The Quality of Medical Interpreting Services Against the Backdrop of Health Tourism in the Valencian Community, Spain, Viewed Through the Lens of the Sociology of Professions

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Título de la tesis

The Quality of Medical Interpreting Services Against the Backdrop of Health Tourism in the Valencian Community, Spain, Viewed Through the Lens of the Sociology of Professions

La calidad de los servicios de interpretación médico-sanitaria en el contexto del turismo de salud en la Comunidad Valenciana desde la perspectiva de la sociología de las profesiones

Memoria presentada por Nina Gavlovych Gavlovych para optar al grado de doctora por la Universitat Jaume I

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RESUMEN

La tesis investiga el concepto de la interpretación médica a través de la lente de la Sociología de Profesiones y la teoría del conocimiento profesional de Freidson (2001), ante la falta de reconocimiento de la figura del intérprete en los centros privados de la Comunidad Valenciana. Numerosos estudiosos del campo de la T&I y de las ciencias cognitivas confirman que los intérpretes necesitan disponer de conocimientos profesionales especializados y formalizados, así como una predisposición psicofisiológica para ejercer el juicio discrecional profesional con éxito. El análisis multimetodológico de datos cualitativos (análisis temático, conversacional, multimodal) y cuantitativos confirma que la identidad profesional híbrida promovida por las demandas del mercado e impuesta intersubjetivamente mediante el discurso institucional a los intérpretes difiere notablemente del autoconcepto que estos profesionales tratan de negociar y mantener. Este estudio pretende encontrar una explicación racional al actual estancamiento en la profesionalización y ofrecer posibles orientaciones hacia una solución viable.

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GLOSSARY

Expert/specialist interpreter – qualified member of a profession (Freidson, 2001, State Variation and Professionalism, §2), who specialises in medical interpreting and holds at least a Master's Degree in this discipline.

Health(care) interpreter – a person, who practices as interpreter in healthcare settings. Some scholars (e.g. Roat & Crezee, 2015) prefer to use this term as it encompasses a broad range of healthcare- and wellness-related domains. The National Accreditation Authority for Translators and Interpreters (NAATI) in Australia also opts to use the term "health interpreter" when referring to "experienced and accomplished interpreters who are experts in interpreting in the health domain" (NAATI, 1977).

Medical interpreter – a person, be it professional interpreter or layperson (non-professional) interpreter, who practices as interpreter in medical centres. The US-based International Medical Interpreters Association (IMIA, 2006) showcases preference for the term "medical interpreter" rather than "healthcare interpreter". In numerous instances throughout this thesis both terms might have been used interchangeably.

Non-professional/layperson/amateur interpreter – a person with a professional/occupational background unrelated to medical interpreting, who practices as interpreter on the basis of his/her alleged foreign language proficiency or degree of bilingualism. A non-professional interpreter lacks university training in T&I, although he/she might have previous work experience.

Professional interpreter/graduate professional interpreter – *trustworthy* professional with ethical and moral discernment, who consciously seeks collective good by exercising professional discretion on the basis of formal, methodised (disciplinarised) and prescriptive body of abstract, esoteric and highly specialised knowledge stipulated in codified texts taught and attainable exclusively through institutionalisation of formal learning i.e. a successful completion of special higher education (university degree). The application of such knowledge requires mastery of practical skill in order to deliver on the professional's commitment to eupraxia, which consists in achieving excellence in performance with guarantee of quality (Freidson, 2001).

(Professionally) qualified interpreter – qualified member of the profession, who possesses specialised training and education to perform a specific professional activity or job (DRAE, 2023). The term carries connotations of professional authority, respect, meritocratic recruitment and excellent quality of performance. It is the training that must qualify the applicant to be employed. "Labor consumers cannot use anyone who does not have the training. This requirement shapes the way employers must constitute the jobs and division of labor of their firm: they are not free to design jobs themselves" (Freidson, 2001, The Occupationally Controlled Labor Market, §5). Renowned sociologists "treat "a" profession as all those who have received the same qualifying vocational training" (Freidson, 2001, The Composition of Professions, §1). Experience in the field alone cannot be considered the main indicator of qualification.

