looking at the current position of individuals within the wider social structure (Bourdieu, 1998).

5 The professional trajectory of the Habitus

Individuals construct and evaluate the objective structures of the field through a process of familiarisation with social practices, starting with the family and then proceeding to broader institutional domains (Bourdieu, 1990b, p. 58). The degree to which habitus internalise the field structures and develop the dispositions to continue reproducing those very same structures will affect the strength of the habitus itself, since clearly internalised structures will lead to a strong habitus—i.e. a strong professional identity—whereas poorly internalised structures will lead to a weak habitus. It is therefore possible to talk about different types of habitus. Maton (2008) explains that there is a habitus for each identifiable social group, from families to artists, from working class to upper class, from students to professors. Scholars have identified different types of habitus, from "individual habitus" to "class habitus" and from "primary habitus" to "secondary" or "professional habitus" (see Benson & Neveu, 2005; Bourdieu, 1990b, p. 60; 2000, p. 157). This section focuses on professional or secondary habitus, which corresponds to a secondary socialisation (i.e. the development of a professional identity).

Agents entering a field of social practice do not necessarily have to bring a specific professional habitus with them, but rather a malleable primary habitus[15]

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[15] Bourdieu explains that an individual's 'primary habitus' slowly transforms into a 'professional habitus', which must be in harmony with the former. Accordingly, this process of transformation

which is compatible with the structures of the field in question and can easily transform into a professional habitus (Bourdieu, 1990b, pp. 52-65). In the field of public service interpreting, Inghilleri (2005b) has argued that the interpreting habitus is the product of the adaptation of individuals' primary habitus to the professional field of public service interpreting. Therefore, professional habitus does not only include professional training, academic qualifications or the acquisition of a specific body of knowledge, but also the personal trajectory of individuals (Bourdieu, 2000, pp. 122-128). In this sense, professional habitus is seen as a specific predisposition, a way of thinking, which is in harmony with the structures of the professional field in which the agent is situated (Artaraz, 2006). Professional identity becomes embodied in the professional habitus. According to Beck and Young (2005), the stronger the professional habitus, the stronger the sense of professional identity, for strong habitus means that individuals have a high degree of awareness with regard to the specific field practice, the service they provide and the needs of others (see section 4.1 of this chapter). In public service interpreting, agents acting as interpreters often develop a strong sense of the service they are providing, for although, in countries such as Spain, they usually lack professional training, they gain experience and may develop a strong professional habitus and a professional identity through their everyday practice in the field. These agents thus have the potential to develop a strong sense of professional autonomy, as explained in the next section.

5.1 *Attitudinal autonomy of the professional habitus*

Despite the strengths of Bourdieu's theory and its extensive use in researching a wide variety of social settings, including the field of public service interpreting, it has a number of limitations (see Inghilleri, 2003, 2005b, 2005c, 2006). As Bourdieu himself has stated, it is necessary to question theoretical models constantly and avoid accepting them at face value. In his own words, it is important to "think with a thinker against that thinker" (Bourdieu, 1990a, p. 49).

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takes place "gradually, progressively and imperceptibly, [...] and passes for the most part unnoticed" (Bourdieu, 2000, p. 11). Primary socialisation, as opposed to secondary socialisation, exercises considerable influence over the structuring process of an individual's professional habitus because the formation of habitus proceeds chronologically and is relatively irreversible (Bourdieu & Wacquant, 1992, pp. 18-20). The transformation from primary habitus into professional habitus thus yields insights into the ways in which professionals adapt to new contexts. However, the aim of this thesis is not to investigate the primary habitus of volunteer interpreters as part of this case study. Notwithstanding, it will examine some instances of primary habitus that will sporadically emerge throughout the analysis of focus groups in Chapter 4 and 5.

A number of scholars have criticised Bourdieu's concepts of field, habitus, and capital for their high level of abstraction and generalisation, which can make the researcher's task more difficult (Jenkins, 2002, pp. 58-59). Critics have also argued that habitus is more socially predictable than Bourdieu initially claims and does not account for social change in the way that he suggests (King, 2000, pp. 426-427). According to King (2000), Bourdieu's attempt to overcome the subject-object dualism is not fully achieved through habitus since individuals' habitus appears to be highly influenced by external stimuli. Additionally, Lareau and Lamont (1988, pp. 155-156) argue that Bourdieu attributes such a wide range of social categories to cultural capital that researchers find it very difficult to conceptualise cultural capital for their specific research. Similarly, Devine-Eller (2005, pp. 13-18) claims that habitus and cultural capital in its embodied form are overlapping concepts since both refer to knowledge that individuals internalise throughout their social trajectories. However, for the purpose of this thesis habitus is understood as the active knowledge that allows individuals to know what to do with their capital whereas cultural capital is passive knowledge. While these criticisms do not represent a major problem for this particular study, the concept of field, as described by Bourdieu with special reference to field boundaries, is of greater concern.

As explained in section 2.4, fields are flexible and relative constructs whose boundaries are constantly shifting. Despite Bourdieu's emphasis on empirical research as the basis for analysing the boundaries of fields, he does not provide a solution to identifying these boundaries effectively, making it difficult to define professional fields such as the field of public service interpreting with its constantly shifting boundaries (Jenkins, 2002, p. 79). The problem with the operationalisation of field and the question of identifying field boundaries pose major obstacles in applying Bourdieu's work (see Jenkins, 2002; Lane, 2000; Swartz, 1997). According to Swartz (1997, p. 122), there is a contradiction between Bourdieu's desire to analyse the internal action of fields in great detail and his emphasis on the impossibility of defining the boundaries of fields. For Brubaker (2004, pp. 151-153), this tension results in a concept that is too broad to grasp. If we cannot identify or define field boundaries, it becomes difficult to draw a sample of data that represents the activity of the field, as there will always be a large area that has not been included. In the field of public service interpreting, the question of boundaries is very important. By delimiting the field of public service interpreting it should be possible to better identify an interpreting

habitus and its objective structures as produced by the field itself, but this requires identifying the boundaries of the field.

In order to overcome the problem that the conceptualisation of field represents for this particular study, a model of professionalisation is introduced to achieve a better understanding of public service interpreting as a professional field.[16] Scholars such as Jóhannesson (1993) and Monzó (2005) have made use of models of professionalisation in conjunction with the Theory of Practice to study specific social contexts. Combining Bourdieu's theory with models of professionalisation can help identify the boundaries of the field of public service interpreting, as I will attempt to demonstrate. The importance of identifying the boundaries of public service interpreting lies in the fact that in many, but not all, countries public service interpreting is a field where agents acting as interpreters have very different social trajectories and therefore very different primary habitus; it is thus necessary to identify some common ground that brings cohesion to the field.

Bourdieu has criticised theories of professionalisation on several occasions.[17] His criticisms are based on the idea that the concepts of profession and professionalisation have been historically conditioned by a normative discourse that imposes a series of social categories *a priori* on the object of study (Bourdieu & Wacquant, 1992, p. 241). However, despite raising these criticisms, Bourdieu acknowledges the potential of these two concepts as tools for examining professional fields as long as researchers take the field as it presents itself and refrain from imposing pre-existing social categories of models of professionalisation upon it (Wacquant, 1989, p. 38). What Bourdieu means by this is that it is necessary to question the social categories of the discourse of professions and the concept itself and avoid any a priori conceptualisation of what we mean by profession. Bourdieu (1988, p. xii) thus proposes to conceptualise or—in Bourdieusian terms—to "objectify" profession in terms of professional field as he does in *Homo Academicus.*

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[16] For the purpose of this thesis, the concept of professionalisation does not exclude non-qualified, non-trained, or non-paid interpreters, since professionalisation is understood as a social trajectory that exists in the form of cognitive structures of the interpreting habitus.

[17] Firstly, he argues that the definition of the concept of profession draws on a pre-existing discourse and therefore excludes any aspect that can be found in the field but that is not included in this discourse. Secondly, the traditional view of professionalisation, according to Bourdieu, is normative rather than descriptive, since models of professionalisation concentrate on the study of the normative aspects of professions, such as codes of ethics, professional associations, entry requirements and so on. Consequently, both concepts, profession and professionalisation, become objects of study in their own right rather than instruments with which to study the field (Bourdieu & Wacquant, 1992, pp. 241-244).

Following Bourdieu's advice, a definition of profession will not be provided in this study and the professional field of public service interpreting will be examined from a Bourdieusian perspective with the help of models of professionalisation. In this context, professionalisation can be interpreted as a social strategy, in Bourdieu's parlance, whereby individuals recognise that their specialised knowledge (or cultural capital) is convertible into economic capital, in the case of paid interpreters, or social capital, in the case of volunteer interpreters, by providing a service to society (Jóhannesson, 1993, p. 270).

In examining the literature on professionalisation, it is possible to identify a wide range of approaches that reflect different researchers' focus of interest.[18] Two of the main approaches to the study of professionalisation are structural models – which focus on bureaucratisation—and attitudinal models—which focus on the individual practitioner. Although this section focuses on attitudinal approaches, a brief explanation of structural approaches will help clarify some basic differences between them and the similarities between attitudinal approaches and Bourdieu's framework.

Structural approaches elaborate models of professionalisation that postulate the existence of a certain organisational structure within professions (see Hall, 1968; Millerson, 1964; Vollmer, 1966; Wilensky, 1964). These approaches describe the process whereby occupations become professions as a succession of stages that include: the creation of professional associations, the implementation of academic training and codes of ethics, and the organisation of political agitation to gain legal protection, among other activities (Wilensky, 1964, p. 139). Structural models assume a high degree of professional organisation and the existence of an administrative body associated with the profession whose responsibility is to control practitioners and to keep intruders out (Jackson, 1970). This administrative body has legal responsibility for the service provided, thus exempting practitioners from direct responsibility towards service users. In this view, decisions made by professionals are not necessarily the most appropriate for the client but rather for the organisation of the profession (Goode, 1969).

This theoretical approach to professionalisation has been criticised by several scholars, and it has been argued that professionals under the managerial

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[18] We can identify several approaches to models of professionalisation in the literature on professions: functional approaches, structural approaches, monopolist approaches, cultural approaches, and attitudinal approaches, among others (see Abbott, 1988; Burrage *et al.*, 1990; Elliott, 1972; Freidson, 1994; Johnson, 1972).

control of administrative bodies lack the creativity and freedom to engage in decision making, two essential aspects of a successfully delivered service (Goldner & Ritti, 1967). As stated by Engel (1969, p. 33), administrative bodies "restrict the professional's freedom and make him dependent on the organisation which, in turn, controls him and inhibits the application of his knowledge and skills". Furthermore, a high degree of professional organisation can lead to a stage of "de-professionalisation", which is the moment where professionals lose complete control over the goals and social purposes of their work and the managerial control is seen as more important than the professional expertise of practitioners (Kitchener, 2000, p. 4). De-professionalisation is also related to Bourdieu's concept of orthodoxy and the idea that strong adherence to the field doxa leads to high degrees of institutionalisation, to "apparatuses", which Bourdieu perceives as negative (Bourdieu, 2000, p. 168). Agents who adopt orthodoxic discourses are often positioned at the heteronomous poles of fields since they do not show any resistance to the field of power or interest in social struggle.

In contrast to structural approaches to professionalisation, attitudinal approaches take into consideration the relationship between individual practitioners and society at large, thus placing more emphasis on individuals and their interaction with the environment than on the organisational structure of the field (see Forsyth & Danisiewicz, 1985; Johnson, 1972; Klegon, 1978). In this sense, it is possible to argue that attitudinal approaches to professionalisation share certain features with Bourdieu's concept of field.

From an attitudinal perspective, professionalisation is seen as a social trajectory where practitioners struggle for prestige and status and use their specialised knowledge (or cultural capital) as a means of achieving their aims (Randall & Kindiak, 2008, p. 346). There are similarities between this view and Bourdieu's idea of field as a field of struggle (see section 2.2 of this chapter) that revolves around the search for power and prestige (or symbolic capital), since according to Forsyth & Danisiewicz (1985, p. 60), "the social process of profession can theoretically exists in the absence of a formally organized occupation". Thus, when researching the process of professionalisation, it is necessary to consider the power that practitioners of certain professions exert over their clients and the wider community when they provide a service which is essential to society and/or is perceived as such (Forsyth & Danisiewicz, 1985).

As Forsyth and Danisiewicz argue,

> if power is central to the concept of profession, and if power in professional occupations appears to manifest itself in the autonomy from clients and from employing organizations expressed by occupational members, then the levels of attitudinal autonomy among occupational members might well provide a means to index the professionalization of occupations. (Forsyth & Danisiewicz, 1985, p. 61)

From this perspective, autonomy, which is essential for the acquisition of a high degree of professionalisation, allows a practitioner "to make his own decisions without external pressures" from his clients and his employing organisation (Hall, 1968, p. 93).

This concept of autonomy takes us back to Bourdieu's view of field as a relative autonomous structure which can be influenced by other fields with a higher degree of autonomy and where individuals struggle for dominant positions and control over the activity of the field (see section 2.2 of this chapter). Both attitudinal autonomy and Bourdieu's relative autonomy share a concern with legitimisation (see section 2.3 of this chapter) in the sense that there must be a social agreement between service providers and service users as regards the service offered and its value in the professional market. As Freidson (2001, p. 76) points out, "recognition of an occupation is connected to its value for the society and its ability to make a significant contribution". Legitimisation and recognition thus help explain the relationship of trust between practitioners and clients with respect to the service provided, since clients rely on practitioners' legitimate specialised knowledge (or cultural capital). Autonomy is then understood as clients' trust that practitioners will carry out their task successfully based on their exclusive competence since "professionals provide work that is important for the well-being of individuals and society" (Rudvin, 2007, p. 53). Trust is essential in order to achieve professional status, or a stronger professional habitus using Bourdieusian terms; in most contexts of public service interpreting, trust is an important element to establish interpersonal relationships between interpreters and service providers (Edwards *et al*, 2005; Tipton, 2010). Service providers need to believe that "interpreters can provide services without distorting their voice or compromising the quality of care" (Hsieh *et al.*, 2010, p. 171). In this context, "legitimacy of meaning is to a large extent assumed because the interpreter is not seen to put anything of the 'self' into the verbalised output which might distort the

original message" (Tipton, 2008, p. 5; emphasis in the original). In addition to the contribution of this model as a tool to explore the boundaries of fields and the positioning of agents, attitudinal autonomy offers the possibility of employing a concept of habitus which is not so vastly influenced by the external structures as initially conceptualised by Bourdieu (see section 4 of this chapter). Attitudinal autonomy provides agents with well-defined cognitive structures, i.e. a stronger habitus, and more agency since it is supported by a network of trust and recognition from agents with stronger habitus.

Goode (1969, pp. 277-279) identifies two central aspects of the concept of autonomy, namely professional knowledge and service ideal. According to Freidson (1994, pp. 121-122), these two aspects are essential in securing a relationship of trust between practitioners and their clients. Practitioners must acquire a specific cultural capital, known as professional knowledge, which must be legitimised as such by the clients who ultimately decide whether or not practitioners and the service provided can be trusted. Freidson (1994) argues that only a specialised—as opposed to general—body of professional knowledge can provide practitioners with control over the service provided. If this monopolised expertise is recognised by clients and society as exclusive, then power and authority will be transferred to the practitioners who possess it (Forsyth & Danisiewicz, 1985). In public service interpreting this body of professional knowledge can be conceptualised in the form of interpreters' linguistic and cultural capital. On the other hand, service ideal implies that there is an intention to serve others (without being subservient) and to provide solutions to clients' needs (Burrage *et al.*, 1990). The service offered must be based on a personal commitment to provide clients with the best solution possible based on the practitioner's exclusive knowledge (Jackson, 1970, p. 6).

In one of the most significant studies within attitudinal approaches, Forsyth and Danisiewicz (1985, p. 73) demonstrate that it is possible to establish the degree of professionalisation, or a professional habitus, by exploring the two general attitudinal variables of autonomy, from the perspective of the client and the employing organisation. They offer a three-phase model of professionalisation which explains the two sources of power behind the acquisition and development of autonomy: the nature of the service provided and the marketing and promotion of the service among clients. In the first phase, which relates to the nature of the service provided and its promotion among clients, practitioners must initially identify their service as essential (as having considerable importance for the

client), exclusive (meaning that practitioners have monopoly of the service and no one else can offer it), and complex (a specialised body of knowledge is needed to perform the service). Moreover, practitioners are responsible for promoting their service among clients and for convincing them that the service they provide is indeed essential, exclusive and complex. According to Goode (1969, p. 244), marketing the practitioners' professional knowledge and service ideal among clients and the wider community is an essential part of the process of professionalisation.

The second phase is based on the results obtained in phase one. If the service has been successfully promoted as indicated in the first phase. That is to say, if the public recognises the service provided as essential, exclusive and complex, it will be considered legitimate. Freidson (2001, p. 65) indicates that successful public recognition, which is equivalent to Bourdieu's concept of symbolic capital, of the value of the service provided is essential to the acquisition of autonomy.

Finally, the third phase concerns the degree of autonomy obtained by the profession under study. In this phase, it is possible to differentiate between those occupations which have achieved autonomy from both the client and the employing organisation and those which have not (Forsyth & Danisiewicz, 1985, p. 63). A high degree of professionalisation will be achieved when practitioners enjoy both types of autonomy.

In summary, a high degree of attitudinal autonomy may lead to a higher degree of professionalisation or, in Bourdieu's parlance, a stronger habitus. By combining both frameworks (Forsyth & Danisiewicz's Model of Professionalization and Bourdieu's Theory of Practice), it should be possible to achieve a better understanding of how public service interpreters in healthcare settings in southern Spain can set, maintain or shift the boundaries of the field and therefore position themselves within the interaction.

6   Concluding remarks

This chapter examined Bourdieu's sociological model with particular emphasis on the concepts of field, capital and habitus, as these constitute a powerful tool for studying public service interpreting in healthcare settings as a field of professional practice. It is essential to identify an interpreting habitus and the degree of professional organisation of the field to achieve a better understanding of the

position of healthcare interpreters in Spanish hospitals with particular reference to their attitudinal autonomy and the doxa of professional associations.

Bourdieu's sociological framework should allow us to analyse the internal structure and the activity of the field of public interpreting in healthcare settings in Spain against the wider social context where interpreter-mediated encounters take place. Bourdieu's model, in conjunction with Forsyth & Danisiewicz's Model of professionalization, will inform my analysis of this sub-field of healthcare interpreting in relation to the adjacent field of healthcare that enjoys a higher degree of autonomy. Drawing on the concept of attitudinal autonomy should prove helpful in identifying interpreters' positions and recognising an interpreting habitus in healthcare settings and assessing to what extent the interpreting habitus acknowledges the doxa of professional associations.

Chapter Two

The field of public service interpreting in the South of Spain and the healthcare interpreter's habitus

1   Introduction

Public service interpreting is a highly diverse social practice that operates in different ways in different national contexts.[19] In Spain, unlike Australia, Sweden, Canada or the US, public service interpreting has not yet reached a high degree of professional organisation and there is very little awareness about this social practice and the role of the interpreter (Rudvin, 2004; Valero Garcés, 2006, p. 37). Most, but not all, public service interpreting encounters occur as a result of the movement of populations, an element that may have had an impact on the degree of professional organisation achieved by individual countries. Spain does not have a tradition as a country of immigration; rather, it has traditionally been a country of emigration (Andión Herrero, 2006). Consequently, there is little awareness among the different authorities and institutions of the need to provide quality interpreting services for non-Spanish speakers. The profession of public service interpreter, as such, has not yet been professionally or institutionally recognised. Therefore, although there are some universities such as the University of Alcalá de Henares (Madrid), the University of Jaume I (Castellón) and the University of La Laguna (Canary Islands) that offer training courses for public service interpreters, the system still works on an ad hoc basis in most healthcare institutions throughout the country (Martin, 2006; Navaza *et al.*, 2009; Sales Salvador, 2005; Valero Garcés & Cata, 2006).

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[19] For a general overview of public service interpreting worldwide, see Bancroft (2005), Hale (2007), Hertog & van de Veer (2006), Roberts (1997) and Valero Garcés (2006, pp. 41-54). For a more detailed overview by country, see the following works: **Australia**, see Chesher (1997), Hale (2004), Merlini & Favaron (2003) and Ozolins (2003); **Austria**, see Kadric (2000), Pöchhacker (1997, 2003) and Pöllabauer (2007); **Belgium**, see Blommaert (2001), Hertog & Vanden Bosch (2003) and Salaets & Van Gucht (2008); **Canada**, see Angelelli (2004b), Clifford (2004), Industry Canada (2007) and Rosenberg *et al* (2008); **Ireland**, see Phelan (2001, 2003); **Italy**, see Rudvin (2002) and Putignano & Tomassini (2003); **Malaysia**, see Bell (2007), Ibrahim (2007) and Ibrahim & Bell (2003); **Norway**, see Saglia (2003); **Poland**, see Tryuk (2007); **Portugal**, see Feijoo (2003); **Spain**, see Ortega *et al* (2009), Sales Salvador (2005) and Valero Garcés (2006, pp. 54-59), and specifically for the South of Spain, see Martin, Foulquié & Gallardo (2003); **South Africa**, see Erasmus (2000); **Sweden**, see Dimitrova (2001), Niska (2003, 2007) and Wadensjö (1998); **Switzerland**, see Bischoff & Loutan (2004); **UK**, see Corsellis (2008) and Corsellis & Cambridge (2003); **US**, see Angelelli (2004a, 2004b), Davidson (2000, 2001), Mikkelson (1996), Roat (2010) and Rosenberg & Swarey (2003).

In particular, Andalucía, where the focus-group interviews, participant observations and audio recordings of interpreted interaction that inform this study were carried out, demonstrates poor awareness and organisation of public service interpreting in healthcare settings. I carried out an initial survey of the different healthcare institutions along the Spanish southern coast, an area that stretches from Huelva (in the West) to Almeria (in the East), between July and September 2009.[20] During this initial fieldwork I was able to establish that only one out of the seven largest hospitals has a full-time paid interpreter on site referred to as *mediadora socio-sanitaria* (social and healthcare mediator);[21] another hospital has paid interpreters with university degrees in translation and interpreting on call when they are needed; one employs a number of bilingual nurses and doctors; two have a team of volunteer interpreters who work as non-remunerated staff and provide daily interpreting services; and two functioned on an ad hoc basis, using volunteer interpreters when/if available. The profession is thus characterised by a wide range of practices among service users and a high demand for languages, but also by a wide range of agents acting as interpreters, poor professional organisation of the field, and lack of financial and institutional support. The complexity and fluidity of this situation call for a theoretical framework that is flexible enough to allow us to consider different macro and micro features and their impact on public service interpreters. Pierre Bourdieu's sociology of culture offers such a framework (see Bourdieu, 1977).

Since Translation Studies started drawing on Bourdieu's theory in an attempt to turn away from the translational product as an exclusive focal point, there have been arguments both for and against the idea of reconstructing the field of public service interpreting as a social field in Bourdieu's sense. Some scholars have argued that public service interpreting and the broader field of translation are not sufficiently established to constitute a social field (see Inghilleri, 2005b; Simeoni, 1998). The influence that other agents involved in the communicative process exercise on interpreters and their habitus has been cited

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[20] Between July and September 2009 I visited the main hospitals along the southern coast to form an impression of the number of foreign patients visiting the hospital and interpreting services available. Information on all healthcare institutions investigated during my initial fieldwork can be found on the official website of the Andalusian healthcare service Servicio Andaluz de Salud, available at https://www.juntadeandalucia.es/servicioandaluzdesalud/ (last accessed December 2009).

[21] See the news section of the *Servicio Andaluz Salud* (Andalusian healthcare service) website, available at https://www.juntadeandalucia.es/principal/noticia.asp?codcontenido=9470 (last accessed November 2009). See also additional interview with this *mediadora socio-sanitaria* in a Spanish newspaper, *El Mundo,* available at:
http://www.elmundo.es/suplementos/salud/2006/655/1142031612.html (last accessed January 2012).

as a major problem, since the presence of other agents with more or less symbolic capital can constrain and influence interpreters' performance (Inghilleri, 2003, 2005b). More specifically, translators and interpreters' poorly defined habitus has been considered the reason for their lack of professional prestige (Simeoni, 1998). However, as explained above, public service interpreting is complex and there may be other factors operating that contribute to the fluidity of the interpreter's position and her/his habitus.

This study assumes that it is possible and desirable to establish public service interpreting as a social field. Treating public service interpreting as a social field should allow us to analyse it from a sociological perspective and to examine dynamic contextual features and their impact on the interpreting activity. Furthermore, it should allow researchers to study the impact of interpreters' actions on the context which is being constantly (re)negotiated between interpreters and other participants in the interaction (Baker, 2006). This sociological approach requires us to take into account all the agents involved in the interpreted encounter and the socio-cultural baggage, in terms of cultural and social capital, that they bring along.

This chapter thus draws on Bourdieu's sociological theory in an attempt to describe the field of public service interpreting. The description offered in section 3 is informed, when appropriate, by two specific healthcare settings in the South of Spain. Yet before offering my own analysis of the field, first it is useful to review the different arguments presented by translation scholars with regard to the current state of the broader translation and interpreting field and the narrower field of public service interpreting in terms of its relative autonomy and therefore its status as a social field, as defined by Bourdieu. This includes a discussion of the different views expressed in the literature with regards to the existence of a specific translation and/or interpreting habitus. The second half of the chapter attempts to reconstruct the field of public service interpreting by applying the theoretical concepts defined in chapter one (field, habitus, and capital). The chapter ends with a final discussion of the application of Bourdieusian concepts specifically in healthcare settings in Spain as a case study.

2   A Sociology of Interpreting: State of the art

2.1   *The social field of public service interpreting as part of the broader field of Translation and Interpreting*

Public service interpreting has remained largely hidden from public view for many years being considered as a peripheral and ad hoc activity, and it has been a neglected social field with low social prestige and public interest—specially in comparison with conference interpreting (Tipton, 2008). Whereas conference interpreting is a clearly structured field with high symbolic power and institutionalised points of entry whose constitutive agents accumulate cultural and linguistic capital to be exchanged for high social status and economic remuneration, public service interpreting lacks all these elements (Sela-Sheffy & Shlesinger, 2008). The main difference between conference interpreting and public service interpreting lies in the status of the parties of the interpreted event; whereas in conference interpreting both parties generally have equal status, in public service interpreting they have unequal status (Snell-Hornby, 2006). Moreover, whereas conference interpreters tend to use internationally recognised and valued languages (e.g. English, Spanish or French, among others), public service interpreting interpreters often work for immigrants whose languages may have "limited diffusion" (Snell-Hornby, 2006, p. 45).

Due to the low status of the profession of public service interpreters and the lack of professional organisation of this social practice in some countries such as Spain, relatively little research has been carried out that analyses the internal organisation of the field and the interaction between the field of public service interpreting and adjacent fields, such as the field of healthcare in the case of healthcare settings or the field of law in court settings. Hardly any research has been undertaken to address the question of whether public service interpreting can be considered a social field in Bourdieu's terms. It is therefore necessary to look at studies within the broader field of Translation as a first step in addressing the more specific question of public service interpreting as a social field. I thus make some reference to the wider field of translation and interpreting in order to address several issues within the public service interpreting context.

One of the main issues raised by scholars who have attempted a sociological analysis of the field is the "subservient" and "submissive" nature of translators and interpreters and its impact on the translatorial habitus (Inghilleri,

2003, p. 249; Sela-Sheffy, 2005, p. 5; Simeoni, 1998, p. 19; Wolf, 2007, p. 115). This subservience, understood as the translator's holding an inferior status vis-à-vis "the dominant professions of the cultural sphere", is related by Simeoni to the idea of an "ill-defined habitus" (Simeoni, 1998, p. 7). Furthermore, Simeoni (1998) suggests that translators' subservience is voluntary, as translators have historically internalised subservience in the form of professional conventions since the earliest episodes of translational mediation where, according to Simeoni (1998, p. 7), the role of translators was that of "servants". In Simeoni's words, "translators seem to have been not only dependent, but willing to assume their cultural and socio-economic dependence—to the point that this secondariness has become part of the terms of reference for the activity as such" (Simeoni, 1998, p. 13). However, Simeoni's views seem rather simplistic; he does not consider that rather than indicating an 'ill-defined habitus', this subservience may be part of the translatorial habitus that has been strongly internalised and is constantly being reproduced during practice (Inghilleri, 2006).

As noted by Inghilleri, it is possible that

> in internalising norms of training in which conduit models of language and invisibility dominated, a particular 'translatorial habitus' could be said to have developed by which translators had 'embodied' a distinctive set of values, beliefs and discursive practices that tended toward subservience to their client, to the public, to the author, to the text, to language itself, or even, in certain situations of close contact, to the culture or subculture within which the particular translational task was required to make sense. (Inghilleri, 2006, p. 1; emphasis in the original)

This can be explained by the existence of asymmetric power relations in every social field due to the influence of the field of power (see Chapter 1, section 2.3) whose dominance means that there are agents who impose social conventions—i.e. doctors, and agents who accept these impositions—i.e. healthcare interpreters—depending on their hierarchical position within the field (Inghilleri, 2004). These internalised impositions prevent translators and interpreters from revolutionizing the field (Sela-Sheffy, 2005). Therefore, translators' and interpreters' subservience could be seen as merely the result of the internalisation of a series of beliefs, norms and conventions, or what Bourdieu (1977, p. 164) calls doxa, which are still enforced by interpreting training institutions and translation scholarship. Doxa thus becomes internalised as dispositions and is

constantly being reproduced by both the field and translators' habitus. In this sense, the field doxa remains unchallenged.

However, the idea of a completely submissive translating or interpreting habitus is not totally in line with the concept of habitus as defined by Bourdieu. While somewhat constrained by social conventions, Bourdieu's idea of habitus is meant to allow room for the exercise of individual discretion (Bourdieu, 2000, p. 64). As Sela-Sheffy explains,

> both conformity and divergence – or what Bourdieu calls "orthodoxy" and "heterodoxy" – are then strategies taken by actors in a certain field, and under certain circumstances. The logic of the field, according to Bourdieu, is that of people constantly striving to gain symbolic capital through (consciously or unconsciously) appropriating prestige-endowing patterns of behaviour, and the habitus is what facilitates their "instinctive" judgement and use of the available choices. It follows that actors in a certain field would tend to be either conservative or revolutionary with regard to the accepted repertoire in the field, depending on their position (or aspired position) in it. (Sela-Sheffy, 2005, p. 5; emphasis in the original)

Therefore, compliance with the norms that promote neutrality, impartiality and general subservience to the social practice must not be considered in merely negative terms, since it sometimes "guarantees maximum prestige" in the case of translation and interpreting scenarios where translators and interpreters must often negotiate their position in relation to institutional agents such as doctors, lawyers and policemen. (Sela-Sheffy, 2005, p. 7). As explained by Clifford (Clifford, 2004, p. 98), an approach which "instructs the translator to follow norms and behave in predictable ways [...] is likely to earn the translator the trust of others". According to Valero Garcés and Gauthier Blasi (2010), translation and interpreting agents are caught up between the doxa of professional associations, which demands neutrality and impartiality, and a model more adapted to the context, which takes into account the internal dynamics of the specific field. The set of norms and conventions internalised by interpreters is what has been previously defined as "translation culture" (Prunč, 1997, p. 59). Prunč defines translation culture as a "diachronically (and diaculturally) variable set of norms, conventions and expectations framing the behaviour of all interactants in the field of translation". In this sense, translation culture, as defined by Prunč, consists of strong dispositions and structures (or habitus) within the field of translation and interpreting.

Furthermore, as Sela-Sheffy (2005, p. 4) argues, the assumption and claims of presumed subservience and submissiveness in the context of the translational habitus "are not always confirmed by empirical examination" as readily as Simeoni claims in his article. The same author also explains that Simeoni's view of the translator's or interpreter's habitus is too naive and static to be part of such a dynamic theory such as Bourdieu's, for the Bourdieusian view of habitus implies a force that allows for transformation and reconstruction of the field where agents are positioned (Sela-Sheffy, 2005), That is to say, there is potential to revolutionise the field via the modification of internal norms. Habitus must be considered a tendency within the field rather than a property of the field:

> It may be argued that in established cultures such as those of English- and French- speaking communities today, which Simeoni probably had in mind, translators are more inclined to comply with overpowering domestic standards. Yet in peripheral or nascent cultures submissiveness is not always a prevailing strategy (Sela-Sheffy, 2005, p. 5).

We can observe such differences within the field of interpreting too. Some authors argue that conference interpreters are more likely to comply with the norms of the field that demand interpreters' invisibility and presupposed submissiveness to the speech than public service interpreters; this means complying with the field training and professional institutions that shape the norms of the field (Marzocchi, 2005, pp. 100-104). The lack of awareness, recognition and uniformity within the profession of public service interpreting as regards the role of public service interpreters and the physical proximity of the interpreters to other interactants facilitate the adoption of an active rather than passive role on the interpreters' part.[22] Public service interpreters must be visible and present during the interaction, making it more difficult for them to assume the role of neutral and invisible agents. Moreover, public service interpreters may sometimes align with institutional representatives as a way of creating a "we-identity" (Baraldi & Gavioli, 2008, p. 5) and being able to share the authority and prestige they enjoy (Davidson, 2000). At other times they may align with the service users (e.g.

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[22] Some authors offer a somewhat different argument. Angelelli (2004b) points out that interpreters in different settings (conference, court and medical) felt equally visible during the interaction. Donovan (2011) argues further that conference interpreters are more confident about their role and less anxious about reshaping the speaker's message. On the other hand, due to the lack of institutionalisation of the field of public service interpreting, public service interpreters remain ambiguous about their position and hence attempt to demonstrate their professionalism by adopting the discourse of neutrality and detachment in theory, even if they assume a more active role in practice.

patients, asylum applicants or tourists) as members of the "guest culture" who are "embedded in the patients' cultural-linguistic community" (Baraldi & Gavioli, 2008, p. 5; Beltran Avery, 2001, p. 13). Pöllabauer (2006, p. 152) thus argues that public service interpreters often suffer from role conflicts and dilemmas relating to issues of loyalty and cooperation with the other interlocutors in the communicative event, as they have to constantly re-negotiate their position within the interaction. Angelelli (2006, p. 183) argues that it is the interpreter's personal choice to adopt a more or less active position in the interaction, based on her/his perception of the other participants and the setting. Hsieh (2004) suggests that interpreters adopt different strategies to maintain a certain level of control in managing turn-taking, omitting utterance and so on. This implies that public service interpreters are not always as submissive as has been previously assumed. Indeed, "shifting sides to keep the loyalty of both service user and service provider is a common feature of public service interpreters who struggle to maintain a positive communicative relation" (Pöllabauer, 2006, p. 158). One cannot claim, therefore, that they are necessarily submissive in relation to either party.

As explained by Bourdieu (2000, p. 20), to agree to participate in the field means "to reproduce the structures of the field". In this sense, it is possible to understand Simeoni's subservience as an example of clear internal dispositions and structures which exist in the field of public service interpreting. Moreover, given that this set of mental (and physical) dispositions has been internalised through practice, interpreters are not necessarily aware of this subservience but may believe they are merely exercising their agency according to their social position within the field. Bourdieu's own fieldwork on masculine domination shows that subservience is to be understood as a feature of clear internalised structures (Bourdieu, 2001, pp. 39-40). The gender domination question discussed by Bourdieu represents a paradigm of all domination, as it is one of the most persistent forms of domination. Bourdieu (2001) explains how women become accomplices in the practices that sustain masculine domination by reproducing the conventions with which they are expected to comply. In the same way, it may be argued, translators' and interpreters' subservience represents a form of domination that has been accepted by both groups as the natural order of the field, as the doxa. Bourdieu (2001, p. 88-96) claims that in order to overcome domination, it is necessary to look at the properties that contribute to the status quo, because the status quo can only be understood by analysing the mechanisms and institutions that reproduce and perpetuate arbitrary conventions. Therefore, if

interpreters scrutinise the norms responsible for their presumed submissiveness, it may be possible to challenge their dominant co-interactants and impose their own norms and structures by writing their own codes. This issue is raised in Clifford's study. He explains that when interpreters enter the field they must initially gain the trust of institutional agents who possess more symbolic capital by accepting the rules of the game or doxa; as their relationship develops, interpreters' symbolic power increases, which allows them to slowly challenge the doxa and become more active agents (Clifford, 2004).

Some reports have shown that written codes and accepted norms are often based on theoretical principles formulated by academics (Angelelli, 2006, p. 176) or codes of ethics developed for conference interpreters (Bancroft, 2005)—an activity which has been shown to differ significantly from public service interpreting. According to Angelelli (2006), if we consider public service interpreting as a socially situated activity, interpreters' position should vary according to each individual situation and the agents involved, for there should be a balance between established standards and the reality of the working environment. However, the field of public service interpreting is not yet prepared to explicitly and openly challenge the doxa (Valero Garcés & Gauthier Blasi, 2010).

The question of translators' and interpreters' 'subservience' has been used not only to challenge the existence of a clearly defined translatorial habitus, but also the very existence of a translation and interpreting field. Simeoni (1998) argues that by acting submissively in relation to other agents with higher symbolic capital (e.g. lawyers, doctors and judges), translators are contributing to the heteronomy of the field of translation and interpreting. Accordingly, the field of translation and interpreting is considered to be a "pseudo- or would-be field", rather than a Bourdieusian field, in the sense that translators and interpreters have a social habitus rather than a specialised habitus (Simeoni, 1998, p. 7). Hermans (1999) rejects the idea of the 'pseudo-field', as articulated by Simeoni, and argues that it is possible to establish a translation and interpreting field in Bourdieu's sense. He presents several examples of elements that differentiate the field of translation from other fields and that help maintain the field boundaries. These boundaries can be observed in the standards (or doxa) set by training programmes and in codes of ethics which, as mentioned above, are constantly being covertly challenged (Hermans, 1999). Furthermore, Hermans (1999, p. 136) points out that translation must be a relatively autonomous field, since "if

translation was wholly heteronomous and translators naturally subservient, would there be any need to exercise tight controls over the interpreters?".

Simeoni (1998) is not the only scholar to question the existence of a field of translation and interpreting. Wolf (2006) appeals to the temporality of translations and interpreting acts to support a similar argument against the existence of a field of translation and interpreting. According to Wolf (2006), the existence of the translational product is bound to the moment and to the adjacent field where it takes place. Moreover, the positions that agents occupy in the field of translation and interpreting are not very well established due to lack of professional organisation. Accordingly, their positions depend to a great extent on the relationships interpreters develop with other agents in adjacent fields, for translational acts do not exist unless there is another field that requires these forms of mediation (Wolf, 2002). If Wolf's idea is applied to the specific case of public service interpreting, it could be argued that the interpreting product is so attached to the legal or healthcare field where it takes place that it only exists by virtue of those other fields and stops existing the moment the interaction ends. The fact that individual episodes of interpreting come to an end, however, does not mean that interpreters stop being interpreters: their interpreting habitus and their cultural and linguistic capital exist beyond and across individual episodes of mediation.

Inghilleri (2005b) offers an interesting view of the field of public service interpreting. She argues that public service interpreting can be seen as a zone of uncertainty "where agents experience uncertainty as to how to 'occupy' particular social spaces they come to inhabit, habitus can become destabilised" (Inghilleri, 2005b, pp. 70-71; emphasis in the original). For Inghilleri (2005b, p. 72), zones of uncertainty are "contradictory and potentially liberatory spaces within a social structure in which contradictions emerge from a convergence of conflicting world views that momentarily upset the relevant habitus". In this light, interpreters have the potential to revolutionise the field from within and change the structures and boundaries of the field. Unfortunately, Inghilleri (2005b) does not expand on this argument and does not provide a sustained explanation about how this zone of uncertainty works, since it is based on the idea that interpreters' habitus has not internalised the field structures and therefore that they do not know the objectives of the field. Accordingly, other agents can impose their own objectives and dispositions because through their symbolic power they can influence interpreters' habitus (Inghilleri, 2005b).

Inghilleri (2005b, p. 71) argues that the field of public service interpreting with reference to the UK, among others, is suffering from "an ongoing struggle to define itself" due to the lack of clear internal objectives and structures. However, this idea is not as straightforward as Inghilleri initially claims. As explained above, there is a clear doxa in the field, enforced by professional associations, that interpreters have internalised in the form of dispositions towards neutrality, invisibility and subservience. Interpreters are consequently positioned at the heteronomous poles of fields where they may be subject to domination by the professional interpreting community and other organisations that endorse this doxa. Moreover, although the profession as such is still fighting for professional recognition, interpreters are aware that they play an essential role in encounters where there are two agents who do not share the same language. In this sense, there is also a clear objective, which is to provide effective communication and to overcome cultural and social barriers created by differences in the social and linguistic capital of agents.

In sum, despite the problems that the field of public service interpreting may present to researchers in terms of unclear boundaries and ill-defined habitus, Bourdieu's theory of cultural fields offers a perspective that allows us to study fields which "lack institutionalized boundaries and defy traditional professionalisation models" (Sela-Sheffy & Shlesinger, 2008, p. 83). In this sense, the field of public service interpreting is as good an example of a Bourdieusian field as the field of French art or French literature studied by Bourdieu himself (Bourdieu, 1993a). Consequently, according to the arguments presented above, it is possible to argue that public service interpreting is a social field and that Bourdieu's categories of habitus, field and capital, as defined in Chapter 1, should allow us to reconstruct it as such. It should thus be possible to analyse the social agents responsible for individual interpreting acts and the internal structures of the field as internalised by individual agents in the form of dispositions.

3   Reconstructing the field of Public Service Interpreting in the Spanish social space

In order to argue the existence of a Bourdieusian field it is necessary to identify certain stakes and individual agents who are interested in struggling for and acquiring these stakes (Inghilleri, 2004). Focusing in particular on interpreting in healthcare settings, this section discusses the different forms of capital at stake in

the field of public service interpreting, the agents who participate in the field by accumulating, exchanging or transferring their capital, and the resulting impact on the public service interpreter's habitus. The discussion draws where appropriate on data from healthcare settings in Spain, where the current study was conducted.

Forms of capital available to agents in any field are embedded within social spaces that are horizontally dominated by a field of power; the field of power acts as the source of field hierarchies and structures all the fields situated within the social space. The workings of the field of power are evident in the power relations developed among agents, and are directly connected with symbolic capital (see Chapter 1, section 3.4). Moreover, the field of power not only influences the field of public service interpreting directly, but also indirectly through the impact of other more autonomous fields that interact closely with the field of public service interpreting. Accordingly, the effect of the field of power is twofold: it can impact the internal hierarchy and functioning of the field under scrutiny, and it can also allow other fields with relatively more autonomy and symbolic power, such as the field of healthcare, to influence interpreters' habitus and the stakes of the field. The field of power is represented by institutional authorities and individual agents who have the economic and political resources to control the field of public service interpreting, such as the *Servicio Andaluz de Salud* (the Andalusian healthcare service) or hospital managers in the particular case studies analysed in later chapters of this thesis. Healthcare authorities and institutions have the symbolic power to establish an internal hierarchy and to legitimise some forms of capital which allow their holders to occupy a higher position within the pre-established hierarchy. It is necessary to examine the position of doctors and interpreters and to ask whether the capital they hold allows them to occupy certain positions within the institutional hierarchy and therefore during the interpreted interaction.

As mentioned above, fields are neither fully autonomous nor heteronomous. Fields are in constant interaction with other fields which may be more or less autonomous and which may influence to a greater or lesser extent the structures of a field (see Chapter 1, section 2.3.2). The field of public service interpreting is situated towards the heteronomous end of the continuum, and does not have a high degree of autonomy in relation to the field of power. The degree of autonomy of a field is defined by its ability to reject external impositions and to generate a logic of its own, governed by its specific form of symbolic capital. In the specific healthcare settings under study, the healthcare system, an

institution with its own specific structure and objectives, influences the interaction between the healthcare field and the public service interpreting field, the positions occupied by agents, the capital at stake, and the legitimisation and value of each form of capital. Therefore, the field of public service interpreting struggles against the healthcare system to reject its external impositions and impose its own. According to Lambert (1994), the impact that institutions have on the translation and interpreting field affects the interpreting activity from the beginning as well as the decisions made by interpreters, who are usually guided by other agents higher up the institutional hierarchy. This impact increases "especially when there is an attempt to react against it" (Lambert, 1994, p. 20). The field of public service interpreting is in constant interaction with other fields such as the field of healthcare, the field of politics, the field of education and the field of law, among others, which requires examining the macro structures that affect each area of interpreting activity in order to understand the functioning of the field of public service interpreting as a whole.

In particular, the field of healthcare is a clearly structured field with well established boundaries and points of entry. The healthcare field in Spain, and therefore in *Andalucía* (the setting of the current study), is regulated by strict written codes of ethics and governed by an institutional body known as *Colegio de Médicos* (Professional Medical Association), which has the power to control which agents can enter the field, to establish a hierarchy of doctors according to the distribution of symbolic and economic capital, and to confer symbolic power on them. Due to its high degree of professional organisation, the healthcare field is highly autonomous and doctors hold a large degree of symbolic power. This autonomy from the field of power allows the healthcare field to legitimate the specific capital at stake as well as to attribute a high value to doctors' cultural capital (i.e. degree in medicine or a medical specialisation), which can be converted into symbolic capital. Although doctors' cultural capital is often converted into economic capital, doctors' prestige and high social status (or symbolic capital) is based on their cultural rather than on their economic capital. In order to illustrate this, we could simply observe the prestige and status of doctors working for NGOs, such as Doctors without Borders, who possess very little economic capital but a large volume of symbolic capital. Consequently, when the field of public service interpreting interacts with the field of healthcare during interpreted medical consultations, both influence each other and impose their own structures upon the other field. The more autonomous field, in this case the

healthcare field, has greater relative autonomy and symbolic power than the field of public service interpreting and can thus shape the structures, dispositions and capital of the latter.

In practice, this constant struggle between agents from different fields and with different degrees of symbolic power in healthcare settings can be observed in the way doctors, who are at the top end of the hierarchy, exert control over healthcare interpreters whose linguistic and cultural capital are not perceived as valuable assets by the wider community (Navarro Montesdeoca, 2006). Hsieh (2010, p. 158) offers several examples of the power invested in doctors by the US healthcare system; in one, for example, "an interpreter was fired because s/he did not perform in a way that was expected by the provider". This is not surprising given that doctors are encouraged to keep absolute control of the medical interview since they hold ultimate responsibility for its outcome and for the patient's well-being. The presence of the interpreter during medical consultations threatens the normal functioning of the doctor-patient interaction, to the point where professional medical associations in Spain have wondered whether doctors can be responsible for the medical interview when they do not know what they are being responsible for.[23] It has thus been suggested that the hierarchical nature of medical institutions is responsible for the low status of healthcare interpreters, since doctors may control the interaction and the positioning of public service interpreters because they enjoy greater authority (Angelelli, 2006). According to Leanza (2005, p. 173), "when researchers observe what happens in medical consultations involving an interpreter, they generally find that the dominant discourse of the institution is confirmed by the intervention of the interpreter" since interpreters feel constrained by this dominant discourse and reproduce it through their activity. As Mason explains,

> the interpreter does enjoy power within the exchange. Gate-keeping, turn-management and general coordination of others' talk are all the mechanisms of power and control invested in the interpreter. But this form of power is to be distinguished from the institutional power invested in the doctor, immigration officer, etc. through their

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[23] The Professional Medical Association in Córdoba (South of Spain) criticised the decision of a regional hospital to hire interpreters claiming that "*No podemos aceptar la falta de privacidad del acto médico, así como el secreto profesional que ha de velar en la relación entre los doctores y los pacientes*" (we cannot tolerate a lack of privacy in the medical consultation or lack of confidentiality between doctors and patients [my translation]). Available at http://www.abcdesevilla.es/hemeroteca/historico-25-09-2007/sevilla/Cordoba/el-colegio-de-medicos-dice-que-el-interprete-rompe-la-privacidad-con-el-paciente_164959294964.html (last accessed May 2008).

> social/institutional position. They are, in effect, the decision makers, initiating the exchange, steering it, closing it down and, often, deciding outcomes. (Mason, 2009, p. 83)

Overall, then, the field of public service interpreting in most countries, including the sub-field of healthcare interpreting, has a low status among other fields, and this may have an impact on the degree of economic and symbolic capital available to agents in the field (Bolden, 2000; Davidson, 2000, 2001).

3.1 Assessing the stakes of the field: linguistic vs. cultural capital

Despite the power invested in interpreters as the only agents in the interaction whose knowledge and skills allow the other agents to communicate effectively with each other, it is not an easy task to define the specific capital of public service interpreting. The prestige-endowing stakes available to interpreters are difficult to identify due to the lack of institutionalised boundaries and the variable internal structure of the field, and a habitus that changes according to the circumstances of the setting where the interpreting act takes place (e.g. healthcare institutions, police stations or courts of justice). However, as already mentioned, interpreters working in healthcare institutions often align with institutional agents in order to gain prestige as shown by previous studies carried out in the US (see Bolden, 2000; Davidson, 2000; Hsieh, 2007). By aligning with doctors, interpreters become institutional agents who share the symbolic power and authority invested in doctors. According to Baraldi and Gavioli, whose research was carried out in Italy, (2008, p. 6; emphasis in the original), interpreters position themselves as members of a prestigious in-group which gives "relevance to the 'voice of medicine' and the contextualisation of medical culture". Blanton *et al.* (2000) argue that aligning with in-groups (e.g. doctors) confers greater social prestige than aligning with out-groups (e.g. foreign patients). In order to position oneself as part of a group, it is necessary to adopt the discourse and moral systems that place oneself as a member of that group (Davies & Harré, 1990); particularly, in healthcare settings interpreters may achieve this by adopting the 'voice of medicine'. That is to say, by aligning with institutional agendas.

As well as the symbolic capital that healthcare interpreters may occasionally share with institutional members, there must be other forms of

capital available to them, especially since interpreters do not always align themselves with doctors. Indeed, as Valero Garcés and Gauthier Blasi (2010, p. 111) mention with reference to the Spanish context, interpreters may also at times align with patients, perhaps because they share their cultural background, and despite the fact that such alignment offers no economic benefits.

Economic capital is often a strong motivation for agents in many fields, but arguably not a specific stake worth struggling for in the field of public service interpreting in many countries. In the specific case of Spain, the main reason for the poor remuneration of the interpreter's activity is a lack of awareness among public services and institutions of the need for this service in a society that is undergoing fast demographic changes and that is receiving increasingly heterogeneous groups, with different degrees of labour, economic, and social stability (Andión Herrero, 2006). As explained in Chapter 1 (see section 6), in order to acquire a high degree of attitudinal autonomy, it is necessary to promote the interpreting activity among the community in order to achieve recognition and legitimisation of the field-specific capital that can be transformed into symbolic capital (Forsyth & Danisiewicz, 1985). Here, linguistic capital may assume greater importance than cultural capital, in its institutionalised form, and be presented as an essential asset in cross-cultural communication that only public service interpreters can provide. However, the field of public service interpreting has somewhat failed to promote awareness of its expertise. In some countries, such as Spain among others, there is some awareness of the importance of using public service interpreters in cross-cultural encounters (i.e. healthcare and court settings), but the budget available is generally too low to hire interpreters trained in public service interpreting (Bischoff & Loutan, 2004; Clifford, 2004; Navarro Montesdeoca, 2006); sources of funding are often uncertain and either arrive late or not at all (Edwards *et al.*, 2005, p. 78). Indeed, some institutional authorities consider that interpreters' expertise and knowledge, as forms of cultural and linguistic capital, are not as valuable as doctors' expertise, and tend to position interpreters at the same level as cleaning staff within the institutional hierarchy, as evident in Navarro Montesdeoca's case study. For example, even though most interpreters employed by the *Ministerio del Interior* (Spanish Home Office) have a degree in translation and interpreting, they are paid as secondary school

graduates (Navarro Montesdeoca, 2006). [24] As Clifford (2004) explains, with reference to the Canadian healthcare system, the low status of the public service interpreter and the poor financial remuneration offer very little incentive to trained interpreters to work for administrative bodies, such as healthcare institutions, police stations or judicial courts, as public service interpreters. Therefore, most trained interpreters opt to work in other more prestigious and better paid fields such as conference interpreting. Consequently, the administration is often obliged to employ interpreters with very little training.

Since there is very little or no economic capital at stake in the field of public service interpreting, there must be another form of capital that interpreters are interested in acquiring and that confers power (if only temporarily) upon them, a form of capital that interpreters can acquire and convert into symbolic capital and some kind of prestige. According to Sela-Sheffy and Shlesinger (2008, p. 86), interpreters in Israel "tend to borrow from social workers and accentuate empathy and care" in a struggle to gain symbolic capital in the form of social recognition. Indeed, many agents in the field of public service interpreting in Spain are volunteers who offer their services out of altruism and a desire to help those who need their expertise (Marinescu, 2003). Accordingly, most public service interpreters who enter the field are looking for some form of public recognition for the good they are doing to society, since public service interpreters allow individuals who cannot access public services due to linguistic and cultural barriers to do so in a more egalitarian manner. This social recognition (or social capital) acquired by interpreters can be converted into symbolic capital, which, according to Monzó (2009), is one of the main focus of the field of public service interpreting together with economic capital.

Another issue which has not yet been adequately investigated is the dichotomy between the cultural and linguistic capital of public service interpreters, and the question of which form of capital may be deemed more essential to providing a quality service. The literature on this matter cites many examples of public service interpreters who enjoy only one form of capital, either linguistic or cultural, and how this tends to have a negative effect on the interaction. Lack of specific forms of linguistic capital is recognised as a problem in the literature but less so by service providers who hire interpreters. In a case studied by Rudvin (2006) in Italy, it was impossible to find an interpreter for

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[24] In Spain, a degree in translation and interpreting is equivalent to a four-year degree. In addition to undergraduate degrees in translation and interpreting, several universities offer master degree courses and other short courses in public service interpreting.

Kurdish female patients. The service provider then decided to hire an interpreter who spoke Farsi, the patient's second language. The negative psychological effects of using the language of the patient's oppressor during the consultation were tremendous. Furthermore, Alexieva (1997) mentions that it is not uncommon in public service settings, in countries such as Bulgaria, to use a language such as English, which is known to both the interpreter and the patient but which is not necessarily the patient's mother tongue. Navarro Montesdeoca (2006) explains that interpreters in a detention centre in Spain were only trained in English and French, languages that most immigrants held at the centre did not understand. Moreover, in those cases where interpreters could speak the immigrants' language, they had not received any training in interpreting. These interpreters found that doctors and police alike were very often reluctant to trust their professional expertise, and the lack of cooperation between the two parties typically resulted in communication failure. In a different scenario, the hospital interpreter did not speak the patients' language, since she was trained in English and German but she was interpreting for Polish doctors, working at a Spanish healthcare institution, with very limited English proficiency (Aguilar, 2008). The hospital had decided to hire the interpreter because she had a degree in translation and interpreting, completely ignoring the importance of linguistic capital.

The academy, on its part, continues to play an important role in delimiting the forms of linguistic capital available to interpreters and their value. Martin *et al.* (2003) point out that trained interpreters employed to work as public service interpreters in Spain have a degree in translation and interpreting and are usually trained in Spanish, English, French and German. However, the majority of immigrants arriving in the South of Spain come from African countries or Eastern Europe and have different linguistic requirements. According to Marinescu (2003), there is no interpreting training available for languages other than European languages in Spanish universities. Mayoral Asensio (2003, p. 129) argues that the lack of training in Spanish institutions in the so-called *lenguas exóticas* (African and Eastern European languages) is perpetuating a situation where the degree of professional organisation of public service interpreters working for certain sectors of the population (specifically illegal immigrants or asylum seekers) is much lower than for those who work with European languages and hence for other sectors.

On the other hand, as demonstrated in other studies, interpreters are sometimes hired exclusively on the basis of their linguistic skills, ignoring the fact

that professional training in interpreting and a certain type of expertise are necessary in order to provide a high quality service. For example, Angelelli (2006), who studied the situation of healthcare interpreting in the area of Los Angeles and San Diego, explains that hospitals very often use bilingual healthcare staff to interpret for patients. These staff members often became confused and unable to differentiate their role as healthcare staff from their role as interpreters. Moreover, using bilingual staff because of their linguistic capital instead of trained interpreters implied that anyone who could speak the patient's language could have the necessary skills and expertise to act as a public service interpreter, resulting in a low perception of interpreters' specialised knowledge (Angelelli, 2006). In a similar study of the advantages and disadvantages of using trained and non-trained interpreters in healthcare settings, Giordano (2007) found that non-trained interpreters, including friends and family, do not have the necessary cultural capital (i.e. professional expertise and training) to provide an accurate service and may be somewhat constrained by their relationship with the patient.

It seems that there is consensus in the literature that public service interpreters must be competent not only in languages, but in the "domain knowledge of an institutionalised communicative situation" (Jiang, 2007, p. 3). In practice, according to Robb and Greenhalgh (2006) and Hsieh *et al.* (2010), public service interpreters with linguistic skills, knowledge of the healthcare system and a commitment to confidentiality are indeed highly regarded by hospital staff and more likely to gain the trust of the service provider. And yet, much of the literature also reports recurring practices in which only one or the other capital is deemed relevant and sufficient from the perspective of service providers.

3.2 The Public service interpreter's habitus: in-between service providers and service users

As pointed out above, the public service interpreter's position shifts constantly along the continuum of neutrality and advocacy (Alexieva, 1997; Beltran Avery, 2001). Public service interpreters are often expected by service providers to place themselves in an invisible position in the consultation room, while constantly moving in and out of the interaction without being considered real participants (Hsieh, 2004). Despite institutional expectations and their own awareness of their conduit role, interpreters may sometimes negotiate their boundaries and their position. Due to this lack of agreement as regards their position and the necessary

skills required of a public service interpreter, it is difficult to talk about one single interpreting habitus. In healthcare settings, in particular, the dispositions inherent to the interpreter's habitus enable interpreters to position themselves in such a way as to facilitate communication between doctors and foreign patients effectively and to promote "cross-cultural adaptation between medical systems and linguistic and cultural minorities, building new shared cultural presuppositions as a 'third culture'"[25] (Baraldi, 2009, p. 123; emphasis in the original). In order to achieve this, interpreters attempt to locate themselves within the positions that are already available in the field. This section looks at the different agents in the field of public service interpreting and their influence on the interpreter's habitus and positioning. The demands, expectations, perceptions and position of other agents may have an impact on the positions and strategies adopted by interpreters in each particular situation and setting. Therefore, a review of different types of interpreting positions (or tendencies) identified by other scholars in the field should help to reconstruct the habitus of the public service interpreter.

There is a wide variety of agents to take into consideration when reconstructing the field of public service interpreting and the interpreting habitus. The most relevant of these are service providers and service users. Service providers such as doctors, lawyers, administrative officials and police officers are situated at the powerful end of the interaction due to their possession of a certain level of cultural and social capital, as well as their symbolic capital in terms of the legitimisation by society at large of the other forms of capital they hold. Service users such as patients, asylum seekers, immigrants, tourists and expatriate citizens, on the other hand, are situated at the weaker end of the interaction due to their lack of linguistic capital (they do not speak the national language), and, in most cases, social, cultural and economic capital. Therefore, different types of service users will have more or less access to social and cultural capital, depending on their socio-economic background. Tourists and some foreign residents will potentially have a great deal of economic and cultural capital, unlike economic and undocumented migrants.

In healthcare settings, and particularly in the two case studies that inform this thesis, the main agents to take into consideration are doctors, interpreters and patients. Although there are other agents such as nurses, administrative

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[25] According to Casmir (1993, p. 411), a 'third culture' is the result of the negotiation between two individuals who, initially belonging to two different cultures, have to (re)negotiate their attitudes, values and believes in order to achieve an understanding with one another.

staff, patients' families and interpreting agencies who also interact with doctors, interpreters and patients, this study places more emphasis on the latter groups as they are usually the only agents who are present during interpreted medical interviews, where the group of interpreters examined in this study habitually work. The discussion thus starts by looking at the profile of service providers. Subsequently, it moves on to examine the profile of service users, with particular reference to the South of Spain, where the current study was conducted. This is followed by a description of the different agents acting as interpreters in the field of public service interpreting. Finally, I attempt to analyse the impact of service users and service providers on the interpreter's position and therefore on the interpreter's habitus.

In terms of **service providers**, in most countries the power of the medical profession is based on the "expert knowledge" and "increasingly powerful social position" held by its members (Robb & Greenhalgh, 2006, p. 436). The position of doctors provides them with authority, power and control over the medical interview, and this means that they can overrule interpreters and ignore their advice (Hsieh *et al.*, 2010, p. 3; Hsieh & Kramer, 2011, p. 28). In addition, doctors' expertise is generally more valued than the type of expertise that allows interpreters to negotiate the linguistic and cultural barrier separating service provider from service user (Hsieh, 2006). According to Hsieh (2006), this means that the position of interpreters is rarely acknowledge in healthcare consultations since the service provider's agenda tends to be the focus of triadic healthcare encounters. In practice, this means that

> the power-hierarchy within the health care system, the interpreter's outsider status, the limited numbers of patients with LEP [Limited English Proficiency], and the pressure to conserve the provider's time all present difficulties in establishing a space dedicated to interpreters (Hsieh, 2006, p. 726)

Despite acknowledgement of the authority of doctors (Hsieh & Kramer, 2011, p. 38), having to rely on a (less powerful) agent, the interpreter, in order to communicate with patients means that medical professionals have less control over the consultation than they would wish (Haffner, 1992). Consequently, Robb and Greenhalgh (2006, p. 453) argue that the medical professional has no option but to trust the interpreter's "competence and commitment", however reluctantly. The literature identifies several ways in which medical professionals can lose

control over the interaction (see Aranguri *et al.*, 2006; Bolden, 2000; Hsieh, 2006; Hsieh & Kramer, 2011). In some studies, researchers found that sometimes interpreters become so familiar with the medical interview and the "voice of medicine" (Bolden, 2000, p. 396) that they position themselves as experts initiating questions that have not been asked by the service providers and answering questions asked by patients without passing this information onto the service provider (Aranguri *et al.*, 2006; Bolden, 2000; Hsieh, 2007). However, although service providers must rely on public service interpreters during bilingual medical consultations, research has shown that medical professionals strive to maintain control of the interaction and monitor interpreters' intervention despite the fact that they do not understand the patients' language (Hsieh, 2010; Hsieh & Kramer, 2011). For example, service providers may challenge an interpreter's performance if they feel that the interpreter is not being faithful or neutral by observing the difference in the length of their intervention and the interpreter's, or by paying attention to certain words that may sound similar in both languages (Hsieh, 2010). Some studies have shown that doctors are often unwilling to trust interpreters completely (or do so only reluctantly) and frequently insist on neutrality and word for word translation (Leanza, 2005; Phelan & Parkman, 1995; Robb & Greenhalgh, 2006). Hsieh *et al.* (2010, p. 173), however, have shown there are four dimensions of the interpreting activity through which interpreters can gain service providers' trust: interpreting competence, shared goals, professional boundaries, and established patterns of collaboration. In consequence, the position of the interpreter is consequently unstable and shifts constantly, depending on the situation and strong demands and expectations of the interpreter's performance on the part of medical professionals (Clifford, 2004). The case studies examined in Chapters 4 and 5 reveal the same factors at play as those identified in the literature (see also Martin, 2006; Mateo Alcalá, 2005). The current study, like previous research, thus highlights the precarious position of healthcare interpreters within the institutional hierarchy of the healthcare system.

In terms of **service users**, and focusing on the South of Spain as a case in point, examination of existing literature and governmental statistics on immigration in the region allows us to identify four sectors of patients who require the assistance of an interpreter to access healthcare services. These groups are identified in the literature as follows: the first group consists of foreign residents and tourists mainly from Western Europe and other Western countries; the second group consists of economic migrants from eastern European countries; the

third group consists of documented economic migrants from developing countries with residence permits; and the fourth and final group consists of undocumented economic migrants from developing countries without residence permits (Andión Herrero, 2006; Santamaría, 2002; Solé & Lurbe, 2006).

Based on socio-economic status, these four types of service users can be classified into two distinct groups. The first group, consisting of foreign residents and tourists from Western Europe and other Western countries, are endowed with sizeable economic and social capital; they leave their countries of origin out of choice, and they are a privileged group (Andión Herrero, 2006). Resident members of this group are known as *inmigrantes sociales* (social immigrants) (Navaza *et al.*, 2009, p. 141). Tourists are seasonal visitors and there is a higher influx of them particularly during the summer (Rodríguez *et al.*, 2008). Since there is the perception that tourism boosts the country's economy, tourists are appreciated by the Spanish population on the whole (Rodríguez *et al.*, 2008, p. 51). On the other hand, foreign residents remain in the country throughout the year and have a relatively strong economic status: they are either retired and have transferred their pensions to Spain in search of a warmer climate; or they have a stable job as language teachers or as qualified workers, usually in multinational companies (Solé & Lurbe, 2006, pp. 41-43). They often own a home in Spain and have high negotiating power with authorities; most enjoy full access to social services due to their legal status as EU citizens, and have the same privileges as any Spanish national (Solé & Lurbe, 2006, p. 109). An example of this sector would be British and German residents and tourists who usually visit and/or live in or around the most touristic areas along the Spanish Southern coast (Rodríguez *et al.*, 2008, p. 45). One important feature of this group is the similarity between their country of origin and Spain in terms of social and healthcare services, which facilitates their access to public services, particularly in healthcare (Rodríguez *et al.*, 2008). They are usually treated positively as a group due to their socio-economic status, although very often their familiarity with the Spanish language and culture is limited and they tend to live in expatriate compounds where they never have to learn Spanish or adapt to Spanish culture (Solé & Lurbe, 2006, p. 81). Additionally, this group seems to be more able to find the resources to overcome linguistic barriers since they have the necessary economic and social means to do so (Solé & Lurbe, 2006, p. 138).

A large sector requiring interpreting services consists of economic migrants who have come to Spain in search of a job and better social conditions (Ramos *et*

al., 2001). This group is composed of three main sub-groups: immigrants from Eastern Europe who have legal status and a residence permit, documented economic immigrants from non-European countries (mainly North Africa) with a residence permit, and undocumented economic immigrants from non-European countries (also mainly North Africa) without a residence permit (Solé & Reyneri, 2001, p. 149). This group is the most difficult to assist because they lack linguistic skills in Spanish as well as familiarity with the Spanish culture and the functioning of social and healthcare services; the cultural distance between this group and the host country is larger than with the first group of Western Europeans and other Western countries (Ramos *et al.*, 2001, p. 325). Within this group it is important to distinguish between documented and undocumented immigrants, because depending on their legal status they may or may not have easier access to public services (Jansá & García de Olalla, 2004, p. 208). The two sub-groups of immigrants with a residence permit (Eastern Europeans and North Africans) are privileged within this group, since they have a legal status within the country and are entitled to receive help from governmental organisations. They are socially visible and usually hold working contracts and enjoy healthcare benefits (Andión Herrero, 2006). They may have a high level of education, but this form of cultural capital is not valued in their case and they often take non-qualified jobs with little economic remuneration and poor working conditions. Although this group is not perceived by the wider community as positively as the first group (the expatriates and tourists), they have the same rights as any other citizen and their access to social services must be facilitated (Solé & Lurbe, 2006, p. 86). They thus have some relative negotiating power. These two sub-groups with a residence permit suffer from a certain level of social discrimination and prejudice, and their integration within Spanish society is relatively slow and hampered (Solé & Reyneri, 2001). The most representative nationalities here are Rumanians, Bulgarians, Moroccans and Algerians (Rumí Ibáñez, 2009). Finally, the least privileged sub-group of all is composed of undocumented economic immigrants without residence permit. This sub-group often comes from conflict zones and underdeveloped countries with a very low economic or social status and a very low level of literacy (Andión Herrero, 2006). The group is hardly visible to the rest of society, and its members usually live under very precarious conditions and are often part of an exploited labour force (Andión Herrero, 2006). They are a marginal group and are highly stigmatised because of their race, culture and religion (Santamaría, 2002, p. 125). Their illegal presence in the country prevents them

from finding a better job and improving their working and life conditions. They are only entitled to basic healthcare assistance, with the risk that if they are reported to authorities they may be sent back to their countries (Solé & Lurbe, 2006, p. 86). They have no negotiating power and are negatively perceived by Spanish nationals (Solé & Lurbe, 2006, p. 110). They come mainly from African and sub-Saharan countries such as Morocco, Algeria, Nigeria and Senegal (Rumí Ibáñez, 2009).

3.3 Agents acting as interpreters in the Spanish healthcare system

Given the diversity of agents who require the service of a public service interpreter, a very wide range of languages is inevitably needed. However, the availability of languages in the field of public service interpreting is somewhat limited, particularly where institutions require trained interpreters (Ramos *et al.*, 2001, p. 325).

Since it is not possible to find public service interpreters with the adequate linguistic capital to cater for certain service users, authorities very often have to turn to volunteers, relatives, friends or bilingual staff who lack any type of training as mediators (Campos López, 2005). This has become a major issue for the profession and also for service users, because the authorities have become accustomed to using unremunerated amateur interpreters. It seems then that Spanish public services are saturated with volunteers, relatives and friends, and there is little space for paid interpreters with training in translation and interpreting to negotiate and influence the structure of the field (Campos López, 2005).

Four types of agents acting as interpreters have been identified in the existing literature on public service interpreting:

Bilingual staff: Phelan and Parkman (1995) explain that using bilingual staff as mediators in Ireland reduces patients' unease during the interaction by avoiding the presence of the interpreter. However, bilingual staff in the US context find it difficult to separate their role as healthcare professionals from their role as interpreter, and this may lead them to make assumptions about patients'

conditions based on their medical expertise and answer questions on behalf of patients, forgetting their role as interpreters (Angelelli, 2006).

Ad hoc interpreters: although some researchers, such as Edwards (2005), have found that patients feel comforted by having friends or relatives acting as interpreters, using friends or relatives can have very negative consequences for the interaction and outcome of the consultation (Phelan & Parkman, 1995). When friends or relatives are used as interpreters, patients may not be as forthcoming about their symptoms or concerns. At the same time, friends or relatives may decide to suppress some information to protect the patient's feelings or because they feel they are entitled to act on her/his behalf in the UK context (Rosenberg *et al.*, 2008). Moreover, this practice may result in breaches of confidentiality and undue extra pressure on family members (Temple, 2002).

Volunteer interpreters: volunteers are often found through organisations that have been created to support and help immigrants (Martin, 2006; Mateo Alcalá, 2005; Valero Garcés & Cata, 2006) in the Spanish context. In the Málaga area we find the *Asociación de Intérpretes Voluntarios para Enfermos* (Association of Volunteer Interpreters for Patients), which provides interpreters to local healthcare institutions. Service providers may place little expectations on volunteer interpreters as regards their degree of training and professionalism—as defined by the professional interpreting community—given that these interpreters may have not received any formal training and may lack awareness of issues such as medical confidentiality, impartiality and neutrality (Phelan & Parkman, 1995). However, some volunteer interpreters may develop awareness of the requirements of the profession through practice and provide an adequate service in time (Valero Garcés, 2003).[26]

Paid interpreters: service providers may place expectations as regards the degree of training and involvement of paid interpreters, as indicated by professional guidelines in relation to neutrality and impartiality (Rosenberg *et al.*, 2008). According to Hsieh and Hong (2010, p. 192), paid interpreters are trained to occupy a "default role", namely the conduit model in the US context. However, Rosenberg *et al* (2008) have shown that paid interpreters usually adopt positions

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[26] In these two hospitals which provide the setting for the current study only volunteer interpreters have been identified.

as active participants in the interaction and go beyond their expected position of language conduits.[27] According to Phelan and Parkman (1995), those interpreters that have received some form of professional qualification may be able to balance the asymmetric power relationship between doctor and patient and mediate the interview successfully. Paid interpreters may also be aware of other issues such as confidentiality, have the necessary skills to overcome cultural barriers and avoid patients' discomfort with regard to certain health issues which may be taboo for certain cultures (Rosenberg *et al.*, 2008).

3.4 *The effect of the diversity of agents on the interpreter's habitus*

The diversity of agents interacting with the public service interpreter, as well as the variety of languages required are important factors to be taken into consideration in reconstructing the field of public service interpreting and identifying an interpreting habitus. Cultural and linguistic proximity to the service user may have an impact on the interpreter's position as perceived by service providers, who generally consider themselves the lead interactants in these interpreted communicative events and place the interpreter and the patient in the same position (Hsieh, 2010). Moreover, interpreters are generally perceived by service providers as members of the out-group, as allies of people of other cultures or nationalities with lower socio-economic status (Miguélez, 2003).

The uncertainty surrounding the position of the public service interpreter has led some scholars to propose a range of roles that different interpreters may assume in different contexts (see Kaufert & Koolage, 1984; Leanza, 2005). Merlini (2009, p. 65) offers the following classification: "translator", "active translator", "cultural informant", "advocate", "culture broker" or "cultural mediator", "bilingual professional", "monolingual professional", "welcomer" and "support". Interpreters may thus position themselves along a continuum between involvement and non-involvement, and adopt one of the positions available depending on the circumstances of each interpreted event and the kind of capital they seek to acquire (Alexieva, 1997; Beltran Avery, 2001).

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[27] Rosenberg *et al.* (2008), Hsieh and Hong (2010) and Hsieh *et al.* (2010) use the terminology "professional interpreters" to refer to paid and trained interpreters (as opposed to family members who are non-trained interpreters). However, to avoid confusing the reader, I retain the term paid interpreters in opposition to volunteers, and trained interpreters when highlighting their degree of training.

Some of the constraints imposed on the interpreter are related to the expectations of the institution for which they work, the expectations of patients, the interpreter's own view of her/his position as mediator, the institutional hierarchy and its regulations, and the working environment (Hsieh, 2004; Rudvin, 2007). Moreover, as well as institutional constraints, there is a tension between the professional role of interpreters and their desire to serve patients to the best of their abilities, on the one hand, and the service provider's desire to control the interaction, on the other (Rosenberg *et al.*, 2008).

According to Merlini and Favaron (2003), this struggle over the control of the interaction leads us to question whether it is possible to expect interpreters to act as invisible parties in a triadic encounter where they have to be present and are the only agents who know both the service provider's and the service user's languages and cultures. As Roberts explains,

> in the absence of commonly accepted standards of practice, the interpreter's task definition may be situated anywhere along the spectrum between those who would limit the interpreter's role to that of linguistic conduit or "language converter" and those who regard cultural brokering or advocacy as an integral component of the interpreter's role. (Roberts, 1997, p. 15; emphasis in the original)

Sela-Sheffy and Shlesinger (2008) argue that it is important to legitimate the different strategies and positions adopted by interpreters in order to achieve a successful understanding of their role and to offer a quality service. This legitimisation is related to the interpreter's active participation (Rosenberg *et al.,* 2008); the effect of the interpreter's knowledge on the dynamics of the interaction (Wadensjö, 1998); the interpreter's right to manage the interactive process by means such as turn-taking (Roy, 2000); the solidarity and cooperation between the interpreter and the service user (Pöllabauer, 2004); and the interpreter's responsibility for ensuring successful communication (Jiang, 2007).

Depending on the strategies available to and adopted by the interpreter, the interpreter's role can be classified into one of the following categories: "conduit", "advocate" or "professional" (Hsieh, 2008, p. 1370). Although different scholars refer to these categories using different labels, the idea is that interpreters can move along the continuum between an active (visible) and a passive (invisible) role. In the conduit role, interpreters are perceived as mere conveyors of messages and provide a word-by-word translation of utterances (Wadensjö, 1998). Acting as 'conduit' often leads to role conflicts between the

expectations of interpreters' and other agents' (Hsieh, 2007). In the role of advocate, the interpreter assumes a more active position with the aim of empowering service users and diminishing the asymmetric power relation existing between service user and service provider (Hsieh, 2008). As 'advocates', interpreters tend to negotiate, mediate and reconcile different positions, but more typically they assume the responsibility of intervening on behalf of the service user (Temple, 2006). As 'professional' interpreters, they are aware of confidentiality issues and the importance of maintaining the boundaries of the interaction, the importance of establishing cooperation and gaining service providers' trust, and the need to have as their main goal the achievement of successful communication (Hsieh, 2008, p. 1367). Chesterman (2007) argues that there must be an optimal point along the continuum between conduit and advocate where paid/professional interpreters should ideally position themselves. This point is where interpreters can adapt the pre-established interpreting norms to each particular context and situation.

Given the impact of service users, the power exerted by service providers, and the different forms of capital available to them, interpreters may adopt a position along the active vs. non-active continuum that includes the positions mentioned above. It is thus very difficult to establish one exclusive interpreting habitus that characterises agents in the public service interpreting field. Depending on language, setting and agents' expectations, interpreters may move from a more passive to a more active position. We might then argue that an interpreting habitus consists of a range of tendencies and preferences of agents that vary in relation to different aspects of their role, and that are susceptible to be influenced by external circumstances and internal dispositions including other agents' expectations, pressure from service providers, issues of hierarchy, available interpreter training, language skills and specialist knowledge (as internal dispositions). In order to examine the habitus of the public service interpreter then, it is necessary to observe each individual case and analyse the circumstances and dispositions that lead interpreters to develop some tendencies and preferences over others. As Bourdieu warns (see Chapter 1, section 7), it is important to avoid making crude generalisations on the basis of limited data. The two case studies examined in this thesis provide data that will allow us to make some observations about the functioning of the field of public service interpreting in healthcare settings, without lapsing into robust generalisations, about

healthcare interpreting in general or the broader field of public service interpreting.

4 Concluding remarks

This chapter has offered a comprehensive review of the scholarly work published in the field of Translation Studies most relevant to the sociological turn of the discipline with an emphasis on public service interpreting. The main arguments as regards the existence of a field of public service interpreting from a Bourdieusian perspective were outlined and examined. This discussion led to the reconstruction of the field of public service interpreting in relation to healthcare settings; this reconstruction was based on previous conceptualisations of the field by other scholars and the different forms of capital, interpreting habitus and types of agents identified in these works.

This chapter has therefore suggested that it is possible to frame the broad field of public service interpreting in healthcare settings as a Bourdieusian field. Moreover, the existence of a zone of uncertainty within the field of public service interpreting, as discussed by Inghilleri (2003) with reference to the British asylum context, may potentially lead to its transformation. The analytical chapters that follow will attempt to describe the sub-field of healthcare settings in the South of Spain in greater detail, taking the field as it comes, as Bourdieu (1992) has suggested.

Chapter Three

Methodological triangulation of focus groups, participant observations and audio-recordings of interpreted interaction

1   Introduction

This study offers a detailed analysis of the positioning of volunteer interpreters in two Spanish healthcare institutions based on a wide range of data—participant observations, interpreter-mediated interaction and focus-group discussions. The core data is the output of focus-group discussions, but where relevant I will draw on the other two sources of data, i.e. participant observations and recorded interaction, to illustrate additional aspects of the positioning of volunteer interpreters within the field of healthcare interpreting.

This chapter offers an overview of the methodology used in this study. It starts with an introduction in section 2 to the three types of data—participant observations, audio-recorded interpreter-mediated interaction and focus-group discussions—on which the analyses offered in subsequent chapters are based; it also highlights the benefits of data triangulation. Section 3 outlines the procedure followed in collecting the different types of data step by step, including a discussion of the appropriateness of a pilot study for this particular research project, and a detailed description of how I developed the questions for the focus groups. This section also discusses the ethical considerations arising from the use of all three different types of data. Additionally, section 3 offers a description of the transcription conventions used and the procedure followed in the data analysis stage.

2   Triangulation of data: participant observation, interpreted interaction and focus groups

Triangulation allows the researcher to draw a more reliable and richer picture of the field and to better understand the phenomenon under investigation (Alves & Gonçalves, 2003). According to Munday (2009, p. 237), triangulation is "a multi-methodological perspective which aims at explaining a given phenomenon from

several vantage points combining quantitative and qualitative methods". The main principles behind triangulation are reliability and validity, since using the strengths of one method to offset the weaknesses of another allows the researcher to minimise methodological bias and construct a stronger research design (Jakobsen, 1999). Flick (1992, p. 194) counters postmodernist criticisms of validity and reliability by explaining that "there is no one reality against which results can be verified or falsified, triangulation gives access to different versions of the phenomenon". Validity and reliability are thus relative notions which allow researchers the possibility of securing relatively unbiased data with a certain degree of assurance (Mathison, 1988).

Triangulation may involve a combination of different types of data, different types of methodological approaches, different researchers and different points in time and space (Flick, 1992). In Translation Studies, several authors have addressed the issue of triangulation, particularly in the investigation of translation technology (see Alves, 2003, 2007; Alves & Vale, 2009; Jakobsen, 1999, 2003, 2006). Jakobsen (1999, 2003, 2006) has made use of triangulation of different data-elicitation methods such as Translog and other protocols in order to investigate issues related to translators' performance and translation strategies. Alves and Gonçalves (2003) and Alves and Vale (2009) also collected data using different translation protocols among a number of translators to study some cognitive aspects related to segmentation and source text-target text relationship. In Interpreting Studies, Gile (2005) made use of triangulation of different methodological tools—observations of translation products through introspective methods, recordings, transcripts and observations—in order to investigate interpreters' decisions from a variety of angles.

Jakobsen (1999) and Sands and Roer-Strier (2006) suggest a combination of approaches to data collection in order to obtain a more comprehensive picture of a given field; this may include the use of interviews, participant observation and recorded data. In the current project, I resorted to three qualitative research tools instead of a combination of quantitative and qualitative approaches. While focus-group discussions provide access to the perceptions of volunteer interpreters, recordings of actual interpreter-mediated interaction and participant observations offer contextual data that is authentic but constrained by the presence of an audio-recording device and the researcher. As Bryman (2004, p. 1142) explains, "for practical reasons one type of methodology will be usually primary in any research study but all research will benefit from an additional method"; the

primary source of data in this study is focus-group discussions. Complementing this primary data with recorded interaction and participant observation should provide a more enriching and reliable description of the field.

2.1 Participant Observation

Participant observation is an ethnographic method of data collection that relies on the researcher not merely observing interaction but also taking part in the field as a member of the group (Hammersley & Atkinson, 2007, p. 15). This methodological tool is appropriate in research areas where access to the field and opportunities for observing field interaction are limited for ethical or other reasons (Jorgensen, 1989, p. 21), as is the case in healthcare settings, such as the one under investigation, where patient confidentiality and privacy can be threatened by the presence of a researcher (Carnevale *et al.*, 2008). In order to ascertain whether participant observation as a tool for collecting data is appropriate for a particular research project, it is necessary to consider several issues: whether the action we intend to describe is observable; whether access to the setting is allowed; whether the size and location can be observed by one person; and finally whether the research questions can be answered by the data obtained through this method (Jorgensen, 1989, pp. 12-22). The research questions posed in the current study cannot be exclusively answered by participant observation; therefore, as mentioned above, the decision was made to combine a number of different methods of data collection. Accordingly, the present study draws on participant observation in combination with focus-group discussions; whereas focus groups elicit "researcher-provoked data", participant observation elicit "naturally occurring data" (Silverman, 2009, pp. 245 & 256).

The purpose of participant observation is thus to observe what participants actually do, as opposed to what they say they do – as in the case of interviews and focus groups. Accordingly, participant observation requires the researcher to become involved by engaging with the main activity of the field through informal conversations and establishing a relationship with participants (Jorgensen, 1989). Spradley (1980, p. 56) recommends that researchers adapt their behaviour to that of participants in order to maximise naturalness and avoid exercising undue influence as an external observer. There are thus several ways to undertake

ethnographic observations, depending on the degree of the researcher's involvement in the field.

Becoming involved in the field under research raises its own problems. Researchers may forget the purpose of the observations and fail to stick to their main role as researchers, a challenge specific to participant observation as opposed to other types of observations where researchers do not become involved in the field. It is also important to monitor and moderate researchers' degree of participation so as not to neglect the observational element of this methodology (Spradley, 1980, p. 67). They must remember at all times that they are both insiders and outsiders and must find ways of recording their observations throughout. Keeping detailed records of observations ensures the accuracy and reliability of the data (Silverman, 2009, p. 210). Researchers must thus observe with a purpose in mind according to the study's research questions. Moreover, it is necessary to plan beforehand the level of detail of observations by deciding on the key questions of what, who, when and how and conducting the observation systematically (Bakeman & Gottman, 1997, p. 2).

In order to maintain an organised and manageable system of observations, researchers should avoid writing very long notes during the observation process because this may be counterproductive as it can affect the researcher's focus (Hammersley & Atkinson, 2007, p. 152). Researchers are recommended to note down key words, summaries, drawings and sketches of the observed dynamics and expand on the ideas soon after the session is finished to avoid missing important details (Spradley, 1980, p. 65). Although I tried to keep a detailed journal of observations, it was very difficult to take extensive notes as I was asked to interact and help on a number of occasions; I therefore decided to do audio-recordings of interpreter-mediated interaction—with the consent of the participants' involved—which allowed me to transcribe them afterwards and examine the utterances in detail.

2.2 Audio-recordings of naturally occurring data: interpreter-mediated interaction

Audio-recorded interpreted encounters have been used by researchers in Interpreting Studies to examine aspects of dialogue interpreting (see Angelelli, 2004b; Baraldi, 2009; Bolden, 2000; Davidson, 2000; Hsieh, 2006; Mason, 1999; Pöchhacker, 1999; Pöllabauer, 2004; Roy, 2000; Wadensjö, 1998). According to

Wadensjö (1998, p. 127), audio-recording is less intrusive than video and allows the researcher to actively engage in the event and pay attention to other informational cues that may assist in analysing the interaction. Meyer and Schareika (2009, p. 19) refer to audio-recordings of communicative events as "participant audition" and explain that this is the only methodology where "the ethnographer influences the data produced as little as possible". Moreover, audio-recordings provide dense linguistic information since a recording can be played back as many times as necessary, thus allowing the researcher to change her/his focus as well as compare the information obtained with other collected data (DuFon, 2002). However, audio-recordings do not offer access to any behavioural data such as non-verbal clues nor to participants' own accounts or feelings of the setting, which is why they need to be contextualised by resorting to other ethnographic tools such as observations, documentary and photographic material, as well as the use of focus groups (DuFon, 2002; Meyer & Schareika, 2009).

2.2.1 The researcher's presence during the interaction

It is important to take into consideration the impact that the presence of the researcher and the audio-recording device may have had on the interaction taking place. However, "while research participants may change their behaviours when they know they are being watched or studied, the extended presence of the participant-observer reduces this reactivity by building trust over time, as they become integrated into the setting" (Carnevale *et al.*, 2008, p. 22). Being aware of this aspect while I was in the field, I was determined to build a relationship of trust with participants and to become a member of their group. Although this was not easy at first, as volunteer interpreters were initially reluctant to be observed and questioned by a stranger, I finally managed to integrate myself within the group, to the extent that I was asked to wear a white gown and to interpret on two occasions.

The disruptive effect of the researcher's presence on the validity of naturally occurring data has been discussed by some researchers in Interpreting Studies. Scholars such as Wadensjö (1992), Roy (2000) and Diriker (2004) have acknowledged this issue and have explained that in all real-life related research the presence of the researcher is necessary despite its drawbacks; not being present raises even more problems for research. This "observer's paradox" is discussed by Labov (1972, p. 209) who explains that "the aim of linguistic

research in the community must be to find out how people talk when they are not being systematically observed; yet we can only obtain these data by systematic observation". The observer's paradox can be overcome to some extent. As Wadensjö (1992) explains, individuals in these types of encounter have a very specific agenda and expectations, and hence it is unlikely that the interaction is affected to a detrimental extent by the presence of the researcher and the audio-recorder. Roy (2000) also argues that face-to-face interaction is complex and requires the participants' full attention; this means that participants forget about the presence of the researcher and audio-recording device after a while. This is particularly true if we consider that this type of encounter already features an external agent, the interpreter, who is not perceived as a primary interactant.

The main subjects under research, volunteer interpreters, are likely to be less apprehensive about being observed since their main concern is not their professional image but rather their contribution to society. As will be discussed in the coming chapters, volunteer interpreters are more concerned about being sympathetic and helpful than other groups of interpreters previously studied by other scholars. Also, in order to further minimise the impact of the audio-recording device and the presence of the researcher, I situated myself as far as possible from the dyadic and triadic exchanges taking place, sometimes to the detriment of audio quality.

2.3 Focus groups

Focus-group discussions are gaining increasing popularity as a research methodology in a variety of academic disciplines outside the social sciences, where the methodology continues to be used extensively and is formally taught as a research tool (see Kitzinger, 1995; Rabiee, 2004). These include public health, an area which is closely related to the topic of the current study. Although this methodology was not actively used by Pierre Bourdieu—whose theory provides the main theoretical framework for this thesis—focus-group discussions offer the possibility of collecting a large amount of data in a relatively limited period of time. They are particularly helpful in the case of the current study, which aims to understand participants' attitudes, beliefs and feelings, and to account for the self-perception of volunteer interpreters in relation to their own positioning within the field. According to Morgan (1997, p. 45), "the hallmark of focus groups is their

explicit use of group interaction to produce data that would be less accessible without the interaction found in a group". The use of focus groups involves conducting "in-depth group interviews in which participants are selected because they are a purposive, although not necessarily representative, sampling of a specific population, this group being 'focused' on a given topic" (Thomas *et al.*, 1995, p. 207; emphasis in the original). The group is described as focus because they do an activity together, such as discuss a particular issue, talk about a product or read a magazine (Greenbaum, 1998).

Similarly to this research project, some researchers have used focus group methodology in combination with Bourdieu's theoretical framework to explore concepts such as field and habitus in other academic disciplines (Merryweather, 2010; Pavlidis, 2009). Most studies adopting a qualitative approach use focus groups in combination with other data-gathering methodologies such as one-to-one interviews and participant observations. Although focus groups have not been extensively used in Translation Studies, some studies have resorted to this methodology to investigate issues pertaining to the role of translators and interpreters in different settings. This small number of scholars has used focus groups either exclusively or, mostly, in combination with in-depth interviews or other ethnographic methods such as surveys.