PART I. INTRODUCTION AND CONTEXTUALISATION

1. INTRODUCTION AND CONTEXT

1.1. SOCIOHISTORICAL CONTEXT

In the last decades, Spanish businesses, economy, commerce, policy choices and responses and civil society have undergone a number of social processes brought by the passing of time and spawned by globalisation. The globalization of production, consumption and finance, also referred to as liberal internationalism, has intensified the social, economic and cultural transactions and the interdependence across national borders. Supranational political organisations such as the European Union - engineered as the result of globalisation - promote international law, which all Member States are enjoined to follow through the processes of transposition and deployment of statutory regulations in their respective territories. The rapidly escalating growth in international movement of services and persons may not have lowered the potential for ideological conflicts, but it has certainly stimulated cultural homogenisation at a global scale, multilingualism –actively promoted by the EU–, and internationalisation of English as lingua franca. At the same time, the Spanish sociodemographic landscape underwent drastic changes with the massive arrival of foreign citizens. According to the Ministry of Inclusion, Social Security and Migration[1], the total number of foreign residents with a valid registration certificate or residence permit residing in Spain amounted to 5,800,468 in 2020, 2/3 whereof were reported to be concentrated in Catalonia, Madrid, Andalusia and the Valencian Community. Spain was visited by 83.7 million international travellers in 2019, with revenues amounting to 92,337 million €, the Valencian Community being the 5th major destination after Catalonia, Balearic Islands, Canary Islands and Andalusia. Even though cross-border healthcare became normalised and recognised under the Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, no statutory provisions –neither at the EU nor at the national level–, have been set forth to regulate language provision in public or private health sector in Spain.

As a result of these migratory flows, the Spanish healthcare scenario is now characterised by the heterogeneity of foreign-speaking patient profiles and therefore finds itself in a desperate need for proper language provision services, which are not being duly provided in the public healthcare settings despite the universalisation of public healthcare for all foreigners under the Real Decreto-ley 7/2018 (Vigario, 2018). Language provision services in the public healthcare sphere are practically inexistent. However, the situation in the private healthcare is different. There are interpreters, but the vast majority are layperson bilinguals.

I need to digress here to clarify that the concept of "bilingualism" is extremely complex and plagued with popular myths, which hinder its correct comprehension. We must understand that there are different types of bilingualism (Blasco, 2007, p.84). The popular belief that bilinguals master two or more languages at a native-like level, which automatically allows them to translate and interpret is not mirrored in the actual reality (Grosjean, 1997 in Blasco-Mayor, 2007, p.85).

[1] The official report and statistics on foreign residents in Spain is available here: https://extranjeros.inclusion.gob.es/ficheros/estadisticas/operaciones/con-certificado/202012/Principales_resultados_residentes.pdf

Not all bilinguals have the same linguistic competence in both languages they purportedly master (in Blasco-Mayor, 2007, p. 85). Many cannot even read or write in one of the claimed languages, many speak with an accent, and very few are actually good translators or interpreters (Blasco-Mayor, 2007). Blasco-Mayor foregrounded the difference between L1+L1 and L1+L2 (2007, p. 84).