One of the most extensive studies in the field of Translation Studies based on data from focus groups was carried out by Kaisa Koskinen in 2008; she combined focus group data with institutional ethnography and observations of an EU translators' unit. Her aim was to explore the organisation and professional identity of the translators at the Finnish unit of the EU. Like the current study, she set out to investigate both texts and the people who produce them. Koskinen's study also shares other similarities with the current project: as a moderator of the focus groups she was familiar with the setting and the topic; she had had no previous training in conducting focus-group discussions; and the participants involved in the focus-group discussions already knew each other. These three aspects also define the present study. I have worked as a healthcare interpreter and I am familiar with the situation of public service interpreters in the Spanish healthcare system; I am a non-trained moderator of focus-group discussions; and participants taking part in my focus groups knew each other beforehand as colleagues in the same interpreting team at the same hospital. Koskinen (2008) acknowledges that focus groups were the most adequate tool to investigate issues of identity among the EU translators since they allowed her to take a step back

from her own position as an insider and learn more from other people's experiences. As in the current study, she also recognises that her position as both researcher and insider exercised some influence on the elicited data.

Another pioneer scholar who used focus groups specifically in public service interpreting is Elaine Hsieh, who has carried out several studies in the US healthcare context, looking at aspects of communication and collaboration between healthcare providers and interpreters (see Hsieh, 2004, 2010; Hsieh & Hong, 2010; Hsieh *et al.*, 2010; Hsieh & Kramer, 2011). Hsieh (2004) examined role-related sources of conflict in interpreters' performance using a combination of focus groups and one-to-one interviews with a number of interpreters in healthcare institutions. In 2010, she interviewed a number of interpreters and healthcare service providers, again using a combination of focus groups and one-to-one interviews in order to elicit their perception on the competition over the control of the interaction (Hsieh, 2010). She also investigated issues of trust between healthcare providers and interpreters using the same methodological combination and justified this combination by explaining that some participants could only be involved through individual interviews due to time constraints (Hsieh *et al.*, 2010). This is a problem that I also experienced, as in two of the focus groups carried out the number of participants was significantly reduced (see section 3.3.4 of this chapter).

Other examples of the use of focus groups in public service interpreting are Bancroft's examination of standards of practice for public service interpreters in different settings around the world, where she used different qualitative approaches, including focus groups, to identify documents on interpreters' standards of practice developed and used by different organisations (Bancroft, 2005). Downing *et al.* (2010) used a combination of focus groups with online surveys to develop a series of national standards for public service interpreters by interviewing groups of practitioners and trainers. Angelelli (2006, 2007) similarly made use of focus groups to investigate several issues in healthcare interpreting in the US. Angelelli (2006) looked at interpreters' opinions on existing standards of practice; and later used the same methodology to test some standards of practice that have been specifically designed as part of a test intended to assess interpreters' performance (Angelelli, 2007). She brought together community members, interpreters and healthcare providers to validate these scripts and to analyse the appropriateness of cultural adaptations for each language (Angelelli, 2007).

Finally, Tipton (2010) examined the perception of social workers of the development of trust between them and the interpreters they worked with, and the socio-cultural norms that underlie the relationship between these two groups of agents. Tipton (2010) resorted to focus groups as a tool to investigate social workers' opinions, beliefs and thoughts on the issue of trust and to find out whether changes in the profession of social workers have had any impact on the relationship of trust that has traditionally existed between social workers and public service interpreters in the UK.

To sum up, although not extensively used within translation studies, focus-group discussions have elicited interesting and useful data for a number of research projects. It is also important to point out that focus groups in Translation Studies have usually been used in combination with other methodological tools such as questionnaires or one-to-one interviews (see Hsieh, 2004, 2010; Hsieh & Hong, 2010; Hsieh *et al.*, 2010; Hsieh & Kramer, 2011; Koskinen, 2008; Tipton, 2010). In this particular project, the use of focus groups has been combined with two additional ethnographic methods: participant observations and audio-recorded interpreter-mediated encounters.

2.3.1 Why focus groups in the current project

Focus groups centre on the interaction between participants and group dynamics and have proved a useful tool in interviewing subjects to obtain a large amount of rich data in a short period of time, a considerable advantage for researchers at PhD level where time is strictly limited. This emphasis on dynamics and interpersonal interaction is also an enormous advantage in fields where the research project is not only time-constrained, but also the amount of information available on the topic under examination is limited and the nature of the topic, the setting or the subjects do not allow for large scale studies (Rabiee, 2004). The number of healthcare institutions available for this project is limited to two hospitals and two interpreting teams with a total number of twelve individuals taking part; this is a significant constraint.

Another advantage of using focus-group discussions is that the data that emerges is rich in the expression of opinions, values and beliefs and should reveal participants' feelings on and perceptions of a particular topic (Krueger & Casey, 2000). Focus groups allow researchers to understand why people behave or believe the way they do (Langford & McDonagh, 2003). In this case, they are an

appropriate tool to research the opinions and perceptions of volunteer healthcare interpreters; information can be elicited in a way that allows researchers to find out why an issue was relevant, as well as what was so relevant about it, in a more natural and less intimidating environment (Morgan, 1997).

Some researchers argue that another advantage of focus groups over traditional interviewing methods, such as one-to-one interviews (where the researcher exercises full control), is that they place the researcher in a less powerful position and the data obtained is thus less likely to reflect her/his preconceived ideas (Rice, 1931). This aspect is particularly relevant for the current project, which aims to identify the doxa of the field, enforced by professional associations, in order to understand its dynamics and the positioning of a specific group of interpreters within it. Focus groups mean a shift from the interviewer to the interviewee, since often the conversation happens among participants themselves rather than between participants and interviewer; the interviewer acts mainly as a moderator to keep the conversation flowing (Jordan *et al.*, 2007). As Litoselliti (2003, p. 12) explains, the "open-ended nature" of focus-group discussions "offers the benefit of allowing insight into the world of the participant in the participant's own language". Here, it is important to find a balance between directing participants to talk about the desired topics and exercising too much control and hence compromising the data (Krueger, 1998b).

Finally, one aspect of focus groups that has been previously perceived both positively and negatively is related to the discussion of sensitive or taboo topics (see Kitzinger, 1995; Lee, 2007; Wilkinson, 2004). While some researchers argue that group work can actively facilitate the discussion of taboo topics "because the less inhibited members of the group break the ice for shyer participants and participants can also provide mutual support in expressing feelings that are common to their group but which they consider to deviate from mainstream culture" (Kitzinger, 1995, p. 301), others argue that individual interviews are more appropriate than focus groups to research such issues (Tonkiss, 2004). In the context of this study, sensitive issues included interpreters' submissive position and lack of social recognition, as will be explained in Chapters 4 and 5, which are common among public service interpreters. Participants are more likely to reveal their actual perception and positioning in relation to the doxa of the profession in a discussion than on a one-to-one basis since group discussions can encourage participants as they enter into a more extended exchange (Culley *et al.*, 2007). At the same time, in a field such as public service interpreting where agents occupy

marginal positions and power relations often lead to the disempowerment of interpreters, being valued as an expert in the field and having the opportunity to work with researchers and be involved in something that makes a difference can be a very empowering experience for some people. However, it is necessary to acknowledge that focus groups can have the opposite effect on participants.

3   Data Collection

The data for the present study was collected through participant observation and focus-group discussions involving a group of volunteer interpreters over a period of two years from the point where contact with these two hospitals was initiated. During this period, I carried out four focus-group discussions and observed over thirty interpreter-mediated encounters and daily routine visits, as well as interpreters' daily activity, internal dynamics and organisation. During the participant observation process, I collected a wealth of documentary, photographic and audio-recorded data, which have been organised into a series of appendices included with this thesis on a CD (see section 4.2 in this chapter). The audio-recordings of interpreted interaction and focus groups have been fully transcribed using Transcriber 1.5.0, an open resource for segmentation, labelling and transcribing speech.

3.1   *Carrying out Participant Observation in a healthcare setting*

The collection of data through participant observation was initiated in August 2009 by visiting two healthcare institutions, *Hospital Virgen de la Victoria* and the *Hospital Costa del Sol*, along the southern coast of Spain. The decision to choose these particular healthcare institutions was based on the size of the institution and the geographical area they cover as well as the number of foreign patients they attend to on a regular basis. The two institutions are *hospitales regionales* (regional hospitals) funded by the regional government *Junta de Andalucía* that have a wide coverage of each southern province respectively and provide a wide array of services. Each hospital is managed individually in relation to interpreting services provided. This means that there is no policy with regard to attending to foreign patients, and each hospital organises its own interpreting service according to public demand and financial resources.

Keeping notes of observations has been essential to keep track of all observed encounters and focus groups carried out, including the date, location and a sketch of the seating arrangement of each encounter and interview. Participant observation also allowed me to identify initial ideas and themes that were further investigated through the analysis of the transcripts of focus groups, interpreter-mediated interaction and daily routine visits.

3.1.1 Documentary and photographic data

During the participant observation period, some documentary and photographic data were collected at the Hospital Clínico and the Hospital Costa del Sol. These data are included in the appendices. Documentary data is useful because it is produced within the context where the interaction takes place and sheds further light on that interaction (Clarkson, 2003). However, this type of data has some drawbacks. These documents are produced in a particular field with a particular purpose, and therefore may be interpreted from different perspectives and may be time-bound (Clarkson, 2003). Accordingly, the researcher should make careful use of this data and attempt to establish the interpretation(s) assigned to them by interactants. Some of the documentary data collected has helped to support the conclusions obtained after close analysis of both focus groups and interpreter-mediated encounters, but I have not treated it as primary data.

The documentary data collected includes newspaper articles about the two interpreting teams at the Hospital Clínico and Hospital Costa del Sol and the *Normas Generales* (henceforward the Interpreters' Handbook) of the interpreting team at the Hospital Clínico (see Appendix IV). These articles in local media offer praise to volunteer interpreters by highlighting their work and their contribution to society; accordingly, their symbolic capital is increased in the local community, which may have an impact on their positioning within the institutions. The Interpreters' Handbook is the most important piece of documentary data collected; it contains the code of conduct for volunteer interpreters, written by the interpreting team itself in collaboration with the hospital manager who had the power to veto any aspect of the handbook that may be considered inappropriate, and a detailed account of the tasks that volunteer interpreters are expected to carry out at the hospital. The code of conduct, unlike other codes of conduct found in the field, stresses sympathy and understanding towards patients rather than neutrality or professionalism. It also associates interpreters with a wide

range of tasks, in addition to mediating between doctors and foreign patients. Some of those tasks include supporting patients' families, managing patients' aftercare and paperwork, and phoning patients' families abroad (see Interpreters' Handbook, Appendix IV).

Some of the photographic data consist of photographs of the interpreters' office space and working facilities, ID cards, and other resources such as patients' lists, archives or the patients' library. The most important photographic data is a photograph of the *Libro interno de Incidencias* (henceforward the interpreters' Daily Report Book) which is mentioned in the Interpreters' Handbook (p. 5) and is an essential resource for volunteer interpreters, as discussed in Chapter 5. This Daily Report Book contains interpreters' notes on foreign patients: interpreters note down anything that may be relevant for the next interpreter, such as problems that need to be addressed, any change in treatment and health condition (see Appendix I which contains all photographic data).

3.2 *Audio-recording of interpreter-mediated interaction and daily routine visits*

I observed a total of nine volunteer interpreters working on these two shifts, with a view to noting differences and similarities between individual interpreters and their relationships with one another. Out of a total of thirty observed DRVs and triadic IMIs, five were audio-recorded in the presence of the researcher and fully transcribed for analysis. These five audio-recorded encounters involved an interpreter and a patient in the case of DRV, and a doctor, an interpreter, a patient and relatives in two of the encounters in the case of IMI. The language combination was Spanish-English in all five encounters. The choice of encounters was primarily based on the ability to obtain permission to record them. Although I was allowed to observe more than thirty DRVs and IMIs, only the individuals present in these five encounters agreed to be audio-recorded and completed a consent form. Part of these audio-recordings has been translated from Spanish into English to facilitate data readability where necessary. It is important to note that translation of audio-recorded data entails some degree of interpretation by the researcher (Meyer & Schareika, 2009). Although I have tried to stay as close to the source text as possible, the translated segments are inevitably influenced to some extent by my own categories and outlook.

3.3 Focus groups and accessing volunteer interpreters' self-perception

Since focus groups are the primary methodology used to elicit data in this thesis, in combination with other ethnographic instruments discussed above, a more extensive discussion of the organisation, preparation and performance of this methodological tool is included here. The following sections offer a detailed explanation of the development process of this methodology with a particular emphasis on the production of the focus group guide which is essential for the success and consistency of individual focus groups.

3.3.1 Why piloting?

Although there is no agreement about the usefulness of pilot studies in qualitative research, some scholars recommend carrying out an initial pilot test (see Litosseliti, 2003; Sampson, 2004; van Teijlingen & Hundley, 2001). Because the use of pilot studies in the literature has not been very systematic, it has led many researchers to overlook their advantages (Sampson, 2004). Pilot tests are important in qualitative research and crucial for the design of a sound study; they can alert researchers to areas of their research that are likely to fail or that may present practical problems as well as offer a preview of the results that may be obtained in the final study (Krueger, 1998a). Carrying out a pilot study can help us assess the adequacy of the research tool and develop and test research instruments such as the adequacy of questions in the case of focus groups (van Teijlingen & Hundley, 2001). But pilot studies offer further advantages. Sampson (2004) argues that pilot studies help researchers to become familiar with the topic and with the technique, particularly those researchers who are new to using focus groups (Litosseliti, 2003).

In this particular case, the pilot study was an initial test of several aspects: the design of the questioning route, the researcher as moderator and note-taker, and logistical aspects such as the setting, the group composition and the effect of audio-recording. A pilot focus group does not need to involve a large number of participants. Litoselliti (2003) recommends four or five participants because the sample is not relevant; what is important is to observe the kind of interaction and dynamics that develop through the questions and the moderator intervention and whether logistics such as room arrangement, seating positions and audio quality

are adequate. Litoselliti (2003) also recommends carrying out a debriefing session to hear participants' ideas and suggestions about the actual focus group design.

Pilot studies may however pose some problems. Although they may reveal some areas that require some improvement in the overall study (van Teijlingen & Hundley, 2001), changing these aspects does not guarantee that the outcomes of the main study are more reliable (Sampson, 2004). As suggested by Krueger (1998a), piloting can be time consuming and sometimes not offer the answer to all problems. He explains that failure of a focus group is not always due to the design of questions but may be due to other reasons such as the skills of the moderator, the environment or the group composition (Krueger & Casey, 2000). Therefore, he suggests that the pilot focus group should not be treated as a simple pilot study, but should be approached with an open mind: "if it works, it's your first group. If it doesn't, it was a pilot test" (Krueger, 1998a, p. 57).

In this study, piloting was highly beneficial because I had no previous experience of running focus groups, and organising a pilot study allowed me to familiarise myself with the methodology, its benefits and its shortcomings. It also helped me improve my skills as moderator and note taker as well as anticipate some of the results that were later obtained. The pilot focus group has thus not been treated as a pilot test but rather as the first focus group of this project, and it was decided that no questions in the questioning route required further modification for the remaining focus-group discussions.

3.3.2 The focus group guide

The idea behind preparing a focus group guide is to help ensure that the moderator does not forget any important details that may influence the outcomes of the session and that each group in the study discusses the same topic and is asked the same questions in order to maintain consistency across groups.[28] As part of the focus group guide, moderators can produce a questioning route and a note-taking template that can help them compare the results obtained.[29] This template should reveal at the end of each focus-group discussion important aspects of what has been discussed and allow the researcher to trace issues in the transcripts of audio or videotapes.

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[28] See Appendix III, for a sample of the focus group guide.
[29] For the purpose of this study the moderator and note taker are the same person and therefore the role of moderator and note taker is interchangeable.

3.3.2.1 Logistics of focus groups

The first step is to send a letter of invitation (via post or email) where the researcher states the objectives of the focus group, a description of what it entails for participants, duration of the session, issues of confidentiality and contact information. The University of Manchester regulations on ethical clearance oblige researchers to produce two documents for participants: a participant information sheet and a consent form (see Appendix II which contains all the ethical documents). The participant information sheet includes all the information mentioned above; all participants in the current study received a participant information sheet prior to the focus group session so that they could make an informed decision as to whether they wanted to participate in the study. The consent form was distributed at the beginning of the session, when I explained again all the information included in the participant information sheet and participants had the opportunity to ask me questions.

A detailed questioning route with the approximate duration of each question and the total duration of the session was included in the focus group guide. The total duration of the session was one and a half hours, half an hour less than was initially planned. This one and a half hour session included: a fifteen-minute introduction, sixty minutes of questions and a fifteen-minute debriefing session.

The location for the focus group was a place that was convenient for the participants and where they felt comfortable. In the case of the pilot focus group, as mentioned above, this had to be carried out at the hospital cafeteria, which presented several difficulties including a severe background noise which made it very difficult to transcribe the discussion fully. However, this problem was successfully overcome by cleaning the background noise to a certain extent.[30.]

Finally, focus group sessions are usually audio-recorded. Focus groups thus provide researchers with two sets of data: data derived from the researcher's own observations and notes taken during the discussion, and transcripts of the discussion. Audio tape transcripts can consequently be used to support the data obtained through observation or as independent sources of data when critically analysed in their own right (Morgan & Spanish, 1984). In this study, transcripts

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[30] In order to clean the background noise, I used Audacity, an open-source audio-editing platform. Audacity allows the user to open the file and automatically discerns individual voices from background, thus making it possible to delete those sections of the file which are not necessary. Although it does affect the quality of the remaining audio, it is still beneficial for transcription purposes.

have been used as an independent source of data that is complemented by observations and actual interaction.

3.3.2.2 The questioning route

A questioning route consists of the set of questions that the moderator uses in structuring the session, particularly in the case of inexperienced researchers.[31] The use of a questioning route presents a compromise in relation to the structure of the focus group and the data obtained, since it starts with general questions and slowly moves towards more specific issues that are closely related to the research questions, therefore it allows very little room for improvisation. Some scholars recognise that the use of a topic guide, "a list of topics or issues to be pursued", is more "conversational" and spontaneous than questioning routes (Krueger, 1998a, p. 9). However, a topic guide requires a skilful and highly experienced moderator, which is not the case in the present study; a questioning route seems more adequate for a researcher who has only recently been introduced to the use of focus groups, because it enhances the researcher's confidence and ensures a higher level of consistency in the study.

Lewis (2000) explains that the questioning route should be designed by adapting the research questions to a focus group format. It is also advisable to design the questions in a conversational manner, with direct, simple and natural wording.[32] Furthermore, the questions should be logically organised from general to specific (Krueger, 1998a).

In order to design robust questions it is necessary to start by preparing a first draft that initially focuses on the content of each question, rather than its exact formulation (Krueger, 1998a). Questions used in the current study were adapted over a period of three months. The process started with an initial draft of questions that were drawn directly from the research questions.

The first step was to avoid extremely long questions with difficult wording or jargon, such as questions 1, 2 and 5 (Morgan, 1997). These questions were worded differently and also divided into smaller fragments that could be easily understood. I also avoided including any questions that could be answered with a simple yes or no, such as questions 4, 5, 10 and 11, since the use of open-ended

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[31] The questioning route is included within the focus group guide. See Appendix III.
[32] The term "conversational" is used in the literature to mean that questions should be casually formulated and participant friendly in order to generate conversation and to avoid intimidating participants with awkward questions, jargon, or unintelligible wording (Krueger, 1998a, p. 3).

questions is more productive and gives participants the opportunity to explain their position, feelings or experiences (Mack *et al.*, 2005). Krueger (2002, p. 6) recommends avoiding "why questions", such as question 7, and instead asking about attributes, characteristics and influences of ideas because 'why questions' require explanations that may seem rational or adequate for that particular situation at the moment the focus group is taking place, but the explanations may not necessarily relate to the real circumstances of the situation in question. Therefore, it is better to use "think back questions" to encourage participants to reflect on past experiences or anecdotes (Krueger, 2002, p. 2) or ask them to give examples or write lists to get them to think about experiences or important aspects of their work (Lewis, 2000). It is also essential to avoid leading questions such as 2, 8, 10 and 11 because they influence participants' responses and impose the researcher's perspectives on the topic *(Mack et al., 2005)*.

Krueger (1998a) suggests that questions should be initially organised according to how long it takes to respond to them: five minutes, ten minutes or fifteen minutes. Five-minute questions should be used at the beginning and at the end of the session ("opening", "introductory" and "ending" questions) and during transition from one topic to another ("transition questions"); ten-minute questions cover important areas to discuss ("key questions") and fifteen-minute questions should be limited to essential issues ("key questions") (Krueger, 1998a, p. 15). He recommends including four to six five-minute questions, four to six ten-minute questions and zero to two fifteen-minute questions in order to plan a ninety-minute focus-group session (Krueger, 1998a). Although it is advisable to only ask around ten questions to avoid an excessively long session, it is important to always have four or five extra questions on the questioning route in case some of the questions lead nowhere and the moderator needs alternatives (Lewis, 2000).

Additionally, because there must be a logical progression to allow participants to become familiar with the topic without feeling pressured to comment on important issues, there must be different types of question and some are more important than others. The moderator must thus be aware of the different types of question and stick to the time allocated to answer each question (Lewis, 2000). Krueger (1998a) establishes five different types of question: opening questions, introductory questions, transition questions, key questions and ending questions. Mack *et al* (2005, p. 42) add another category: direct/indirect probe questions.

'Opening questions' are asked at the beginning of the session to break the ice, to introduce everyone, to make people feel comfortable and get participants talking (Krueger, 1998a, p. 23). Everyone is expected to answer an opening question, which should be designed to elicit facts rather than opinions. The opening question is thus not supposed to start a discussion and elicit relevant information; it is a simple warming up exercise to build an in-group feeling. The opening questions developed for this specific focus group are phrased to ask interpreters about their background and their motivation to be interpreters since most of them are volunteers. Indirectly, these questions may also elicit information on what capital is available in the field of public service interpreting by encouraging comments on what they gain by volunteering as interpreters:

- *Let us find out some more about each other by going around the room…*
- *Tell me your name and tell me about your interpreting background.*
- *What motivates you to work as an interpreter here?*
- *Why do you volunteer as an interpreter in this hospital?*

'Introductory questions' are designed to introduce the topic and to gain some insight into basic opinions (Krueger, 1998a, p. 24). These questions are intended to encourage participants to start interacting with the group (Halcomb *et al.*, 2007). Krueger (1998a) suggests phrasing these questions to ask about first experiences with the topic under research and about how participants see or understand the topic. In order to formulate robust questions, I designed introductory questions using the 'think back' strategy recommended by Krueger (2002, p. 6).

- *Think back and tell us about your early experiences working as an interpreter in this hospital.*
- *Think back and tell us about an important moment for you as an interpreter in this hospital.*

These questions encourage participants to recall past memories and how they began their interpreting job. They may also bring up some important issues related to their work and perhaps to other agents involved in the field. The

questions help the researcher form an initial picture of the way they see the activity of healthcare interpreting.

'Transition questions' gradually move the discussion from the introduction towards key issues and from one topic to another topic (Krueger, 1998a, p. 25). They serve to connect the participants and the topic under research (Halcomb *et al.*, 2007). I designed four transition questions that connect the discussion with four potential issues. Each transition question is linked to a set of key questions and each set of key questions focuses on a different aspect related to the research questions for the study, discussed below. Since time is limited to ninety minutes, it was not possible to use every single question nor to discuss every issue, but it was useful to have a wider range of choices, particularly for pilot testing, because it was difficult to know what questions would provide richer data prior to the focus group session.

- *Think back to your first day in this hospital. How did you feel? What happened that day? Who do you remember the most that day?*

- *Have there been any changes since you started? If so, how have things changed? Are these changes positive, negative or both?*

- *Tell us about your relationship with other members of staff here at the hospital. How would you describe the working environment in this hospital?*

- *Could you describe a typical day at work? From the moment you arrive at the hospital until you leave, what do you do?*

'Key questions' are crucial for any study (Krueger, 1998a, p. 25). Moderators must make sure that they allow plenty of time for a full discussion and use probe questions if necessary;[33] researchers must pay particular attention to these key questions during the analysis stage. Key questions start about "one third to half way into the focus group" (Krueger, 1998a). They are designed in such a way that the first part of the question focuses generally on facts and the following parts of the question focus on opinions, interpretations and perceptions (Halcomb *et al.*, 2007). For the purposes of this study, I designed four sets of key questions, each set dealing with an aspect of the research questions. The first and second set of questions are related to aspects of positioning and hierarchy within the healthcare institution, addressed in research questions 2 and 3, about the main agents in the field and the positions available for healthcare interpreters. Indirectly, these

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[33] The questioning route was designed taking into consideration the length of each type of question and the number of questions (see Appendix III, for a sample of the focus group guide).

questions should elicit information relating to research question 1 about the structure and internal organisation of the field. The questions are designed to be conversational and natural, and to hide the intention of the researcher in asking them. I placed positive questions before negative questions and uncued questions before cued questions, as recommended by Krueger (1998a).

The first set of key questions was related to positioning and institutional hierarchy:

- *Take a piece of paper and write 5 positive things about working in this hospital, [pause] now write 5 negative things.*
- *Think back to an experience you had in this hospital that was outstanding. What happened? Was anyone else involved?*
- *Think back to an experience you had in this hospital that was disappointing. How would you avoid that situation again? Was anyone else involved?*
- *Think back and tell us about an unsuccessful encounter. In what way was it unsuccessful? What could have been done differently?*

The second set of key questions also relates to positioning and institutional hierarchy:

- *Suppose you were in charge, what kinds of changes would you make around here to facilitate the outcomes of the interaction?*
- *If you could change one thing in this hospital to improve interpreters' performance during consultations, what would you change and what's the main reason for changing this particular thing?*
- *If you were a doctor,*
  - *What would you change around here?*
  - *Would you do things differently?*
  - *What things would you change?*
- *How would you build/improve a relationship of trust with interpreters?*
- *What needs improvement? How can it be improved?*
- *Tell us about any changes you have tried to make? Were you successful? What role did other people play in your success?*

The third set of key questions is related to institutional gate-keeping activity and should elicit data to answer research questions 1, 2 and 3 about the internal

structure, the main agents and the positions available in the field for healthcare interpreters.

- *When you need advice, who is the first person you talk to? Who would be the first person you would ask?*
- *Who decides who becomes a hospital interpreter?*

The fourth set of key questions is related to the objective structures of the field and the feel for the game that constitutes part of the healthcare interpreters' habitus. Indirectly, these questions also address aspects related to the main agents and positioning.

- *Tell us about the procedure you follow during consultation. Is there any specific way to go about it? Or does it change depending on the situation?*
- *How does it work here? Are interpreters given some guidelines/advice about how to proceed during consultation? Or are interpreters supposed to know what to do?*

The final set of key questions respond to the last research questions about the capital available in the field and the capital that interpreters bring to the field of public service interpreting. This set of key questions does not have a transition question associated with it since the questions can be integrated in any of the question sets above. They can be used towards the end of the session.

- *If you have to point out some qualities of a hospital interpreter, what would they be?*
- *If someone asked you what does it take to be an interpreter in this hospital, what would you say?*
- *Think back and tell me about a situation that you couldn't deal with? How did you feel? What was the reason you couldn't deal with it?*

'Ending questions' help to summarise and bring the discussion to an end progressively to avoid an abrupt ending (Krueger, 1998a, p. 26). These questions allow participants to reflect on the discussion and to bring up aspects they consider important and that may not have been mentioned during the session. Some ending questions are particularly useful at the piloting stage because

participants may bring up issues during this part of the discussion that may be worth including in the final focus group. The questions are as follows:

- *If you were the moderator, what would be the next question you would ask the group?*
- *Think of what we talked about today. What do you think is the most important aspect that we have discussed?*
- *Are there any final comments, recommendations or thoughts you may have on the topic we have discussed today?*
- *Have we missed anything?*

Questions asked during the four focus groups carried out were selected depending on the level of engagement that participants showed. Although the same questioning route was used consistently throughout the four focus groups, some participants engaged more with some aspects and other participants engaged more with other aspects. Some questions were thus answered in more depth by some groups than others. But in general, most of the questions provided interesting insights to the field, as we will see in the following chapters.

3.3.3 The role of the moderator as note-taker

Most focus groups organised in any field have a moderator and a note taker. The moderator should not be expected to take notes, but rather concentrate on keeping the flow of the discussion in the right direction (Krueger, 2002). The role of the moderator is thus fundamental for the success of the focus group. S/he must make sure that the logistics are adequately set up, the recording equipment working and the note-taking process clear. Greenbaum (1998) recommends that moderators must be objective and have the expertise to raise interesting questions to the group, interpret them appropriately and write the necessary reports. The moderator must develop skills to maintain group discussion and be familiar with the topic in order to be able to identify when/if a crucial discussion requires follow-up questions and probes; it is also advisable that s/he appears similar to the rest of the participants, namely in terms of ethnicity, age, gender and dressing code (Krueger, 2002). Morgan and Scannell (1998) suggest that moderators should refrain from reacting to any cues and encourage participants to expand on an idea by using verbal or non-verbal means of communication, for example head nodding

or short verbal responses. Moderators must also be aware of the group dynamics and be able to identify different types of participant: the expert, the dominant talker, the shy participant or the rambler and make sure that all participants have the opportunity to share their ideas with others (Krueger, 2002).

Since the moderator plays such an important role and has so many responsibilities, the literature recommends that there should be two people in the room, one acting as moderator and another assisting the moderator with the note taking process and the logistics, mainly because the note taking task requires writing down any quotes, key points or themes that emerge during the discussion and preparing any follow-up questions needed (Krueger, 2002). Moreover, the note taker should note any body language or non-verbal activity that may be relevant in particular instances (Halcomb *et al.*, 2007). However, because this is a PhD thesis and funds are limited I had to act as both moderator and note-taker at the same time, which is why I decided to audio-record the sessions; the audio recorded material allowed me to follow the interaction. Moreover, one of the advantages of acting as both moderator and note-taker is that sometimes being familiar with the topic and creating a relaxing atmosphere for participants is a good starting point for successful focus groups, for "whatever the professional background of the facilitator, it is important that the group can accept and relate to him or her" (Greenbaum, 1998, p. 38). Indeed, sometimes professional moderators hired by organisations are not very familiar with the topic under research and they are not able to relate to participants' experiences, opinions and beliefs, which can have a negative and discouraging effect on participants (Koskinen, 2008, p. 86). In my case, familiarity with the topic and, mainly, familiarity with the participants was crucial for this project. Although they had agreed to take part, when I arrived I found that they were reluctant to answer any of my questions and to take part in an audio-recorded interview for fear that they may get into trouble if they revealed too much information about the healthcare institution they were working for. I had to visit both institutions on several occasions and spend some time with interpreters before they agreed to being interviewed. Gaining participants' trust and acting as one of the team was essential to both successful focus groups and participant observation in this project.

3.3.4 Debriefing session

The debriefing session is usually carried out between the moderator and note taker exclusively, immediately after the focus group. The purpose is to log additional information, to discuss or clarify any issues that did not work well and to identify any missing information (Mack *et al.*, 2005). However, because I was the only person in the room running the focus group, the debriefing session took place between me and those participants who wanted to stay and offer me feedback about the session. This feedback was essential particularly at the piloting stage because it reassured me that the questioning route was adequately planned and did not require any further modifications.

3.4 The data sample

The data sample for this study was constrained, as will be explained below, by the number of interpreters available at the time when the fieldwork was carried out, and also their willingness to cooperate in the study. Although I have tried to take into consideration as many recommendations as possible, it was necessary to make some accommodations in terms of sample composition and sample size in order to obtain the best possible results.

3.4.1 Sample composition

The literature recommends selecting a group that is representative of the larger population and is homogeneous in terms of sharing some features—for example, gender, age-range, social background—in order to avoid power issues and to allow participants to feel comfortable with each other and engage in discussion (Rabiee, 2004). As explained by Kitzinger (1995), the presence of participants who do not form part of the group can alter power relations among members of the group and can mean a breach of confidentiality when delicate issues may be discussed, aspects that may constrain participants' interaction, particularly when the group is not homogeneous. On the other hand, differences in age, gender or social factors can also generate a wider range of opinions (Mack *et al.*, 2005). Moreover, it has been recognised that focus groups do not accurately represent the larger population but rather constitute a sample of it (Morgan, 1993). Researchers who do not emphasise the use of homogeneous groups recommend that participants

do not know each other in order to encourage more spontaneous or honest answers and to avoid the influence of pre-existing power relations (Rabiee, 2004). The main idea is to organise groups where participants have common interests and feel comfortable when sharing their views with other participants. In this research project, sample composition was constrained by the actual institutional composition of the groups of interpreters. Each group of participants consisted of those interpreters working at the two healthcare institutions under investigation. Participants knew each other and had developed a previous working relationship. Moreover, since these interpreters were volunteers of a local NGO, they were likely to have forged a relationship outside the hospital and shared similar views on society and volunteering.

Four focus groups were carried out including a pilot study that has already been briefly discussed above. The first focus group, the pilot study, was carried out on 26 November 2010 at 3pm at the cafeteria of the Hospital Costa del Sol. There were four participants present and it lasted for approximately one hour and twenty minutes followed by a ten-minute debriefing session that was not audio-recorded. This focus group was carried out in English and participants engaged very well with the discussion, talking to one another rather than to me. In this sense, I consider this as the most successful of all focus groups. It was not possible to organise another focus group at this hospital due to the personal circumstances of the interpreters' coordinator.

The remaining three focus groups were carried out at the Hospital Clínico. The number of participants varied between two and four participants in each of the three groups. The second focus group was carried out on 12 January 2011 at the interpreters' office, which is situated on the ground floor of the hospital premises, next to the administration offices. The interpreters' office is large enough to accommodate a desk, two large storage cupboards and a round table with chairs which seats five to six people at a time. There were three participants—four for a short while as one of the interpreters had to leave to take a phone call—, and it lasted for approximately one hour and fifteen minutes with a few minutes of debriefing at the end that was not audio-recorded. This focus group was carried out in Spanish: two of the participants were English and one was Spanish. Of the three focus groups carried out at the Hospital Clínico, this was the longest and most successful in terms of the participants' level of engagement and information provided.

The third focus group was carried out on 14 January 2011 at the interpreters' office at the Hospital Clínico. There were two participants and it lasted for approximately one hour without a debriefing session. This focus group was also carried out in Spanish: one of the participants was Moroccan and one was French. The focus group required considerable effort on my part to encourage both participants to maintain a discussion rather than answering my questions on a one to one basis. Although I managed to keep the discussion flowing most of the time, there were some moments where participants addressed me rather than discussing an issue among themselves; it was less interactive than Focus Groups 1 and 2. A focus group consisting of only two participants proved difficult to manage and less productive.

The fourth focus group was carried out on 19 January 2011 at the interpreters' office at the Hospital Clínico. It lasted for approximately one hour without a debriefing session and again consisted of two participants for the most part—three participants at times, as one of the interpreters was on call and she left and returned a number of times. This focus group was carried out in Spanish: one of the participants was English, one was French and the third one was Armenian. As with Focus Group 3, it required much effort on my part to maintain a discussion and avoid slipping into interview mode, especially because the third participant kept leaving and returning every time the phone rang.

3.4.2 Sample size

Most authors recommend between three and four focus groups in order to obtain data that is representative of the particular social group under investigation, as mentioned above, in order to be able to identify patterns or themes across groups (see Krueger, 2002; Krueger & Casey, 2000; Merryweather, 2010; Morgan, 1995). This study had to contend with a limited number of participants that could take part in the focus groups, since the total number of individuals available between the two hospitals is under forty. I therefore had to recruit participants on the basis of their willingness to be involved in this research. Moreover, although it is advisable to run three or four focus groups for each social group under study in order to allow for comparison of the data collected, this study was constrained again by the number of individuals available. The study thus involved a total of four focus groups: one pilot test—which became the first focus group—and three additional focus groups.

The size of a focus group should be large enough to generate discussion but not so large that it discourages some participants from sharing their views with the group (Krueger & Casey, 2000). Morgan and Spanish (1984, p. 256) explain that in their study "the number of ideas generated did not double as group size increased from four to eight". Recommendations for sample size are between four and twelve participants, although it is advisable to over-recruit by 20% since some participants may fail to attend. As mentioned above, three or four participants tend to generate an interesting discussion, whereas two participants make it very difficult to maintain a discussion and run the risk of the focus group turning into a one to one interview. In Focus Groups 1 and 2 I did not have to resort to too much control; the group generated rich discussions that provided very interesting data. In Focus Groups 3 and 4 I had to direct the discussion more often and ask more individual questions due to the reduced number of participants. The data obtained through Focus Groups 3 and 4 have thus been used sparingly and cautiously. I have relied more heavily on the pilot focus group and the first focus group at the Hospital Clínico since both focus groups were composed of four participants and the data obtained through these is more reliable.

3.5 Ethical considerations

The main ethical concern that arises from doing an ethnographic study that uses three methodological approaches—participant observation, audio-recorded interpreter-mediated encounters and focus-group discussions—is how to maintain the privacy and confidentiality of each participant, since the nature of ethnographic data is such that information is released in the presence of other participants and the researcher (Halcomb *et al.*, 2007).

The first step was to obtain permission from the two healthcare institutions under study to enter the premises as a researcher to carry out participant observation and focus-group discussions. Only one of the institutions considered it necessary to take my project to the Hospital Ethical Commission, and a letter was produced granting the researcher access to the healthcare institution to carry out participant observation and focus groups, and to contact the necessary individuals within the institution that were to be invited to take part in the project. In order to ensure privacy and confidentiality I produced a participant

information sheet, approved by the School's Ethical Committee, for those participants taking part in the audio-recordings of interpreter-mediated interaction and focus-group discussions. These participant information sheets described the study and gave participants the opportunity to ask any questions about it. Participants were assured that no personal information that could identify them as individuals would be recorded or disclosed by the researcher, and therefore privacy and confidentiality would be guaranteed. Informed consent was sought at all times and a consent form was freely signed by each individual taking part in the different stages of this project, including interpreters, doctors, patients and their relatives. In the first instance, participants were informed of the purpose of these audio-recordings and the procedure of being audio-recorded as they were asked to act as if there was no researcher present where possible. I tried to intervene as little as possible in the interaction and kept as far as possible from participants. However, this raises an ethical concern in a healthcare context: what "if participants forget that they are being studied and disclose information that they intend to share in a therapeutic relationship rather than with a researcher?" (Carnevale *et al.*, 2008, p. 22). In order to address this ethical issue, participants were reminded at all times of their right to withdraw from the research project. Moreover, participants were asked whether there was any part of the interaction that ought to be omitted from the recordings once the consultation had finished; in other words, they had the opportunity to reconsider their agreement, even if they had forgotten about the researcher's presence during the consultation.

In the specific case of focus groups, participants were reminded of the confidentiality agreement between them and the researcher as mentioned above, and were informed that as researcher I was committed to maintaining complete privacy and confidentiality and would not disclose any personal or confidential information revealed to me during the focus-group discussions. Informed consent was sought and each participant was asked to read the participant information sheet and sign a consent form before the focus groups started. However, focus-group discussions presented an additional ethical concern. Focus-group discussions involve the presence of more than one individual at any given time, which means that the researcher cannot guarantee complete confidentiality on behalf of other participants. Some researchers propose solving this problem by asking participants to use pseudonyms or first names exclusively in groups where they do not know each other (Halcomb *et al.*, 2007). However, in this project, participants on each focus group were co-workers at the same healthcare

institution and already knew each other, so it was impossible to guarantee complete confidentiality with respect to co-workers. As researcher, I pointed this out to participants, and although confidentiality and privacy were guaranteed on the researcher's side through informed consent, it was the responsibility of individual participants involved in the focus group not to reveal the information disclosed outside the discussions. Every effort was made to remind participants of this issue.

4 Data Analysis

The data collected consist of four audio-recorded focus groups and their transcripts, two audio-recorded daily routine visits (DRV) and their transcripts, three audio-recorded interpreter-mediated interaction (IMI) and their transcripts, documentary and photographic data from internal and external sources and participant observation notes.

4.1 Transcription conventions

On average an interaction lasting one-hour can take five or six hours and a total of thirty to forty pages to transcribe; the analysis must be systematic, sequential, verifiable, continuous and appropriately reported (Krueger, 2002, p. 5). The level of detail depends on the level of accuracy necessary for each particular analysis (Ives, 1995, p. 99). As explained by Diriker (2004), transcription means representing the oral discourse in written form, and it is necessary to start by assuming that there is already a degree of implied interpretation by the researcher. Following Diriker's advice for the simplification of transcripts, I have tried to omit phonetic transcription to a large extent, because it is not necessary for the purpose of the present investigation, and in order to facilitate reading the texts. Since this research project does not set out to analyse individual words and structures but rather the overall meaning of utterances, the level of detail included has been kept to a minimum. Additionally, as part of the transcription conventions used, names were consistently substituted with others in order to protect the identity of participants while simultaneously allowing the reader to recognise individual characters and their contribution to the discussion. In the case of focus-group discussions conducted in Spanish as well as those sections of

interpreter-mediated interaction that took place in Spanish the transcripts include an English gloss in italics below individual speech turns (please see Appendix V about transcription conventions used).

4.2 Organisation, coding and analysis of data

For practical and organisational purposes, all the data collected was stored and organised into five folders which correspond to five appendices. These folders were stored on a CD which has been included with this thesis. Each folder has been labelled with an appendix number and a name that provides a brief description of the data contained in each particular folder.

The materials in these appendices have been cross-referenced within the body of the thesis. All five audio-recordings of IMI and DRVs and four focus groups have been fully transcribed to facilitate segmentation and to provide a context for the extracts quoted in the body of the thesis in Chapters 4 and 5. Readers can go to the appendices of the thesis if they wish to see a complete transcript of each focus group, IMI and DRV included. All the transcripts are thus attached to this thesis in Appendix V.

4.2.1 Coding and Analysis: Identifying categories to define interpreters' positioning in the field of healthcare

In order to carry out the analysis of the data, I resorted to Qualitative Content Analysis, a methodological tool often used in anthropology and sociology (see Kohlbacher, 2006; Krippendorff, 1980; Mayring, 2000). Qualitative Content Analysis has been described as "any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings" (Patton, 2002, p. 453). Qualitative Content Analysis[34] (QCA) "focuses on the characteristics of language as communication with attention to the content of contextual meaning of the text" (Hsieh & Shannon, 2005, p. 1279) and allows the researcher to analyse selected texts in order to respond to specific research questions, thus converting raw data into categories or themes (Zhang & Wildemuth, 2009). This methodological tool can either be informed by an inductive approach where themes or categories arise after careful

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[34] The purpose of this section is not to offer a literature review of QCA but an account of the process I followed in order to code and analyse the data.

examination of the texts under investigation; or deductive approach, where the researcher generates a series of categories or themes from previous studies or theories and identifies those in the texts (Berg, 2001). QCA following a deductive approach is what Hsieh and Shannon (2005, p. 1281) have identified as "directed" qualitative content analysis. According to Potter and Levine-Donnerstein (1999), the first step is to identify an initial set of key concepts that will be used as coding categories for the analysis of texts, and to operationalise those concepts according to the theoretical framework adopted. Although this analytical approach seems rather broad, it allows researchers a large degree of freedom in examining the data and identifying patterns that may belong to predetermined categories as opposed to analysing the data using software programmes which are more mechanical and quantitative. Although there are a number of existing software programmes (CAQDAS Comparison, CDC EZ-Text Computer Assisted Qualitative Data Analysis Software (CAQDAS) Networking Project among others) to help researchers with the coding process and analysis of data, I decided to do "the old fashioned analysis strategy" coding and analysis manually by reading the transcripts, highlighting relevant stretches with colored marking pens and inserting the predetermined categories, as recommended by Krueger (2002, p. 6). As pointed out by Hammersley and Atkinson (2007, p. 158),"it is important to recognize that there is no formula or recipe for the analysis of ethnographic data. There are certainly no procedures that will guarantee success". Therefore, I resorted to combining inductive and deductive approaches to QCA and treating the analytical process as an interactive process between myself, the researcher, and the data where ideas influence the data as much as the data influence the ideas (Hammersley & Atkinson, 2007).

Initially I thought of classifying the data under two themes: interpreters' self-perceptions vs. actual interaction. However, this idea was immediately discarded as it failed to provide a clear focus, and it was more interesting to identify certain themes within the data that allowed me to combine perceptions with actual interaction. The first step was to transcribe the focus groups carried out. As I was transcribing the focus groups, I created a concept tree of the pilot focus group which was based on the research questions and compared this concept tree with the remaining focus groups in order to establish similarities and patterns among them. The patterns that emerged from these data were related to issues of institutionalisation, alignment and autonomy. These three themes are present throughout the focus groups and are discussed by most participants as

important issues. I identified examples that clearly illustrated these themes in the transcripts and highlighted them using one colour for each identified theme, thus establishing a colour code for the analysis; I then classified every example under the corresponding category using the assigned colour. The three themes are closely linked to Bourdieu's theoretical framework and enabled me to establish a link between the information arising from the data and the theory. I also compared the data emerging from the audio-recordings to other sources of data collected, such as the Interpreters' Handbook and the photographic data and established that it supported several statements made by interpreters in the focus groups, particularly those aspects related to interpreters' position as spokesperson (see Chapter 5, section 3).

Transcribing the IMIs and DRVs was labour intensive due to audio quality. It was undertaken while simultaneously reading the existing literature on dialogue interpreting in search for categories that could be applicable to my data.[35] As well as identifying some of the themes that had emerged from the focus group data mentioned above, which I highlighted in the corresponding colour code, I also observed that some of the categories relating to interpreters' positioning in the field that had been previously identified by other scholars were emerging from my data. Since fieldwork notes were not extensive, the audio-recordings of the IMIs and DRVs became an essential asset at this stage, and I listened to them repeatedly, partly because the transcribing process was tedious and slow.

Accordingly, I made a list of potential categories based on previous research: [36] spokesperson (Mason, 2005); alignment (Wadensjö, 1998); gate-keeping (Davidson, 2000); information screening (Davidson, 1998, 2000); taking over someone's turn (Roy, 2000); monitoring (Hsieh, 2010; Hsieh & Kramer, 2011); and co-diagnostician (Hsieh, 2006). I identified a significant number of segments that can be classified under three main categories with their corresponding subcategories: alignment (with the healthcare institution and with patients), gate-keeping (involving monolingual interaction, mono-directional translation and information screening) and interpreters acting as language conduit (such as doctors correcting the interpreter's rendition, doctors completing

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[35] I use two different concepts to refer to ideas identified: themes and categories. I see themes as broader than categories, and therefore use themes to refer to issues such as institutionalisation, legitimisation and bureaucratisation which are broader topics; and I use categories (and sub-categories) to refer to concrete ideas such as alignment, speaking on behalf of patients, gate-keeping, or language conduit, which can be classified within the broader themes.
[36] The initial list was more extensive and included some categories related to interpreters' positioning that did not emerge from the data in the audio-recordings of IMI and DRVs.

the interpreter's utterance and doctors taking over an interpreter's turn). After careful examination of all IMIs and DRVs transcripts, I was able to find relevant examples that illustrate all these identified categories and subcategories, and coded all the transcripts following the colour scheme.

Once I identified all the categories and sub-categories that emerged from the audio-recordings of IMIs and DRVs, I went back to the focus groups to examine those transcripts again; I searched for examples that might fall under any of the categories and sub-categories established and compared these categories with the themes that had initially emerged from the focus groups. The data analysis process thus involved a constant moving back and forth from the data to the ideas and from the ideas to the data, inducing and deducing and constant revisiting of ideas. As well as finding examples of those categories and sub-categories in the focus groups that I connected to examples in the IMI and DRV data, I was able to establish links between themes and categories and sub-categories that led me to the overarching theme of interpreters' positioning and autonomy, as explained in Chapters 4 and 5.

The resulting analysis is spread across two chapters: one that addresses the broader themes of institutionalisation, legitimisation and bureaucratisation (see Chapter 4) and one that deals with the categories and sub-categories (see Chapter 5). Although organised in two chapters, themes and categories are closely linked; neither chapter is fully self-contained.

5 Concluding remarks

This chapter has discussed the advantages of methodological triangulation, especially when conducting qualitative research. In this particular case, I have presented three methodological tools: participant observation, audio-recordings of interpreted interaction and focus-group interviews. Each methodology was discussed in depth and the advantages and limitations of each were highlighted. A special emphasis was given to the focus groups since it is the primary source of data for this study and is a complex methodology that requires a great deal of preparation and anticipation. The ethical implications of conducting research in a healthcare context were also examined. Finally, the data collection process was explained step by step, and the analytical approach used discussed and justified.

The following chapters offer a detailed analysis of the data obtained through the methodology outlined.

Chapter Four

Institutionalisation, Legitimisation and Bureaucratisation as external manifestations of the positioning of volunteer interpreters in the sub-field of healthcare interpreting

1   Introduction

The aim of this chapter is a) to introduce the reader to the setting in which this research took place by providing a brief overview of the institutions and people involved; and b) to analyse volunteer interpreters' positioning within the healthcare institutions they work at by looking at their degree of institutionalisation within each hospital. The degree of institutionalisation that interpreters enjoy is however also directly affected both by the degree of legitimisation of the field structures and by the degree of bureaucratisation, or professional organisation, of the interpreting service.

This chapter also examines the internal structure and hierarchy of the sub-field of healthcare interpreting within the wider healthcare field and discusses the two main traits of institutionalisation found in it: a) legitimisation, a process that entails the recognition of the field structures specifically by those agents with more symbolic capital, and the resultant positions available to interpreters; and b) organisational bureaucratisation, a process that involves the interpreting team becoming an official association, and the resultant bureaucratic properties such as ID badges, an Interpreters' Handbook and daily reports.[37]

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[37] According to Weber (1947), the process of bureaucratisation includes some traits such as division of labour, hierarchy of authority, written rules and regulations, among others.

2 Volunteer interpreting in the Costa del Sol: the case of the Hospital Clínico and the Hospital Costa del Sol

Very little literature is currently available on volunteer interpreting, particularly in healthcare settings.[38] What studies are available tend to focus on the skills of volunteer interpreters as opposed to paid interpreters.[39] The literature therefore offers little help in revealing how this particular sub-field is organised and structured and how agents position themselves or are positioned within it.

This study focuses on a specific group of volunteer interpreters who work at two different healthcare institutions along the Costa del Sol.[40] Despite their status as volunteers, as opposed to paid healthcare staff members, the particular group under examination has become increasingly institutionalised in the Spanish context and their positioning within the healthcare institution has been legitimised to a greater or lesser extent by both the healthcare institution and other staff members who recognise volunteer interpreters' work as necessary and important for the institution and beneficial for foreign patients with no knowledge of Spanish. Interpreters, however, occupy a set of fluid positions, which constantly shift depending on the positions occupied by other agents with stronger habitus and symbolic capital, as well as the value attributed to their main asset, i.e. linguistic capital, within specific situations.

The first of the two groups of interpreters under examination was established in 1988 at the Hospital Clínico in the city of Málaga. This group at the Hospital Clínico was the first one to offer volunteer interpreting services at the Costa del Sol and, therefore, is discussed first. Currently this group of interpreters consists of eighteen members. Doctor Bermúdez, who worked at the Hospital Clínico at the time, took a special interest in the lack of resources available to foreign patients in the hospital, and the constant communication problems healthcare staff had to face when dealing with foreign patients who could not

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[38] Studies that focus on the work carried out by volunteer interpreters working in different contexts include Boeri (2008, 2010) and de Manuel Jerez *et al.* (2004).

[39] See Ku and Flores (2005), Monroe and Shirazian (2004), and Villarruel *et al.* (1999) among others.

[40] Although I am examining two separate healthcare institutions, each with its own interpreting team, both teams of interpreters can be treated as essentially one group as they all started at the same institution, the Hospital Clínico, in 1988. They later decided to expand by offering their services to the Hospital Costa del Sol in 1995, and some of the original members moved to that hospital. Although they organised themselves into two separate organisations, the coordinator at the Hospital Costa del Sol initially worked at the Hospital Clínico and was vice-president of its association; this allowed her to replicate the process of setting up volunteer interpreting at the Hospital Costa del Sol and put the same types of procedure in place. Additionally, the data obtained through the focus groups and participant observation seems to indicate that these interpreters are a homogeneous harmonious group, therefore it was not necessary to consider individual differences, disagreements, and relations among interpreters as affecting their positioning.

speak Spanish.[41] He decided to create a group of volunteer interpreters to attend to the linguistic needs of foreign patients. The group started with a few doctors who could speak a foreign language but it soon added new members. The doctor was soon joined by a foreign resident, Jackie, who had been living in Spain for a number of years, and who became the coordinator of the interpreting group[42] and, later on, the first president of AIVE in 2002.[43] Jackie's working languages are Spanish and English. The internal structure of AIVE consists of a president, Antoinette, a secretary, Pauline, and a treasurer, Salvador, who are at the top end of the hierarchy, and the remaining members whose main duty is to approve any changes that may be suggested. AIVE's current president is Antoinette, whose working languages are Spanish, English and French. She has not been part of AIVE for many years as she explained to me initially, which explains why she directed me to talk to Jackie as Antoinette considered that Jackie could provide me with more information. Salvador is the current treasurer of AIVE and one of the oldest members of the group. He was also the former secretary of AIVE and his working languages are Spanish, Italian and French. Finally, Pauline is the current secretary of AIVE although she was off work temporarily and was unfortunately not available to take part in the focus groups; she is often mentioned by other members as an integral part of the team.

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[41] See Appendix IV for a copy of a newspaper article on this topic "¿Que le duele qué? Comunicar para curar". Doctor Bermudez can be identified by his real name, as declared in the newspaper article, since this information is in the public domain. However, I will avoid using participants' real names throughout this thesis as stated in Chapter 3 to maintain their anonymity. Every participant taking part in this project has thus been assigned a fictitious name.

[42] Jackie, the coordinator of the initial team of interpreters, holds a large volume of symbolic capital as a result of being the co-founder of the interpreting group, together with Doctor Bermúdez, and having her position as coordinator legitimised by the hospital director and doctors at the time; and, later on, by becoming president of the association, which saw her legitimised by her peers. She is no longer officially responsible for any aspect of the association. However, from the notes taken through participant observation and informal conversations with the interpreters, it is important to point out that despite the fact that she no longer occupies an official position within the association, AIVE, she is still highly respected by her peers. When I wanted to interview the current president of the association, Antoinette, she directed me to Jackie to obtain more details. Also, during an informal conversation between her and her colleague, she was asked to go back and take her former position as coordinator of the interpreting group because she is constantly consulted by the rest of the team; Jackie still runs the training sessions for new members and remains in charge of accepting or rejecting new members.

[43] AIVE (Association of Volunteer Interpreters for Patients) was founded in 2002 as a requirement by the Regional Government, *Junta de Andalucía*, who urged the unofficial organisation of volunteer interpreters at the Hospital Clínico and Hospital Costa del Sol to become institutionalised, from a bureaucratic point of view, in order to be able to receive some financial assistance to cover expenses such as fuel, meals and stationery, as well as to be provided with insurance cover. This meant that they had to establish an internal hierarchy, which included a President, a Secretary and a Treasurer. They also had to create an Interpreter´s Handbook that included the articles of the association and the regulations, in agreement with the hospital management, that established the boundaries of their work at the hospitals. As will be discussed in Chapter 5, this step was not welcomed by all members because of the degree of bureaucratisation that it entailed and the fact that it gave the hospital further control over them.

When AIVE was founded, the team of interpreters created the Interpreters' Handbook, which contains the articles of the Association and a code of conduct that determines the nature and boundaries of interpreters' work at the hospital. As the interpreters explained to me, and mention in the Handbook, the interpreters' work is always subject to the discretion of the hospital director, who can at any time revisit interpreters' work and boundaries within the healthcare institution. As I had the opportunity to observe during fieldwork, the Handbook has mostly been influenced by interpreters' work ethics prior to their institutionalisation process, and their code of conduct differs in significant aspects from traditional codes of conduct set up by professional associations and academic institutions. Furthermore, their code of conduct deviates from what the field doxa, as established by professional associations, usually prescribes. In this sense, interpreters show a high degree of autonomy in shaping the boundaries of this sub-field and the extent to which they can position themselves within the wider field of public service interpreting. Their work is based on the principles of sympathy, kindness and confidentiality, as can be seen in the Interpreters' Handbook (see Appendix IV, p. 4).

Focus Groups 2, 3 and 4 were carried out at the Hospital Clínico (see Chapter 3, section 3.3.2.4). Focus Group 2 involved four participants: Jackie, Salvador, Catherine and Hannah. Hannah and Catherine have been part of the association for a number of years. Hannah's working languages are English, Dutch and Spanish. Focus Group 3 consisted of two participants: Antoinette, who has already been introduced, and Fadilah. Fadilah has worked at the hospital for a number of years and her working languages are Arabic, English and Spanish, although the language she mostly uses is English. Focus Group 4 consisted of mainly one participant, Catherine, whose working languages are English and Spanish; although Catherine took part in Focus Group 2, she had to leave the room on several occasions to take phone calls, which is why we decided to rearrange an individual interview so that I could hear her opinion on all aspects discussed with the rest of the interpreters. In this focus group, she was joined by Antoinette and Artúr (an Armenian member whose working languages are mainly English and Spanish) every now and then. This interview-cum-focus-group proved rather complex because participants continually moved in and out of the discussion.

Focus Group 1 consisted of four participants: Dorothy, Julianne, Cordula and Rebecca. Dorothy is one of the most important members of the initial group

that set up interpreting services at the Hospital Clínico. She is currently the coordinator of the interpreting team at the Hospital Costa del Sol. As will be observed in the following sections, Dorothy acted as vice-president of AIVE until she left to set up the new interpreting team at the Hospital Costal del Sol with the help of Doctor Pizarro, who was the hospital director when the hospital first opened to the public. Dorothy had a wide social network that included several members of local and regional government *Junta de Andalucía.* Her husband, Peter, also worked as a volunteer interpreter and was responsible for recruiting her as a volunteer interpreter. She also set up an independent association; separate from AIVE, but with the same structures. That association receives the same financial help from the hospital and its members are waiting to be granted an office space similar to that occupied by AIVE in the Hospital Clínico. Thus, as explained above, although they are independent, the two groups are essentially part of the same group of volunteer interpreters with the same degree of institutionalisation and the same working ethics.

Cordula, another participant in Focus Group 1, has English, German and Spanish as working languages and also worked at the Hospital Clínico before moving to the Hospital Costa del Sol. Julianne's working languages are Dutch, English and Spanish, and she started work as an interpreter at the Hospital Costa del Sol. Finally, Rebecca, whose working languages are English and Spanish, also started at the Hospital Costa del Sol.

Most members of the team at the Hospital Costa del Sol started there and were instructed by Dorothy, who had been trained by Jackie when she initially joined the team at the Hospital Clínico as pointed out by Jackie herself (see Excerpt 3, lines 1-6). Moreover, while I was doing participant observation I noticed that both teams follow the same system and daily routine and they both prioritise values such as sympathy and empathy towards patients over others such as neutrality or confidentiality, something that is observable throughout the focus groups. The position of this group of volunteer interpreters at both hospitals, the Hospital Clínico and the Hospital Costa del Sol, is legitimised by a high degree of institutionalisation accompanied by a notable degree of bureaucratisation and explicit organisational structures. The extent of the process of institutionalisation emerges from the data obtained through focus groups and also from the audio-recordings of interpreter-mediated interaction, as discussed below.

3 Volunteer interpreters as institutional agents

Volunteer interpreters in this context occupy the position of institutional agents. This position implies that volunteer interpreters are considered members of the healthcare institution and, as such, they are often treated as members of the healthcare team. As institutional agents, volunteer interpreters hold privileges such as an office space, the right to eat at the staff canteen, and access to all the administrative offices, as will be explained in detail in the next two subsections. The next two sections thus offer an in-depth description of the position of volunteer interpreters as institutional agents and the impact of both symbolic traits such as legitimisation and organisational traits such as bureaucratisation on this position.

3.1 Symbolic traits of Institutionalisation: Legitimisation

This section deals with legitimisation as the internal manifestation of institutionalisation since it comes from the recognition of agents themselves—i.e. doctors legitimise interpreter's positions within the field of healthcare—of the field structures that include interpreters' positions. In order to secure legitimisation, agents must agree that interpreters' position and linguistic capital are valuable so that it can be converted into symbolic capital that simultaneously confers on interpreters a certain degree of autonomy and power. This section aims to describe how interpreters' positions are recognised by different agents and the influence of other agents on the recognition of these positions and the boundaries of the sub-field of healthcare interpreting.

Excerpt 1 (FG 2, Hospital Clínico, lines 18-26, Appendix V):

1	**Researcher**:	Me podéis decir un poco como decidisteis empezar a montar el tema de
2		la interpretación, ¿cómo se os ocurrió?
		Could you tell me a little bit about how you started to set up the
		interpreting team? How did the idea come together?
		{...}
3	**Jackie**:	Y a mí por una vecina que era enfermera en el Hospital Civil y me contó
4		la necesidad que tenía el Doctor Bermúdez para gente para ayudar a
5		traducir, ahí empecé.
		In my case it was through a neighbour who was a nurse at the Hospital
		Civil who told me about the need that Doctor Bermúdez had for people to
		help him with translating, that's where I started.

From this account, it seems that Doctor Bermúdez, who set up the interpreting team at this hospital, had the appropriate symbolic capital to assign certain positions and structure the field, a similar situation to that discussed in Excerpt 2 below. Potentially, this led other agents in the field to recognise these interpreters' positions and legitimise them as part of the natural order of the field; as part of the internalised objective structures of the field of healthcare. Legitimisation here is principally administered by those agents with a stronger habitus in the field such as doctors who have enough symbolic power and relative autonomy to legitimise others, in this particular case, and also by the hospital directors as will be pointed out below.

This initial group of volunteer interpreters was composed of 22 members.[44] In 1995, Dorothy, who had been volunteering for five years at the Hospital Clínico, moved to the Hospital Costa del Sol in the town of Marbella, just as the hospital opened its doors to the public. It was at this time that the second group of volunteer interpreters was formed, following the suggestion of Doctor Bermúdez who had help set up the first group at the Hospital Clínico. In Excerpt 2, Dorothy explains how this second group of volunteers came together:

Excerpt 2 (FG 1, Hospital Costa del Sol, lines 28-34, Appendix V):

1	**Dorothy**:	{…} He [Dr Bermudez, the director of the Hospital Clínico] said:
2		"They're going to build a hospital in Marbella, why don't you go and
3		speak to the director, the new director, Doctor Pizarro?" So we went
4		out and he [Dr Pizarro] said: "Give me a proposal, what do you want to
5		do?" So I gave him a proposal, and so you know I wrote down the whole
6		thing of what we wanted to do, what I thought should happen, and he
7		said: "Fine". And that's how it started. So we were here when the doors
8		opened. So I've been here for 16 years, you know?

In her account, Dorothy, the coordinator, emphasises the legitimisation of the interpreting group, as defined by Bourdieu (see Chapter 1, section 5). As she explained, the project was set up by herself and the hospital director of the Hospital Costa del Sol. The hospital director, being the agent with a stronger habitus and symbolic capital (as was also the case with the Hospital Clínico), had the authority to legitimise any position in the field and attribute volunteer interpreters' linguistic capital a significant value to allow it to be transformed into

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[44] See Focus Group 2, Hospital Clínico, line 34, Appendix V.

symbolic capital. According to Bourdieu (1989, p. 23), "symbolic capital is a credit; it is the power granted to those who have obtained sufficient recognition to be in a position to impose recognition". The symbolic capital of volunteer interpreters thus allowed them to occupy a well-established position that provided them with sufficient autonomy to internalise and reproduce their own dispositions. Moreover, in stating that the interpreting team started the same day the hospital opened to the public sixteen years ago, the coordinator emphasises their alignment with the healthcare institution, an issue I discuss further in Chapter 5 below. Similarly, she legitimises her own strong position when she points out that it was her (lines 4-6) and not others who initiated the team at the Hospital Costa del Sol.

As described above, the hierarchy and structure of the two groups under examination are therefore similar, but there are some nuances that may be important to point out at this stage in order to later understand individual agents' alignment and degree of autonomy.[45] While the first group at the Hospital Clínico was established by Doctor Bermúdez in collaboration with Jackie, the second group was entirely the responsibility of Dorothy, who planned the project and presented it to the hospital director, Doctor Pizarro, as is evident in Excerpt 2. Moreover, the coordinator at the Hospital Costa del Sol enjoys a higher degree of symbolic capital since her position was not only legitimised by the hospital director, as mentioned above, but also by the regional government delegate, as she explains in Excerpt 3, and the local media.[46] This suggests that she holds not only linguistic and symbolic capital, but also a large volume of social capital in the form of prestigious social connections. In Excerpt 3, interpreters at the Hospital Clínico talk about Dorothy´s position and her social connections with the regional government *Junta de Andalucía*. This grants her a high degree of symbolic capital as will be evident at a later stage when she establishes her autonomous position in the wider field (see Excerpt 29, lines 38-40, Chapter 5) and her strong position as coordinator by controlling the conversation within the sub-field (see Excerpt 10, line 3 in this chapter).

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[45] The issue of autonomy is discussed in detail in Chapter 5. Autonomy is difficult to separate from questions of legitimisation and alignment. Interpreters' degree of autonomy is a feature of and impacts on the position they adopt in the field. Depending on how much autonomy, and therefore symbolic capital, they possess interpreters will be able to situate themselves within a more or less dominant position in the wider field of healthcare.

[46] See Appendix IV for a newspaper article about the coordinator at the Hospital Costa del Sol.

Excerpt 3 (FG 2, Hospital Clínico, lines 612–639, Appendix V):

| 1 | **Jackie**: | Dorothy aprendió de aquí. Ella venía los sábados con Peter, su marido. |

1   **Jackie**:   Dorothy aprendió de aquí. Ella venía los sábados con Peter, su marido.
Dorothy learnt here. She used to come on Saturdays with Peter, her husband.
{...}

2   **Salvador**:   Además, a ella la pusimos como vicepresidenta, ¿no te acuerdas?
Moreover, we made her vice-president. Remember?

3   **Jackie**:   Sí, sí, posiblemente.
Yes, yes, possibly.

4   **Salvador**:   La primera asamblea que tuvimos y eso, a ella la pusimos como
5   vicepresidenta. Ella hacía parte de aquí de la asociación, para que ella
6   pudiera plantear aquello, también allí.
In the first meeting we had, we made her vice president. She was part of the association here, so that she could set up the other thing as well there.

7   **Researcher**:   Allí, claro.
There, of course.

8   **Salvador**:   Y no lo ha hecho porque no ha querido.
And she hasn't done so because she has not wanted to.
{...}

9   **Jackie**:   Yo diría que Dorothy está más organizada que nosotros.
I would say that Dorothy is better organised than us.
{...}

10   **Salvador**:   Además Dorothy estaba muy relacionada porque cuando fuimos a ver
11   al delegado de gobernación, venía ella con nosotros. Y el delegado de
12   gobernación le conocía a ella perfectamente. Y al marido, porque
13   falleció el marido.
Dorothy was also very well connected because when we went to see the government representative, she came with us. And the government representative knew her very well. And her husband, because her husband died.

14   **Researcher**:   ¿Sí?
Did he?

15   **Salvador**:   El marido era también una persona que se dedicaba mucho al
16   voluntariado. El marido de Dorothy.
Her husband was also a person very dedicated to volunteerism. Dorothy's husband.

The Hospital Clínico interpreters in Excerpt 3 make a point of mentioning that the interpreter who established the interpreting team at the Hospital Costa del Sol started work earlier, with them, at the Hospital Clínico, and that she functioned as the Vice-President of AIVE for a few years. This, they thought, would allow her to bring the same degree of institutionalisation to the group she had started at the Hospital Costa del Sol, which she did but through an extension of AIVE, instead of

joining as part of the same association.[47] As explained by Bourdieu (1990a, p. 138), "the power of constitution, a power of making a new group, [...] can be obtained only at the end of a long process of institutionalisation", a process which can go from the symbolic, i.e. norms, rules, beliefs, to the organisational, i.e. constituting an actual official association such as AIVE which functions as part of the hospital (Scott 2008). Dorothy was provided with enough power and authority in the form of an official title, "vice-president", to bring the same level of professional organisation to the Hospital Costa del Sol interpreting group, which she did through an extension of AIVE, called *Los Claveles*. Her social capital is clearly acknowledged in lines 10 to 13: it takes the form of social connections with the regional government *Junta de Andalucía*. This suggests that the coordinator at the Hospital Costa del Sol enjoys a higher degree of social and symbolic capital than Jackie, the coordinator at the Hospital Clínico. Her social capital and symbolic capital allowed her to occupy a position that other agents can recognise and legitimate, which explains why she is at the top of the hierarchy and appears to enjoy so much power.

As discussed above, the position of both groups was initially legitimised by each hospital director, Doctor Bermúdez and Doctor Pizarro, respectively, who attributed a high value to interpreters' linguistic capital, thus allowing it to be converted into symbolic capital. Interpreters thus came to occupy legitimate positions within the sub-field of healthcare interpreting, positions that could be recognised by other institutional agents within the wider field of healthcare. Interpreters accordingly came to be considered part of the healthcare institution, as is evident in the following two excerpts:

Excerpt 4 (FG 1, Hospital Costa del Sol, lines 183-186, Appendix V):

1	**Cordula**:	I think the director we had before he spoke to all the doctors and the
2		nurses and he said that we would help the hospital, and it would be
3		good for the patients, so they had a different understanding of what we
4		really do.

In Excerpt 4, Cordula is nostalgic about the former director, Doctor Pizarro, who seemed to understand their position in the field and who valued the service they

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[47] The current secretary of AIVE explains why they decided to set up separate associations (see Focus Group 2, lines 580-590, Appendix V).

provided to the healthcare institution and patients. He seemed to have engaged in explicit legitimisation of interpreters' position by explaining to hospital staff the value of the service provided by interpreters. This director produced and imposed structures that positioned interpreters within the healthcare institution, thus strengthening their position within the healthcare field. The same thing seems to have happened at the Hospital Clínico, where, in Excerpt 5, Jackie also points out that the previous director, Doctor Bermúdez, understood and valued the service provided by volunteer interpreters.

Excerpt 5 (FG 2, Hospital Clínico, lines 75-76, Appendix V):

1 **Jackie**: Pero al principio el director, o uno o dos, creo que tenía más interés en,
2 con nosotros.
But at the beginning the director, either one or two of them, I think he was more interested in us.

In both excerpts, interpreters acknowledge that their positions were legitimised by individual hospital directors, that these were the agents with enough symbolic capital and autonomy to (re)produce and impose these structures and positions onto other agents within the sub-field of healthcare interpreting. Here, legitimisation, as a form of institutionalisation, means that there are certain positions that are recognised and established as autonomous spaces, and that certain agents who hold certain forms of capital and habitus are authorised to occupy those positions (Bourdieu, 1998, p. 222). However, as the conversation among participants in both focus groups developed (see Focus Group 1 and Focus Group 2, Appendix V), the degree of legitimisation and professional autonomy that interpreters enjoyed during the first few years of working at both hospitals seemed to be under threat as new hospital directors put some distance between them and the interpreting team and the relationship started to cool. The hospital directors at both hospitals who had initially legitimised interpreters' position and capital retired and new ones came into the sub-field of healthcare interpreting, as can be observed in the continuation of Excerpt 4.

Excerpt 4 continued (FG 1, Hospital Costa del Sol, lines 370-376, Appendix V):

6 **Cordula**: But everything has gone down a bit.
7 **Dorothy**: Yeah, they were nicer, yeah.

8	**Cordula**:	At the beginning they were really, really nice, really nice. And with
9		every director it changes, every director has a catch, you know so...
10	**Julianne**:	It's a financing problem.
11	**Cordula**:	It's true! Everything is, is...
12	**Dorothy**:	Well I'm still waiting for the tea and cakes from the ex-director,
13		Ricardo.

The new hospital directors at both hospitals do not seem to be as involved with the interpreters and less willing to legitimise their position and linguistic capital to the same degree as previous directors. Therefore, the relationship between the interpreters and the healthcare institution, represented by the hospital director, has changed over time and a new hierarchy has been introduced where interpreters are not allowed to occupy positions at the top of the hospital hierarchy. Under the new circumstances interpreters had to face the fact that new agents entering the field are more reluctant to accept the field structures the way volunteer interpreters have known them in the past, and some agents began to question and challenge interpreters' position and their linguistic capital as a valuable asset that can be transformed into symbolic capital, as evident in Excerpt 6, which is worth quoting at length.

Excerpt 6 (FG 1, Hospital Costa del Sol, lines 138-211, Appendix V):

1	**Dorothy**:	No, I mean there's obviously changes wherever you are, you know,
2		and I mean and I think in some ways, yes, I mean, a lot of them, still,
3		the older ones that have been here since the beginning.
4	**Julianne**:	They do still sometimes.
5	**Dorothy**:	They are, um, - are [very thankful to us] but some people don't.
6	**Julianne**:	[Yes, they are very nice.
7	**Cordula**:	Although they speak English they still call us.
8	**Dorothy**:	Yeah, yeah.
9	**Julianne**:	Yes, that's right yeah.
10	**Cordula**:	Although they're here [16 years and] they learnt all English [and they
11		say: "I'm not] quite sure", I always let them speak and if they, you
12		know, you jump in, I admire this, they do this really (.) but the new
13		ones, the younger ones they think they can do it all. I mean some do
14		speak very good English.
15	**Julianne**:	['Cos it's easier.
16	**Dorothy**:	[From me,
17		I used to teach them.
18	**Julianne**:	They are very tall.
19	**Cordula**:	Yeah, but, - but, so what?
20	**Researcher**:	But of course it depends...
21	**Rebecca**:	Then sometimes it's the fault of the patient also, because the patient

22		so often won't say: "Oh, I didn't understand could you explain that
23		again?"
24	**Dorothy**:	They won't say to the doctors but they will say it to us, so of course
25		they (.)- and whenever the doctor comes in, you know what it's like,
26		we do the same thing in our own languages, you know, you're so sort
27		of in awe of this doctor that comes in, and you, and it's like he's God
28		right, and you know, I see the patients, going: "Yes, yes, yes!", but then,
29		I understand but they don't understand a word.
30	**Julianne**:	It hasn't sunk in, you know? [In here (( )) that's it. Yeah, cos it's so
31		quick, the doctor only stays for a few minutes.
32	**Dorothy**:	[No, they are nervous, they are frightened
33		too.
		{...}
34	**Cordula**:	People come in now, new doctors and new nurses and they think we
35		are intruding, uh? Yeah? They see us as intruders, uh? You know,
36		what are you doing here? But we can't go now after 16 years to
37		nurses who are new here, I'm so and so, we have our badge, we have
38		our badge and all the colleagues…
39	**Julianne**:	I mean they know us, but one of the big problems is…
40	**Cordula**:	They know us but they are sometimes very rude to us.
41	**Dorothy**:	Yeah, well, yeah, occasionally, but um…
42	**Julianne**:	But, I think that's just probably because we are foreigners, definitely, I
43		get that feeling, yes.
44	**Cordula**:	The person who leads the hospital even they don't respect you…
45	**Dorothy**:	Yeah, exactly.
46	**Cordula**:	If you ask for an appointment you don't get it. You won't talk with
47		them and that is the thing, a communication problem, between
48		everyone. We're friendly with all the staff for 16 years now, with
49		doctors and everyone, it's a friendly situation, it's the newer ones that
50		come in, they don't understand the system and nobody told them and
51		nobody told them that's how I see it.
52	**Dorothy**:	Yeah, that's true.
53	**Rebecca**:	I would agree with that.
54	**Julianne**:	Yeah.
55	**Rebecca**:	The fact that there isn't that communication from the top through…
56	**Dorothy**:	Yes, that's probably true.

Interpreters are clearly aware that their position is being threatened by the entry of new agents into the field. These new agents are referred to as new(er) ones or younger ones (doctors and nurses) in lines 12, 13, 34, 37 and 49 and 60 and 61 (in the continuation of the excerpt below) as opposed to old(er) ones, in lines 3 and 64 (in the continuation of the excerpt below), who, as discussed above, had previously internalised the field structures that reproduced the volunteer interpreters' position and linguistic capital. Older doctors and nurses are positively evaluated by interpreters because these legitimise their [the interpreters'] position and need interpreters' linguistic capital, thus attributing a

high value to this asset. Interpreters resort to bureaucratic traits such as name badges in lines 37 to 38 (an issue that will be further discussed in section 4), to their length of service as interpreters (lines 10 and 36) and to institutional alignment to claim a high degree of institutionalisation for themselves when confronted with younger or newer agents who often see interpreters as "intruders" (line 35). Newer agents who "do not understand the system" (line 50) challenge their position because the new hospital director has failed to legitimise their position and impose the field structures onto the new agents. Not only do new agents fail to accept the interpreters' position as part of the natural order of the field, but they also fail to acknowledge interpreters' linguistic capital as a valuable asset in the healthcare field: many of these new agents possess, or at least claim to possess, interpreters' linguistic capital.

The concept of an existing functioning system does not only emerge in the focus groups but also in the audio-recordings of daily routine visits. This system, which in Bourdieusian terms is known as the objective structures of the field, is important for interpreters because it reveals the recognition of their position within the field. Other agents must recognise and legitimate this system so that they can position themselves as healthcare interpreters.

Excerpt 7 (DRV 2, lines 12-19, Appendix V):

1   **Interpreter**: I do hope really that soon you'll be out.
2   **Patient**:   I hope so.
3   **Interpreter**: I wish you all the best. If you need..., as you know the system,
4   whenever you need anything...
5   **Patient**:   Yeah.
6   **Interpreter**: Good luck, Thomas?
7   **Patient**:   Thank you very much.
8   **Interpreter**: Bye.

In Excerpt 7, one of the interpreters explicitly mentions the system, in line 3. She starts with "if you need…" (line 3). From my observations of DRVs, this phrase tends to signal the beginning of an explanation of how the system works, as in "if you need an interpreter you can call us Monday to Friday".[48] But the interpreter realises that the patient already knows the system and further explanation is therefore not necessary. This suggests that the patient in this case recognises and

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[48] This is a repeated pattern of daily routine visits for those patients who are new and need a brief explanation of how the interpreting service works.

legitimates the interpreter's position and linguistic capital, thus strengthening the structures of the field that support this position.

Because of the problems that interpreters currently experience with the entry of new agents in the field, the relationship between interpreters and healthcare staff has slowly deteriorated, as they openly explain in the continuation of Excerpt 6.

Excerpt 6 continued (FG 1, Hospital Costa del Sol, lines 673-681, Appendix V):

57 **Cordula**:   But like the relationship with the nurses has cooled down.
58 **Julianne**:   Deteriorated a bit, yeah.
59 **Cordula**:   It's not as nice and camaraderie, it's not there anymore.
60 **Researcher**: Is it because they're new? Or...
61 **Cordula**:   The new ones [(.) Some of them are still nice, yes. But a lot of them
62   have gone and....
63 **Dorothy**:   [Not all of them, though Cordula, some are certainly
64   nice, the old ones are still very sweet.
65 **Dorothy**:   Yeah, I know that's true, yeah.

Interpreters are thus aware that their relationship with the hospital director and the rest of the healthcare staff has worsened. On the one hand, the new director, still the agent with the strongest habitus and the symbolic power to reproduce the field structures and to legitimise their capital, does not recognise and therefore does not legitimate interpreters' positions or linguistic capital as a valuable asset in the field. On the other hand, other healthcare staff members do not treat interpreters as equal agents, as part of their "camaraderie" (line 59), who occupy a similar position within the healthcare institution, despite the high degree of bureaucratisation they have achieved over time. Newer agents do not internalise and reproduce the same field structures as older agents; they challenge those structures of the field that allowed interpreters to occupy relatively autonomous positions. Volunteer interpreters, whose habitus is often weaker and who are usually positioned towards the lower end of the healthcare institutional hierarchy, are constantly struggling to resist the challenge of agents with a stronger habitus and more symbolic capital who are able to impose their own structures and dispositions.

Interpreters at Hospital Clínico raise the same issues. When asked about their relationship with the healthcare institution, and whether they felt that their work was being recognised, they explained that their relationship with the

director, and with the healthcare institution in general, had deteriorated, although their relationship with the rest of the staff seems to remain pleasant. In Excerpt 8, interpreters openly discuss their relationship with both the healthcare institution and the rest of the hospital staff, and make it very clear that they have lost their special relationship with the hospital director (lines 7, 9, 11, 12 and 16).

Excerpt 8 (FG 2, Hospital Clínico, lines 169-200, Appendix V):

1	**Researcher**:	Vosotros os consideráis... o sea, qué relación tenéis con lo que es la
2		institución y con el respecto al resto de la plantilla...
		Do you consider yourself...? I mean, what kind of relationship do you
		have with the institution and with the rest of the staff?
3	**Salvador**:	Muy buena, muy buena.
		Very good, very good.
4	**Hannah**:	Con la institución muy poca. Yo francamente con la administración no
5		tengo nada que ver, pero con las enfermeras normalmente bien, con
6		las auxiliares, pero con la administración... ahí es como la Moncloa, ahí
7		no tengo nada que ver. Ni me va, ni se nada, pero sí...
		With the institution very little. To be honest I have nothing to do with
		the management, but I usually get on well with the nurses, with the
		auxiliary staff, but with the management... it's like the Moncloa (House
		of the Spanish President) in that place, I have nothing to do with them.
		It has nothing to do with me, and I know nothing, but well...
		{...}
8	**Salvador**:	[Se ha perdido] ya el contacto que] teníamos, el contacto que
9		teníamos con la gerencia se ha ido enfriando quizás porque a nosotros
10		no nos ha interesado, ir a presentarnos. Al principio lo hacíamos.
		We have lost the contact we had. The contact that we had has been lost,
		the contact we had with the management has cooled off, maybe because
		we haven't been interested in going to introduce ourselves. At the
		beginning we used to do it.
11	**Hannah**:	[Se ha perdido, y...no sé por qué.
		It's been lost, and... I don't know why.
12	**Jackie**:	[Se ha perdido.
		It's been lost.
13	**Jackie**:	Sí, nosotros fuimos. Hemos ido - Pauline y yo fuimos.
		Yes, we went. Pauline and I went.
14	**Salvador**:	Pero al gerente siempre hemos ido a presentarnos.
		But we have always gone to introduce ourselves to the director.
15	**Jackie**:	Sí, sí, sí, Pauline y yo...
		Yes, yes, yes, Pauline and me...
16	**Salvador**:	Y ahora ya, pues en invierno, y ahora ya estamos más bien olvidados
17		ni nos han invitado para la fiesta de Navidad.
		And now, well this winter, now we have basically been forgotten about,
		they haven't even invited us to the Christmas party.
		{...}
18	**Salvador**:	No, pero más bien por culpa de nosotros, que no hemos querido ir,
19		formar esa relación con ellos...

		No, I would say it is more our fault that we haven't wanted to go, to establish that relationship with them….
20	**Hannah**:	Yo pienso que el director sabe que aquí hay intérpretes y no ha hecho
21		nada por invitarnos…
		I think that the director knows that there are interpreters here and he hasn't taken the time to invite us…
22	**Salvador**:	Pues claro que lo sabe, si el firma [los...
		Of course he knows, he's the one who signs [the…
23	**Hanna**:	[El papeleo
		[The paperwork

We can observe how Salvador changes his opinion very abruptly from very positive in line 3 to very negative in line 8 and again in line 16, when Hannah brings up their poor relationship with the healthcare institution. Moreover, it seems that he is trying to justify this deterioration by partially assuming responsibility for it—for himself and the rest of the group—in lines 8 to 11 and then again in lines 18 to 19. Perhaps he is trying to retain some symbolic power by establishing that this loss of interest between the interpreters and the healthcare institution is reciprocal, and that interpreters have also lost interest in establishing a relationship with the hospital director. He may be trying to show that they do not need the director's approval to be part of the healthcare institution and, therefore, do not need to actively seek a relationship with him. This would strengthen the impression of an autonomous position for interpreters within the field.

In the continuation of Excerpt 8, interpreters carry on discussing their relationship with the healthcare institution and bring up the lack of recognition and gratitude on the latter's part.

Excerpt 8 continued (FG 2, Hospital Clínico, lines 353-363, Appendix V):

24	**Researcher**:	Sí, simplemente si creéis que hay un reconocimiento dentro del
25		hospital, por lo menos.
		Yes, basically whether you think that there is recognition within the hospital at least
26	**Jackie**:	Sí, sí, sí, sí. Dentro en Moncloa creo no tanto, pero…
		Yes, yes, yes, yes. I don't think we have any inside the Moncloa, but…
27	**Researcher**:	Bueno, tampoco porque no… A lo mejor no tenéis contacto.
		Well, maybe because you haven't… Maybe you don't have contact with them.
28	**Salvador**:	Eh… exacto. Antes teníamos más contacto. Yo, cuando yo estaba de
29		secretario, de vez en cuando íbamos ahí y hablábamos con…
		Erh… exactly. Before we had more contact. When I was the secretary we would go there sometimes and talk to…

30	**Jackie**:	La última vez fuimos Pauline y yo y él dijo que iba a mandarnos una
31		carta agradeciendo a cada uno y nunca… pero, eso aparte. Si lo más
32		importante es que nosotros estamos… los pacientes están
33		agradecidos, los médicos están agradecidos, y la gente aquí está
34		agradecida.

Last time Pauline and I went there and he said that he was going to send us all a letter thanking each one of us and it never happened…. but that aside. The important thing is that we are… patients are grateful, doctors are grateful, and people here are grateful.

In Excerpt 8 and the continuation of Excerpt 8, interpreters refer to the management office as "La Moncloa" (lines 6 and 26), which is the official house of the Spanish President, the equivalent of Downing Street in the UK. This reference reflects their view of the hospital director's attitude towards the interpreting group at the Hospital Clínico, implying that he is positioned at the top end of the hierarchy and that he shows no interest in those agents who occupy a lower position down the hierarchy, particularly interpreters. Their efforts to establish contact with him have not been successful. Their social capital, in the form of social networking with the management office, has diminished, and this has had consequences for their ability to accrue symbolic capital. At the same time, they claim that their relationship with other agents in the field is good, and that these agents recognise and legitimise their position and value their linguistic capital. But as we will see in the following excerpts, the interpreters at Hospital Clínico are not consistent in their portrayal of these relationships.

In excerpts 6 and 7, which have been extracted from two different focus groups, one at each of the hospitals under study, we can observe the same pattern in interpreters' description of the way things have changed at each healthcare institution. In both cases, interpreters' relationship with the hospital director has deteriorated, and this has had an impact on their position by allowing other agents to challenge it, especially newer agents who have recently entered the field and have not internalised the structures the way they were known to interpreters. That is to say, they have not developed a view of these structures as encompassing a position for interpreters. What is particularly relevant here is the extent to which the recognition of interpreters is dependent on individuals who occupy a higher position within each hospital (rather than in the field of healthcare as a whole). This suggests that their position is precarious, not formally configured as part of the field structure but randomly allocated by powerful individuals in the field.

One issue already alluded to which is consistent throughout all four focus groups and has affected interpreters' position and legitimisation and, hence, their degree of institutionalisation is the devaluation of their linguistic capital as the most valuable asset they can offer to the healthcare institution, the asset they can transform into symbolic capital. In Excerpt 9, one of the interpreters acknowledges this issue openly.

Excerpt 9 (FG 4, Hospital Clínico, lines 115-118, Appendix V):

1 **Catherine**: {...} Yo lo que noto es que... personalmente considero que más y más los
2 médicos hablan inglés y se comunican relativamente bien con sus
3 pacientes y por lo tanto que nuestro trabajo de intermediario, de
4 traducción, interpretación bicultural, bidireccional, es menos.
   {...} What I've noticed is that... personally I think that more and more
   doctors speak English and communicate relatively well with their
   patients and therefore our work as translators, of bicultural two-way
   interpretation, has decreased.

In the following four excerpts, extracted from all the focus group sessions carried out, we can observe that interpreters' position shifts constantly depending on other agents' position and volume of linguistic capital. Where doctors hold sufficient linguistic capital, or at least believe they do, as emphasised in Excerpt 10 (lines 24-25), interpreters' linguistic capital loses its value in the field. This has a considerable impact on interpreters' position, rendering it less legitimate, and undercutting their ability to use this capital in negotiating the rules of the game and reproducing the structures they had previously internalised. This issue remains a locus of on-going struggle between interpreters and those doctors who have or believe they have the relevant linguistic capital, but does not feature in their interaction with those who do not hold any linguistic capital. The latter continue to attribute a large value to interpreters' linguistic capital, thus allowing them to transform it into symbolic capital within specific encounters. Once again, this points to the precarious nature of the interpreters' positioning within this field.