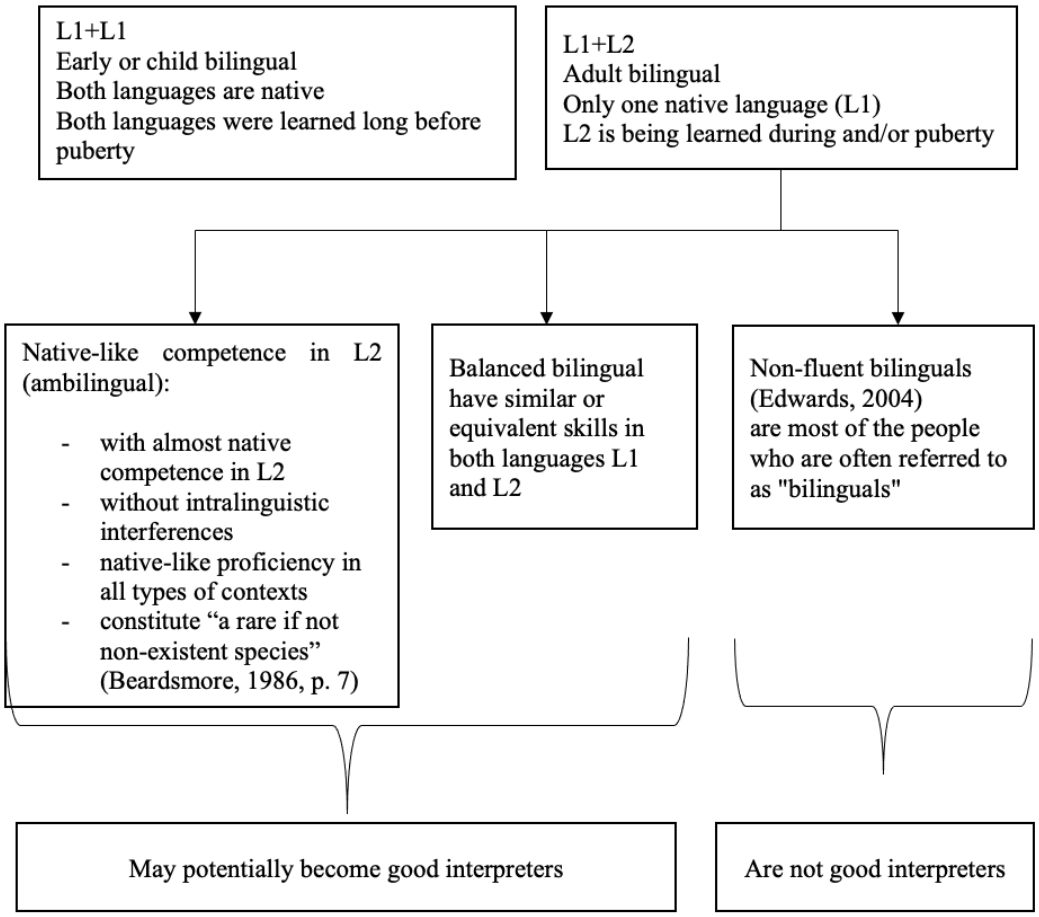


Figure 1. Information for the graph extracted form Blasco-Mayor, 2007, pp. 84-86

Thus, we need to be extra careful, because many social actors may use the term bilingual to refer to people, who could have had "bilingual upbringing" ("family bilinguals", McCarty, 2014), those who could have been provided with "bilingual education" ("school bilinguals"), or those who underwent their own bilingual development ("individual bilinguals"), however their "simultaneous" (starting at birth or infancy) contact with both languages does not make them automatically good interpreters, as well as their "consecutive or sequential" (after formation of the native language mindset) acquisition of L2 (McCarty, 2014) does not make them automatically actual bilinguals and good interpreters either. Many social actors use the above described types of bilinguals interchangeably without even pondering or grasping the difference between them. Grosjean (1977, as cited in Blasco-Mayor, 2007, p. 85) indicates that, in fact, there are more bilinguals than monolinguals in the world and they can be found in any part of the world, social class and age. However, all of them have different degrees of bilingualism, and not all of them could become

interpreters or act as interpreters. The vast majority of non-experts does not seem to comprehend this, which denotes generalised confusion and misidentification.

To add to this, globalisation has blurred occupational boundaries for many professions. Occupations such as MI now find themselves in the new grey zones of interoccupational transition, whereby new social forms and socio-professional occurrences precipitated by the internationalisation of markets and multilingualism are emerging, rendering traditional profiles such as public service interpreter totally anachronistic. That is why the phenomenology of professions and professional development against this very specific socio-historical and socio-cultural backdrop became of such great interest to me. It was not about delineating the traits that professions have in common and stacking these traits up against the characteristics of the newly emergent occupations, it was about studying the phenomenon of the need for MI in private medical facilities of a very specific geographic region within the context of yet another phenomenon of medical tourism spawned by globalisation and internationalisation of markets. The geographical parochialism of this thesis as well as the non-generalisability of the final results were sought to be compensated by the multifaceted and multidimensional research methodology.

1.2. THE PHENOMENON

Even though the main focus of this thesis will be kept on the newly emergent phenomenon of MI in private medical settings, an overview of the language provision alternatives adopted in the public sphere is still of paramount importance to this study. Due to the lack of consideration and minor importance that is being attached to the issue of (the quality of) interpreting services in medical settings, this service is practically inexistent in public health sphere, while the quality of this service in private healthcare is neglected and disregarded. As a consequence, the figure of medical interpreter in public healthcare services in Spain has not been institutionalised, it simply does not exist on the institutional level, therefore it is nearly impossible for the interpreters to get hired (Rodríguez, 2009, p. 145). Valero has also decried the lack of language provision services:

> In Spain as yet there are no professional interpreters in healthcare settings, despite rising numbers of people who do not speak Spanish and need access to hospitals and healthcare centres. As a consequence, a high percentage of interlinguistic communication is carried out by volunteers who know the languages and cultures better than their interlocutors, but who do not have any formal training and very often are unaware of the existence of interpreting as a profession. From the healthcare professional point of view, they are also expected to perform a wider role in which the activities of interpreting and mediating are blended, without clear boundaries, in the sense that they do not see the need to translate everything, and may omit or add information. (Valero, 2010, p. 234)

The following alternatives are currently being adopted in the public healthcare settings of the geographical area of interest:

- Deployment of T&I students, who are undertaking non-remunerated placements, formalised through an educational cooperation programme agreement between the student, the company and the university (Real Decreto 592/2014, pp. 4-11)

- Deployment of students in their final years of the Official School of Languages or Escuela Oficial de Idiomas (Niño-Moral, 2008, p. 1068)
- Deployment of accredited intercultural mediators who have been awarded a grant from the Regional Health Authorities of the Valencian Community[2] in accordance with Orden 8/2011[3], of 19 May, of the Regional Ministry of Solidarity and Citizenship, which regulates the accreditation of intercultural mediators and the Register of Intercultural Mediators of the Valencian Community. In terms of the university education, the applicant must hold one of the following university degrees: Degree in Psychology, Law, Sociology, Social Work, Political Science, Translation and Interpreting, and Social Education (Generalitat Valenciana, 2019[4])
- Deployment of layperson interpreters, who belong to the immigrant community and who undertook not regulated courses financed by private companies, such as Obra Social La Caixa (Burdeus & Arumí, 2012, p. 29)
- Deployment of volunteers from various NGO's, whose position in some cases has been institutionalised (Aguilar, 2015)
- Deployment of intercultural mediators otherwise referred to as "*agentes de salud comunitarios* [community health workers]", and members of minority communities with unspecified educational background in a number of public facilities (Vall d'Hebron located in Barcelona, La Unidad de Medicina Tropical del Hospital Universitario Ramón y Cajal in Madrid, El Hospital Universitario Juan XXIII of Tarragona, centro de atención primaria Drassanes in Barcelona, El Hospital del Mar and El Hospital de Mataró in Barcelona) (Burdeus & Arumí, 2012, p. 29)
- Deployment of telephone interpreting (provided by private companies such as Dualia[5] and Interpreter Solutions[6])
- Deployment of multilingual interactive software (Burdeus & Arumí, 2012, p. 31)
- Use of iconographies provided by the Health Ministry of the Generalitat Valenciana, Spanish Paediatric Association and Spanish Society of Family and Community Medicine, where the most frequently used phrases come in different languages (Personal communication of one of the interviewed doctors, 2019[7])

The situation is different in the private sphere though. The procurement managers in numerous private healthcare facilities do recognise the need for language provision, however the problem there lies in the fact that virtually anyone can access the position of an in-house interpreter.

[2] I have opted for the foreignization in the translation of "la Comunidad Valenciana" as "the Valencian Community" following the example of the Encyclopaedia Britannica https://www.britannica.com/place/Valencia-autonomous-area-Spain.
[3] Orden 8/2011, of 19 May, of the Regional Ministry of Solidarity and Citizenship, which regulates the accreditation of intercultural mediators and the Register of Intercultural Mediators of the Valencian Community.
[4] For further information: https://www.gva.es/es/inicio/procedimientos?id_proc=17178
[5] For further information: https://www.dualia.es
[6] For further information: https://www.interpretsolutions.com
[7] For further information: https://www.castillalamancha.es/sites/default/files/documentos/20120511/test_ingles.pdf

Misconceptions about bilingualism lead non-experts to believe that any bilingual person can be employed as interpreter, despite there being university degrees that offer training in translation and interpreting since 1972. Consequently, the body of knowledge underlying MI has already been codified, formalised and disciplinarised in this country, as today many national universities offer different undergraduate and postgraduate academic degrees and research programmes to expand the knowledge base of this discipline, however, instead of being perceived as a reinforcement element of the BA in T&I which facilitates and streamlines the learning process, bilingualism has officially become a waiver of the obligation to have successfully completed a university degree. Hyperbolic overestimation of medical professionals' ability to communicate in a foreign language when in reality the self-assessed caregivers are fumbling for the right words constitutes yet another problem. Such statement is, of course, not meant to be an overgeneralisation, but rather an account of what I perceived as a commonplace occurrence during my professional practice. Nonetheless, this observation was also upheld by Angelelli:

> At least four factors contribute to the current complex situation of language and access to healthcare in the EU. Those are: 1) the communicative needs within the multilingual and mobile EU; 2) popular beliefs and assumptions on minimum requirements to communicate appropriately; settling for ad-hoc, low quality and inconsistent responses in lieu of professional solutions to meet language needs and to provide access to services; 4) the perception of an allegedly disproportionate cost of quality language provision. These factors are exacerbated by a monolithic and almost unchallenged view that current ad-hoc language provision in healthcare settings is not an issue and does not need coordinated planning (i.e. "language is irrelevant; we manage"). (Angelelli, 2015, p. 9)

In the same vein, the fallacy that English actually works as a *lingua franca*, which everyone can communicate in, exacerbates patient's and medical workers' overestimated competency. Such overvaluation may be qualified as a "false fluency" (Cox & Lázaro, 2016, p. 40).

A closer inspection on such trustful dependency on amateur interpreters reveals that the knowledge and skill underpinning the process of interpreting is not viewed as the "professional expertise". The "key external players" (the grantors, resource holders and decision-makers of the language provision) (García-Beyaert, 2015) have not proven to be amenable to the professionalisation proposals and seem to backpedal on the scholars' and academics' urge to bar entry to amateur self-proclaimed interpreters who may compromise the quality of medical care. However, the problem does not lie in the marketisation of bi-/plurilingualism and deregulation of MI, whereby the government allows market forces to determine the performance of their employees. The main fulcrum of the issue lies in the professional under-recognition and underestimation of the complexity of professional knowledge and skill inherent in MI as a multifaceted communicative event, whose formalisation is absolutely essential for the *successful* interaction. This poses a dilemma because in this case the quality of an expert intervention and the quality of the performance of an unqualified practitioner cannot be judged by evaluating the immediate result. As maintained by Freidson (2001, Credentialism section, § 2-4): "Unfortunately, full information is conspicuously absent for many goods and services in the empirical marketplace. Much of what is available is only the attractively distorted and selected information of commercial advertising", just like in the case of allegedly language proficient medical professionals, hybrid profiles such as intercultural mediators and international patient care assistants. As mentioned before,

globalisation has blurred occupational boundaries for many professions, and sometimes "choices must be made too quickly for full investigation, as in a medical or legal emergency" (Freidson, 2001, Credentialism section, § 2-4). However, it is absolutely crucial that we understand that:

> Most important is the fact that even if full information were available about much of the work that professionals do now, not even the educated middle class could understand it and make fully informed choices. [...] While it is true, as Giddens noted, that "technical expertise is continuously reappropriated by lay agents as part of their routine dealings with abstract systems, [nonetheless] no one can become an expert ... in more than a few small sectors.... The lay person – and all of us are lay persons in respect of the vast majority of expert systems – must ride the juggernaut" (Giddens 1990: 144–5). (Freidson, 2001, Credentialism section, § 2-4)

Therefore, governments may very well allow market forces to determine the performance of their employees and exercise their right of caveat emptor, "but exception to the rule should be made for services dealing with life-threatening conditions such as those provided by" health-related occupations, namely interpreting in medical field. "Caveat emptor may operate in the market place but not in the solicitor's [doctor's, my digression] office" (Mungham & Thomas, 1983, Introduction section, § 1). Therefore, there is clearly a need to question the pertinence and appropriateness of the tasks carried out *during and outside the interpreted event* by the members of hybrid profiles. It is necessary to determine the extent of permissiveness as well as the degree of laxity and the radius of the leeway that these hybrid roles are granted by the employers. Otherwise, as a result of the foregoing, the patient's fundamental right to quality medical care is often violated, as their inalienable right to receive full and adequate information about their state of health, prognosis, tests and interventions is not safeguarded.

However, the "key external players" (both "grantors" and "receivers") (García-Beyaert, 2015) do not seem to "accept the professional argument" that MI "is too complex and esoteric for the untrained to understand, so that in circumstances where the wrong choice can be fatal [see Singh, 2018, my digression] the range of choices must be limited to safe ones" (Freidson, 2001, Credentialism section, § 1-5). I am convinced that "consumers" in the case of MI "are not effectively equipped to choose among available [...] services in their own interest" (Freidson, 2001, Credentialism section, § 1-5), even though they may be fully convinced that they can distinguish between an excellent and a subpar performance and that there is nothing difficult about it. They just believe that no specialised or esoteric knowledge requiring the exercise of discretion is actually behind interpreting. Many external players do not believe that the person in charge of interpreting ought to have an "effective command over a defined body of knowledge and skill" (Freidson, 2001, Credentialism section, § 1-5), thus rendering credentialism and licensing unnecessary. Subsequently, MI is not viewed as a profession per se, which leads to the formation of hybrid roles and profiles imposed by the market demands. This thesis zooms in on these ersatz alternatives that have colonised the niche of MI and explains why this occupation is still not immunised against dilettanti.

1.3. INSPIRATION AND MOTIVATION

My professional experience as a medical interpreter in a number of private medical centres of the study relevant geographic region constitutes the major source of inspiration for this thesis. This study is meant to be an openly ideological research including reflexivity, because my own personal and professional experience, values, history and biography are not only mirrored in this thesis, but shape it. I seek to ground my understanding of the professional performance of medical interpreters in the thorough analysis of the current situation, and most importantly, in the deep analysis of immediate interaction of medical interpreters with other social actors, be it "key internal or key external players in the development of the interpreting profession" (García-Beyaert, 2015, p. 45). With this manuscript I intend to deliver on my commitment to make a modest contribution towards a possible improvement of the work conditions, job security, job quality, and pay increase of the medical interpreters. However, the problem and the core of my motivation is the fact that we may not be focusing on the real latent issue causing de-professionalisation of the discipline in this field. Even though the curriculum of modern universities has diversified producing new areas of competence (Translation and Interpreting BA, Master's Degree in Medical Translation, and so on) no status of "profession" is being assured for its graduates, because the university in Spain does not exercise its "cognitive authority" (Freidson, 2001) in the professional field of Translation and Interpreting, a step that is an absolute must for the discipline authentication. What happens is that all recognised professions in Spain are coordinated through professional associations, which is something that the university cannot take control over. However, in order for a professional association to be established, the profession has to be regulated by the law, which must enshrine a standard or a norm that would regulate professional competence, expertise or knowledge underlying such competence. The legal system must determine the requirements for access to the profession, so that by law there is a set of responsibilities that can only be carried out exclusively by a professional with an academic qualification.

The impression that all professional careers can only advance and revamp is absolutely false, and this statement was the point of departure of this thesis. This fact is my major motivation for professionalisation, which this thesis is meant to promote and contribute to, while my daily workplace struggle for recognition constitutes my biggest inspiration for this study. Thanks to this research I realised that the institutionalisation of the intellectual tradition of this discipline, as well as the implementation of closure devices (establishment of professional consciousness, code of practice, licensing, unionisation, voluntary certification and representation by professional associations, creation of ethical subcommittee responsible for the practice of the discipline) will be unsuccessful unless the "professional knowledge and skill" (Freidson, 2001) underlying this discipline is acknowledged through the professional socialisation process.