Excerpt 10 (FG 1, Hospital Costa del Sol, lines 76-124, Appendix V):

1	**Researcher**:	What do think? Have there been any changes at all? You know in all
2		these years?
3	**Dorothy**:	Give you opinion, then your opinion and then I'll give...
4	**Cordula**:	Everything has changed.
5	**Julianne**:	Ok, well, I think...To be honest, I think yes, because of the influx of
6		people on the coast, I think that has changed the services, yeah. They
7		have deteriorated to be honest for the patients...I think so, also we're
8		not quite so much involved with the doctors anymore, we're very,
9		very rarely called. I do an afternoon so it's not quite the same as the
10		morning pass.
11	**Dorothy**:	In the morning we still get [called a lot, it depends on the day.
12	**Cordula**:	[Yeah, but, yeah, but, but...
13	**Dorothy**:	Yeah, I know.
14	**Julianne**:	A few years ago, I would say up to about sort of 2000, 2001...
15	**Cordula**:	We were always called, always.
16	**Julianne**:	Yes, we were always called, all the time, now, very little.
17	**Dorothy**:	Well, they are also hiring more doctors who speak English, who speak
18		other languages.
19	**Julianne**:	Well, it's the same really. So many now speak English.
20	**Researcher**:	Do you think that that's the reason? That more people speak English?
21		What about other languages?
22	**Julianne**:	[Oh yeah, yes.
23	**Cordula**:	[Yes, yes, yes.
24	**Dorothy**:	Well, mind you...Some do, but let's face it, a lot of the problem is that
25		they think they speak English but they don't really, and as I was
26		saying to you before it's not their fault, 'cos they're trying and they
27		shouldn't have to speak English, I mean, it's their country, but by the
28		same token they should say: "Look! My English is not great, I need an
29		interpreter".
30	**Researcher**:	I need someone.
31	**Julianne**:	That's right, yeah.
32	**Cordula**:	And often what happens is that the patient says I don't understand a
33		word and so you've got to be very <u>diplomatic</u> with the doctors
34		obviously, you know? I mean not all of them are like that, but some of
35		them are...
36	**Julianne**:	And then also you get the situation where a lot of the doctors here
37		don't really care that much for us here, so the patient could be asking
38		for an interpreter and the doctor would be saying, NO, NO, NO, NO!!!
39		They don't bother.
40	**Cordula**:	[And they can speak enough.
41	**Julianne**:	[Or we speak enough English] or whatever and the problem is that
42		they don't speak that well, and so, and I know for a fact that when I
43		have been here I had a friend who came along, who was English or
44		spoke English, and doesn't speak any Spanish, knew I was here on a
45		Monday afternoon and...
46	**Dorothy**:	And they didn't call up you?
47	**Julianne**:	NO. They told, she was told that there was no interpreter present,
48		some personnel.
49	**Dorothy**:	Well, that's not right, yeah.

As can be seen in Excerpt 10, one of the main issues that concern interpreters at the Hospital Costa del Sol is that some doctors speak, or believe they can speak, the language; they think they are able to provide a service as interpreters just as effectively, particularly where English is concerned. Therefore interpreters' linguistic capital is no longer considered an asset that can be exchanged to acquire autonomy and symbolic power. The value of English, in particular as a form of linguistic capital, is susceptible to challenge. And, since doctors have a stronger habitus and more symbolic capital, interpreters cannot struggle against these agents to impose their dispositions and safeguard their roles as language brokers. Being dominated and overruled by the agents with a stronger position in the field, interpreters have to deploy strategies of subversion in order to be able to safeguard their own position and the value of their linguistic capital. These strategies of subversion can be observed in some of the interpreter-mediated interactions, where interpreters try to restore their position (see Excerpt 12 in this chapter) and where they align with patients and challenge doctors' decisions (see Chapter 5, section 1.2). Another issue that emerges from this excerpt concerns the internal hierarchy of this sub-field; in line 3 Dorothy assigns each participant in the focus group a speech turn to answer my question, which is indicative of her position as coordinator at the top of the hierarchy, one who enjoys a symbolic capital legitimised by other interpreters.

It is interesting to observe how interpreters put distance between themselves and the healthcare institution on this occasion by establishing a 'they' versus 'us' theme throughout the excerpt; this contradicts other occasions where interpreters appear to want to be part of the healthcare institution by resorting to several bureaucratic traits (see Excerpt 6 in this chapter). Moreover, in Excerpt 10 interpreters use the word "diplomatic" (line 33), which they also use again in Excerpt 30 in line 6 (see Chapter 5); it is evident that they know they have to be very careful not to directly challenge doctors' linguistic capital since this may cause some tension between them and the doctors. This need to avoid confrontation and tension underscores their inferior status or position within the sub-field.

In the following excerpt, Fadilah also mentions that the number of doctors who speak English is increasing, and that this is having an impact on the number of phone calls interpreters receive from doctors to translate between them and foreign patients.

Excerpt 11 (FG 3, Hospital Clínico, lines 24-62, Appendix V):

1   **Fadilah**:   En inglés se enteran, pero es que quieren... tú sabes que es que a veces
2   tienes que hacer una traducción que sea más exacta. Los médicos
3   dicen que de verdad te necesitan. Aunque hablan inglés, pero te
4   llaman. Te llaman para muchas cosas. Y francés por supuesto, que la
5   mayoría no lo hablan, entonces sientes que estás haciendo algo que
6   ayudas... y los árabes...

They understand English, but sometimes they want to... you know sometimes we have to do a more literal translation. Doctors say they really need you. Even though they speak English, they call you. They call you to do lots of things. And in French of course, which the majority of doctors don't speak, there you feel like you're doing something to help... and the Arabic speakers...

{...}

7   **Researcher**: Y, al principio... ¿crees que han cambiado mucho las cosas? ¿Son
8   diferentes antes y ahora? ¿Has notado diferencias?

And, at the beginning... Do you think things have changed a lot? Are there any differences between then and now? Have you noticed any differences?

9   **Fadilah**:   Sí, sí. Cada año notas alguna diferencia. Antes había mucho trabajo, no
10   paramos. Bueno, por ejemplo, el busca no paraba. Somos dos y cada
11   vez estás en urgencias, quirófano, sube, baja... ahora notamos que la
12   cosa un poquito más tranquilita.

Yes, yes. Every year you notice some differences. Before we used to have lots of work, we didn't stop. Well, for example, the pager never stopped. There're two of us and all the time we are in the emergency room, surgery, up and down... Now we've noticed that things are a bit quieter.

13 **Researcher**: ¿Y por qué crees que...? ¿Hay menos pacientes?

And why do you think...? Are there fewer patients?

14 **Fadilah**:   Yo creo que no es menos pacientes. Es que cada vez que los médicos
15   hablan más...

I don't think there are fewer patients. It's the fact that more and more doctors speak better...

16 **Researcher**: ¿Más inglés?

Better English?

17 **Fadilah**:   Más inglés. Sí. Antes era solo llamadas de inglés, muchos, muchos
18   ingleses.

Better English. Yes. Before, there only used to be calls for English speakers, many English speakers.

Although she explains that some doctors still need their services and are grateful, Fadilah recognises that despite the increase in the number of English speaking patients, English is not as valuable an asset as it used to be because doctors are increasingly acquiring the same asset. She mentions that other forms of linguistic capital, such as French or Arabic, are more valuable than English (lines 4-6) on this market. This may have an impact on individual positions occupied by

individual agents who possess different forms of linguistic capital, as each individual form of linguistic capital may be valued differently according to its scarcity or availability in the field. This issue has not been pursued in the current study, and the only insight offered here consists of the few instances where interpreters have spontaneously referred to it.

In the continuation of Excerpt 11, Fadilah's opinion shifts. In lines 25 to 26, she complains that the behaviour of some doctors towards her makes her feel that her position is being threatened, whereas in lines 28 to 31 she describes other doctors as friendly and collegial. The legitimisation of the interpreter's position thus seems to be dependent upon individual members of the dominant hospital class of doctors who have the symbolic power and autonomy to legitimise interpreters' position and linguistic capital, or otherwise, as discussed above.

Excerpt 11 continued (FG 3, Hospital Clínico , lines 248-271, Appendix V):

19	**Researcher**:	Sí. ¿Y las cosas más frustrantes de este trabajo? Lo más frustrante, lo
20		más negativo, lo más...
		Yes, and the most frustrating things about this job? The most
		frustrating or most negative, the most...
21	**Fadilah**:	Lo más negativo, no es siempre, por ejemplo, una vez cada dos años
22		que encuentras algo que te choca, algo... por ejemplo: un paciente
23		viene y te dice: "Por favor, ¿puedes venir conmigo a una consulta?" y
24		vamos, y el médico te dice: "lo siento es que hablo inglés", y te lo dice
25		malamente, entonces... Entonces digo... por lo menos tenían que
26		haberte informado bien para decirte que el médico habla... cosas así.

The most negative aspect, it doesn't always happen, for example, once every two years you come across something that surprises you... for example, a patient comes and says to you: "Please can you come with me to a consultation?" and we go and the doctor says, "I'm sorry I speak English" and he says it to you in a rude manner, so... So what I think... at least they should inform you properly and tell you that the doctor speaks... and things like that.

{...}

27	**Fadilah**:	Y también los médicos de urgencias son todos un encanto, la verdad.
28		Cuando te llaman y esto te lo agradecen mucho, muchísimo. Yo por
29		ejemplo, el Doctor Jiménez es... me ve y me dice: "¡Ay, compañera!" y
30		yo digo, "¿compañera de qué?". Son gente la verdad que no hay nada
31		que decir... te lo agradecen...

And also the doctors in the emergency room are all lovely, honestly. When they call you they are really grateful, really. In my case for example, when doctor Jimenez sees me he says "Hey, my colleague!" and I say "in what way am I your colleague?" They are the kind of people that you can't really say anything bad about... they are grateful to you...

What is interesting in this particular excerpt is the fact that while Fadilah is recognised as an equal by some doctors, as suggested by the use of *compañera* (colleague) (line 29-30), she rejects this offer of equality by questioning the basis of their relationship as colleagues. It is possible that Fadilah sees doctors as agents with a very strong habitus who occupy positions at the top end of healthcare institutional hierarchy and, having been forced to occupy a position at the low end of the hierarchy in the past, she cannot accept this new degree of legitimisation. Her habitus has internalised the structures of the sub-field of healthcare interpreting that position interpreters as dominated agents and she is unable to (re)produce the structures that this doctor is trying to establish in this particular instance. Thus, depending on the doctor's dispositions towards interpreters, the latter will see their position and capital as either legitimate or not, and their perception of their own positioning will change accordingly. Interpreters' positions are hence very unstable and can be easily challenged. In this scenario, English features as a particularly problematic form of linguistic capital that is increasingly being devalued in the field.

The same issues arose outside focus-group discussions, in actual interaction between interpreters, patients and doctors during interpreter-mediated consultations and interpreters' routine visits to patients. In Excerpt 12, extracted from an interpreter-mediated interaction, the interpreter tries to establish her position in the field by explaining to the patient how and when the interpreting service operates, but the doctor undercuts this attempt by intimating that this service is not absolutely necessary.

Excerpt 12 (IMI 3, lines 296-305, Appendix V):

1	**Relative**:	Ok. If something happens from day to day, and we need to, we need
2		you to, I mean we just ask for someone.
3	**Interpreter**:	There's an interpreter every day except Saturday and Sunday, ok?
4		{...}
5	**Doctor**:	Dígale de todas maneras que nosotros también hablamos inglés, lo
6		que pasa es que hoy queríamos, porque eran muchas cosas, y
7		queríamos que lo entendieran bien.

Tell him that in any case we also speak English. It is just that today we wanted, because there were lots of things, we wanted them to understand them properly.

8	**Interpreter**:	They speak some English but as it was a lot of things together...
9	**Doctor**:	Muy bien.

Very well

10	**Relative**:	Oh, yes, yes. A lot of things, I appreciate. Yes, thank you very much. We

| 11 | | appreciate now what you've done. Thank you! Thank you very much |
| 12 | | indeed. Thank you, thank you now, thank you. Yes, thank you! |

In line 5, the doctor—who we can assume speaks English and understands the conversation taking place between the interpreter and the patient's relative— interrupts the interpreter to point out to the patient that he speaks English and only called the interpreter because the information to be provided was very important and complex (lines 5–7). Interestingly, given his proclaimed command of English, instead of addressing the patient's relatives directly the doctor asks the interpreter (in Spanish) to pass on this information to the relatives. He thus challenges the interpreter's position as the only agent with the linguistic capital to negotiate the rules of the game while simultaneously calling on her to deploy this capital, which he has just devalued. Consciously or not, the interpreter, for her part, devalues the doctor's proclaimed skill in speaking English when she says "They speak 'some' English" (line 8; emphasis added), a formulation which allows her to reassert her position as the agent in possession of the relevant linguistic capital. Somehow, although the doctor assigns less value to her linguistic capital, the interpreter is able to ensure that her position and capital is recognised and legitimised by the patient's relative in lines 10 to 12, when he praises very emphatically and repeatedly the service provided by the interpreter. This emphatic praise does not come across very clearly from the audio-recording, but the relative's gaze, as recorded in my diary, showed that he was distinctly addressing the interpreter as he spoke: from a participant observer's point of view, there is no doubt that he was expressing gratitude to the interpreter and not the doctor.

Once the consultation had ended, as he was leaving the patient's room, the doctor once again stressed that he only called the interpreter to make sure the family understood everything. He thus continued to use his symbolic power to constrain the interpreter's position and devalue her linguistic capital, as observed in the continuation of Excerpt 12.

Excerpt 12 continued (IMI 3, lines 317-321, Appendix V):

13	**Doctor**:	Es que yo quería explicarle esto bien y además quería que la familia, el
14		paciente lleva ingresado 5-, 4 ó 5 días y nunca habíamos hablado con
15		la familia y queríamos explicarles todas estas cosas, como la situación
16		es un poco compleja, para que lo entendieran bien. Muchas gracias.
17		¡Venga, hasta luego!

It's that I wanted to explain this to him properly and I also wanted the family, the patient has been here for 5-, 4 or 5 days and we have never spoken to his family and we wanted to explain all these things to them, because the situation is a bit complicated, so they would understand it properly. Thanks very much. Ok, see you later!

Given that the interpreter managed to gain the recognition of the patient's relatives, despite the doctor's attempt to challenge her position and devalue her linguistic capital, the above exchange may be interpreted as an attempt on the part of the doctor to assert his authority in response to the direct exchange between the interpreter and the patient, from which he was excluded. The exchange posed a threat to his position as the main interlocutor in the medical interview. As a result of the doctor's attempt to restore his authority, the interpreter's linguistic capital and hence the symbolic capital she possesses as the holder of such a valuable asset are devalued.

Unlike Excerpt 12, where the patient legitimises the interpreter's position, in Excerpt 13, extracted from a routine visit of one of the interpreters to a patient who has been at the hospital for some time, the interpreter tries to establish her position within the healthcare institution by highlighting the value of her linguistic capital to the patient and on this occasion, the attempt is undercut by the patient's recognition of the doctors' access to the same linguistic capital.

Excerpt 13 (DRV 1, lines 13-17, Appendix V):

1   **Interpreter**: If there's any problem you can always ask for us.
2   **Patient**:   Yes.
3   **Interpreter**: So, if you need anything you ask for an interpreter.
4   **Patient**:   Yeah, and that's, the doctor here speaks English also.
5   **Interpreter**: That's fine. Get better soon then.

The interpreter's quest for patient recognition and legitimisation of her position and linguistic capital fails, and she seems unable to pursue it further (she gives up the attempt in line 5) as she realises that the patient does not accept her linguistic capital as a valuable asset in the field.

The overall picture that emerges from the above analysis is one in which interpreters' position within the sub-field of healthcare interpreting is both complex and precarious. It fluctuates up and down the hierarchy of the field

depending on the value attributed to their linguistic capital by those agents with a stronger habitus and symbolic power who can legitimate the value of this capital, particularly agents that occupy the top positions in the field, such as hospital directors and doctors. Thus, although linguistic capital is an essential asset in the healthcare field, in cases where this capital is shared by other institutional players, its value decreases and interpreters who do not possess other forms of capital find themselves on the margins of the game. This precariousness is particularly acute in the case of interpreters offering English as their main linguistic capital. However, we have also examined some instances where interpreters' linguistic capital can be seen as a threat to those doctors who seek to hold the same linguistic capital and who witness how interpreters' linguistic capital is transformed into symbolic capital legitimised by patients and their relatives.

As well as the sought after legitimisation of their position by other agents in the field of healthcare, particularly those with a stronger habitus, volunteer interpreters have at their disposal a series of bureaucratic assets that allow them to take part in the field as institutional agents and therefore gain additional symbolic capital as explained below.

3.2 *Organisational traits of institutionalisation: Bureaucratisation*

Volunteer interpreters in the two institutions under study offered their services outside any interpreting-specific institutional structures for a number of years, as described in section 2. At the time, there was free movement of members and very little discipline (see Excerpt 14, lines 10-12). The later bureaucratic institutionalisation of the organisation that led to the formation of the official association AIVE (section 2 of this chapter) was not the result of a deliberate decision by the interpreting team.[49] It was an imposition of the Regional Government *Junta de Andalucía* who wanted some control over the organisation (lines 14-20). Interpreters' autonomy and professional discretion are perceived as threatened by institutional impositions and power in this instance, as evident in Excerpt 14.

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[49] I distinguish here between institutionalisation as a bureaucratic process (Bourdieu, 1998; 1986a) and institutionalisation in the sense of recognition and legitimisation by the institution and other institutional agents of the position that interpreters occupy within an institution (Bourdieu, 1990a).

Excerpt 14 (FG 2, Hospital Clínico, lines 65-162, Appendix V):

1   **Researcher**: Pues si creéis que las cosas han ido siendo cada vez más fáciles o se
2   han ido complicando...
                 So, do you think things have become easier or have they become more
                 complicated?

3   **Hannah**:   A nivel informático sí porque antes no teníamos la lista así de los
4   extranjeros y esto lo han introducido que está muy bien y después
5   han facilitado la lista con... que va por habitaciones también otra
6   mejora.
                 As regards IT facilities, yes, because before we didn't have a list like this
                 of foreign patients and they have introduced it which is very good, and
                 then they have provided us with this list with... which is organised by
                 rooms which is another improvement.

7   **Salvador**:   Y... yo pienso que la cosa ha ido para mejor.
                 And, I think that it has improved.
                 {...}

8   **Jackie**:   Pero al principio el director, o uno o dos, creo que tenía más interés
9   en, con nosotros.
                 But at the beginning the director, either one or two of them, I think he
                 was more interested in us.

10   **Salvador**:   Sí, al principio, no existía como organización, es decir, que no
11   estábamos declarados como asociación, automáticamente se iba, se
12   sabía un poco de disciplina...
                 Yes, at the beginning, we didn't exist as organisation, I mean, we were
                 not established as an official association, automatically we would come
                 here, there was very little organisation...

13   **Jackie**:   Al principio y muchos, muchos años.
                 At the beginning and for many, many years.

14   **Salvador**:   Sí, muchos años, sí, sí, se era parte de una asociación, lo que ocurre es
15   que nos ha obligado el gobierno a formarnos, o sea, a declararnos
16   como asociación, precisamente hemos hecho todos los trámites
17   necesarios y demás. Y se ha visto por otra parte de que hay un
18   rechazo en los antiguos que no asimilan muy bien eso de la
19   asociación, preferirían ser de libre como antes, no puede ser que ya
20   desde el gobierno, ya nos exige esta...
                 Yes, for many years, yes, yes, we were part of an association, what
                 happened was that the government forced us to institutionalise
                 ourselves, or rather to establish ourselves as an association, so we have
                 taken all the necessary steps and all that. And, on the other hand, there
                 has been a rejection from the more senior members who can't
                 assimilate very well the idea of the association, they would prefer to
                 have the freedom we used to have before, it shouldn't be that the
                 government, that now they require this...

21   **Researcher**: Pero ¿había mucha diferencia entre antes de ser asociación y después
22   o...?
                 But, was there much difference between before being an association
                 and afterwards or...?

23   **Jackie**:   Sí, estuvimos mucho más FELICES.
                 Yes, we were much HAPPIER.

24   **Hannah**:   Sí, creo...

		Yes, I think…
25	**Jackie**:	Menos problemas.
		Fewer problems.
26	**Researcher**:	Yo pensaba que era al contrario, que al ser asociación sería más fácil,
27		porque...
		I thought that it was on the contrary, that being an association would
		be easier because…
28	**Salvador**:	No, porque como esto lo hacen...
		No, because they do this in order to…
29	**Hannah**:	No, porque ya te exigen un presidente, te exigen un secretario, te
30		exigen esto y lo otro, ya hay algo de dinero por medio, entonces ya la
31		cosa se complica...
		No, because now they require you to have a president, they require you
		to have a secretary, they require this and that of you, there is some
		money involved, and so things become more complicated…
		{...}
32	**Salvador**:	Hemos conseguido que nos pagaran el hacer los kilómetros y ese tipo
33		de problemas, compensar los gastos que tenemos, una miseria, pero
34		bueno. Lo que se pretende es que no se tenga gastos. Por lo menos el
35		venir a trabajar...
		We have managed to get them to pay for the petrol and those kinds of
		problems, cover the expenses we have, a pittance, but still. The idea is
		not to have any expenses. At least coming to work…
36	**Researcher**:	Sí, por lo menos que no os cueste nada.
		Yes, at least it should not cost you anything.
37	**Salvador**:	Exacto, también que nos paguen el café. Pero bueno, que la comida y
38		eso que sea gratis, y los kilómetros para venir también. Gracias a
39		Dios...
		Exactly, and they pay for the coffee. But also the food and other stuff are
		free and the petrol to come as well. Thank God…
40	**Jackie**:	Bueno, las comidas siempre han sido gratis, desde el Hospital Civil.
		Well, meals have always been free, since we were in the Hospital Civil.
41	**Salvador**:	Sí, pero que digo que hemos conseguido también, lo de… pretender de
42		que los transportes no nos salga caro, es decir...
		Yes, but what I'm saying is that we have managed also to, to… try to get
		the transport partially covered, I mean…
43	**Jackie**:	Bueno, hemos luchado por una oficina. ¿Te acuerdas?
		Well, we have fought for an office. Do you remember?
		{...}
44	**Salvador**:	Pero ahora... ahora en cambio, ahora pues nosotros tenemos una
45		oficina, tenemos un sistema más informático, tenemos archivos para
46		guardar las cosas que antes no se podía hacer...
		But now, now on the other hand, now we have an office, we have a IT
		system, we have cabinets to keep things that we couldn't do before…
		{...}
47	**Salvador**:	Tenemos aquí un fichero de todos los voluntarios que vienen.
		We have a filing cabinet here with all the volunteers who arrive.

The interpreters in Excerpt 14 above begin by arguing that things were easier before they became officially associated as part of the healthcare institution, because the degree of bureaucratisation involved was lower, and they had more flexibility in organising the group and the way they carried out their activity (line 23). However, according to Bourdieu (1986a, p. 457), a high degree of "institutionalisation[50] [is] the most perfect form of social recognition, that is more or less secretly pursued by all associations". Accordingly, although both groups of volunteer interpreters did not initially seek a high degree of institutionalisation in the form of bureaucratisation, they can now appreciate some of the benefits of this process and the way this institutionalisation has shaped the field and their positions. In lines 3 to 6 and from line 32 to the end of Excerpt 14, interpreters enumerate these benefits. As pointed out by Weber and Parsons (1947), a consequence of bureaucratisation is the increase in the degree of systematic routinisation, which can be observed in this excerpt, as interpreters are now better organised and have more resources available to them than before. As we have also observed in earlier examples, they appeal to some bureaucratic traits (see Excerpt 6, lines 37-38 in this chapter) to strengthen their position in the field.

Both groups of interpreters work within a pattern of organised shifts that are "sacred" for them.[51] Each association provides each respective hospital with a detailed list containing information about each interpreter, their languages and a contact number, as well as a list of daily shifts and the names of those interpreters covering each shift.[52] Interpreters are equipped with two internal hospital phones to ensure that they can be contacted by healthcare staff who require their mediation in the emergency room, a consultation room and the front desk. [53] They are also provided with a list of patients every morning at the beginning of their shift, giving them access to information on all the foreign patients in the hospital, where these patients are located and what language they speak, as indicated by the coordinator at the Hospital Costa del Sol (see Excerpt 15, lines 1-4).[54]

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[50] See meaning of 'institutionalisation' in page 123.
[51] See Focus Group 3, Hospital Clínico, lines 308 to 311, Appendix V.
[52] See Appendix I for a photograph of the interpreters' shift list.
[53] See Interpreters' Handbook, p. 5, Appendix I.
[54] See Appendix I for a photograph of the patients' list provided by the hospital.

Excerpt 15 (FG 1, Hospital Costa del Sol, lines 424-435, Appendix V):

1	**Dorothy**:	Yes, here is the list that we get every morning {...}, so we write down
2		the name of the patient, where they are, this is the room and whether
3		they are by the window or by door, and we write down a list, then we
4		write in our book, so...
5	**Cordula**:	We all do our little notes about each case for the next interpreter,
6		sometimes, they are for...
7	**Dorothy**:	So this is really for the next patient that comes in, I mean next
8		interpreter, so they know what's been done and also if there's
9		problems.
10	**Julianne**:	Any pending cases or anything like that, yes.

In both Excerpt 15 (line 4) and in Excerpt 16 (line 3), interpreters mention "the book" and explain what kind of information should be written down in it. This Daily Report Book is referred to in the Interpreters' Handbook[55] as "*Libro interno de Incidencias*" (Internal book of incidents) and contains all the information interpreters gather during their daily routine visits to the patients, such as patients' health problems, any paperwork completed, any problems that may have arisen or may have been solved, and any other issue that may be relevant for the next shift.[56]

Excerpt 16 (FG 2, Hospital Clínico, lines 526-539, Appendix V):

1	**Researcher**:	Que no os reunís para hablar de... para cómo cambiar las cosas o
2		adaptar...
		Do you have meetings to talk about... to change or to adapt things...?
		{...}
3	**Salvador**:	No, pero nosotros nos guiamos más por libro. Para las cuestiones
4		laborales o sea del trabajo que hacemos aquí, miramos siempre el
5		libro cuando venimos y vemos que es lo que ha pasado en esa semana.
6		Y más o menos vemos si uno no quiere intérprete, si otro tiene otras
7		necesidades, si tenemos que ponernos en contacto con la asistente
8		social. Ya viene aquí reflejado en el libro, o sea que cuando nos
9		reunimos no tenemos ni por qué hablar de ello.
		No, but we are mostly guided by the book. As regards work matters, the
		work we do here, we always look at the book, we come and we see what
		has been happening that week. And more or less we can tell if someone
		doesn't need an interpreter, if someone else has other needs, if we need

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[55] See Appendix IV for a copy on the Interpreters' Handbook. This Handbook, drawn by the interpreting team in accordance with the hospital management's regulations, includes the association norms that regulate its functioning, and a section on interpreter's duties and conduct at the healthcare institution. It also includes a list of resources that should be made available to interpreters.

[56] See Appendix I for a photograph of the interpreter's Daily Report Book.

to get in touch with the social worker. It's all included in the book, so
when we meet up we don't even have any need to discuss these things.

10   **Researcher**: Sí, que lo tenéis todo bajo control a diario.
       Yes, you have everything under control on a daily basis.

11   **Jackie**:   Sí, sí, sí.
       Yes, yes, yes.

12   **Salvador**:   Sí, porque lo consultamos en el libro.
       Yes, because we check the book.

Interpreters at both hospitals view this book keeping activity as a serious and relevant part of their work, as will become apparent in the discussion of interpreters' alignment in the following chapter. Reporting their daily activity in this Daily Report Book can be understood as a further consequence of the process of institutionalisation that requires more clarity and transparency of interpreters' activity in the hospital. The same way nurses are obliged to keep records of any administered treatment, interpreters are asked to keep records of their activity that may include mediating between doctors and patients, sorting out patients' paperwork and contacting patients' relatives (see Interpreters' Handbook, Appendix IV). There is thus a high degree of internal organisation characterising the way interpreters work that is comparable to other healthcare staff, which in turn reflects a high degree of institutionalisation: they adopt a systematic approach to their work and are aware of their position and its boundaries. A high degree of institutionalisation in this sense also suggests a certain degree of professional organisation and professional autonomy (see Chapter 1, section 5).

Other bureaucratic traits found in the field, which also reflect a high degree of professional organisation and institutionalisation, include allocated parking spaces for interpreters on institutional premises; refund of petrol costs incurred in driving from their homes to the hospital;[57] provision of coffee and meals at the staff canteen for up to four interpreters on a daily basis;[58] a white gown, and ID card issued by the hospital to provide interpreters with access to all hospital facilities and sections.[59] These last two bureaucratic features seem to be extremely relevant for interpreters and the way they position themselves as institutional agents. In Excerpt 6 (lines 36-37), Cordula states that the name badge provides them with sufficient authority within the institution, and they thus have no need

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[57] See Appendix I for a photograph of the petrol claim form provided by the hospital.
[58] See Interpreters' Handbook, p. 5, Appendix I.
[59] See Appendix I for a photograph of interpreters' ID card, and see Interpreters' Handbook, p. 5, Appendix I.

to seek recognition from healthcare staff. Additionally, the white gown plays an important role in identifying interpreters as institutional agents, since it allows them to access certain areas of the healthcare institution. During the participant observation process, I was given a white gown to wear since otherwise I would not have been able to accompany interpreters into patients' rooms. A name badge and a white gown are thus essential for entering the field and playing the game.

Other traits include hospital insurance in case of accident and cover for vaccinations; [60] archives that contain information related to every volunteer interpreter who has worked for the association and the minutes of meetings held by the association;[61] and an office space within the healthcare institution where interpreters can hold meetings and keep all the materials listed above.[62] All these elements position interpreters as insiders who belong to the healthcare institution, like any other healthcare staff member. Volunteer interpreters in the two hospitals under study are institutional players provided with the same facilities as other healthcare staff members, although their position within the healthcare institutional hierarchy fluctuates according to the value of linguistic capital in this healthcare market and the extent of their recognition by more powerful agents within the healthcare institution. Lack of recognition could be related to the lack of remuneration in the case of volunteer interpreters; it may be that despite having acquired a high degree of bureaucratic institutionalisation, the lack of economic capital contributes to lower symbolic capital. This issue is not pursued here since the data collected offers no basis for comparing the status and position of paid interpreters and volunteer interpreters.

Probably one of the most important outputs of the process of institutionalisation described here is the Interpreters' Handbook.[63] This Handbook establishes the boundaries of volunteer interpreters' position within the healthcare institution and regulates their relationship with healthcare staff to some extent. It describes interpreters' tasks within the hospital, which, contrary to what is dictated by codes of conduct found in the wider field of public service interpreting, are varied and require a range of skills that are not usually considered part of public service interpreting, such as being "cheerful and

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[60] See Interpreters' Handbook, p. 5, Appendix I.
[61] See Appendix I for a photograph of the interpreters' archives.
[62] Interpreters at the Hospital Clínico already have an office space. Interpreters at the Hospital Costal del Sol are waiting for an office space as the hospital is being expanded and they have been told that they will be provided with an office space in the new building.
[63] See Appendix IV for a copy of the Interpreters' Handbook.

sympathetic with compassion and understanding" (see Interpreters' Handbook, p. 4, Appendix IV).

Tasks to be carried out by interpreters include the following:[64]

> 1. *To visit foreign patients on a daily basis.*
> 2. *To do shopping for the patients or sort out any other request.*
> 3. *To offer patients books and newspapers to read in their own language.*
> 4. *To accompany patients to consultation rooms (Volunteer interpreters will not assume the role of the healthcare professional)*
> 5. *To offer moral support to patients' relatives where necessary and contact religious representatives at the request of the patient.*
> 6. *To offer moral support to terminally ill patients and patients with no family or friends accompanying them.*

One of the main activities of interpreters, as established in the Handbook, consists of daily routine visits to patients (see task 1 above), which are an integral part of interpreters' duties.[65] In Excerpt 17, interpreters explain how they work in similar ways to matrons in the UK (lines 1 and 8), in the sense that they concern themselves with patient's well-being and dedicate part of their time to support and help them.

Excerpt 17 (FG 1, Hospital Costa del Sol, lines 248-277, Appendix V):

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1   Dorothy:   {...} I said you know one of the things in England we used to have we
2              called matrons, right? We don't have those anymore, but they were
3              fantastic because they used to go around some hospitals, go around
4              every day, see all the patients and they would chat to them see if they
5              were alright, talk to their staff, see if there was any problems.
6              {...}
7   Cordula:   But in reality, that's what we do now, even if we're not called so we
8              go.
9   Julianne:  That's right, to keep company and holding their hands or whatever,
10             yes, talk to them.
11  Cordula:   We go, - we go, that's why we have our list, we go and see and ask, we
12             are so and so and so.
13  Julianne:  Yeah, say something to them, a bit sociable.
14  Cordula:   We are interpreters, do you need anything? Is there anything we can
15             do for you? [so and that's what sometimes they have questions,]
16             sometimes they say leave me alone...
17  Dorothy:              [Oh, yeah, sure, I mean, well, I mean..., yeah, exactly.
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[64] My translation from the original in Spanish (see Appendix IV).
[65] See Interpreters' Handbook, p. 4, Appendix IV, for a description of what a routine visit entails.

In Excerpt 17, as well as Excerpt 18 below, interpreters demonstrate awareness of the importance of daily routine visits. As pointed out in the Interpreters' Handbook, during these visits interpreters have the opportunity to talk to patients and to offer them moral support. This is seen as such an integral part of their task that volunteer interpreters who were not willing to engage in this activity in the past were seen as problematic, and consequently excluded (Excerpt 18, lines 21-22).

Excerpt 18 (FG 2, Hospital Clínico, lines 366-469, Appendix V):

1	**Researcher**:	Sí, sí, yo creo que también. Si, bueno que he observado que tenéis
2		como dos... por lo que he observado estos días, que tenéis como dos
3		funciones. Está la función de ir con el médico cuando el médico
4		necesita una traducción, pero luego aparte vosotros mismos vais
5		hablando con los pacientes...

Yes, yes, I think so too. Yes, well, I have observed that you have two... for what I have observed these days, that you have two roles. The role of accompanying the doctor when the doctor needs translation, but also you go and talk to the patients on your own initiative.

6	**Salvador**:	Sí, sí.

Yes, yes.

7	**Jackie**:	Hablando con los pacientes, sí, sí. En realidad, esto es lo más
8		importante de nuestro trabajo... hablando con los pacientes,
9		ayudándolos. Pero si el médico nos necesita... Pero es que hemos
10		tenido gente que no le gusta hablar con los pacientes. Ellos
11		solamente quieren interpretar para los médicos, y esta no es
12		nuestra función.

Talking to the patients, yes, yes. Actually, that is the most important part of our job... talking to the patients, helping them. But if the doctor needs us... But we have had people who don't like talking to the patients. They only want to interpret for the doctors, and that is not our role.

13	**Researcher**:	Y ¿ese fue en principio, cuando vosotros empezasteis, esa fue las
14		ideas que teníais?

And, was that in the beginning, when you started, was that the idea that you had?

15	**Jackie**:	Sí, por ejemplo, en el Hospital Civil yo pocas veces me tenía que
16		interpretar para los médicos. Sí, hablé yo siempre con los
17		pacientes, sentaba con ellos. Mucho, mucho tiempo. Y (.) antes
18		también los pacientes nos agradecían más. Porque yo tengo una
19		carpeta llena de cartas, tarjetas, dando las gracias (.) y hoy, - hoy en
20		día apenas recibimos nada, nada de...

Yes, for example, in the Hospital Civil I hardly had to interpret for doctors. Yes, I talked to the patients most of the time, I sat down with them. A long, long time. And, (.) before, patients were also more grateful to us. Because I have a file full of letters, cards, thanking me (.) and these days, - these days we hardly receive anything, nothing

		at…
		{…}
21	**Jackie**:	Tú tienes que entrar amablemente para animar a los pacientes,
22		amabilidad. Porque hemos tenido uno que hemos tenido que echar.

You have to come in very nicely to cheer up the patients, with kindness. Because we had to fire one person.

| 23 | **Researcher**: | ¿Sí? |

Really?

| 24 | **Jackie**: | La única en 22 años que yo llevo, bueno, ya voy para 23. |

The only one in the 22 years that I have been here, well, nearly 23 now.

{…}

25	**Jackie**:	Claro, y tú no puedes opinar. Como digo, tienes que entrar con una
26		sonrisa. Aunque a lo mejor la paciente es desagradable contigo… la
27		mayoría de las veces, tienes que bueno es así o así, y a lo mejor tú
28		sales y…

Of course, you can't give your opinion. As I say, you have to come in with a smile. Even if the patient is rude to you… most of the time, you have to, well, it is like this or like that, and perhaps you leave…

Volunteer interpreters' daily routine visits to patients then reveal an aspect of their positioning that has a direct impact on the issue of professional autonomy. This service seems so relevant to them that in lines 11 to 12 the coordinator states that translating is not their role; their main role is visiting patients and talking to them, although as we have been able to observe in previous extracts they usually do not have time to provide this service now as often as they would like to. The importance of this service may lie in the fact that during daily routine visits there are no other agents available and interpreters' position is very unlikely to be threatened by those with a stronger habitus and some linguistic capital. Perhaps more importantly, given the on-going devaluation of their linguistic capital, as discussed in section 2 above, it is important for their positioning in the field that interpreters are able to offer another form of capital, based on the values promoted by social work, and that this capital is legitimised by the healthcare institution. This form of capital, directly derived from interpreters' social work, could fall into the category of social capital as an essential contribution of networks and trust that promote well-being, a sense of belonging and decency as individuals blessed with social capital set out to engage in mutually beneficial collective actions (Landhäußer & Ziegler, 2006, p. 205). Interpreters can deploy this social capital among agents who recognise and value this type of asset, such as patients, and can accrue symbolic capital in this exchange. In addition, they can also deploy linguistic capital among doctors in instances where these agents

are willing to legitimate it as a unique asset. It seems therefore that different forms of capital are recognised and valued differently by different agents in this arena. However, given that those agents who may (or may not) recognise linguistic capital as valuable have the strongest habitus and symbolic power in the field; it is they, rather than the patients, who can shape interpreters' position and constrain their autonomy. The Interpreters' Handbook is thus an essential asset for interpreters, not because it stresses issues of confidentiality and neutrality but because it legitimises their social capital by recognising as part of their main tasks activities such as daily routine visits, sorting out patients' paperwork and appointments, and offering moral support to relatives, among other things.[66] This list of tasks bestows more recognition on interpreters and legitimates the social capital they bring into the field.

4   Concluding remarks

As discussed in the previous sections, it is possible to identify two different traits of the degree of institutionalisation of volunteer interpreters: a) institutionalisation in the form of legitimisation of interpreters' position, and b) institutionalisation in the form of organisational bureaucratisation. Both forms of institutionalisation have considerable impact on the positions interpreters are allowed to occupy in the field and on the positions they choose to occupy. Different positions imply different degrees of attitudinal autonomy and which may lead to different patterns of alignment, either with the healthcare institution or with the patients; these issues will be discussed further in Chapter 5.

This chapter has examined the degree of institutionalisation of this group of volunteer interpreters by looking at both processes of institutionalisation. In terms of the first process, it examined the legitimisation of interpreters' position within the healthcare institution by agents with a stronger habitus and symbolic capital, such as doctors and, especially, the hospital director, as well as the legitimisation of their linguistic and social capital. In terms of the second process, it described the process of bureaucratisation leading to the setting up of an official association, AIVE, with a highly organised hierarchy, an Interpreters' Handbook and several resources. In the following chapter, I focus on the issues of alignment and autonomy and draw on all three types of data once more to discuss how and

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[66] See Interpreters' Handbook, p. 4, Appendix IV.

why interpreters may choose to align themselves with the healthcare institution or with patients, and how this affects and, simultaneously, may be affected by interpreters' degree of institutionalisation. I also explore the extent to which interpreters' degree of professional (attitudinal or relative) autonomy influences and is influenced by both their degree of institutionalisation and alignment.

Chapter Five

Alignment and Autonomy as internal manifestations of the positioning of volunteer interpreters in the sub-field of healthcare interpreting

1 Introduction

Chapter 4 looked at several aspects that shape the field structures and therefore the positions that volunteer interpreters in healthcare settings are able, obliged or willing to adopt in each encounter. The focus was on external manifestations of interpreters' positioning, specifically processes of legitimisation and organisational bureaucratisation. This chapter deals with other aspects that influence interpreters' positions within the field: those that concern issues of alignment and autonomy. Here, interpreters' positioning can be looked at from two different perspectives: how interpreters position themselves in relation to the healthcare institution and other non-institutional agents; and what positions they occupy within the hierarchy of the field depending on how much autonomy they are able to enjoy at any given time. Interpreters' positioning is reflected in both the standpoint they adopt in relation to the healthcare institution, that is their institutional alignment, or with respect to the patients if they align themselves with the latter; it is also reflected in how interpreters position themselves, or are positioned, along a continuum ranging from a high degree of autonomy to a low degree of autonomy, that is from a more dominant to a more dominated position.

2 Alignment of volunteer interpreters

It is difficult to separate alignment from autonomy, and vice versa, for both are intrinsically related to one another: interpreters may align with the healthcare institution in order to gain more autonomy and symbolic power; and may align with patients when they possess a high degree of autonomy that allows them to prioritise the interests of patients even against those of the healthcare institution or institutional agents. This section focuses on the first issue related to

interpreters' alignment with the healthcare institution and/or with patients, and section 3, below, examines the issue of autonomy. The discussion of interpreters' alignment draws on focus groups and interpreted interaction. While interpreters' narratives will allow us to understand how they perceive their relationship to the healthcare institution and how they position themselves as (non-)institutional agents, actual interaction will reveal what happens in reality when interpreters have to negotiate their position in relation to both institutional and non-institutional agents.

2.1 Interpreters' alignment with the healthcare institution

Interpreters' alignment has been discussed in several studies (see Angelelli, 2004a; Beltran Avery, 2001; Davidson, 2000, 2001; Wadensjö, 1998). Many researchers agree that interpreters may align themselves with the service provider or service user. However, in cases where interpreters are part of the healthcare institution, as is the case in this study, they often align with the healthcare institution as a way of strengthening their position as institutional agents. Interpreters create a "we-identity" as in-group members by signalling their alliance with other institutional members (Baraldi & Gavioli, 2008, p. 5), a strategy which may provide them with additional symbolic capital by allowing them to identify themselves with dominant agents at the top of the hierarchy—those with a stronger habitus, such as doctors—rather than with the dominated agents at the weaker end of the hierarchy, such as patients (Angelelli, 2004b).

In this particular context, the fact that the volunteer interpreters under study have been providing a service for sixteen and twenty five years at the Hospital Costa del Sol and Hospital Clínico, respectively, may explain why they may at times develop a sense of ownership, as discussed above (see Chapter 4, section 3), and of alignment with the healthcare institution. On the other hand, as interpreters explain in Excerpt 6, sometimes they are seen as "intruders" (see Excerpt 6, line 35 in Chapter 4) because they are foreigners, and hence as non-institutional members situated outside the national 'we-identity'. Interpreters may thus align with the healthcare institution in order to enhance their identification with the society in which they live, to belong to that society as an extension of their belonging to the healthcare institution. In Excerpt 19 below, interpreters' need to identify themselves with the in-group is clear in the way they criticise

foreigners who still have not learnt to speak Spanish after so many years in the country. They seem keen to distinguish themselves from the out-group of foreign visitors who are perceived negatively by both healthcare staff members and Spanish society at large, because of their lack of integration into Spanish society and their tendency to live in ghettos where they do not have to learn Spanish.

Excerpt 19 (FG 4, Hospital Clínico, lines 276-301, Appendix V):

1	**Researcher**:	Algo frustrante (.) algo que encontréis frustrante, o difícil. ¿Lo
2		más difícil o frustrante de hacer esta... este trabajo?

Something frustrating (.) something that you find frustrating, or difficult or frustrating to do… in this job?

3	**Catherine**:	No, yo no tengo (.) o sí. Pero que no conste en acta, ¿eh? Por favor,
4		bueno, que luego lo puedes poner si quieres. Yo, me saca de
5		quicio, los ingleses que llevan viviendo 25 años en España y no
6		saben decir ni buenos días. Me saca de quicio. Y yo sé que es,
7		quizás es injusto... pero mira, el alemán... un alemán que he ido a
8		ver esta mañana, no me acuerdo como se llama y esto te lo
9		comenté...

No, I don't have (.) or well yes. But don't include it, ok? Please, or well, then yes you can include it if you want. What annoys me are those English people who have been living in Spain for 25 years and don't even know how to say good morning. It drives me mad. I know that it's, that maybe it's not fair… but look, the German, the German I went to see this morning, I don't remember his name, and I already mentioned this to you…

10	**Researcher**:	Sí.

Yes.

11	**Catherine**:	Entonces, lleva once años viviendo Alora, y habla perfectamente
12		español. Con once años debería haberle...

So then, he's been living in Alora for eleven years and he speaks Spanish perfectly. Eleven years should be enough to…

13	**Antoinette**:	Los alemanes son distintos.

Germans are different.

14	**Catherine**:	Claro, no, pero ¿por qué, por qué? Porque los ingleses, según
15		ellos, viven en, porque se lo han permitido ellos, viven en esa
16		especie de [guetos.

Of course, no, but, why, why? Because English people, according to them, they live in, because they have allowed themselves to, they live in those kinds of [ghettos.

17	**Antoinette**:	[En guetos.

[In ghettos.

18	**Catherine**:	"Ay no, pero es que, aquí también no, porque todo el mundo
19		quiere aprender inglés". No hijo mío, no quieren aprender inglés,
20		es que tienen [que aprender inglés] por narices, a pesar de que tú
21		estés en su país... Y eso es lo que me saca de quicio. Que luego lo
22		puedes poner... como tú quieras.