The lack of a reactionary backlash on the part of the receivers of the service due to indiscriminate eligibility to practice in this environment, and the lack of social payoff in the case of professional MI made me feel compelled to cover this topic both for the sake of patients and colleagues. I am also interested in knowing why the relevant decision-makers and law-makers backpedal on the imposition of the statutory provisions that would regulate this health-related occupation, and why the existing research on crippling and far-reaching consequences of interpreting errors does

not galvanise into the implementation of such regulations. The acquisition of social sympathy constitutes a substantive preoccupation and interest for me, since the prerogative of the title must be negotiated and accomplished on daily basis, which can only succeed if the social actors know who you are and what your role is. Hopefully, I will succeed in throwing an interesting light on the current situation and the prospective solutions to the existing problems.

1.4. OBJECTIVES

Thus, the main purpose of the present thesis is:

- To contribute to the sensitisation of the relevant external players (García-Beyaert, 2015) to the salience and indispensability of the professional knowledge and skill of medical interpreters in the context of multilingual and multicultural communication events
- To determine whether such sensitisation is still possible
- To determine how such sensitisation can be achieved
- To determine whether there are still chances to professionalise
- To determine how far did the profile hybridisation go in this field
- To determine how the academia will react to the current market demands and professional identity impositions upheld by the institutional ethics of each medical facility
- I am also seeking to investigate how the power behind discourse overrides the power in discourse, which in this case and within the context of social constructionism comes to represent the asymmetry of the power relations between the government, the "elites" (Freidson, 1983, 2001), the grantors of the service, the policy-makers, the recourse holders and the professional interpreters, who seek to negotiate, contest and establish their professional identity by the exercise of their power in discourse and through the intersubjective identity construction.

This study pursues self-interests of the author in that it seeks to throw light on how can a professional medical interpreter achieve the much desired and coveted for social recognition status, prestige, prerogatives, legal protection of the title, governmental patronage, social closure, and most importantly the economic payoff to the specialised, abstract, esoteric knowledge, the lengthy formal university education, and the investments made into career development.

My altruistic motivation is based on my willingness to ensure compliance with the existing regulations in the patients' right to information. It is my contention that the existing alternatives to professional MI are subpar and may jeopardise patient's right to make informed decisions regarding their health and wellbeing.

1.5. RESEARCH QUESTIONS

My point of departure for this thesis is that "any 'problem' does not have an 'objective existence' for the simple reason that" any occurrence or phenomenon considered a "problem" is "always [a] problem for someone", in that "one person's problem is another's solution" (Burr, 2003, p. 153). So the key question that this thesis aims to answer is whether what I consider to be a "problem"

is also a problem for somebody else, or whether I am just problematizing certain aspects of my practice on the basis of a personal prejudices or convictions.

Thus, this thesis will seek to provide valuable and useful insights in four main areas: a) the difference between the language knowledge acquired as the means to improve employability, as the means to communicate at the amateur level, or as specialist/expert knowledge; b) language proficiency credentials; c) current market demands; and d) professionalisation plausibility.

The main research questions, which sought to explore and ferret out the social processes occurring in a very specific location and in a very particular context and leading to the current state of affairs are the following:

I. Why is MI in the private healthcare settings of the VC still either dismissed, dispensed with or delivered by laypeople if the patients who seek cross-border healthcare are willing to cover its costs and the excuse of limited public budget is no longer applicable?

II. Why is the dire need for quality language provision in the private clinics and hospitals not being addressed by professional graduates when the excuse of exotic languages of lesser diffusion is no longer applicable because the languages spoken by the users of these services are mainly European[8]?

III. Why has MI not been professionalised yet despite the fact that the higher education institutions in Spain have the cognitive authority over the codified, formalized and disciplinarised professional knowledge of MI since 1972[9]?

IV. Why were relatively low numbers of graduates being recruited by the private clinics and hospitals even though many of these facilities have signed educational cooperation agreements on extracurricular external work placements with a number of Spanish universities teaching translation and interpreting?

V. Why is nobody concerned with the fact that the patients' right to medical information enshrined in the Ley 16/2003 sec. 3, Ley 41/2002 art. 4 and Ley 10/2014 art. 50 is not being complied with, and subsequently, why the language issue is not being problematized or foregrounded in the EU and/or national legislative texts?

VI. Are there still chances to professionalise, if so, how can this process be accomplished and by whom? Do we owe it to ourselves to try?

1.6. INTERDISCIPLINARY AND MULTI-METHOD APPROACH

It is worth noting that a pluridisciplinary and multi-method approach was adopted for this research. The disciplines that I have been working with include Translation and Interpreting (Pöchhacker & Kadrič, 1999; Angelelli, 2014, 2015, Moreno et al., 2007; Flores, 2006; Mikkelson, 1999; Ortega-Herráez & Blasco-Mayor, 2018; Phelan et al., 2020), the Sociology of the Professions (Freidson, Rueschemeyer, Horobin, Dingwall, Mungham, Thomas, 1983), Freidson's (2001) Sociology of Professional Knowledge within the framework of the sociology of the

[8] And taught at the national universities.

[9] Which is when the first Translation and Interpreting Degree was established at the Autonomous University of Barcelona.

professions, Sociology and Communication Theory and Social Constructionism, (Burr, 2003), Discursive Psychology (Edwards & Potter, 1992; Wiggins & Potter, 2007)) applied to Conversation Analysis (Schegloff, Sacks, Atkinson, Drew, Heritage, as cited in DeMarco's personal communication and as cited in Flick et al., 2004), Multimodal Critical Discourse Analysis (Paltridge, 2012), Social Psychology and Intersubjective Identity Construction (Bucholtz & Hall, 2005) applied to Thematic analysis (Braun & Clarke, 2006).

1.7. STRUCTURE OF THE THESIS

This thesis is divided in three parts: Introduction and Contextualisation, Sociology of the Professions and the concept of Professional Knowledge, and Empirical Evidence. The first part, which constitutes the prolegomenon of this thesis, contains the groundwork, which serves as the point of departure for the following investigation. It contains a general overview of the current situation of medical interpreting. The first subsection encompasses the geopolitical, sociohistorical, sociodemographic and legislative contexts (including EU, national, and regional regulations). The second subsection encapsulates a literature review on the current status quo of the occupation on the international, national and regional scale. It explores the issues of conceptual heterogeneity, terminological fuzziness, the dangers of non-professional language provision, and different ad hoc alternatives to professional MI (from now onwards, MI).

Part II develops a research agenda to extend the study of the concept of MI as a discipline in order to scrutinise it through the lens of the sociology of professions. Upon completing the review of the different stages and mechanisms of professionalisation it was clear that the reason behind the failure to successfully implement those mechanisms is the generalised under-recognition of the complexity, the specialisation and the esoteric character of the professional knowledge and skill underlying MI.

Social recognition is essential for professionalisation, however in this case public opinion on the typology of professional knowledge dissents from the professional graduate interpreters' self-concept. The majority of social actors view MI expertise as automatised, mechanised, tacit, everyday knowledge possessed by every bilingual person, contrary to the opinions of numerous scholars in the field of T&I, neurolinguistics, neurophysiology and genetics, who confirm that MI requires a vast amount of codified, specialised, formalised knowledge as well as genetic and physiological predisposition to exercise the discretionary specialisation successfully. Therefore, the professional identity and category that is being allocated to MIs differs markedly from the professional identity that these professionals seek to negotiate and maintain. However, the idea of social determinism and critical realism, based on power relations and ideologies, which discursively generate our reality, knowledge and description of the world as we know it, explains why the interpreters as agentic and conscious social actors fail to re-position themselves and negotiate the professional category that is being imposed on them by the "key external players" (the government, businesses, grantors and receivers) (García-Beyaert. 2015). The MI's agency to discursively (re)construct their identities and their proximate environment by influencing major social structures and algorithms is minimal.

The aforementioned misconception and underestimation of professional knowledge, the government authorisation for market forces to determine the performance of the employees through "institutional ethics" (Freidson, 2001), and the lack of clear "jurisdictional boundaries" (Halliday, 1987, cited in Freidson, 2001), which renders this expertise "insufficiently codified" and "undistinctive" from the skill of any self-reported bilingual person, result in an incorrect compartmentalisation of tasks, with a clear gravitation toward hybridised profiles.

These already solidified hybrid identities are social constructs designed to maximise the profits. These identities are imposed, maintained and altered "on social ground" and reified through "dialogic linguistic performance" (Bucholtz & Hall, 2005) based on the five principles of intersubjective identity construction (emergence, positionality, indexicality, relationality and partialness principle) deconstructed in the last chapter of this part.

Part III contains the results and discussion of the data corpus that has previously been subject to a multimethod analysis approach. Quantitative data corpus is constituted by the information provided by 53 respondents (24 medical professionals, 21 interpreters, 8 patients) via questionnaires. Data were obtained from 5 different medical centres located in the Valencian Community. The qualitative data corpus is constituted by information provided by 62 respondents (46 doctors, 3 nurses, 7 patients and 6 interpreters) via in-person semi-structured interviews; 4 audio recordings of naturally occurring medical encounters; and 1 news report broadcast on Spanish national television. I resorted to the data triangulation, which allowed me to assess the phenomenon from several vantage points. Thematic Analysis (Braun & Clarke; Bucholtz & Hall), Conversation Analysis (Schegloff, Sacks, Atkinson, Drew, Heritage), and Multimodal CDA (Paltridge, Mackay) were carried out to probe the robustness of the previously formed conceptual associations. The findings clearly echo and statistically represent the ideas expressed in Part I and Part II.