"Oh no, but it's that, here you don't have to, because everyone wants

to learn English". <u>No, dear, no</u>, they <u>don't want</u> to learn English, it's just that they have [to learn English] no matter what, despite the fact that you are in their county. And that drives me mad. Later you can put it any way you want.

23	**Antoinette**:	[Que aprender inglés.
		[To learn English.
24	**Antoinette**:	Y luego los médicos se enfadan mucho con ellos ¿eh? Los
25		médicos, ¿eh?
		And doctors of course get upset with them, ok? Doctors, ok?
26	**Catherine**:	Sí, sí, sí. No, no, no.
		Yes, yes, yes. No, no, no.

Catherine, in particular, feels very strongly about this issue, perhaps because she is an English native speaker who has overcome the language barrier herself and does not understand how other people like her do not make an effort to integrate but rather prefer to live in 'ghettos' (line 16). It could also be that she, more than other interpreters, is often identified with the out-group of English speakers since she shares the nationality of those agents. Antoinette reinforces this argument by claiming that other nationalities such as Germans are different. In the continuation of Excerpt 19, Catherine points out the consequences of the behaviour of this social group for the healthcare staff who feel obliged to learn English to make up for their limitations.

Excerpt 19 continued (FG 4, Hospital Clínico, lines 651-662, Appendix V):

27	**Catherine**:	{...} Con o sin razón, pero ha tenido un problema con la enfermera de
28		noche, que no sé qué no sé cuánto, y dice que el problema es que no
29		habla inglés. Realmente, pero el médico tampoco. Pero el médico si
30		habla inglés porque...
		{...} Rightly or wrongly, he has had a problem with the night nurse and this and that, and he says that the problem is that she doesn't speak English. Actually, but the doctor doesn't either. But the doctor does speak English because...
31	**Researcher**:	Porque le pone voluntad, también.
		Because he makes an effort, as well.
32	**Catherine**:	Por razones profesionales, lo necesita. Pero no le puedes obligar, el
33		hospital no le puede...
		For professional reasons, he needs it. But you can't force him, the hospital can't...
34	**Researcher**:	Obligar a nadie.
		Force anybody.

35	**Catherine**:	"There should be at least one". "Pero ¿por qué? <u>Why</u>?" "Well, because
36		you've just said there are 40 English patients". "BUT WE'RE IN
37		SPAIN!"[67]

In Excerpt 19 and its continuation, Catherine and Antoinette thus discuss how frustrating it is for both doctors and themselves that foreigners do not learn Spanish after so many years in Spain. Both appear to align themselves with the host society and the healthcare institution while simultaneously detaching themselves from the out-group of foreign patients. During participant observation, I noticed that healthcare staff would often complain to the interpreters about those patients who could not speak Spanish, as if interpreters were responsible to some extent for their lack of communication skills. Interpreters in turn would make it clear that they agreed with the healthcare staff and would explain that they did not support nor encourage this behaviour. It seems important for interpreters not to be identified with this social group. This issue is especially interesting considering that interpreting service users consist of this group of foreign people, without whom an interpreting service would not be necessary; and to some extent the existence of this service is sending the message that Spanish is not necessary as there are people at the hospital who can speak Spanish and English and can sort out patients' problems on their behalf. In this context, who the interpreters align with allows them to gain social capital by expanding their social network among members of the host society.

In excerpts 20 and 21, interpreters portray themselves as institutional guardians. The language they use, such as "that is frustrating" in line 3 or "you have to bite your tongue" in line 5, reflects their attitude towards those patients who complain about this healthcare institution in particular or the Spanish healthcare system in general.

Excerpt 20 (FG 1, Hospital Costa del Sol, lines 483-491, Appendix V):

1	**Cordula**:	{...} On the other hand, it's some people who only moan, moan,
2		moan, nothing is good, everything is better in England or Germany
3		and that is frustrating.
4	**Julianne**:	Yeah, they do tend to compare...
5	**Cordula**:	And then you have to bite your tongue not to say why don't you get
6		off into your country, and I have said it twice, if it's so good in your

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[67] The interviewee switches to Spanish at this point and says: "But, why?"

| 7 | | country then why don't you go back, if everything is so bad I |
| 8 | | wouldn't stay if I was you. |

In Excerpt 20, Cordula is talking about patients who come to the hospital and complain about the care they receive. During participant observation, I noted that interpreters have considerable respect for the Spanish healthcare system; some showed me an article from a British newspaper with the title "Feeling ill? Get to Spain quick" (see Appendix IV) and commented that the Spanish healthcare system is far better than the British or German systems. The same attitude can be observed in Excerpt 21, where Jackie expresses frustration at foreign patients' complaints about Hospital Clínico, saying "esto me saca de quicio" (this drives me mad; line 3).

Excerpt 21 (FG 2, Hospital Clínico, lines 320-322, Appendix V):

1	**Jackie**:	Cuando te echan la culpa los pacientes, o que algo no va bien con el
2		tratamiento, o criticando la seguridad social española, los españoles,
3		esto me saca de quicio.

When patients blame you or when something is not going well with the treatment, or when they criticise the Spanish Healthcare System, or Spanish people. This drives me mad.

Similarly to the interpreters at the Hospital Costa del Sol in Excerpt 20, Jackie seems to feel very strongly about patients who criticise the society she is now part of. It seems that in both cases interpreters are seeking to project themselves as members of this healthcare institution and of Spanish society at large; they wish to be recognised as insiders rather than outsiders. In both excerpts, they try to position themselves as part of the healthcare institution and therefore as members of the host society while detaching themselves from 'foreign people'. There is thus a high degree of institutional alignment among these two groups of volunteer interpreters, which may be a consequence of their status as foreigners and hence outsiders.

The tendency to position themselves as institutional guardians, perhaps to gain social and symbolic capital, can also be observed during medical encounters. In Excerpt 22, one of the interpreters had come to see a patient who had just

arrived in the observation ward. [68] The interpreter praises the quality of the hospital three times within a short stretch, extending the praise to the Spanish healthcare system as a whole. In lines 1, then line 4 and finally in line 13, the interpreter not only praises the Spanish healthcare system but discredits other hospitals in the area which are privately run by international companies and aim to attract foreign patients by promoting their bilingual staff.

Excerpt 22 (IMI 2, lines 12-25, Appendix V):

1 **Interpreter**: First of all, I'll tell you, you are in a good hospital, you're in good
2   hands.
3 **Patient**:   I know that.
4 **Interpreter**: Try to relax. It's a good hospital.
5 **Patient**:   [Far better (.)] than the one I was in before.
6 **Interpreter**: [Try to relax.
7 **Interpreter**: You have been before?
8 **Patient**:   No, they put me into this International... and I came out (( )) and I
9   then... when I got back to the hotel...
          {...}
10 **Patient**:   When I got back to the hotel and I felt worse and they wanted to send
11   the doctor, but I don't want a doctor back at that international
12   hospital, so I said no, Spanish hospital.
13 **Interpreter**: Spanish hospital. It's much better, I think.

Interpreters' identification with the healthcare institution can thus be strong, and it benefits the institution in various ways. As institutional agents, interpreters align themselves with the hospital and the national healthcare system against competitors and any party whose interests may conflict with their institutional partners. In this respect, they self-regulate and do not need to be monitored by the healthcare institution, as evident in Excerpt 23, where interpreters at the Hospital Costa del Sol discuss the fact that they are instructed not to deal with private insurance companies.

Excerpt 23 (FG 1, Hospital Costa del Sol, lines 212-232, Appendix V):

1 **Cordula**:   Like when this problem with this private insurance, we were told
2   you're not supposed to do that, and that and that, no I mean, we
3   wouldn't want to do it anyway.
4 **Dorothy**:   Yes, I mean, why should we want to get involved with the insurance,

[68] Excerpt 22 is part of Excerpt 38, which will be discussed more extensively in section 3.2.1 below. Only a section of Excerpt 38 has been included here to avoid repetition.

5		you know?
6	**Cordula**:	Why would we get inv- (+involved), why should we get involved with
7		the private insurance people? Why should we sort out [private
8		insurance? That is not our thing to do.
9	**Dorothy**:	[And we are, we
10		are... (()) with the private insurance.
11	**Dorothy**:	And I think one of the things that I'm, I get annoyed about it's the fact
12		that, you know, during the years that I've been here, and, I'm sure the
13		others have experienced it too, is that I have really helped them get
14		out of an awful lot of difficult situations..
15	**Julianne**:	Oh, yeah!
16	**Dorothy**:	I mean we had people that were going to sue the hell out of the
17		hospital and we've talked them down and said: "Listen, this happened
18		because of this". And not a word of that's very kind, thank you, which I
19		mean I'm not expecting thanks, but they should appreciate that we're
20		not just an instrument here, we're not just pretty faces!! You know, we
21		have got a brain to our name!

As institutional agents, interpreters feel that they know the boundaries and which side they stand on. They know that they are allies of the healthcare institution and, as such, they would never side with private insurance companies. They thus feel slightly offended about the insinuation that they may help private insurance companies. In this excerpt, interpreters discuss some problems that the healthcare institution has had in the past with patients' complaints. From the way they protect the institution, it is clear that they provide a service that goes beyond linguistic mediation and overtly wish to be granted that position within the field (line 20). In the following two excerpts, the way interpreters talk about their routine and past experiences reveals the same attitude.

Excerpt 24 (FG 1, Hospital Costa del Sol, lines 424-443, Appendix V):

1	**Dorothy**:	Yes, here is the list that we get every morning and the girl has
2		outlined the foreign patients, right? now obviously we also go
3		check through to see if she got everybody on it, so we write down
4		the name of the patient, where they are, this is the room and
5		whether they are by the window or by door, and we write down a
6		list, then we write in our book, so...
7	**Cordula**:	We all do our little notes about each case for the next interpreter,
8		sometimes, they are for...
9	**Dorothy**:	So this is really for the next patient that comes in, I mean next
10		interpreter, so they know what's been done and also if there's
11		problems.
12	**Julianne**:	Any pending cases or anything like that, yes.
13	**Dorothy**:	And also too, as I was saying to you before, this is very important

14		for us to keep as a record, because something could happen,
15		maybe they're going to complain about the hospital so we can look
16		back and see what actually happened, you know? So it's important
17		for us.
18	**Cordula**:	If they refuse, if they refuse to take anything, because those things
19		we write down. Some people are very nice, some people are very
20		(.) *exigente*.[69]
21	**Dorothy**:	Yes, very *exigente*.

The interpreters' Daily Report Book keeping activity is thus seen as a way to protect the healthcare institution and, as they reiterate, it is very important for them to engage in this protective attitude (lines 13 and 16).

A similar situation is mentioned in Excerpt 25, where Catherine recounts what happened to her that morning with one of the patients who wanted to make a complaint about the nursing staff.

Excerpt 25 (FG 4, Hospital Clínico, lines 120-128, Appendix V):

1	**Catherine**:	{...} He tenido un caso esta mañana, no un caso, una señora que se
2		quejaba, un paciente que se quejaba del trato de las enfermeras que
3		estaban de guardia de noche. Y entonces, "bueno y ¿qué puedo
4		hacer, me puedo quejar, dónde me tengo que quejar?" Digo, "yo
5		personalmente esperaría a ver qué pasa esta noche". Si ha sido,
6		porque a lo mejor ha sido un día terrible en la planta. Puede ser,
7		¿no?, entonces antes de... pero claro... Entonces es más como... yo
8		encuentro que en muchos casos es más como consejero, como
9		asesor un poco.
		{...} I've had a case this morning, not a case, a lady who was
		complaining, a patient who was complaining about the treatment
		from the nurses who were on night duty. And so, "well and what can I
		do, can I complain, where can I make a complaint? I said to her
		"personally I would wait to see what happens tonight". If it has been,
		because maybe it was an awful day on the ward. It might have been,
		mightn't it? So before... but of course... So it's more like... I think that
		in many cases it's more like an advisor, a bit like a counsellor.

Catherine again acts as institutional guardian here and mediates on behalf of the healthcare institution by calming the patient down and dissuading her from making an official complaint. She aligns herself with the healthcare institution and tries to justify or downplay the cause of the patient's complaint. Her

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[69] "Exigente" means demanding. It serves to emphasise the point being made and is picked up by Dorothy in the next line.

awareness of her position and symbolic power that enables her to act as institutional guardian is evident in line 8, where, talking about interpreters' tasks, she says: "es más como consejero, como asesor un poco" (it's more like an advisor, a bit like a counsellor)—clearly recognising that her responsibility goes beyond linguistic mediation.

2.2 Interpreters' alignment with patients

Interpreters do not only align with the healthcare institution but also with patients in some instances. This could be explained by looking at interpreters as members of the "guest-culture" that they share with foreign patients (Baraldi & Gavioli, 2008, p. 5). However, since patients are at the weaker end of the hierarchy in this field, interpreters may only align with them when they have enough autonomy and symbolic power to position themselves as patients' allies. This alignment sometimes works against the interests of the healthcare institution, which is why interpreters must enjoy a legitimate position to act in this manner.

In Excerpt 26, Rebecca is very explicit about her motivation to help the community.[70]

Excerpt 26 (FG 1, Hospital Costa del Sol, lines 65-69, Appendix V):

1 **Rebecca**:   I wanted (.) To be honest with you, I wanted to give something to the
2   community because the community's been good to me. And (.) You
3   know one thing, because I have always worked for myself I'm able to
4   organise my time and so I just wanted to do something good for the
5   community, and I thought it was a good idea.

Rebecca feels some responsibility towards foreign patients, which may lead her to align herself with them when possible. The issue of the we-identity and the "interpreter embedded in the patients' community" emerges again as Rebecca talks about the "[patients'] community" as her community (line 2) (Betran Avery, 2001, p. 6). At times, the degree of tolerance and compassion shown by

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[70] During a coffee break, Rebecca told me that she works as a freelance translator and her main clientele is British expats who either live in the Costa del Sol already or are planning to move there and require translations of official documents. When she mentions "community" during the focus groups she is thus referring to that community that has given her work all these years and to whom she is grateful for that work (see Excerpt 26, line 2).

interpreters towards foreign patients extends to the latter's inability to speak Spanish, despite the frustration witnessed in Excerpt 20 with respect to the same issue.

Excerpt 27 (FG 1, Hospital Costa del Sol, lines 125-131, Appendix V):

1	**Cordula**:	Some doctors even say: how long you are here? And then people say 25
2		to 30 years, and they say you are long enough here you should speak
3		and the patient gets frustrated. Most of all they are frustrated when
4		they can't understand when somebody is speaking a language because
5		it's a hard accent so they call us and they say sorry but I couldn't
6		understand what he said and you are, you feel bad, he said: Oh, I
7		explained that with you.

Thus, although interpreters try to protect their position as institutional agents, they may align with patients out of sympathy and compassion, or perhaps because of the residue of the we-identity they may experience as members of the guest-culture.

In the following excerpt, interpreters comment on their motivation for undertaking volunteer work. Whereas Hannah and Jackie are concerned for society in general, Salvador seems to identify with foreign patients because he has been in a similar situation in the past.

Excerpt 28 (FG 2, Hospital Clínico, lines 1-17, Appendix V):

1	**Researcher**:	La primera pregunta es sobre la motivación. ¿Qué motivación tenéis
2		para ser intérpretes voluntarios?
		The first question is about motivation. What is your motivation to work
		as volunteer interpreters?
3	**Hannah**:	Bueno, para mí es por hacer algo por, para la sociedad y además creo
4		que podemos hacer una labor importante.
		Well, for me it's to do something, for society, and also I think that we can
		do an important job.
5	**Jackie**:	La satisfacción de poder ayudar…
		The satisfaction of being able to help…
6	**Hannah**:	A los demás.
		Others.
7	**Jackie**:	Ayudar la gente, la satisfacción…
		Helping others, the satisfaction…
8	**Hannah**:	Es una labor muy gratificante.
		It's a very gratifying job.
9	**Jackie**:	Exacto, exacto.

Exactly, exactly.

10   **Researcher**: ¿Tú opinas lo mismo Salvador?
             Do you think the same Salvador?

11   **Salvador**:   Psi, uhm, bueno después la experiencia que uno ha tenido en el
12   extranjero, cuando va una persona que habla, que está enferma y que
13   anímicamente también está afectado y te hablan en un idioma que tu
14   no entiendes parece que te está agrediendo, pero si hablan mi idioma
15   eso me tranquiliza y yo lo veo aquí.

                 Erm, well, after the experiences that one has had abroad, when a person
                 who speaks, who is ill and who is affected emotionally as well and they
                 speak to you in a language that you don't understand, it seems like they
                 are attacking you, but if they speak my language, it calms me down and
                 I see the same thing here.

At least some interpreters are thus motivated by sympathy for foreign patients and want to help them out, though this does not seem to affect their position as institutional agents. On the contrary, these examples of attitudinal autonomy seem to further strengthen their institutional positioning.

Excerpt 29 below is very illustrative of interpreters' dual position within the healthcare institution: as institutional agents and patients' guardians. Here interpreters are discussing what they consider to be the deficiencies of the healthcare service. In line 4, Cordula expresses sympathy for the patients who receive this poor service. Interpreters emphasise the particular situation of elderly patients and the lack of social responsibility on the part of the hospital. Several issues are worth commenting on here: a) interpreters, despite being institutional agents, at times align with patients in ways that challenge the healthcare institution: "you have to fight with the doctors" (lines 5 and 22); b) interpreters consider that it is their responsibility as institutional agents to address this problem "we don't have a social worker here" (lines 7-8). The use of 'we' reveals interpreters' alignment with the healthcare institution and the fact that they assume a degree of responsibility for the patients' well-being as members of the healthcare team. In this instance, the 'we-identity' emerges to indicate their belonging to the institutional community; c) interpreters consciously take on a different role by occupying the position of social workers when these are not available at weekends: "it's us at the weekend" (line 15); in doing so they adopt values characteristic of social workers, such as patience, compassion and tolerance. Interpreters indicate that they do not occupy that position by choice (line 18), being aware of the shift in their position away from the legitimate boundaries of the sub-field of healthcare interpreting which establish that they

cannot do the work of social workers although they can draw on their values (see Interpreters' Handbook, p. 4, Appendix IV).[71] Their concern for the patients' well-being and fear that no one else will occupy the position of carer, "who else is gonna do it?" (line 23), overrule their respect for established practices.

Excerpt 29 (FG 1, Hospital Costa del Sol, lines 501-562, Appendix V):

1	**Cordula**:	The worst is when old people come on a Friday afternoon into the
2		observation…
3	**Dorothy**:	And no one cares for them.
4	**Cordula**:	…and they don't want keep them in and they just chuck them out
5		and then you have to fight with the doctors and tell them that
6		there's nobody at home, ok, they say that this is not a nursing
7		home, I do understand that, but we don't have a social worker
8		here…
9	**Dorothy**:	[On the weekends.
10	**Cordula**:	[On the weekends.
11	**Dorothy**:	And also the thing is too that…
12	**Cordula**:	During the week there's a social worker and you can say tomorrow
13		morning, but we have Friday afternoon to Monday morning and
14		that's three days so those people cannot be in front of the door, and
15		it's us at the weekend, we have to fight with the doctors and they
16		really hate us sometimes because…
17	**Julianne**:	They see you coming, and there's a problem.
18	**Cordula**:	Yeah and I say I'm not social worker but I know this lady cannot go.

{They talk about the problem in the different wards}

19	**Dorothy**:	You know this is what I don't understand, cos they are available.
20		But [we have to do it, we have to find the places for them]. And I,
21		and, I mean I have gone to the residence with one of the patients.
22	**Cordula**:	[So we have to fight, we have to (( )).

{They talk about how they had to accompany some patients to different healthcare institutions in the past}

23	**Dorothy**:	So I mean, who else is gonna do it?
24	**Cordula**:	That is Friday afternoon, and then, when the doctor in the morning
25		says it's an alta, why can't he fff- (+f word) (.) sign the papers? Why
26		do they have to wait until 5 in the afternoon!
27	**Julianne**:	[That's right], yes, but they doctors are not thinking about that.
28	**Dorothy**:	[Yeah, exactly.
29	**Cordula**:	But that is, it drives me nuts…
30	**Julianne**:	They don't understand.
31	**Cordula**:	And I feel so sorry for the people, but either wait until sometimes 8
32		o'clock, when I go at 8 o'clock the people who are still there waiting
33		to be taken away by ambulance and our hands are tied and our
34		hands are tied, we can't make a big fuss because we are only
35		interpreters and we don't get [too involved], you know, you can't

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[71] According to the Interpreters' Handbook, while drawing on values of care and sympathy for the patients borrowed from the hospital social workers is encouraged, interpreters are not to occupy the position of social workers as such. In this instance they show awareness of this issue.

36		talk for the people.
37	**Julianne**:	[That's right].
38	**Dorothy**:	Yeah, I generally do, I generally make a fuss because I know the
39		heads of the department and I always go to the top which is not
40		really very good.

The resulting narrative is somewhat contradictory, because it moves from a position of complete engagement (lines 18-25) to a position of complete neutrality (lines 35-36). From this narrative it is not possible to discern which one of those positions is the one being adopted in the field. It is possible that the sudden shift towards neutrality is a defence mechanism to cover up forms of social activism in a context where neutrality and impartiality, enforced by the professional community, shape the boundaries of the wider field of public service interpreting. In the following excerpt, from the same focus group, Julianne and Dorothy also explain that they "really don't want to get involved" (lines 3-4). However, the ironic tone of the discussion (lines 8-9) and the use of words such as "diplomatic" and "careful" (line 6) seem to imply otherwise.

Excerpt 30 (FG 1, Hospital Costa del Sol, lines 233-242, Appendix V):

1	**Researcher**:	Have you personally tried to make any changes like I know you tried
2		to raise money for certain things. Have you personally tried...?
3	**Julianne**:	No, because we really don't want to...
4	**Dorothy**:	Get involved.
5	**Julianne**:	No, no, I think they wouldn't actually appreciate that.
6	**Dorothy**:	Yes, we have to be very careful, <u>very diplomatic</u>...
7	**Julianne**:	Yeah, yeah.
8	**Rebecca**:	We've made a couple of suggestions and it's not been (.) well
9		received.
10	**Researcher**:	Yeah, it's a shame really; I mean you're doing something here.
11	**Julianne**:	And we do see also quite a bit.

It seems that interpreters want to get involved since they "do see also quite a bit" (line 11); and have suggestions about how to improve the system, but they are aware of the boundaries of their position. Additionally, it is possible to observe the different positions occupied by different interpreters within the hierarchy: the coordinator overtly acknowledges her activism, possibly because she has a large volume of symbolic capital that allows her to "go to the top" (Excerpt 29, line 39).

However, in Excerpt 31, there seems to be again a shift in interpreters' positioning. If in the previous excerpt Dorothy acknowledged her activism, in this excerpt she explains how she complies with institutional norms.

Excerpt 31 (FG 1, Hospital Costa del Sol, lines 294-339, Appendix V):

1	**Dorothy**:	Well, that's what we all do, we interpret when they're coming for the
2		visiting hours and I mean I think that like you said in UCI (Intensive
3		Care Unit) and much more of the time we had to phone families in
4		their countries, you know, we had to tell them all the bad news or
5		they've got me on the phone and said what's happening? So we had to
6		find out with the ahm... I mean we're not supposed to give a medical
7		report over the phone but you can't do that cos a lot of their families
8		would phone, I mean they have no idea, they're living in another
9		country [there's no way that] they're gonna know and no one is going
10		to tell them so I always talk to the doctor and say how are they doing
11		and so that I can at least say to the patient's family look you know
12		they're stable now but maybe you should come over or whatever, you
13		know?

{They carry on discussing the issue of not giving medical reports over the phone}

14	**Dorothy**:	You see another thing too is the intimacy thing, they're big arguing
15		obviously not talking about patients' diseases and whatever, and we
16		shouldn't and yet I see so many of the doctors talking to about just
17		anybody who comes in and it makes me so mad. {...}

{They carry on discussing the issue of not giving medical reports over the phone}

18	**Dorothy**:	I mean a lot of them say: "Look, shall I come over now? Is it very
19		serious?" And they don't give any information. I always say: "Look
20		either yes or no", because I don't think it's fair, I really don't.
21	**Julianne**:	They always say try tomorrow, roughly between let's say 9 and 12 or
22		something. They try, and they can't get hold of the doctor.
23	**Dorothy**:	The doctor won't talk to them.
24	**Julianne**:	No, the doctor won't. Exactly he's not gonna get out of his way to
25		speak to them, so they try again the next day...
26	**Dorothy**:	And they don't understand anyway, so...
27	**Julianne**:	It's very frustrating for them. And we don't say anything, often we
28		don't know. I mean if we do know something, yes I do.
29	**Dorothy**:	Well I didn't do.
30	**Julianne**:	I did say, I did say.
31	**Dorothy**:	Yeah, I didn't do.

In this excerpt, it is actually Julianne, whose symbolic capital is not as abundant as Dorothy's, who admits in line 30 that she does give medical reports over the phone "I did say, I did say". Perhaps Dorothy considers that confidentiality is more important than neutrality, since she mentions the importance of "the intimacy thing" (lines 14-17). It may be that breaking confidentiality is perceived as a

serious offence, whereas breaking neutrality means having a social conscience. This constant shift between activism and neutrality has been observed in both institutions. During the participant observation period, I noted that interpreters considered comforting and caring for patients essential. On one occasion, one of the interpreters was getting frustrated with one of the patients who did not want to follow the doctor's instructions. She spent more than twenty minutes convincing the patient to get a walking frame and at some point I could see she was getting very frustrated by the patient's refusal. In another instance, the interpreter asked the nurses to look at the nurses' log book to check a patient's treatment and specialist appointment because she was concerned that she was not getting adequate healthcare treatment. The interpreter found out that this patient had not been given an appointment with the psychiatrist as requested due to miscommunication between the patient and the nursing staff. These two instances suggest that interpreters' concern for patients' well-being and their active engagement may lead to better service, sometimes by challenging healthcare staff and in doing so shifting the field boundaries.

The incongruity between what they do and what they think they should sometimes do is a consequence of the structures internalised by interpreters in the form of standards of good interpreting practice. Very often professional standards of practice are concerned with neutrality, impartiality and confidentiality and do not allow interpreters to negotiate their positioning according to the needs of each individual encounter. However, in practice, interpreters tend to accommodate to the situation, as demonstrated by other scholars (see Davidson, 2000; Hsieh, 2004, 2006, 2007; Leanza, 2005; Rosenberg *et al*, 2008), even if it means deviating from their prescribed position. When asked about important qualities of healthcare interpreters, interpreters point out confidentiality, patience and compassion, which may explain why they show so much concern and sympathy for patients' well-being as observed in the following excerpt.

**Excerpt 32** (FG 1, Hospital Costa del Sol, lines 745-761, Appendix V):

1 **Researcher**: One quality of an interpreter, the most important quality...
2 **Dorothy**:   Patience, tolerance.
3 **Julianne**:   And ahm, how you say...?
4 **Dorothy**:   COMPASSION! I think.
5 **Julianne**:   Yes, compassion, yes.
6 **Cordula**:   And don't talk [about it, from one] patient to the next, [I would say]

7		[it's (.) [inti- (+intimacy) (.) no,] inti- (+intimacy)...
8	**Dorothy**:	[Yes, from one patient...] [Yes, exactly
9	**Julianne**:	[I think compassion is probably, is the most important.
10	**Dorothy**:	[Intimacy, ahm, yeah, ahm...
11	**Cordula**:	Secrecy, no, it doesn't...
12	**Dorothy**:	I speak (hhhhhh) 15 languages, English the better and I can't think of
13		the word...
14	**Cordula**:	CONFIDENTIAL!
15	**Dorothy**:	Yes, confidentiality, yes exactly!
16	**Cordula**:	We have to be confidential, not talking... like that has nothing to do
17		with breaking this, because we don't name any...
18	**Julianne**:	No, no.

Interpreters are talking about confidentiality here, but cannot recall the appropriate term—referring instead to "intimacy" in lines 7 and 10 (also mentioned in Excerpt 31, line 14) and "secrecy" (line 11). They seem vaguely familiar with the standards of practice dictated by the doxa established by the professional interpreting community without necessarily being conversant with the terminology or the principles themselves. Again, interpreters' position in this sub-field is very loose and dynamic, which leads them to adapt to individual encounters and accommodate patients' needs rather than feel constrained by any standards of practice that may be imposed by other institutions.

3   Attitudinal autonomy of volunteer interpreters

As discussed above, autonomy cannot be examined without making reference to issues of legitimisation and alignment, analysed in the previous sections, since autonomy is simultaneously a cause and a consequence of these. There is a constant re-adjustment of autonomy, legitimisation and alignment in each interpreted encounter, and together these re-adjustments have considerable impact on the positions interpreters are allowed, obliged or willing to occupy.

Interpreter's Position
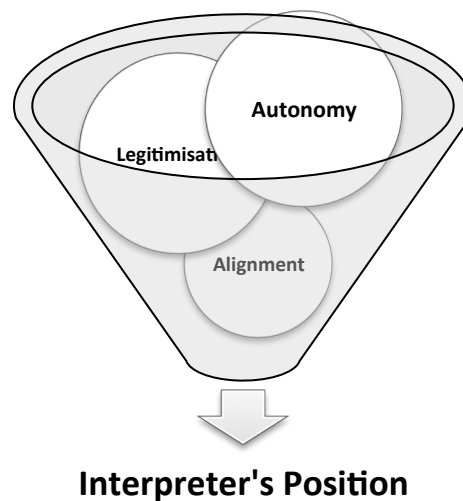
As observed in Chapter 1, autonomy can never be absolute and is always relative to the attitude of agents operating in the field of power. A high degree of autonomy can afford agents access to dominant positions, whereas a low degree of autonomy forces agents to occupy dominated/submissive positions with very little or no symbolic power; the latter also means that the possibilities to interact and shape the structures and boundaries of the field become very limited. On the one hand, autonomy is related to legitimisation in the sense that in order to provide a service there must be a relationship of trust between those who provide the service and those who benefit from it. In this light, service users will then have to recognise—legitimise—and rely on this service. On the other hand, it is related to alignment because interpreters with a high degree of autonomy do not need to align themselves with agents in dominant positions in order to gain symbolic power and, therefore, can align with those in dominated or weaker positions without losing the symbolic capital they hold.

Yet, autonomy goes beyond alignment and legitimisation because autonomy is in itself an instrument that allows agents to assert their position in the field. It is not possible to claim that interpreters occupy one position, but rather a series of diffuse or ambivalent positions that move along a continuum between a high and a low degree of autonomy depending on the dispositions of agents in each encounter.

Interpreters' position in relation to their degree of autonomy

LANGUAGE CONDUIT — GATE-KEEPER — SPOKES-PERSON
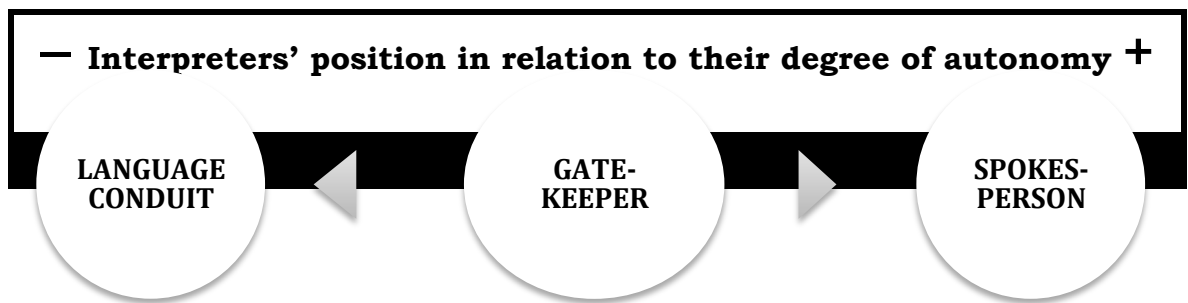
Analysing both interpreters' narratives and their behaviour as well as other agents' behaviour during interpreted interaction will allow us to discuss interpreters' positioning as the degree of autonomy increases or decreases in relation to the field of power. In the following excerpts, I discuss how interpreters' positioning is constrained and therefore shifts in each particular scenario, particularly in the presence of agents with a stronger habitus and more symbolic capital, i.e. doctors, who embody the structures of the field of power.

This section is divided into three parts each examining different positions as a consequence of different degrees of autonomy, starting from the most autonomous to the least autonomous position. I will attempt to demonstrate that interpreters are sometimes forced to occupy these positions; sometimes they choose to occupy these positions willingly; and at other times they challenge those agents who impose these positions upon them.

3.1 The interpreter as the patient's spokesperson

The literature abounds with examples of interpreters going beyond the task of translating between doctors and patients in the strictest sense of the word (see Beltran Avery, 2001; Bolden, 2000; Davidson, 2000; Hsieh, 2007, 2010; Leanza, 2005; Roy, 2000; Wadensjö, 1998). In these studies, interpreters' performance deviates from the doxa with respect to neutrality and impartiality, and from role boundaries as interpreters position themselves as advocates, co-diagnosticians, co-interviewers, managers, authors, principals, spokespersons, and cultural brokers, among others.[72] Hsieh (2008, p. 1370) refers to interpreters who act on behalf of patients as "overt-advocates", as opposed to "covert-advocates". This terminology raises a problem in the sense that "advocate" denotes the empowerment of patients, which is not necessarily the case in the examples

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[72] Different scholars use different terminology to refer to the same positions (see Bolden, 2000; Davidson, 2000; Hsieh, 2007, 2008; Leanza, 2005; Roy, 2000; Wadensjö, 1998).

observed and analysed in this thesis (Hsieh, 2008, p. 1373). The concept of "spokesperson" introduced here is less loaded and does not necessarily imply the empowerment of any of the parties, but simply the idea that interpreters carry out activities that patients cannot undertake due to the latter's healthcare condition and linguistic limitations (Mason, 2004). Interpreters' position as the patient's spokesperson is legitimised in the Interpreters' Handbook, with some restrictions. The following extract from the Interpreters' Handbook outlines interpreters' duties within the hospital and the boundaries of their position:

> Averiguar si hay problemas o preguntas motivados por su falta de conocimiento de español e intentar solucionarlos. Si tienen problemas con el seguro deberemos ponernos en contacto con el personal de Trabajo Social. No debemos hacer el trabajo que corresponde a los asistente sociales. (Interpreters' Handbook, p. 4, Appendix I)

> *Interpreters must find out whether there are any problems or issues related to the patients' lack of knowledge of the Spanish language and they must try to sort them out. If they have any problems with their health insurance interpreters must get in touch with social workers. We [the interpreters] must not do social workers' job [my translation].*

According to this quote and additional role descriptions found in the Interpreters' Handbook (see Appendix IV), interpreters are expected to act on behalf of patients to sort out their healthcare insurance in cooperation with social workers; make clinical appointments; and, in general, deal with any problem that may arise during the patient's stay at the hospital (see Excerpt 35 in this chapter).[73] This provides interpreters with a high degree of autonomy to act as "fully-ratified participants" within the field and to initiate a wide range of activities on behalf of patients without being monitored by the institution (Mason, 2005, p. 34).[74] During participant observation, I was able to observe an instance where an interpreter was asked to sort out some paperwork for a patient. This interpreter went to the administration office; she opened a filing cabinet, extracted a file, made a photocopy, took it to the appointment desk, made an appointment and put the file back into the filing cabinet. The fact that this behaviour seemed natural to the

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[73] Through participant observation, I had the opportunity to witness all the different duties that interpreters have to carry out on a daily basis. I observed interpreters rearranging appointments, calling patients for new appointments and announcing the death of a patient to family members.
[74] Mason (2005, p. 34) refers to three different positions that interpreters may adopt during interpreted encounters, depending on their degree of involvement: non-person, an involved translator and fully ratified participant.

administration staff indicates the degree of trust placed in interpreters and the professional autonomy they enjoy with regard to the healthcare institution.

In Excerpt 33, Hannah and Jackie recall two occasions where they had to act on behalf of patients.

Excerpt 33 (FG 2, Hospital Clínico, lines 286-303, Appendix V):

1	**Jackie**:	Sí, sí. Luego, lo que sí tenemos es ayudar a la gente cuando sus
2		familiares fallecen.
		Yes, yes. Then, what we have to do is to help people when their
		relatives die.
3	**Hannah**:	Sí, yo por ejemplo...
		Yes, I, for example...
4	**Jackie**:	Te puedes quedar con ellos hablando, tranquilizando,
5		consolándolos...
		You can stay with them talking, calming them down, comforting...
6	**Hannah**:	Yo ahora mismo estaba con una señora que ahora que el marido
7		está impedido también. Ella no tan mayor, pero sí mucho más
8		mayor. Y el marido no va a poder venir, entonces he llamado al
9		consulado y ha atendido mi compañera, a ver qué se puede hacer,
10		qué instituciones hay, qué asociaciones hay, entonces ella se
11		pondría en contacto con el marido a ver cómo se pueden ir al
12		hospital y estas cosas. Pero claro, has solucionado algo, puedes
13		hacer... muchas veces puedes solucionar algo.
		Right now I was with this lady that now, that her husband is disabled
		also. She is not so old, but yes, older than him. And the husband is not
		going to be able to come, so I have rung the consulate and I have
		spoken to a colleague, to see what can be done, what institutions
		there are, what associations there are, and so she would contact the
		husband to see how they can come to the hospital and those things.
		But, of course, you have sorted something out, you can do something...
		sometimes you can sort something out.
14	**Jackie**:	Hasta Australia hemos llamado una vez, hace años, al consulado, y
15		son más amables de gente. Porque cuando hemos llamado eran
16		sobre las 4 de la madrugada allí en Australia, y se pusieron en
17		contacto con la familia del hombre, y bueno, no digo nada más, pero
18		se comportaron genial, genial. Sí, sí, sí.
		We have even rung Australia once, years ago, to the embassy, and
		they're really nice people. Because it must have been 4am in Australia
		when we rang and they got in touch with the family, and I have no
		words, they were really, really nice. Yes, yes, yes.

As the interpreters explain in this excerpt, their job involves helping patients, comforting their families, sorting out funerals, paperwork, and any other issue that needs taking care of; these activities require a high degree of initiative and

cultural capital. Accordingly, interpreters are aware that they do more than 'interpreting'; this has been confirmed by the data obtained through the focus groups, interpreted encounters and participant observation. In Excerpt 34, Dorothy and Julianne describe the boundaries of their role.

Excerpt 34 (FG 1, Hospital Costa del Sol, lines 278-285, Appendix V):

1	**Dorothy**:	I mean the thing is that on the whole we do a hell of a lot for the
2		patients and we do more than they actually do here, we are actually
3		doing social work, sometimes we are doing every type of job in the
4		hospital, I mean here barring medicine, I mean, do most of the other
5		stuff here and I think a lot of the time they don't really appreciate
6		what we do, you know? [Probably they do] I don't know but I mean
7		we've never heard any word from them.
8	**Julianne**:	[Yeah, yeah, true.

In this context, interpreters get highly involved in their position as patients' spokesperson, echoing social workers' role, a characteristic that has been previously identified in other studies of public service interpreting (Laster & Taylor, 1994, p. 220; Sela-Sheffy & Shlesinger, 2008, p. 86). In this specific setting, interpreters deploy social capital in the form of care and sympathy for the patient, in exchange for the patient's recognition and gratitude. There are different instances throughout the different focus groups where interpreters show their disappointment seeing that patients do not show as much gratitude now as the used to show in the past (see Excerpt 18, Chapter 4). However, both groups of volunteer interpreters have received an award for Outstanding Achievements by the *Junta de Andalucía*, which they proudly display in their respective offices (see Appendix I), and they have also featured in different local newspapers (see Appendix IV).

Interpreters interiorise certain structures as part of their social and professional trajectory in this sub-field of healthcare interpreting, and for them it is not unorthodox to act on behalf of patients and carry out any task that may be necessary to provide an adequate service for foreign patients; volunteer interpreters in this study seem to go beyond the field doxa described in similar studies and prescribed by training institutions and other organisations. In previous studies, scholars have found differences between what interpreters say they do, often following what codes of conduct and standards of practice

prescribe, and what they really do (during interpreted interaction). However, interpreters in this study are an example of heterodoxy since they overtly accept a departure from the doxa of the professional interpreting community that prescribes neutrality and impartiality, and draw on their own standards of practice as stated in the Interpreters' Handbook (Appendix IV, p. 4).

In the following two excerpts, interpreters act on behalf of the patient during a medical consultation. In Excerpt 35, the interpreter arrives at the observation ward and approaches a patient who has just been brought in.[75]

Excerpt 35 (IMI 2, lines 29-71, Appendix X):

1   **Interpreter:** And what can I do for you?
2   **Patient:**   Well, could you ring the Bel Playa?
     {The patient explains that he was taken to the hospital after passing out in the toilet; his luggage was still at the hotel; he asks the interpreter to sort this out for him, because one of his colleagues was still in the hotel and he could take care of his luggage while he was hospitalized}
3   **Interpreter:** Meanwhile if Mr Homan takes your luggage I think (( )) and if you
4   go back to your hotel I think you can always book for one day more,
5   and we'll arrange the (( )). I'll come back to tell if everything is
6   sorted, ok?
7   **Doctor:**   ¡Hola! ¿La intérprete?
                Hello! The interpreter?
8   **Doctor:**   Has hablado [con... Y ¿qué quiere?
                Have you spoken [to ... and what does he want?
9   **Interpreter:**   [Sí, con el señor... que] está preocupado porque hoy se
10   iba de viaje de vuelta.
                      *[Yes, with Mr... that] he is worried because he was
                leaving today.*
11   **Doctor:**   No se puede [ir, vamos]. No se puede porque tiene el riñón
12   fastidiado.
                *No, he can't [leave, of course]. He can't leave because his kidney is
                damaged.*
13   **Interpreter:**   [No, ¿no?
                [No, right?
14   **Interpreter:** Pero entonces para que su equipaje que ya estaba empaquetado
15   para que se [lo llevemos a otro] señor [amigo ahí en] el hotel.
                *He's asking that his luggage that was already packed, that [we take it
                to another] gentleman, [a friend at] his hotel.*
16   **Doctor:**   [Lo traigan para acá.]   [¡Ah! Vale pues...
                                      *[They bring
                it here].   [Oh, ok, then...*
17   **Doctor:**   Ah, ya está. Que eso lo estáis arreglando ya vosotros...

Ok, that's it. You are already sorting that out…

18	**Interpreter**:	Yo lo arreglo, [pero luego] volveré [a decirle] lo que ha pasado,
19		¿vale?

Yes, I'll sort it out, [but then] I'll come back [to tell him] what happened, ok?

20	**Doctor:**	[¡Ah, vale!] [a decirle
		[Oh, ok] [to tell him
21	**Doctor:**	De acuerdo, para que no tenga, que no esté preocupado…
		Alright, so that he doesn't have to, so that he doesn't worry…

{The interpreter leaves the ward and goes to the office where she rings the hotel and asks them to get in touch with the patient's friend so that he could take care of his luggage. The interpreter then comes back to the ward and informs the patient that the problem has been sorted out}

22	**Interpreter**:	¿Cómo se llama él?
		What's his name?
23	**Doctor:**	James Dean, bueno…
		James Dean, ok so…
24	**Interpreter**:	It's alright. I phoned to the hotel so your luggage will be put in the
25		room opposite, ok?

Excerpt 35 confirms that interpreters occupy a legitimate position as patients' spokespersons: not only does the interpreter visit the patient in the ward and offer her services without being monitored, but also when the doctor approaches her to inquire about the patient's circumstances it is evident from his speech that he has already taken it for granted that she will sort the problem out: "Ah, ya está. Que eso lo estáis arreglando ya vosotros…" (Ok, that's it. You are already sorting that out…) in line 17. Moreover, the interpreter does not convey to the doctor the health related information provided by the patient himself prior to the doctor's arrival. The interpreter occupies the position of main interlocutor in this encounter, thus placing the doctor as a simple informant. During the interpreter-doctor exchange, she only mentions the luggage situation (lines 9-10 and 14-15), while omitting all the details related to the patient's health, discussed in Excerpt 38 below. Once she comes back to the ward, she again takes charge of the situation by asking the doctor about the patient's name (line 21) so that she can address him directly, thus consolidating her position as the main interlocutor. For the interpreter, it is more important to position herself as the patients' spokesperson, a position that provides her with a high degree of autonomy and symbolic power and turns her into the main interlocutor, than to adopt the role of mediator by establishing a direct doctor-patient relationship. She willingly adopts the position of spokesperson by a) addressing both doctor and patient in the first

person; and b) choosing what information to pass on, an issue that will be discussed in further detail in section 3.2.

In Excerpt 36, a further example of an interpreter positioning herself as spokesperson, she asks the doctor whether it is necessary to make an appointment to get a blood test three times. She asks the first time in line 1 and the doctor's reply is that it is not necessary. She immediately poses the question again (line 5), but as the doctor chooses to ignore this repetition, she resumes the interpreting activity. However, she picks up the question again in line 11 even though the doctor is already indicating that an appointment is not necessary. She is not content until she receives an actual date and time in lines 10 and 13, when the doctor and nurse finally agree to provide this information.

Excerpt 36 (IMI 1, lines 50-70, Appendix V)

1   **Interpreter**: Entonces, ¿dónde pide cita o [cómo va eso?
        So, ¿where can she get an appointment or [how does it work?
2   **Doctor**:   [No, no hay que] pedir cita. (.) Entonces,
3   que simplemente una mañana, eh, [como no tiene que guardar, como
4   no...
                                                        [No, it's not necessary] to
        make an appointment (.) So, one morning she can, ehm, [since she
        doesn't have to keep, since...
5   **Interpreter**:   [Entonces, ¿para eso no le van a
6   dar una cita?
                                                        [So, are you not
        going to give her an appointment?
7   **Doctor**:   Sí, pues aproximadamente 15 días antes de la cita se hace los análisis,
8   lo mejor es venir los jueves o los viernes por la mañana que hay
9   menos gente y a partir de las 10 se hace los análisis.
        Yes, so approximately 15 days before the appointment she has to do the
        tests, the best thing is to come on a Thursday or Friday in the morning
        when there are less people and from 10 am she can do the test.
        {...}
10   **Doctor**:   Nos vamos a ver el 23 de mayo.
        We are going to see each other on the 23rd May.
11   **Interpreter**: Eh, ¿tiene que pedir cita para eso o no?
        Ehm, does she need an appointment for that?
12   **Nurse**:   Aquí se la damos.
        We'll give her the appointment here.
13   **Doctor**:   A las 10.40.
        At 10.40.

It may be that the doctor does not usually give this information to patients as the appointment details are included on the medical report provided at the end of the consultation. However, the interpreter is determined to provide this information for the patient and the doctor finally agrees to release it. As observed in previous excerpts, as well as positioning themselves at the same hierarchical level as healthcare staff, which allows them to claim a large volume of symbolic capital and strengthens their habitus, interpreters enjoy a high degree of autonomy for several reasons: a) they feel they can intervene in shaping the doctor-patient relationship by positioning themselves as 'fully-ratified participants'; b) they act on behalf of patients, thus adopting the position of main interlocutor at times; and c) they exert control over the information flow and filter the information that should be exchanged between doctors and patients. Interpreters' autonomy in this sub-field is thus a result of the existing relationship of trust between the healthcare institution and the interpreters, who have been part of the relevant institution for a number of years.

3.2 The interpreter as informational gate-keeper

With increased questioning of the notion of neutrality and impartiality in interpreting, interpreters' position as informational gate-keepers has been given more attention (see Davidson, 2000; Hsieh, 2006, 2007, 2008; Wadensjö, 1998). Interpreters are able to adopt the position of informational gate-keepers as the holders of exclusive knowledge (linguistic capital) that facilitates the medical interview, even though this capital may be shared with other members of healthcare team (see section 3.3 of this chapter). Interpreters thus enjoy a large volume of symbolic power within the interaction because they exercise some control over it (Mason, 2009, p. 83; Wadensjö, 1998, p. 68). Depending on the degree of autonomy that an interpreter enjoys in each particular encounter, the relevant control or gate-keeping mechanisms can range from monolingual dyadic conversations between the interpreter and the patient to information screening where the interpreter may decide to omit, add or alter certain information. The main argument behind informational gatekeeping, as explained by Hsieh (2006, p. 726), is that the "institutional culture treats the provider's [doctors'] time as a scarce resource and pressures the interpreter to conserve the provider's time". In positioning themselves as gate-keepers, interpreters may intend to save time and

facilitate the doctor's work by not overloading him/her with useless information that may not contribute to the medical interview (Davidson, 2000). Interpreters may thus adopt what Bolden (2000, p. 396) calls the "voice of medicine", translating only those contributions that they consider relevant according to their medical expertise in each case.

It is not surprising that interpreters acquire some medical knowledge over time. As insiders, interpreters have the opportunity to familiarise themselves with institutional procedures and medical language relating to treatments and diagnosis. This medical knowledge can itself be turned into a form of cultural capital that they can deploy when necessary. In Excerpt 37, Antoinette describes her knowledge of different medical procedures that may allow her to adopt the 'voice of medicine' in interpreted medical interviews.

Excerpt 37 (FG 4, Hospital Clínico, lines 467-474, Appendix V):

1   **Antoinette**: Se aprende mucho, se aprende mucho, ¿eh? se aprende mucho. Es
2   que la anestesia lo sabemos. La anestesia es siempre lo mismo. La
3   tensión, la analítica, si le han operado ya, de que le han operado...la
4   anestesia ya, nos conocemos el rollo...
                    You learn a lot, you learn a lot, right? You learn a lot. We know all
                    about the anaesthetic. The anaesthetic is always the same. Blood
                    pressure, analysis, if they have had an operation before, what
                    operation they had... the anaesthetic, by now we know the whole
                    thing...
                    {...}
5   **Antoinette**: En urgencias. Qué pasa si ha bebido, si bebe...
                    In casualty. What happens if they have been drinking, if they drink...

Expert knowledge may allow interpreters to act on behalf of healthcare providers, as Hsieh (2007, p. 1369) points out: "when interpreters provided services that overlapped with providers (e.g., providing medical information), they claimed the identity of a member of the health care team". This issue of interpreters acting on behalf on the healthcare provider has also been extensively discussed by scholars (see Angelelli, 2004a; Beltran Avery, 2001; Bolden, 2000; Davidson, 2000; Hsieh, 2006, 2007; Leanza, 2005; Mason, 2004). Scholars refer to these interpreters, who work in healthcare settings on a regular basis and have thus developed an expertise knowledge, as "co-diagnostician" or "co-interviewer" since they tend to take an active role in the process and treatment of patients (Davidson, 2000; Hsieh, 2007). By positioning themselves as medical experts, interpreters acquire a

large volume of symbolic capital that contributes to their autonomous position and a stronger habitus.

3.2.1 Monolingual dyadic interaction: Interpreter vs. Patient

In previous sections (see Chapter 4, section 3; and section 1 of the present chapter), I discussed monolingual dyadic interaction between interpreters and patients as an example of interpreters' expression of alignment and a signal of their legitimisation during daily routine visits. Yet monolingual dyadic interaction can also evidence a high degree of autonomy among volunteer interpreters, especially when doctors are present. It can signal a relationship of trust between healthcare staff and interpreters.

There are several cases of monolingual dyadic interaction, with or without the doctor's presence, in my data. Those instances where there is no doctor present occur during "daily routine visits" (see Chapter 4, section 3) carried out by interpreters; the visits, which are described in the Interpreters' Handbook, signal the legitimisation, and therefore institutionalisation, of volunteer interpreters as members of the healthcare team. They provide interpreters with a high degree of autonomy that "involves the feeling that the practitioner [interpreters] ought to be allowed to make decisions without external pressures from clients [doctors]" (Hall, 1975, p. 82). Excerpts 7 and 13, discussed in Chapter 4, are two examples of monolingual dyadic interaction without the doctor's presence where interpreters demonstrate autonomy in shaping the field structures and position themselves within the wider field as legitimate institutional agents and gate-keepers. This gate-keeping activity allows doctors to keep their workload on time (Hsieh, 2007) because daily routine visits, as examples of monolingual dyadic interaction, allow doctors not to get involved in situations where their presence is not strictly necessary and where interpreters can deal with the situation by mediating between patients and nurses or by positioning themselves as patients' spokesperson in dealing with administrative services.

Additionally, there are examples of monolingual dyadic interaction embedded in triadic encounters where the doctor is present. In these triadic encounters there is a shift in the interpreter's position from a "non-person" or "an involved translator" to a "fully-ratified participant" and vice versa (Mason, 2005, p. 34). In these instances of monolingual dyadic interaction: a) the interpreter is responsible for her own exchanges; b) her utterances are not necessarily

translations of words uttered by the doctor or the patient; c) there is no direct doctor-patient interaction; and d) relationships are developed between doctor-interpreter and interpreter-patient (Bolden, 2000). In these specific examples of interpreted interaction, interpreters adopt the position of gate-keepers and use their autonomy and symbolic power to lead the exchange and force the doctor to occupy a secondary position. The following examples are extracts from three different medical interviews where the interpreter, at some point during the interaction, changes her footing and addresses the patient directly, thus occupying the position of main interlocutor and pushing the doctor into the background.

Excerpt 38 contains the longest monolingual dyadic exchange between an interpreter and a patient found in the corpus of this thesis (over six minutes long); it continues with Excerpt 35, discussed in section 3.1 above. Although the doctor is present in the observation ward, it was very busy at that time and the doctor seemed to be engaged with other patients. Perhaps in an attempt to cooperate with the doctor as a member of the healthcare team, the interpreter initially approaches the patient on her own and establishes a direct interpreter-patient relationship, thus positioning herself as 'fully-ratified participant', a position which proves impossible to alter from that moment onwards (see Excerpt 35 and Excerpt 42 in this chapter).

Excerpt 38 (IMI 2, lines 1-50, Appendix V)

1   **Interpreter**: You asked for an Interpreter?
2   **Patient**:   Yes.
3   **Interpreter**: That's me. What can I do for you?
4   **Patient**:   Is this Intensive Care?
5   **Interpreter**: Sorry?
6   **Patient**:   This ward?
7   **Interpreter**: Yes.
8   **Patient**:   Is this Intensive Care?
9   **Interpreter**: No, no, no, no, you are at observation, so [don't worry!] No, not too
10   bad, [not too bad.
11   **Patient**:   [hhhhhhh]
12   [Not too bad, now...
13   **Interpreter**: First of all, I'll tell you, you are in a good hospital, you're in good
14   hands.
15   **Patient**:   I know that.
16   **Interpreter**: Try to relax. It's a good hospital.
17   **Patient**:   [Far better (.)] than the one I was in before.
18   **Interpreter**: [Try to relax.

19	**Interpreter**: You have been before?
20	**Patient**: No, they put me into this International... and I came out (( )) and I
21	then... when I got back to the hotel...

19 **Interpreter**: You have been before?
20 **Patient**:   No, they put me into this International... and I came out (( )) and I
21   then... when I got back to the hotel...
               {...}
22 **Patient**:   When I got back to the hotel and I felt worse and they wanted to
23   send the doctor, but I don't want a doctor back at that international
24   hospital, so I said no, Spanish hospital.
25 **Interpreter**: Spanish hospital. It's much better, I think.
26 **Patient**:   Much better.
27 **Interpreter**: Yes, yes. (.) Yes, ok.
28 **Patient**:   Yes, so this is where I am?
    {The patient explains that he was taken to the hospital after passing out and his luggage is still at the hotel; so he asks the interpreter to sort this out for him}
29 **Patient**:   Because I was staying in the Bel Playa, I went to the toilet and I
30   couldn't get up and I fell on the floor.
31 **Interpreter**: Yes, but don't worry in this moment about this, alright? I think, first
32   of all, let's wait for the doctor, see if you can go back, if you can't go
33   back {...}.

The patient takes this opportunity to recall what happened to him before he was taken to hospital while the interpreter listens to the story and takes charge of the situation by positioning herself as 'co-interviewer'. The interpreter thus adopts the voice of medicine by initially comforting and reassuring the patient about his situation, using phrases such as "you are in a good hospital, you're in good hands" (lines 13-14); "try to relax" (lines 16 and 18); and "don't worry in this moment about this, alright?" (line 32). The interpreter, who has probably experienced plenty of similar medical interviews in the past, is drawing on her medical expertise to act on behalf of the healthcare provider and offer the patient an adequate service, even if this means going beyond her canonical position as interpreter. The interpreter's high degree of autonomy and symbolic power allows her to inform the patient that his condition is not too serious (lines 9-10) even though she has no information about the patient's condition except what the latter has mentioned during their encounter. This deviation from the principle of neutrality could have serious consequences for the patient since his condition was as yet unknown. It may be that the interpreter is drawing on her experience once again and she is certain that if the patient is in the observation ward his condition cannot be too serious. Consequently, the interpreter is acting as member of the healthcare team by a) welcoming, comforting and reassuring the patient; and b) offering expert opinion on the state of the patient's health; these two areas belong to the doctor's field of action. At the same time, the interpreter may not have

intended to adopt this position upon her arrival; to some extent it may have been imposed on her. In any case, by doing so, the interpreter has saved the doctor's time because, as we will see in Excerpt 42, the doctor will find that the interview has been initiated by the interpreter and he will not have to exchange any initial greetings with the patient.

This pattern seems common in this healthcare setting, and doctors do not seem to be threatened by the interpreter's strong positioning; consequently, there is no overlapping of positions but rather cooperation between interpreters and doctors in order to facilitate the doctor's work and to protect the patient's well-being. In this regard, doctors and interpreters work as a team where the interpreter, as informational gate-keeper and spokesperson, may exert more control over the information flow than the doxa of the professional community allows. The major problem in this encounter is that the interpreter's position as spokesperson, examined in Excerpt 35, gets in the way of her position as gate-keeper. As pointed out by Candlin (Wadensjö, 1998, p. xvii; cited in Davidson, 2000, p. 382), interpreters "are always placed in this contested arena between being providers of a service and being agents of authority and control". Interpreters are confronted simultaneously with a range of available positions which they have to choose from. In this particular case, the interpreter opts to position herself as the patient's spokesperson and neglects her position as informational gate-keeper, thus failing to pass on relevant information to the doctor which the patient has provided (see Excerpt 35).

The following example of monolingual dyadic interaction (Excerpt 39) lasts for approximately two minutes and takes place while the doctor is carrying out a physical examination of the patient. The monolingual conversation taking place between the interpreter and the patient's relative is arguably not directly relevant to the medical interview, which may explain why the interpreter decides not to convey the relative's questions.

Excerpt 39 (IMI 3, lines 251-284, Appendix V):

{The doctor is looking at the patient's analysis results and doing a physical examination}
1 **Relative**:   We have a reserve to pay in a, in a hotel, but.... uhm, not knowing the
2   date when he'll be discharged…
3 **Interpreter**: Is he going back to England?
4 **Relative**:   No he lives in Spain, he lives in Spain, in Fuengirola, uhm, but we…
5 **Interpreter**: TURN TOWARDS THE DOCTOR! [The interpreter is indicating the

6		patient to follow the doctor's directions] That's good man, a boy!
7	**Relative**:	So at the moment, we have reserved that yesterday, we want (( )) but
8		we knew he couldn't go home, (( )) the doctor says for several weeks.
9	**Interpreter**:	Yes, he says so, yes.
10	**Relative**:	Is he staying in this ward?
11	**Interpreter**:	Well, he said in this ward, yes.
12	**Doctor**:	Muy bien.
		Very well.
13	**Interpreter**:	¿Ya?
		Finished?
14	**Relative**:	And what is this ward? Just, what is...?
15	**Interpreter**:	Well, it's a ward where the, for infections.
16	**Relative**:	I see, yes, ok.
17	**Interpreter**:	Where they control the infections. Everything is under control with
18		the infections, that's why he's here.
19	**Relative**:	I see, so it's a control environment. So it's not like everybody is
20		walking around with swine flu or anything like that.
21	**Interpreter**:	NOOOO.
22	**Doctor**:	¿Qué dice, qué dice?
		What's he saying, what's he saying?
23	**Interpreter**:	Dice... [addressing the doctor]. No, no, no (( )) [addressing the
24		patient's relative.
		He is saying... [addressing the doctor]
25	**Relative**:	We weren't sure whether we were gonna catch from him or he was
26		from us.
27	**Interpreter**:	Le estaba diciendo que no hay tanta gente aquí paseando con el, como
28		se dice... este gripe...?
		I was telling him that there aren't so many people wandering around
		with, how do you say...the flu...?
29	**Doctor**:	¿Gripe A?
		Swine flu?
30	**Interpreter**:	Eso.
		That's it.
31	**Doctor**:	No.
32	**Interpreter**:	He dicho que todo está bajo control aquí para las infecciones y todo.
		I've told him that everything is under control here for infections and
		everything.
33	**Doctor**:	Aquí lo que tenemos ahora mismo, bueno, pues la mascarilla es para
34		evitar pasarle a él alguna infección.
		Here what we have right now, well, the mask is to stop anyone giving
		him an infection.
35	**Interpreter**:	Evitar, sí. Sí, acabo de decirle [addressing the doctor]. So keep your
36		mask on for his sake. To prevent it, yes. That's what I just told him. So
37		keep your mask on for his sake [addressing the patient].
		To avoid, yes. Yes, I've just said [addressing the doctor].

Initially, the doctor allows the interpreter to maintain a separate conversation with the patient's relative and does not seem interested in monitoring the interpreter.

However, once he has finished examining the patient, he wants to restore his position and regain control of the interaction by signalling to the interpreter to bring the dyadic interaction to an end in line 12. Although the interpreter acknowledges this interruption with "¿Ya?" (Already?) in the following line and realises that the doctor has finished examining the patient and that the medical interview must be resumed, the dyadic interaction does not end there. The monolingual dyadic interaction continues for six more turns until the doctor interrupts the conversation in a more assertive manner. Although the doctor is challenging the interpreter's position in this instance, she makes an effort to re-align herself by letting the doctor know that information she has provided is accurate (indirectly enhancing her cultural capital); she uses assertive mechanisms such as "le estaba diciendo", "he dicho" , "acabo de decirle" repeatedly (lines 27, 32 and 35). Several aspects are worth pointing out here: a) the interpreter assumes that the question is not relevant for the medical interview and does not want to overload the doctor with it; and b) she adopts a position as 'fully-ratified participant' since she has been legitimised as such by the same doctor throughout the encounter – a doctor who has constantly addressed the patient in the third person (IMI 3, lines 22, 31, 135, 158, 193 and 297). The interpreter's role thus constantly shifts between being a 'fully-ratified participant' with a high degree of autonomy and being a service provider who is monitored by more powerful agents in the field.

However, not all interpreters establish monolingual interaction with patients as a means of cooperating with doctors by keeping the interview short. Excerpt 40 is a short monolingual dyadic conversation between the interpreter and the patient in the middle of a medical interview.

Excerpt 40 (IMI 1, lines 39-49, Appendix V)

1	**Doctor**:	Es que… se lo pregunto porque tiene que hacerse unos análisis aquí
2		en el hospital, ¿vale?
		I'm asking because she needs to get some tests done at this hospital, ok?
3	**Interpreter**:	You have to do another test but in this hospital, not in Fuengirola.
4	**Doctor**:	Puede ser aquí o en el Costa del sol, me da igual.
		It can be here or at the Costa del Sol, it doesn't matter to me.
5	**Interpreter**:	Ahm, what you prefer in Hospital Costa del Sol or here?
6	**Relative**:	Here.
7	**Interpreter**:	Here? [(hhhhhh)] You're more confident in this hospital?
8	**Relative**:	[(hhhhhh)]
9	**Relative**:	This is better than Costa del Sol.

10 **Interpreter**: Well... I don't know, my daughter works there.
11 **Relative**:   Oh, sorry!
12 **Interpreter**: Ahm...
13 **Doctor**:   Muy bien, pues nada... pues...
                     Very well, so then... so...

Although the interpreter and the patient exchange only a few turns, the interpreter manages to convert the medical consultation into a personal discussion over the quality of different hospitals, which has nothing to do with the purpose of the patient's visit. The doctor does not show any intention of monitoring the conversation that has just taken place; in fact, he is unable to judge whether this conversation is going to continue. The doctor probably thinks the interpreter is being cooperative and does not realise that she has turned the medical interview into a semi-private discussion of the merits of the two hospitals. In this instance, the interpreter does not seem concerned about the doctor's schedule in this particular encounter.

In the examples of monolingual dyadic interaction presented above, the interpreter assumes a position as 'fully-ratified participant' regardless of the doctor's presence and agenda. Moreover, doctors do not seem to question interpreters' behaviour, thus showing a high degree of trust in their commitment to carry out their job to the best of their abilities as members of the healthcare team. Therefore, doctors do not tend to challenge interpreters' position as gate-keepers and work with them as a team. In cases where interpreters' position is challenged by a doctor, they will try to restore their position and their professional autonomy. As discussed above, a high degree of trust translates into a high degree of autonomy (Forsyth & Danisiewicz, 1985) that allows interpreters to occupy well-established positions as highly autonomous agents with strong habitus and symbolic capital (in the form of linguistic and cultural capital).

3.2.2 Mono-directional translation

As well as monolingual dyadic interaction between the interpreter and the patient, there are other control mechanisms that interpreters have at their disposal to position themselves as informational gate-keepers. In the following instances, interpreters choose to translate in one direction, from the doctor to the patient, but not the other way around. It may be that as a reflection of their alignment with doctors, there is an assumption that the doctor's voice is more important

than the patient's; the patient's voice is thus submerged and fails to steer the medical interview. Davidson (2000) examines similar instances where interpreters are more concerned with making the doctor's voice heard than the patients', which has a huge impact on interview outcomes and on the doctor's perception of the patient's needs. Alternatively, interpreters may be adopting the voice of medicine because they believe that they have the medical expertise to discern what information is relevant and what is not (Bolden, 2000).

In the following excerpt, the interpreter dutifully translates every utterance initiated by the doctor. However, she fails to translate fully the responses of the patient and her relative in lines 3, 9, 10 and 12. The patient's and her relative's contributions are responses to the doctor, who is trying to make an initial assessment of the patient's current health condition. While the interpreter acknowledges that the patient's health has improved, based on but not directly translating the patient's responses (line 4 and 11), the doctor does not seem concerned that the interpreter is not translating the patient's or her relative's utterances. This suggests that the doctor trusts the interpreter's capacity, as a member of the healthcare team, to discern what information is relevant for the medical interview. There seems to be an understanding between them whereby the interpreter has control over the flow of the conversation and the information to be passed along.

Excerpt 41 (IMI 1, lines 5-34, Appendix V)

1	**Doctor**:	¿Cómo estamos?
		How are you?
2	**Interpreter**:	How are you?
3	**Patient**:	Not bad, thank you.
4	**Interpreter**:	Good, ok, good.
5	**Doctor**:	¿Y qué tal del estómago?
		And how is your stomach?
6	**Interpreter**:	How is your stomach?
7	**Doctor**:	¿Las náuseas y eso?
		The nausea and the rest?
8	**Interpreter**:	Your stomach, no… still vom- (+vomiting)… still nauseous?
9	**Patient**:	No, a lot less, thank you. And…
10	**Relative**:	Yeah, yeah. I think it was the tablets that were causing the problems.
11	**Interpreter**:	Yes and now that's better.
12	**Relative**:	Yes.
13	**Interpreter**:	Fine.
14	**Doctor**:	Bueno, pues, la analítica muy bien.
		So then, the tests are good.

15	**Interpreter**:	So the tests, erhm, are very well, so…
16	**Doctor**:	¡Están perfectos!
		They're perfect!
17	**Interpreter**:	Perfect! (hhhhhh)
18	**Doctor**:	Muy bien, muy bien. ¿Alguna novedad que contarme? ¿Alguna cosa
19		nueva?
		Very well, very well. Do you have any news for me? Anything new?
20	**Interpreter**:	Do you want anything to tell Doctor? Is there anything that you want
21		to tell him?
22	**Relative**:	No, she's been well apart from the problems with the hip.
23	**Interpreter**:	You have problems with the hip?
24	**Patient**:	(( ))
25	**Relative**:	Yes, it's probably the bones are rubbing together, but the doctor says
25		she is too old to [operate.
26	**Interpreter**:	[Operate.
27	**Interpreter**:	Sí, tiene problemas con la cadera y dice que el médico ha dicho que ya
28		no la operan.
		Yes, she has problems with the hips and the doctor says they will not
		have surgery on her.

Although initially the doctor's utterances seem to be routine questions (lines 1, 5 and 7), in line 10 the patient's relative provides some information about the cause of the patient's health problems that may be relevant to the medical interview. The interpreter acknowledges this information, "Yes, and now that's better" in line 11, yet she does not translate this information back to the doctor. It is not until line 27 that the interpreter decides to translate back for the doctor what the patient's relative has just said. However, before doing so, she makes sure that she has gathered enough information to pass on to the doctor by asking the patient's relative to elaborate further on the information (line 23). As informational gate-keeper, she controls when and how much information is exchanged between the doctor and the patient as she tries to find out all the facts before translating for the doctor so that he does not have to ask any further questions, thus speeding up the interview. In this sense, the interpreter is acting as a 'co-interviewer', anticipating the doctor's questions. In any case, she fails to make the patient's voice heard and does not allow any direct interaction between the doctor and the patient. The purpose of the medical interview is to some extent defeated by the lack of communication between the doctor and the patient, for, as the medical expert, the doctor does not have access to all the information provided and he is unable to further explore the patient's current state of health if necessary. As in previous examples, this often means that relevant information is not passed on and the medical interview is in some respects not as efficient as it could have been

because the interpreter is more concerned about her autonomous position as gate-keeper than establishing direct communication between the doctor and the patient.

Although the following Excerpt 42 does not follow a distinctive pattern of monolingual conversation or mono-directional translation, it does include instances of mechanisms of gate-keeping as well as of information screening. One important aspect of this excerpt is that the doctor does not exchange any greetings or routine questions with the patient; instead, he begins the exchange by providing information about the patient's state of health, since, as we saw in Excerpt 38, the interpreter has already done so. From lines 1 to 17, the interpreter communicates exclusively with the doctor in a monolingual conversation where instead of rendering the information provided to the patient, she decides to ask the doctor questions until she has gathered all the information she considers necessary about the patient's healthcare condition, thus taking full control of the interaction and positioning herself as gate-keeper. In this sense, we cannot consider the interpreter's turns as translations of the doctor's utterances, but rather as part of two separate conversations, first with the doctor and then with the patient, somewhat similar to the organisational communication pattern described by Bolden (2000, pp. 394-395). This communicative pattern is not surprising considering that it was the interpreter who initiated the medical interview, an event that was not only legitimised but also encouraged by the doctor (see excerpts 35 and 38 in this chapter).

Excerpt 42 (IMI 2, lines 72-105, Appendix V)

1	**Doctor**:	Sigue un poquito todavía con una infección respiratoria y una
2		insuficiencia del riñón, un fallo renal, ¿eh? que va mejor, el riñón ya
3		está orinando, y ha empezado a orinar y ha empezado…. y entonces
4		nada más. Y después tiene un poquito de sangre por el culete pero
5		yo creo que son hemorroides, yo creo que son (( )), ya se lo (( )) ¿de
6		acuerdo? Y se tiene que quedar ingresado unos días hasta que el
7		riñón funcione.

He is still with a little bit of a respiratory infection and with a malfunctioning of the kidney, a kidney failure, ok? It is going better, the kidney is already urinating, it has started to urinate, and it has started… and so nothing else. And now, he has a little bit of blood in the bum but I think is haemorrhoids, I think it's (( )), I will (( )), ok? And he has to stay in hospital for a few days until the kidney starts working.

8	**Interpreter**:	Pero ¿a planta?

But, in the Ward?

9	**Doctor**:	En la planta, lo que pasa es que no hay camas y como no hay camas
10		tendrá que quedarse aquí y tendrá que quedarse ingresado unos
11		días.

In the ward, what happens is that there aren't any beds and since there aren't any beds he will have to stay here and he will have to stay hospitalised for a few days.

| 12 | **Interpreter**: | ¿Solo unos días? |

Only for a few days?

13	**Doctor**:	Pero yo creo que será poco tiempo [porque la verdad es que está]
14		evolucionando muy bien ¿eh? y si todo va bien pues se podrá ir de
15		alta, ¿vale?

But I think it will be for a short time, [because the truth is that he is] developing very well, ok? And if everything goes well, he will be able to leave, ok?

| 16 | **Interpreter**: | [Sí, sí, claro, estupendamente. |

[Yes, yes, of course, fantastic.

| 17 | **Interpreter**: | Muy bien. |

Very well.

18	**Patient**:	Is that good news or bad news?
19	**Interpreter**:	No, no, I think it's good news, [because the] Doctor says you are
20		improving, eh? So the kidney wasn't working [and now] it's already
21		working, eh? But there's still a little bit infection in your chest.
22	**Doctor**:	[Good news!
23	**Patient**:	[Working.
24	**Patient**:	[The patient starts coughing to indicate the doctor that he has
25		problems breathing] Now look! I choke.
26	**Interpreter**:	Yes, yes. That's what the doctor says there's still a little bit infection
27		so you'll stay for some days in hospital not too much because you
28		are getting better, eh? So, when the...
29	**Patient**:	Will the inhaler do any good?
30	**Doctor**:	{in English} (( ))
31	**Patient**:	No?
32	**Doctor**:	Yes, a bit. Sí, un poquito.

Yes, a bit. Yes, a little bit.

33	**Interpreter**:	A little bit.
34	**Doctor**:	A little.
35	**Interpreter**:	So you will go to the ward when there's a bed free. This is
36		observation, this is observation. So you will go to a room when
37		there's bed...

In addition to the interpreter's intervention in directing the doctor-patient relationship in this medical interview, from line 17 to the end of this excerpt, there are some interesting issues to note. One is the patient's attempt to be included in the interaction by posing a question (line 18) to establish direct communication with the doctor. He later starts coughing loudly and says: "Now look! I choke!" (lines 24-25) as if he was trying to get the doctor's attention and let the doctor know that he has a problem with his breathing. However, the interpreter steers

the doctor-patient interaction once again in line 26 where she acknowledges the patient's problem with a very condescending "yes, yes, that's what the doctor says", as if implying that the doctor is already aware of his situation and does not need more information.

The doctor also tries to communicate directly with the patient by attempting to speak English (lines 22, 30, 32 and 34). The doctor seems to possess some linguistic capital and is able to monitor the conversation by answering the patient's question even though the interpreter has failed to translate this for him (line 19). However, his linguistic capital seems very limited and he is not capable of expanding his answer further than "Good news!" (line 22), which he repeats after the interpreter's own utterance in line 19 "No, no, I think it's good news". In fact, it is impossible to know whether he has understood the patient's question or whether he picks up the interpreter's response and is simply repeating after her. When the patient asks about the inhaler (line 29), the doctor takes over the interpreter's turn unsuccessfully, for, although he answers in English, his utterance is incomprehensible even for the patient, who seems to have misunderstood (line 31). The doctor tries to overcome this miscommunication problem, but again his English is so limited that the interpreter has to intervene (line 33). Thus, although the doctor makes an effort to take charge of the interaction, his linguistic capital is not sufficient and he is unsuccessful; he is obliged to remain an observer, at which point he decides to leave the encounter.

The interpreter accumulates so much autonomy and power in this encounter that she dominates the interaction throughout the interview. She steers the doctor-patient communication, she does not allow the patient's voice to be heard by the doctor and she controls the exchange of information by providing the patient with only a summary of what the doctor says between lines 1 to 17. As the interpreter screens the information flow, she fails to let the patient know about his haemorrhoid problem (lines 4-5), information that the patient does not have the opportunity to either confirm or refute, thus preventing important medical information from being exchanged.

In fact, if we observe the whole encounter (IMI 2, Appendix V), instead of looking at short extracts, we can have a general view of what is happening. In this medical interview the doctor and the patient are not addressing each other but the interpreter, which is further accentuated by the use of the third person to address the patient; this pattern of behaviour, according to Hsieh (2008), does not

reinforce the doctor-patient relationship. The doctor seems to be satisfied with the position of 'co-interviewer' that he is obliged to occupy and the position of informational gate-keeper the interpreter has assigned to herself. Providing the interpreter with so much power over the functioning of the medical interview allows the doctor to move on more quickly from one patient to the next by avoiding formal greetings, irrelevant routine questions and additional ending structures. The interpreter seems to be responsible for opening, conducting and closing this medical interview at all times as the doctor only stays very briefly and only to inform the interpreter, not the patient, of the patient's healthcare condition. The interpreter occupies the position of interviewer and the doctor seems to be no more than an informant who provides the interpreter with the medical information to conduct the interview. The interpreter thus enjoys a high degree of autonomy that she can convert into symbolic power.

3.2.3 Information screening

Although the following excerpts could also be analysed under the category of monolingual dyadic interaction between the interpreter and the patient, they do not qualify as conversations, strictly speaking, since the interpreter and the patient hardly exchange two or three utterances and the duration of these exchanges is only a few seconds. It would also be possible to argue that both monolingual dyadic interaction and mono-directional translation are examples of information screening since interpreters use these mechanisms to control the exchange of information between the doctor and the patient. As with previous examples of gate-keeping, it is possible to assume that the interpreter's intention is to filter the information exchanged between doctor and patient in order to speed up the medical interview and help the doctor keep to his schedule. Volunteer interpreters in this field have enough power and authority to discern what information and which questions should be rendered. In Excerpt 43, after the interpreter has translated the doctor's utterance and provided the patient with information regarding her next appointment, the patient's relative tries to clarify the appointment date (line 4) and location (line 8). In both cases, the interpreter answers the questions herself without getting the doctor involved in this digression, possibly to avoid prolonging the medical interview more than necessary.

Excerpt 43 (IMI 1, lines 58-76, Appendix V)

1 **Interpreter**: So 14 days more or less two weeks before the next appointment you
2   come to the hospital from 10 o'clock and then you make another test,
3   and he said if you come on Thursday or Friday are less people.
4 **Relative**:   Ok, that's good, and is it (.) two weeks?
5 **Interpreter**: Two weeks before.
6 **Relative**:   Do we have the test where we used to go for the blood test?
7 **Interpreter**: Yes.
8 **Relative**:   Same place?
9 **Interpreter**: Yes.
10 **Relative**:   Thank you!
11 **Patient**:   [The doctor is looking for the blood test results] This one.
12 **Relative**:   [Ahm, (.)   ] blood pressure?
13 **Interpreter**: [Hand it over.
                    {...}
14 **Interpreter**: On the 23rd May, now you will get the paper, you have to come back.
15 **Relative**:   Go back to here?
16 **Interpreter**: Yes, two weeks before, you know, the test.
17 **Relative**:   Ok, gracias.
18 **Interpreter**: Here is your report.

The interpreter is confident that she does not need to check this information with the doctor first, and the doctor does not show any interest in knowing the content of the conversation, since he is busy looking at the patient's paperwork (as in Excerpt 39). If the interpreter had involved the doctor in the conversation following the strict pattern of doctor-interpreter-patient-interpreter prescribed by the doxa, then the doctor would not have been able to look at the report in the meantime and the consultation would have taken longer. Although according to Hsieh (2008), this interaction pattern does not encourage doctor-patient communication, it does fulfil other roles such as keeping the doctor's workload on track. In this case, as in previous examples, doctor and interpreter are working as a team to achieve more efficiency.

Finally, in Excerpt 44, we can observe a further example of information screening, which, on this occasion, is more evident than in the previous excerpt for two reasons: a) the length of the interpreter's rendition is one third of the doctor's initial utterance; and b) the information rendered by the interpreter does not correspond to the information provided by the doctor.

Excerpt 44 (IMI 3, lines 217-223, Appendix V)

1	**Doctor**:	Cuanto tiempo puede estar ingresado puede ser prolongado porque
2		necesita antibióticos, ahora mismo sabemos dos cosas principales,
3		que tiene una infección, una infección complicada con una infección
4		del hueso.

The time he has to remain hospitalised could be really long because he needs antibiotics; right now we know two things, that he has an infection, a complicated infection of the bone marrow.

5	**Interpreter**:	And then there is the complication of the infection of the bone at the
6		back.
7	**Doctor**:	Y solo para eso necesitará antibióticos de manera prolongada.

And for that only he will need antibiotics for a long period of time.

8	**Interpreter**:	So he will be in hospital quite a while just only for that.

The interpreter's decision to screen information provided by the doctor has particular relevance since in this encounter the doctor has previously briefed the interpreter (see IMI 3, lines 5-8, Appendix V) and explained to her that the reason why he called her was because he wanted to make sure that the patient's relatives were aware of the patient's condition. It seems that it was the first time that the doctor had met the patient's relatives and so he wanted to provide a detailed account of the patient's condition. Therefore, the interpreter's decision not to inform the patient's relatives that he is taking a large amount of antibiotics, even though the doctor repeats it twice (lines 2 and 7), and the fact that it is the main reason why he has to remain hospitalised so that he can be treated for his infection, is difficult to understand. Unfortunately, focus groups and interpreted encounters were recorded at about the same time and I was unable to ask interpreters about the issues emerging from the recordings. However, if we analyse the transcript of this encounter as a whole, it is possible to recognise several aspects that may have contributed to the interpreter's positioning in this instance: a) clearly the doctor does not know how to work through an interpreter in terms of the length of the utterances he produces, which the interpreter struggles to render on several occasions in lines 48, 71 and 138-139 (IMI 3, Appendix V); and b) the doctor breaks the doctor-interpreter relationship of trust with his constant interruption and monitoring as will be observed in excerpts 45 to 49 in section 3.3 below. These two aspects may have affected the interpreter's confidence and memory span and therefore her capacity to render information accurately.

We have seen examples where the interpreter's gate-keeping position has obstructed the doctor-patient interaction and sometimes she has even failed to pass on relevant information to both doctor and patient in an attempt to cooperate with the doctor and allow him to keep his schedule. However, interpreters' power and authority to act as spokesperson or gate-keepers is invested in them by doctors themselves, who provide interpreters with a high degree of professional autonomy to occupy these positions. Doctors rely on interpreters acting as spokespersons and informational gate-keepers and they legitimise both positions, as observed in previous excerpts. Moreover, doctors fail to promote direct doctor-patient interaction by addressing the patient in the third person instead of using the first person prescribed by interpreting standards of practice, thus turning the interpreter into a 'fully-ratified participant' in the interaction rather than a mediator, and providing interpreters with a high degree of autonomy and symbolic power that strengthens their habitus.

3.3 The interpreter as language conduit

While doctors are responsible for the authority and power invested in interpreters, they also have the capacity to withdraw that power and authority. Doctors' stronger habitus and symbolic capital allows them to occupy the highest positions available in the field hierarchy and structure the field and the positions that other agents occupy; they can ratify interpreters' positioning within the sub-field of healthcare interpreting as full participants, involved participants or non-involved participants. As mentioned above, the power interpreters enjoy does not come from occupying a dominant position per se, but rather through their accumulation or monopolisation of resources, particularly linguistic capital, which is essential in bilingual medical consultations. In this sense, interpreters' symbolic power is under threat the moment that other agents in the field who have also accumulated enough linguistic capital to communicate with foreign patients take part in the interaction, especially if these agents have a stronger habitus than interpreters. As pointed out by Alexieva and Anderson, "the relative power and status enjoyed by an interpreter as the only bilingually competent—and therefore the 'controller of scarce resources'—participant are likely to be reduced if one or more of the other participants has even a passive knowledge of both languages"

(Alexieva, 1997; and Anderson, 1976; cited in Mason, 2005, p. 33; emphasis in the original)

Although in the following excerpts doctors do not generally seem to monitor the interpreting activity on purpose, there are examples in the literature where doctors may develop different strategies to supervise interpreters' performance even in those cases where they lack the appropriate linguistic capital (Hsieh, 2010). Some of these strategies consist of monitoring the length of utterances and paying special attention to key words or to non-verbal cues (Hsieh, 2010, p. 156). Interpreters' position is influenced by the extent to which doctors are able to monitor their performance, since in some instances a doctor may go as far as challenging an interpreter's performance, particularly if the doctor possesses relevant linguistic capital. In the following sections, I will examine some examples found in the data where doctors try to correct the interpreter's rendition of their utterances, complete the interpreter's utterance, or try to overtake the interpreter's turn when they understand a question posed by the patient. In all cases, the linguistic capital of the doctor is not sufficient to perform the medical interview without the mediation of an interpreter, but in some cases it may allow him to monitor the interpreter's performance, which may result in a constant struggle for authority, control and power over the flow of the interaction.

3.3.1 Doctor corrects interpreter's rendition

In the following two excerpts, extracted from the same medical interview, the doctor is able to identify a couple of instances where the interpreter's rendition of his utterance is not completely accurate. The doctor's linguistic capital allows him to monitor these deviations from the original utterance and correct the interpreter accordingly. He produces the corrections in Spanish, probably because he does not have much confidence in his English.

In Excerpt 45, the doctor is explaining the possibility that the patient's pacemaker may have to be removed as the patient may have an infection in his heart, which may be a consequence of an infection in the pacemaker. In translating the doctor's utterance, the interpreter is more assertive about the possibility of having to change the pacemaker than the original utterance of the doctor suggests. The doctor uses "porque en ese caso" (because in that case) in line 8, in the sense that if there is an infection in the pacemaker this may have to be removed, which the interpreter fails to render in the same terms (line 10). The

doctor realises this and points out to the interpreter that the pacemaker will only be removed "si está infectado" (if it's infected), which the interpreter then translates verbatim in line 12.

Excerpt 45 (IMI 3, lines 54-64, Appendix V)

1	**Doctor**:	Entonces le estamos haciendo pruebas para comprobar si hay
2		infección de las válvulas del corazón o infección del cable porque si la
3		hubiera...
		So, we are doing some tests to check if there's an infection in the heart
		valves or an infection in the cable because if there was...
4	**Interpreter**:	They are going to do tests to find out whether it's from the valve of
5		the heart or from the [tube.
6	**Relative**:	[from the tube.
7	**Interpreter**:	Exactly.
8	**Doctor**:	Porque en ese caso habría a lo mejor que retirarlo pero tenemos que
9		tener seguridad de que es el cable del marcapasos.
		Because in that case, it would be necessary to remove it but we have to
		be sure that it is the pacemaker cable.
10	**Interpreter**:	Retirar el... They may have to remove the cable from the pacemaker.
		To remove the... They may have to remove the cable from the
		pacemaker.
11	**Doctor**:	Pero si está infectado, no...
		But if it is infected, otherwise...
12	**Interpreter**:	If it's infected, if not, no...

The interpreter does not react to the doctor's monitoring and the interview carries on as usual, which may suggest that interpreters are used to being monitored. There are no signs that show to what extent the doctor's behaviour affects the interpreter's position on this particular occasion, although the impact is clear in other instances (excerpts 44 and 47). It is evident that the interpreter's abilities and authority are called into question, and this has a great effect on the interpreter's autonomy.

In the following excerpt, the interpreter does not allow the doctor to finish his utterance and starts translating before the doctor has finished, which may reflect negatively on the doctor's authority. The interpreter then finishes her translation assuming that she knows what the doctor intends to say in line 11 "about his heart". However, the doctor was referring to the bone marrow (line 13). In anticipating the doctor's utterance, the interpreter may have intended to contribute to a smoother and faster medical interview, thus helping the doctor to continue with the rest of the information. Moreover, it is also possible that the

interpreter is trying to re-align herself as a 'fully-ratified participant' by asserting her position within the interaction.

Excerpt 44 continued (IMI 3, lines 224-229, Appendix V)

9 **Doctor**:   Y después hay que también ver que está [ocurriendo en la…
                     And then it is necessary also to see what is happening in [the…
10 **Relative**:   [Quite a while is…?
11 **Interpreter**: And then, then they will have to find out about his heart.
12 **Relative**:   Yes.
13 **Doctor**:   No, la medula ósea también.
                     No, the bone marrow also.
14 **Interpreter**: Oh sorry! They'll have to find out about the bone marrow.

In line 13 the doctor points out the interpreter's mistake and she has no option but to apologise (line 14). The interpreter has once again lost her authority and power and therefore her autonomy. The effect of the doctor's linguistic capital is twofold: on the one hand, it guarantees the accuracy of the interpreter's utterances as the doctor can constantly monitor her renditions; on the other hand, the interpreter's skills and expertise are called into question, which causes her to lose any autonomy she may previously have been granted.

3.3.2 Doctor completes interpreter's utterances

Another consequence of doctors' constant monitoring is that during moments where the interpreter shows slight hesitation when rendering the doctor's utterance, the doctor may decide to complete her translation, thus demonstrating that a) he can monitor the interpreter's turn; and b) he possesses linguistic capital and does not, strictly speaking, need an interpreter; the latter impression he often defeats by using Spanish rather than English.

Excerpt 46 features two instances where the doctor completes the interpreter's utterances as he observes a slight hesitation in the interpreter's speech. However, the way the doctor finishes these two renditions is different. In the first instance, he provides a rendition in English, which as we can observe in line 4 is easy because it is only one word: "spine". But in the second instance, in line 11, he only provides the information in Spanish, possibly because he is not capable of producing a full sentence in English and does not want to expose his limited linguistic capital. Thus, although his capital allows him to monitor the

interpreter's renditions, he is unable to take over the interpreter's turn completely, which helps restore the interpreter's positioning in this encounter as the participant with the highest volume of linguistic capital.

Excerpt 46 (IMI 3, lines 35-74, Appendix V):

1	**Doctor**:	Y tenemos la sospecha... bueno infección en la sangre y en la vértebra,
2		porque tiene también una infección en la vértebra lumbar.
		And we have the suspicion... well the infection in the blood and in the
		vertebra, because he also has an infection in the lumbar vertebra.
3	**Interpreter**:	And in his... [in his] spine.
4	**Doctor**:	[spine.
		{...}
5	**Doctor**:	¡Claro! Habría que ponerle después uno nuevo. Entonces, por el
6		momento lo que estamos es poniéndole antibióticos y haciéndole
7		pruebas que se ha hecho una y ahora tiene que hacerse otra para ver
8		si hay complicaciones en el corazón.
		Of course! It would be necessary to put a new one later. So, for the time
		being what we are administrating is antibiotics and doing tests, he has
		done one and now he has to do another one to see if there are
		complications in his heart.
9	**Interpreter**:	They are going to... at the moment they are giving him antibiotics and
10		they are doing tests to see... eh... the...
11	**Doctor**:	Si hay problemas en el corazón.
		If there are problems in his heart.
12	**Interpreter**:	If there's a problem in his heart.

In the next excerpt, we can observe the doctor's lack of linguistic capital where again he tries to complete the interpreter's turn when he notices she hesitates in completing her rendition. Possibly because previously the interpreter had already experienced constant monitoring by the doctor, she starts to lose confidence in her own skills. This excerpt is clearly illustrative of the effect of doctors' constant monitoring on the doctor-interpreter relationship of trust, and, therefore, on the interpreter's degree of autonomy. In line 1, the doctor initiates his turn by addressing the interpreter with "Dígale" (Tell him), which emphasises the doctor's authority and constrains the interpreter's position by establishing a dominant-dominated relationship between the doctor and the interpreter while simultaneously acknowledging the interpreter as 'fully-ratified participant' by addressing the patient in the third person. In line 5, the interpreter apologises because she could not follow the doctor's utterance and has forgotten the information he provided, which may be a consequence of the pressure exerted on

her. The doctor repeats the information in line 7 and the interpreter starts translating but she has problems uttering the word "paralysis" in English, even though she is a native English speaker. At this point, she is probably very stressed and cannot produce an adequate translation. The doctor tries to help her this time in English, but all he manages to utter is "Stop" (line 11).

Excerpt 47 (IMI 3, lines 135-148, Appendix V):

1 **Doctor**:   Pero dígale que ahí pues el problema es que pueda tener algún
2   trastorno en la sangre o bien que tenga la medula, la fábrica de
3   sangre, parada a lo mejor por medicamentos o por alguna otra razón.
4   *But tell him that there, that the problem is that he could have some*
                    disorder in the blood or perhaps that he has the bone marrow, the blood
                    factory paralyzed perhaps due to medicines or another reason.
5 **Interpreter**: Disculpas, (hhhhhh) cuando termina ya he olvidado {addressing the
6   doctor}. He could have something wrong with his blood, the
                    beginning...
                    Apologies, (hhhhhh) when you finish I have already forgotten
                    {addressing the doctor}.
7 **Doctor**:   O puede tener una paralización de la médula ósea por fármacos que
8   haya tomado.
                    Or he could have a paralysis of the bone marrow due to medicines that
                    he has taken.
9 **Interpreter**: Or he could have paral- (+paralysis), paral- (+paralysis) (.) uuuyyyy
10   no me sale en inglés.
                    Or he could have paral- (+paralysis), paral- (+paralysis) (.) uffffffffff it
                    doesn't come out in English.
11 **Doctor**:   Stop, ehhh... {the doctor is trying to find a word for paralysis}.
12 **Interpreter**: Yeah, but, pero hay palabra en inglés.[76] Uhm... it's the white cell count
13   me ha dicho, no? Los ehh...
14 **Doctor**:   Paralización de la producción de, de...
                    Paralysis of the production of, of...
15 **Interpreter**: Sí. His blood factory could be paralyzed.

The interpreter dismisses the doctor's help by telling him in lines 12 to 13 that "Stop" is not the correct word and that there is a more appropriate term in English to refer to "paralización". To some extent, the interpreter has managed to re-position herself in the interaction as the person with the highest volume of linguistic capital. She shows that she possesses more linguistic capital than the doctor, even though her authority and expertise are still in question, as can be

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[76] The interpreter is mixing Spanish and English in this utterance, possibly as a result of the stress she is enduring by the constant monitoring of the doctor: "Pero hay una palabra en inglés" (*But there's a word in English*) {...} Los ehhh... (*The ahm...*).

observed in her constant shifting between English and Spanish in lines 12 to 13 and 15 where we can identify the pressure she is under and how it has affected her confidence. As discussed above, interpreters' positioning is fluid and can be easily challenged by those agents who occupy positions higher up the hierarchy; in this sense, interpreters' authority and autonomy are to some extent virtual qualities that depend on how other agents choose to structure the field.

3.3.3 Doctor takes over interpreter's turn

As well as correcting interpreters' renditions, doctors' linguistic capital may also allow them to take over an interpreter's speech turn in those cases where they understand a patient's question posed in English. In these instances, doctors may decide to answer a patient's questions without waiting for the interpreter to provide a translation. As discussed above, although doctors' linguistic capital, in this context, allows them to monitor interpreters' activity, it does not necessarily allow them to utter complex and coherent sentences in English. An example of this can be observed in the following Excerpt 48.

As we have discussed above, the doctor's linguistic skills are not good enough to produce complex utterances in English. His utterances are simple and he does not risk making any mistakes, probably to avoid jeopardizing his authority in front of the interpreter. In both instances, the doctor decides to answer the questions posed by the patient's relative by copying the exact words uttered by the relative. However, in the second instance, the doctor combines Spanish and English to answer the patient's question as he does not know the English word for "probablemente" (probably), which illustrates the low volume of linguistic capital that he possesses, because as soon as he needs an alternative answer he has to resort to Spanish.

Excerpt 48 (IMI 3, lines 167-168/230-231, Appendix V)

1	**Relative**:	Is that like an endoscope or something?
2	**Doctor**:	An endoscope, yes.
		{...}
3	**Relative**:	I see, yes, so quite a while is a few days or a few weeks or...
4	**Doctor**:	*Probablemente* a few weeks.
		Probably a few weeks.

Accordingly, when the answer to a patient's question requires a more complex linguistic structure, the doctor does not take any risks and produces the answer in Spanish, as can be seen below. In Excerpt 49, we can observe the same pattern repeated up to three times, where the doctor interrupts the interpreter—who had already started to render the patient's questions immediately after being uttered—and takes over her turn. The doctor seems to understand the questions posed by the patient's relative in lines 1, 10 and 18 and provides an answer, but he does so in Spanish.

Excerpt 49 (IMI 3, lines 123-130/246-259, Appendix V)

1	**Relative**:	When can we expect to get the results from the tests today?
2	**Interpreter**:	[Ahm…
3	**Doctor**:	[Eso,] hoy podremos saber algo pero el resultado definitivo, porque
4		eso se mira en un microscopio unas gotitas, pero también se hay que
5		hay también que hacer cortes, teñirlo, y eso tarda más días, eso puede
6		tardar hasta una semana.
		Today we can find something out, but the final results, because we have
		to look at them in the microscope and put some drops, but also we have
		to do some cuts, die it, and that takes longer, it could take up to a week.
7	**Interpreter**:	They can see something. They look in the microscope. They have to
8		do cuts in it and everything that takes a bit longer, but they can see a
9		little result today.
		{…}
10	**Relative**:	Is he on painkillers?
11	**Interpreter**:	¿Está toma- (+tomando)...?
		Is he tak- (taking)…?
12	**Doctor**:	¿Que si está tomando todavía analgésicos?
		Whether he is taking painkillers?
13	**Interpreter**:	Sí.
		Yes.
14	**Doctor**:	Ahora mismo no, si los necesita se los daremos pero ahora mismo él
15		está sin dolor.
		Not right now, but if he needs them we will give them to him, but right
		now he doesn't have any pain.
16	**Interpreter**:	No, not now, not at the moment. If needs them they'll give him them,
17		but at the moment he doesn't need them.
18	**Relative**:	Now, if he wants to, he's keen to sit in the chair sometimes, is that
19		possible or not?
20	**Interpreter**:	Él tiene muc-(+ muchas ganas)…
		He would like ve-(+ very much…)
21	**Doctor**:	Sí, se puede sentar.
		Yes, he can sit down.
22	**Interpreter**:	Gracias. Yeah.
		Thank you. Yeah.

In all three instances, the answer to the questions posed by the patient's relative require linguistic skills that the doctor does not possess, so in order to avoid making mistakes, he produces the utterances in Spanish and relies on the interpreter to render the information. Despite his low volume of linguistic capital, the doctor succeeds in challenging the interpreter's position in several ways: a) he interrupts the interpreter's speech turn which shows that, as the agent with the stronger habitus and symbolic power, he has the authority and power to control the flow of the interaction, thus turning the interpreter into a non-person; b) he shows that he possesses linguistic capital, if only a low volume, and, therefore, the interpreter is not the only agent who possesses it, thus devaluing the interpreter's linguistic capital; and c) he manages to get the interpreter to acknowledge his linguistic capital and show her appreciation by thanking the doctor for doing what should be her job in line 22. Moreover, it seems that the doctor is more interested in establishing his position as the agent with the strongest habitus—by interrupting the triadic communication flow even though his volume of linguistic capital does not allow him to directly communicate with the patient's relative—than in working cooperatively with the interpreter—who dutifully tries to render the relative's questions and is interrupted by the doctor—to speed up the interview. In the second instance, not only does the doctor interrupt the interpreter's turn, which breaks the smooth flow of the interaction, he also has to check with the interpreter that he has understood the question posed by the patient's relative in line 10. In this case, the doctor is responsible for slowing down the medical interview.

All the examples in this last section have been extracted from the same encounter. If we look at the whole transcript from a wider perspective rather than focusing on specific instances (see IMI 3, Appendix V), we can observe that the doctor is constantly challenging the interpreter's position. The doctor persistently emphasises that he wants the interpreter to translate what he is saying – on six occasions throughout the medical interview—by uttering: "Dígale" (Tell him) (IMI 3, lines 22, 30, 135, 158, 193 and 297), even though the interpreter has dutifully translated every utterance from the beginning of the interaction without being asked to do so. It seems that the doctor wants to strengthen his position within the interaction by establishing his authority as the medical expert with some linguistic knowledge, although ironically by addressing the patient in the third person he is positioning the interpreter as a 'fully-ratified participant' with her own voice. For the first eleven minutes, the interpreter translates, mostly

accurately, back and forth between the doctor and the patient's relatives, thus reinforcing direct doctor-patient interaction and without adopting any other position than that of language broker. The interpreter seems aware of the boundaries of the interpreting activity and wants to promote a doctor-patient relationship by positioning herself as non-involved participant, a pattern which the doctor constantly breaks by acknowledging the interpreter as an interlocutor. It is clear from the beginning of this encounter that the doctor wants to establish himself in a dominant position and place the interpreter in a dominated position by denying her any autonomy and, therefore, any power. As described in Excerpt 12 (see Chapter 4), the doctor wants to make it clear that he possesses enough linguistic capital to communicate with patients without an intermediary, as he explains on two different occasions.

In the instances described in this section, interpreters' autonomy is thus relative and is constantly being threatened by agents who possess some linguistic capital which constitutes the interpreters' main asset. As discussed above, interpreters' autonomy and power are based on the lack of linguistic skills of other agents who require interpreters' linguistic expertise to communicate with one another, rather than their own position within the field structures. The moment that interpreters' linguistic capital loses its value, it can no longer be converted into symbolic capital that interpreters can deploy in order to take an active part in the field. They have a low degree of autonomy to reproduce their own structures and legitimise their positions within the field of healthcare. However, interpreters are aware of their inferior position in the field, and although they recognise doctors' limited linguistic capital and know the value of the linguistic capital they bring to the field, we have observed that they have to be very diplomatic and careful when challenging doctors' authority and linguistic capital (see Excerpt 10 in Chapter 4 and Excerpt 30 in this chapter).

4   Concluding remarks

This chapter has discussed the internal manifestations of the positioning of volunteer interpreters. Internal manifestations refer to interpreters' negotiating power as regards their alignment and their attitudinal autonomy. Depending on the degree of negotiating (or symbolic) power that interpreters hold at any given time, they will shift their positioning along the continuum from a strong position

such as patients' ally or patients' spokesperson to weak positions such as language conduit.

Volunteer interpreters' negotiating or symbolic power is influenced not only by their dispositions or cognitive structures, but also by the objective structures of fields and the external manifestation of their positioning. In this sense, external and internal manifestations of interpreters' positioning feed and strengthen each other. As will be explained, the degree of institutionalisation is directly related to interpreters' alignment and degree of autonomy in each specific encounter; interpreters are therefore constantly (re)negotiating their position as these variables—i.e. institutionalisation, alignment and autonomy—shift. As Bourdieu (1977, p. 78) points out, the objective structures of the field are reproduced by the cognitive structures of the habitus and vice versa.

Chapter Six

Conclusions

Drawing on data from the South of Spain, this thesis set out to examine public service interpreting in healthcare settings as a potential field in the Bourdieusian sense, with a view to describing some of the features that distinguish it from the field of healthcare and from other types of interpreting. Using as a case study the interpreting service provided by local non-profit organisations of volunteer interpreters at two healthcare institutions, it explored the positions occupied by these interpreters and the relationship between them and other agents located in the field, particularly healthcare staff and patients. The study drew on Bourdieusian concepts such as field, habitus, capital and doxa in order to reconstruct the field of public service interpreting in this context and reveal the impact of volunteer interpreters on the delimitation of the field boundaries and ethics.

The importance of this thesis is twofold. To the best of my knowledge, it is the first investigation that: 1) has consistently engaged with Bourdieu's theoretical framework and applied the concepts of field, habitus, capital and doxa in a sustained case study of healthcare interpreting; and 2) has described the position of a group of volunteer interpreters with a high degree of institutionalisation that has allowed them to interact in the field as legitimate agents of the healthcare team and work side by side with doctors, thus occupying positions located towards the autonomous pole of the field.

Finally, before proceeding to the discussion of the findings, two points are worth highlighting here. First, positing volunteer healthcare interpreting in the South of Spain as a field, and assuming that the interpreters under study operate in one rather than two fields (i.e. public service interpreting and social work) is consistent with a Bourdieusian analysis for the following reasons: these volunteer interpreters offer daily interpreting services within two hospitals thus covering the needs of these healthcare institutions similarly to any other paid interpreting service around the world, regardless of their status as volunteers. Moreover, everything seems to indicate that volunteer interpreters in this context are perceived as interpreters by a) the healthcare institution which provides them with an office space within; b) the regional government *Junta de Andalucía* which

provides them with an official ID card that states "Intérprete" (see Appendix I); c) the local media which has written extensively about these interpreters (see Appendix IV); d) healthcare staff members who call them to communicate with patients and refer to them as interpreters; e) patients who call them to communicate with doctors and refer to them as interpreters; and f) interpreters who call themselves interpreters. Considering these aspects, assuming that interpreters are located within the field of public service interpreting when this field overlap with the field of healthcare in healthcare settings seem to match the findings. Second, it goes without saying that the results of findings of the study could have been different if a different group of interpreters had been studied with a different language combination, and working with a different socio-economic group of patients.

In what follows I revisit the research questions articulated in the introduction and outline the implications and limitations of this study, before suggesting a number of avenues for further research.

1 Discussion of findings

The first and overarching research question posed in this thesis was as follows:

1) To what extent can public service interpreting be considered a field in Bourdieusian terms, with particular reference to volunteer interpreting in healthcare settings in Spanish hospitals?

As argued in the Introduction and discussed in greater detail in Chapter 2, public service interpreting has not yet been treated as a social field in the existing scholarly literature, especially with reference to healthcare settings. However, describing public service interpreting as a Bourdieusian field is feasible insofar as Field Theory caters for shifting boundaries within and between fields and provides tools for reconstructing fields that lack strong objective structures and therefore well-defined habitus. Bourdieu (2000) argues that a field exists from the moment there are agents prepared to play the game; these agents are socialised into a field habitus that endows them with the necessary knowledge of the rules of the game. In this particular context, the field of public service interpreting in healthcare

settings in southern Spain emerges from the need for mediation between Spanish-speaking service providers (doctors, nurses and social workers, among others) and non-Spanish speaking service users (foreign patients). Unlike monolingual, dyadic medical encounters, linguistic capital becomes an essential asset for the success of the medical interview. Linguistic capital also comes to represent the field-specific capital, which interpreters deploy to enter the game and take part in triadic medical interviews. The agents involved in these triadic exchanges bring their social and historical trajectories to the encounter and place different demands on the interpreter.

In one of the few works that engage with public service interpreting in Bourdieusian terms, Inghilleri (2005b, p. 73) evokes Bourdieu's "zones of uncertainty" to speak specifically of weak positions in social spaces where the field activity is still ill-defined and the positions do not match the expectations of the agents who occupy them. The activity of agents in such 'zones of uncertainty' may be heavily influenced by other, adjacent fields, yet agents have the potential to use these instances of confusion to create new forms of legitimate practice instead of conforming to the original field structures. Inghilleri (2005b) discusses public service interpreting in the context of asylum hearings as an example of this locale. Zones of uncertainty are liberatory spaces characterised by contradictions and conflicting views regarding the position of agents and their habitus, and can become sites for generating new positions and for the consolidation of a stronger habitus (Inghilleri, 2005b). This discordance "creates the potential for agents to redefine their roles thus challenging [sic] a change 'from within'" (Wolf, 2007, p. 138; emphasis in the original). According to Bourdieu (Bourdieu, 2000), agents in zones of uncertainty may be forced to temporarily step outside the game, thus acquiring the possibility to articulate more coherent structures that reduce the gap between agents' cognitive structures and the field structures. In other words,

> Zones of uncertainty leave their occupants the possibility of defining them by bringing in the embodied necessity which is constitutive of their habitus, their future depends on what is made of them by their occupants, or at least those of them who, in the struggles within the 'profession' and in confrontations with neighbouring and rival professions, manage to impose the definition of the profession most favourable to what they are. (Bourdieu, 2000, p. 158; emphasis in the original)

Zones of uncertainty arise from a revealed gap between the demands placed on interpreters by the professional interpreting community in terms of impartiality and neutrality "as a way to ensure that interlocutors can speak for themselves" (Inghilleri, 2012, p. 124), and the demands that arise during the actual practice of public service interpreting. In the face of uncertainty as to what positions they are supposed to occupy, interpreters' habitus experiences a moment of hesitation and reflection that leads to the generation of new practices and structures. In the specific context of volunteer interpreting in the two hospitals under examination, interpreters situated in this zone of uncertainty have responded to the problematic gap in two ways: first, by drawing up a code of ethics that encompasses a series of dispositions they have identified during their social and professional encounters as interpreters in these specific healthcare settings; and second, by institutionalising their position and legitimising different degrees of autonomy which allow them to assess each encounter and shift their positioning accordingly (Chapters 4 and 5). As a result, the high degree of contradiction and instability that initially gave rise to the zone of uncertainty has decreased to a large extent and a new field is starting to emerge outside of the sphere of influence of the professional interpreting community.

This initial question constitutes part of the rationale of this study and leads to three more specific questions. The first is as follows:

2) Who are the main agents in the field of public service interpreting in healthcare settings in Spanish hospitals?

A number of agents from different fields are integral to the functioning of public service interpreting. These agents fall into three categories: healthcare service providers, service users and interpreters. Agents' habitus embodies the structures of the field in which they are situated and its properties depend on the agents' capital and position within the field hierarchy (Bourdieu, 2000). Agents who are positioned in highly autonomous fields, such as the healthcare field, typically exert more power over agents situated in less autonomous fields such as public service interpreting. The stronger habitus of doctors imposes the embodied structures of the healthcare field onto weaker agents, guided by the doxa that consecrates the healthcare field hierarchy where doctors occupy strong positions. However, this description of the power relations between the fields of healthcare

and public service interpreting does not correspond to the actual dynamics identified in the specific context under examination. On the one hand, agents situated at the autonomous pole of the field of healthcare do appear to have internalised a strong habitus that reproduces the structures of the field. They also hold widely recognisable forms of cultural and symbolic capital that allow them to occupy strong positions. On the other hand, the habitus of foreign patients does not function adequately within the field of Spanish healthcare: since foreign patients often do not hold sufficient cultural, linguistic, social and/or economic capital to play the game, this places them at the heteronomous pole of the field of healthcare, where they occupy subordinate positions in relation to healthcare staff members. Doctors, as legitimate agents in strong positions within the healthcare field, enjoy a high volume of symbolic power and can initiate, conduct and close medical interviews with Spanish-speaking patients directly. However, when they conduct medical interviews with non-Spanish speaking patients, doctors do not possess the adequate linguistic capital to communicate directly, and the value of their symbolic capital therefore depreciates. In these situations, symbolic power is redistributed, and part of it is then claimed by healthcare interpreters who have the requisite linguistic capital and can use this capital to strengthen their position in the field.

An interesting division operates with respect to agents in the field of public service interpreting. The findings of the current study suggest that volunteer interpreters are situated relatively close to the autonomous pole of the Spanish field of public service interpreting in what Inghilleri (2005b) has defined as a zone of uncertainty. These agents hold recognisable forms of linguistic, social and symbolic capital, as discussed in Chapters 4 and 5, and demonstrate their autonomy in various ways (see Chapter 5, section 3). On the other hand, the existing scholarly literature suggests that paid/professional interpreters are positioned at the heteronomous pole of the field and that they have been socialised into a weaker habitus that leads to their domination by the field of healthcare, the professional interpreting community, the doxa and other agents, despite the fact that these interpreters may also hold linguistic and other forms of capital (see Angelelli, 2004a; Cirillo & Reggio, 2010; Freed, 1988; Gentile, 1991; Hsieh & Hong, 2010; Inghilleri, 2003, 2005b; Mason, 2004; Metzger, 1999).

Volunteer interpreters in the two hospitals under examination acquired more autonomous positions after a period of hesitation and reflection during which they overtly challenged the field doxa, enforced by professional

associations, and generated new interpreting practices that are codified in the Interpreters' Handbook (Appendix I). Volunteer interpreters' habitus has been shaped by their own experience as foreigners and by their trajectories within a healthcare institution where they occupy consecrated positions with legitimate forms of linguistic and social capital. Their habitus leads them to choose among a range of positions according to the demands of each encounter, and depending on the linguistic and social capital they can deploy at any given time. Interpreters' habitus and their position in the field are thus constantly influenced by the increase and decrease in the value of their linguistic and social capital.

The dynamic, shifting positioning of volunteer interpreters raises a specific question and a number of interrelated sub-questions:

3) What positions are available to volunteer interpreters in the field of public service interpreting in healthcare settings in Spanish hospitals?
> *a) What positions do volunteer interpreters adopt?*
> *b) What positions are imposed on volunteer interpreters?*

Before discussing specific positions that are either imposed on or adopted by the volunteer interpreters in this study, it is important to comment briefly on some factors that influence the ability of interpreters to shift positions. Bourdieusian fields can never achieve absolute autonomy, as explained in Chapter 1. Thus, despite being situated at the autonomous pole of the sub-field of healthcare interpreting, volunteer interpreters' shifts of positioning are as influenced by the objective structures of the field (see Chapter 4) as they are by the cognitive structures of the habitus (Chapter 5). The external manifestations of shifts in positioning are related to issues such as institutionalisation, legitimisation and bureaucratisation, aspects that affect volunteer interpreters' institutional position as described below. Legitimisation and bureaucratisation are both elements of institutionalisation, with the former representing the symbolic recognition by other institutional members and the latter the material realisation of this recognition. The legitimisation of the figure of the interpreter within the healthcare institution by other institutional agents provides the interpreter with a high volume of symbolic capital, deriving from legitimised linguistic and social capital, that allows him or her to adopt certain positions. However, since legitimisation

depends on the attitude of other agents, it can fluctuate, causing a simultaneous oscillation of the volume of symbolic capital held by interpreters. Bureaucratisation, on the other hand, is a more stable element that is internalised in the interpreting habitus since it involves tangible assets to which interpreters become entitled in these settings. These tangible assets include ID cards, office space, a handbook, food vouchers and a white gown, among others (see Chapter 4, section 2). Legitimisation and bureaucratisation both enhance the volume of symbolic capital held by volunteer interpreters as members of the healthcare institution and the healthcare team, and contribute to the consecration of their linguistic and social capital. Institutionalisation, as both bureaucratisation and legitimisation, has been an essential factor in transforming the field in this context.

The internal manifestations of shifts in positioning relate to issues such as alignment and the degree of attitudinal autonomy, aspects that influence interpreters' positioning in single encounters. Volunteer interpreters can choose to align either with the healthcare institution or with foreign patients, and each alignment provides them with different forms of capital.[77] Alignment is closely linked to the level of interpreters' institutionalisation since the volume of symbolic capital they hold allows them to choose among these possibilities to varying degrees. Finally, the last manifestation of interpreters' positioning is related to the degree of attitudinal autonomy. Interpreters' attitudinal autonomy is their ability to recognise their own position as essential and important and the way this is reflected in their capacity for decision-making. Like alignment, the degree of attitudinal autonomy is dependent on the degree of institutionalisation, especially legitimisation. Attitudinal autonomy has its basis in the degree of trust that other agents confer on interpreters, which can be observed in the degree of institutionalisation and legitimisation (Forsyth & Danisiewicz, 1985). A high degree of attitudinal autonomy is crucial for interpreters' ability to negotiate and shift positions.

The structures of fields are the result of a dialectic relationship between field and habitus. Since the external structures are imposed by the field and the internal structures are adopted by the habitus, the resulting positions that arise from these structures are neither totally imposed nor completely adopted but are rather relatively imposed and adopted at any given time. The shift between

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[77] There is no evidence in this study that they attempt to align with the professional interpreting community.

imposed and adopted positions can happen so fast and so often within single encounters that we cannot talk about stable positions, but only about positioning.

In Chapters 4 and 5 several positions were discussed: the interpreter as an institutional agent; the interpreter as an institutional ally; the interpreter as a patient's ally; the interpreter as a patient's spokesperson; the interpreter as an informational gate-keeper; the interpreter as a language conduit. These positions often overlap with one another, and volunteer interpreters tend to shift their positioning according to the needs of each encounter. As I have already argued, it is virtually impossible to separate these positions totally, as imposition and adoption are dependent on the individual circumstances of each encounter and the power relations that develop between the three agents in the triadic interaction. However, for the sake of analytic clarity, the discussion that follows will describe each position individually while exploring the features that may cause this position to be imposed or adopted within the context under examination.

Volunteer interpreters have acquired a high degree of institutionalisation within the field of healthcare, which has allowed them to occupy the position of **institutional agents** (see Chapter 4). By creating AIVE (the Association of Volunteer Interpreters for Patients), they have formally legitimised their position as volunteer interpreters and established themselves as members of the healthcare institution. This has provided them with several tangible assets, as mentioned above, and has reaffirmed a position for them as members of that institution (see Chapter 4, section 4). Interpreters perceive themselves as institutional players and act accordingly—by wearing a white gown, eating at the staff canteen, sorting out medical appointments, using administration facilities or visiting patients at their own initiative—and also by exercising their agency and shifting their positioning according to the specificities of each encounter. This position is not only shaped by interpreters' cognitive structures, but also by the degree of legitimisation that doctors, as the agents with the strongest habitus, wish to grant them. As institutional agents, interpreters have access to the hospital administration services and are often expected to carry out routine visits to patients without doctors' supervision, open and close medical consultations or advise patients' on medical appointments, among other practices.

Since so much trust is placed in them as institutional agents, interpreters look after the healthcare institution and its members and protect it from patients' complaints. Institutional expectations lead interpreters to adopt the position of

institutional allies (see Chapter 5, section 2.1). Accordingly, interpreters mediate between the healthcare institution and patients in order to avoid official written complaints or lawsuits, while asserting the high quality of the healthcare service provided by the institution and healthcare staff. Aligning with the healthcare institution allows them to increase the volume of social capital they hold by expanding their social network; it also gives them a sense of belonging not only to the institution but also to the local society where it is embedded. This is of particular relevance for this group of interpreters whose social capital was very low upon their arrival in Spain. In addition to social capital, alignment with the healthcare institution provides interpreters with more symbolic capital by presenting themselves as healthcare experts, a position that is reinforced by the white gown, the name badges and a high degree of institutionalisation.

However, these interpreters are also members of the large foreign community in the Malaga area, and thus often align with foreign patients (see Chapter 5, section 2.2). As a **patient's ally**, the interpreter can deploy and acquire different forms of capital. This position is more available when interpreters already hold a sufficiently high degree of attitudinal autonomy and symbolic power that they can then use to impose their own dispositions. In this position, interpreters deploy social capital in the form of sympathy, kindness and care for foreign patients, mirroring social workers' and community matrons' role – by working both independently and as part of the healthcare team. The interpreter's position as the patient's ally ensures that foreign patients receive the same degree of care as local patients, who often have families and friends around, and that treatments are adequately understood and followed by visiting patients on a regular basis. In order to guarantee this, interpreters keep a journal where they note down all the information related to each patient they visit on a daily basis for the next interpreter who comes in. Alignment with foreign patients provides interpreters with symbolic capital in the form of individual gratitude from patients and social recognition from the local foreign community. In this specific respect, volunteer interpreters, who do not align with the professional interpreting community in general, do not embrace the doxa of professional associations.

The three positions discussed above relate to interpreters' relationship with the healthcare institution; the following positions are adopted according to interpreters' degree of attitudinal autonomy at any given time (see Chapter 1). Interpreters' attitudinal autonomy exists as a continuum, from a high to a low degree, with agents adopting different positions along that continuum (see

Chapter 5). In this particular context, I was able to identify three main positions, which are not mutually exclusive. The higher the degree of autonomy that interpreters enjoy the more symbolic power they have to impose their own structures. The position of **patients' spokesperson** is one in which interpreters enjoy the highest degree of autonomy. This degree of autonomy provides interpreters with a large volume of symbolic power that they can use to act on behalf of patients, even if at times their actions might go against the interest of the institution. As patients' spokespersons interpreters organise medical appointments, sort out patients' paperwork, aftercare, nursing homes, talk to patients' families over the phone and deal with any difficulties that arise— sometimes against the declared hospital regulations. Although this position is traditionally sanctioned by the doxa enforced by the professional community, in this context it is ratified and encouraged by doctors, nurses and social workers alike since it very often means that interpreters can help reduce the workload of healthcare staff while ensuring service quality and patient satisfaction (see Chapter 5, section 3.1).

The next position down the continuum of autonomy is one where the interpreter acts as an **informational gate-keeper** (see Chapter 5, section 3.2). This position can be identified by the volume of information that interpreters convey between doctors and patients. Here, interpreters exercise their autonomy by screening information in several ways, from maintaining monolingual dyadic interaction with patients to mono-directional translations from the patient to the doctor, or simply omitting utterances. As informational gate-keepers, interpreters use their cultural capital—in the form of medical expertise acquired during their professional trajectory at the hospital—in order to cooperate with doctors as members of the healthcare team. In this position interpreters disclose and use their expert knowledge to visit patients without supervision, where they check on patients' progress and provide any necessary assistance while they are hospitalised, and to accelerate the pace of doctor-patient interviews, thus reducing doctors' workload. However, as explained in Chapter 5, this position can also affect the relationship between doctor and patient that is at the heart of a medical interview, and interpreters may fail to transmit important information, as shown in excerpts 41 and 42 (Chapter 5).

The final position identified at the lower pole of the autonomy continuum is one where the interpreter acts as a **language conduit** (see Chapter 5, section 3.3). Despite interpreters' high degree of institutionalisation, their frequent alignment

with the healthcare institution and the high degree of autonomy they often enjoy, their habitus remains weak in comparison with that of doctors. Even though interpreters in this specific context deploy social capital in addition to linguistic capital, the latter prevails as the field-specific capital without which there would be no need for mediation. Linguistic capital, complemented in this setting with social capital to strengthen the interpreting habitus, becomes an essential and valuable asset for interpreters as long as it is held exclusively by them. The moment doctors acquire even a minimal volume of linguistic capital, even if their linguistic competence does not allow them to carry out a medical consultation without the interpreter's mediation, the value of the interpreter's linguistic capital decreases, thus placing interpreters in weaker positions within the field hierarchy. Doctors may use their linguistic capital to correct interpreters' renditions (see Chapter 5, section 3.3.1), complete interpreters' utterances (see Chapter 5, section 3.3.2) or take over interpreters' turns (see Chapter 5, section 3.3.3). These acts situate the interpreter in a subordinated position with regard to other healthcare agents. In some instances (see Excerpt 12, Chapter 4; and Excerpt 47, Chapter 5), interpreters use their attitudinal autonomy and symbolic capital to challenge doctors' dominant position and re-position themselves as the holders of the field-specific capital, hence increasing their attitudinal autonomy. Finally, interpreters' positioning is not only affected by other agents and their practices or by their own attitude towards autonomy, but also by the doxa.

This leads to the final research question:

4) To what extent do interpreters' positions acknowledge the doxa in the field as encapsulated by traditional codes of ethics and the expectations of other agents?

While the previous questions aimed at identifying the agents who populate the field under examination and interpreters' positioning within it, this question is concerned with the doxa of the field as currently defined by existing codes of ethics and standards of practice drawn by the professional interpreting community, including training institutions, professional interpreters' associations and employing institutions (Bancroft, 2005). The question of the doxa is central to the definition of an interpreting habitus that inclines interpreters towards certain preferences, dispositions and positions within the wider field of public service

interpreting. The doxa influences interpreters' habitus through a series of presuppositions that organise practice and are accepted by agents as undisputed conventions. Traditionally, interpreters are expected to adopt a neutral and impartial position; they are required not to take sides and not to get involved with service users; and they are obliged to be subservient to other agents in the interaction and behave as non-participants, thus turning the three-persons [mediated] encounter into a dyadic interaction (Bancroft, 2005). These codes of ethics [78] have 'freed' public service interpreters from any responsibility and therefore from any agency. They have emphasised neutrality and impartiality despite continued challenges by various scholars (see Baraldi, 2009; Davidson, 2000; Edwards *et al.*, 2005; Hsieh, 2006; Hsieh & Hong, 2010; Wadensjö, 1998). These scholars have shown that there is considerable discordance between actual interpreting practice and the principles of neutrality and impartiality promoted by most professional associations around the world (see Bancroft 2005). The continued questioning of these principles has led to a heterodoxic discourse. The belief in neutrality, which was taken for granted in the past, is now part of a debate where both scholars and professionals can choose to agree or disagree with different positions. Orthodoxic discourse is embraced by those who want to maintain the structures of the field of public service interpreting as established by the doxa, whereas heterodoxic discourse is adopted by those who want to challenge the doxa and transform the field structures. Public service interpreters very often choose to adhere to an orthodoxic discourse that is in line with the discourse of employing institutions, professional associations and training organisations, a decision that allows them to project a high degree of professionalism and earns them symbolic capital through alignment with the professional community. Whereas heterodoxic discourse places volunteer interpreters in autonomous positions, orthodoxic discourse places them in heteronomous positions. Public service interpreters in heteronomous positions have very little capital outside the field; their position is consecrated insofar as they follow the field demands and regulations and refrain from struggle and resistance to domination (Bourdieu, 2000). On the other hand, public service interpreters situated at the autonomous pole, who bring in capital from outside the field of public service interpreting, "can distantiate themselves from the internal beliefs and hierarchies" to avoid subordination (Bourdieu, 2000, p. 159).

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[78] See Bancroft (2005) for a comprehensive report on existing standards of practice around the world.

According to Bourdieu, autonomy increases the further one moves away from the heteronomous poles of the field.

As can be seen in the variety of positions they are able to occupy, volunteer interpreters go beyond the established boundaries of the interpreter's role by acting on patients' behalf, screening information or offering patients support and care. In this sense, volunteer interpreters' habitus does not adhere to the doxa of the professional community, but rather to a view of the interpreter's role that is more holistic and more humane, one that allows interpreters to use their expert knowledge flexibly, exercise their agency and take responsibility for their actions. Although at times these interpreters claim they would not "make a big fuss because we [interpreters] are only interpreters and [they] don't get too involved" (see Excerpt 29, Chapter 5), on the whole they tend to reject this role and acknowledge that they "have to fight with the doctors" while "be[ing] very careful, very diplomatic" (see excerpts 29 and 30, Chapter 5). There is still an internal battle between an orthodoxic and heterodoxic discourse, but in most cases volunteer interpreters in this study adopt a heterodoxic discourse. They employ strategies of subversion to replace the doxa with new doxic beliefs based on kindness, sympathy and care for the patient. They choose to detach themselves from the professional community and shape their own interpreting practice by introducing elements from social and community work as mentioned above.

2   Implications and limitations of the present study

On the whole, the findings of this study suggest that it is possible to reconcile the gap between the objective structures of the field and the cognitive structures of the interpreting habitus by generating new collective expectations that give interpreters more agency and more responsibility, allowing them to shift their positioning according to the demands of each encounter. The vision of the interpreter as a neutral, impartial language machine has long been the ideal that the profession of public service interpreting has promoted. Although the role of the interpreter as advocate has been debated within the profession and the academic field, the heterodoxic discourse has been highly criticised by employing institutions due to the repercussions that this positioning may have for the institutions and its members, especially in court interpreting, where interpreters' intervention may have considerable impact on the outcomes of an asylum

application or a trial. Interpreters are thus monitored by institutional agents and are not provided with enough autonomy to express their own opinions as experts, in the same way as social workers and other professionals in similar positions. This is particularly visible in the case of social workers, whose position as institutional agents has been consecrated and accords them a high degree of autonomy that allows them to "form relationships with people and assist them to live more successfully within their local communities by helping them find solutions to their problems. Social work involves engaging not only with clients themselves but their families and friends as well as working closely with other organisations".[79]

This study shows that volunteer interpreters working in the healthcare system in southern Spain have been able to achieve a similar status to that of social workers. Interpreters in this context are allowed to exercise their agency and build direct relationships with foreign patients. However, this process is not always smooth, and at times the struggle between interpreters and doctors reaches confrontational levels, where interpreters are reminded that they occupy a weaker position vis-à-vis doctors. Their autonomy is still relative to the power held by doctors: in order to acquire the ability to occupy positions that lie beyond the officially sanctioned boundaries of their role, they must first ensure that they are acknowledged, accepted and legitimised by professionals who occupy higher positions in the healthcare system.

The findings of this case study are very specific to the context of the two hospitals in southern Spain. It is uncommon for volunteer interpreters to achieve such a high degree of institutionalisation and recognition within any social field, and this limitation must be taken into account. The positions discussed above may only be available to interpreters working in this specific context, and it is therefore not possible to generalise or extrapolate these findings to other contexts, whether in healthcare or other settings within the same region or the national territory. It may well be that paid interpreters in the same sector or volunteer interpreters in other sectors within the same geographical area (or other areas) occupy different positions and adopt an orthodoxic discourse that places them in dominated positions.

It is also necessary to acknowledge some methodological limitations of this project. During the data collection process there were several incidents that

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[79] This description of social work has been taken from the NHS website. Available at http://www.nhscareers.nhs.uk/details/default.aspx?id=519 (last accessed March 2012).

eventually led to the modification of the initial aims of the thesis. I had initially intended to include paid interpreters in the research project, as well as doctors' perceptions of the position of public service interpreters, and to rely totally on focus-group interviews. However, difficulties with obtaining access to some subjects meant that the methodology had to be modified to incorporate two new methodological tools that became unexpectedly available to me: participant observations and audio-recording of interpreted encounters. As I could not gain access to doctors' or paid interpreters' perceptions, I had no option but to restrict the study to volunteer interpreters and aim to provide an in-depth analysis of their positioning. A number of events also had an impact on the nature of data obtained through focus groups. The first focus group had to be carried out in an unorthodox location, the hospital cafeteria. During the remaining three focus groups, interpreters were constantly interrupted by emergency phone calls to which they had to respond immediately, thus abandoning the interview. This meant that I had to stop the interviews several times, thus losing momentum and often the thread of the discussion. The smoothness of the first focus group suggests that the interruptions that constantly affected the other three focus groups may have had a significant impact on the responses and the way the discussions developed.

I chose to audio record interpreted interactions and focus groups in order to be able to check the data during the analysis and avoid relying on memory. However, it is necessary to acknowledge the impact that the presence of the digital recorder as well as my presence may have had on the interviews and interaction. Some of the interpreters felt intimidated by my presence in the hospital and were concerned about my intentions. Luckily, this was overcome by building a relationship of trust with interpreters over the duration of the fieldwork trip by spending time with them and interacting with them outside consultations. It is worth noting that I was asked to conduct the interview in English during the first focus group to prevent the rest of the hospital staff from understanding the content of the interview.

3   Areas for further research

Due to the space restrictions set for PhD theses, it has not been possible to discuss various issues that have emerged from the data in any depth. For

example, I identified linguistic capital, social capital and symbolic capital as the three major forms of capital that are deployed and gained in the field under examination. However, I have not been able to discuss each form of capital and the way it manifests itself in the field in any detail. In particular, although Bourdieu reduces every form of capital to economic capital, it is possible to argue that in this specific context interpreters seek symbolic capital in the form of social recognition rather than any form of financial remuneration, direct or indirect. This clearly has implications for Bourdieu's argument and represents one area which requires further research. It would be interesting to look at the different forms of capital available and focus especially on the use of social capital in this field as a valuable asset, often more valuable than linguistic or economic capital. Social capital in this specific context exists in several forms: interpreters' social network within the hospital as institutional agents, interpreters' social network outside the institution as a source of social recognition and awards, and finally in the form of sympathy and kindness towards patients which places them as patients' allies and earns them patients' gratitude.

A related, potential area for further research would involve examining the different forms of capital that exist in the field of social work and the extent to which they overlap with those available to volunteer interpreters. A comparative study of these two fields could lead—if the findings were positive—to a revision of the existing doxa that establishes the value of each form of capital in the sub-field of healthcare interpreting and sets neutrality as a basic principle governing the field.

An alternative research line could involve examining a different social context where public service interpreting is becoming an essential component of public services; where there is also a high demand for public service interpreters in both Court and Healthcare services; where there are rigid codes of ethics and standards of practice; and where public service interpreters work mostly full-time and are paid by the institutions that employ them. Examples of countries where situations of this type abound include the US, Canada and Australia. In order to provide a context for this potential research, it would be interesting to add a historical component in order to understand the past and how it has shaped interpreting practices of the 21st Century. I have identified one context from the early 20th Century in the US where interpreters not only acted as social workers

but they were also officially asked to do so. In *The Immigrant's Day in Court*,[80,] Claghorn states that

> Especial [sic] effort should be made, however, to increase the supply of competent interpreters, and to include in their equipment so much of the qualifications of the social worker as would enable the interpreter to supplement the work of the probation officer who is unfamiliar with foreign languages, but does understand the principles of probation and the institutions of this country. (Claghorn, 1923, p. 243)

This report was published in 1923 around the time when Ellis Island served as a busy immigrant inspection station (from 1892 to 1954).[81] At the Ellis Island Museum I also identified some documents related to the interpreting service, where the complexity of the interpreter's role was emphasised. [82] Several photographs and webpages which relate to interpreters at Ellis Island are also available online. According to these informal sources, Fiorello La Guardia, who later became Mayor of New York City, was an interpreter with a salary of $1,200 from 1907 to 1910. Several webpages describe interpreters' work and explain that "their patience and skills frequently helped save an immigrant from deportation".[83] Although these sources are informal, they suggest the existence of a body of archival documentation that may be interesting to examine from a Bourdieusian perspective.

This very preliminary examination of the data from informal sources suggests that interpreting policies and practices in the US seem to have changed between the early 20th century and the early 21st century. The field seems to have evolved, from adopting a doxa that promoted involved interpreters towards the doxa of neutrality and impartiality enforced by professional associations. This suggests that the doxa can be questioned and that there may be other models that

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[80] The Immigrant's Day in Court is part of a collection of reports published in 1923 by the Division of Legal Protection and Correction of Studies in Methods of Americanization where they present the results of a study on the process of Americanization. The research team that collected the data for this volume was directed by Kate Holladay Claghorn who also acted as editor of this particular volume.

[81] Ellis Island Foundation and Museum. Information available at http://www.ellisisland.org/genealogy/ellis_island_visiting.asp (last accessed March 2012).

[82] I visited Ellis Island Museum in January 2012 where several documents related to the interpreting service are being exhibited. Some of these documents include letters from immigrants, reports written by the interpreters, reports written by the immigration authorities and several photographs. The Museum has a webpage available at http://www.ellisisland.org/genealogy/ellis_island_visiting.asp (last accessed March 2012).

[83] This information has been extracted from a blog on immigration available at http://www.ohranger.com/ellis-island/immigration-journey (last accessed March 2012). However, the same information appears in other sites where they recall the immigration process on Ellis Island.

are more relevant to the profession. At any rate, it would be interesting to examine the motivations for these changes and whether the field of politics and economy and the narratives they elaborate of immigration and immigrants may have some impact in terms of motivating this change. Perhaps the political and economic narratives circulating during the period of US expansion during the 19th and early 20th centuries had an impact on interpreting policies, in the same way that current political and economic narratives which reveal increased hostility towards immigrants may also shape current interpreting policies. Where in the late 19th and early 20th centuries interpreters were encouraged to side with and aid immigrants (see Claghorn, 1923), in the 21st century the practice of advocacy is discouraged and impartiality and neutrality are being imposed by standards of practice and codes of ethics drawn by interpreting professional associations (Bancroft, 2005).

Ultimately, this study has demonstrated that the field of public service interpreting, including interpreting in the healthcare system, by both paid and volunteer interpreters, is a rich area of research, and that Field Theory offers a robust set of conceptual tools for examining it as a highly consequential area of social practice.

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