The quantitative analysis revealed a generalised confusion regarding the typology of knowledge of MI's and the necessity of formal higher education, as well as regarding the nature of the tasks that should fall within the MI's remit.

The conversation analysis showcases how a hybrid professional identity is being discursively and intersubjectively imposed on the professional interpreter during medical consultations. The interpreter fails to reject the imposed identity due to the power asymmetry that permeates the "institutional ethics" and institutional discourse (Freidson, 2001). The multimodal critical discourse analysis showcases tendency towards hybridisation of profiles and blurry interoccupational boundaries. Non-verbal communicative signals served to identify two main hybrid profiles: multilingual receptionist and multilingual patient care coordinator.

The thematic analysis within the paradigm of Social Constructionism demonstrates how Freidson was right when he stated that "profession" is a "folk concept" (1983). Many interactants were not sure whether the discipline of MI requires formal education, and if so, what kind of education. The informants were unfamiliar with the typology of professional knowledge underlying MI. The fact that experience, bilingualism, polyglotism, philology, and personal traits are presented as viable alternatives to professional language provision denotes de-mystification of profession. The imperativeness of medical training for MI denotes strong gravitation towards

hybridisation of profiles, blurred interoccupational boundaries, failed division of labour and de-professionalisation. The hybridisation in this case is bidirectional:

- On the one hand, there are new occupiers represented by bilingual or self-identifying language proficient medical workers, who seek to improve their socio-professional status and competitiveness by conducting consultations in a foreign language and by "relinquish[ing] the less attractive [routinised] tasks" (Hughes as cited in Dingwall, 2016) and delegating them to interpreters.

- On the other hand, there are interpreters, who adopt such roles as co-consultant, co-diagnostician, co-therapist, social worker, and psychologist inter alia. It is worthwhile noting that the professional category that is being officially assigned to them is that of "administrative assistant", which has much lower level of competencies than interpreter, as reported in ISCO-08 and CNO-11.

This study is certainly not designed to be the last word on the subject, it only aims to find a scientific and rational explanation for the current impasse and offer possible orientations toward a viable solution.

2. MIGRATORY PHENOMENA

The main question that I shall be seeking to answer in this chapter is why high-quality MI is salient in the study-relevant sociodemographic context. Spanish society in general and Valencian society in particular are characterized by an increased tendency towards multilingualism and multiculturalism. As reported by Rodríguez et al. (2009), "language barriers have become increasingly evident in Spanish hospitals and health centres as the profile of patients and society in general has changed" (p. 141, my translation). Rodríguez et al. distinguish between "economic immigrants" and "social immigrants". According to the authors, although all foreigners and newcomers are classified as immigrants, it is common to observe that this particular term is especially associated with "economic immigrants", i.e. those who come from less economically developed countries and who arrive in Spain fleeing the difficulties that severely hinder their ability to lead a decent and dignified life in their countries of origin, be it due to ailing economy or war. Social immigrants, on the other hand, enjoy:

> High socio-economic level, belonging to cultures closer to our own, among whom we can find professionals, technicians, students or retired people with high earning power. Most immigrants from the European Union belong to this group. (Rodríguez et al., 2009, pp. 141-142, my translation)

For a better understanding of the magnitude of the migratory and tourist influx, I shall furnish the readers with information, tables and figures provided by the National Institute of Statistics that detail data on the tourism and immigration. Thus, according to the Permanent Immigration Observatory, which reports to the General Secretariat of Objectives and Inclusion and Social Welfare Policies of the Ministry of Inclusion (La Moncloa, 2021)[10], whose goal is to provide an overview of the phenomenon of migration in Spain, the population covered by the study exceeds 5.8 million for the first time and includes both those who have a valid residence permit and those EU residents in free movement who hold a registration certificate. To be more precise, the total number of foreigners with a regularised status (holders of a valid registration certificate or a residence card) residing in Spain in 2020 amounted to 5,800,468, 61% (3.535.964) of whom are subject to the EU free movement regime. Just for the record, The EU Free Movement Scheme is the legal regime that applies to nationals of European Union and EFTA countries, as well as to their family members who are non-EU-EFTA nationals and have certain family links with EU-EFTA1 nationals. The number of foreigners resident in the general regime stands at 2,264,504. The statistical breakdown shows that 15 nationalities account for almost 75% of all foreign residents in Spain. Eight of them correspond to European Union countries, among which Romania (1.079.726), the United Kingdom (381,448) and Italy (350,981) stand out. Among the most numerous groups of non-EU countries are those from Morocco, China, Venezuela and Ecuador.

[10] Official report issued by Permanent Immigration Observatory of the General Secretariat for Inclusion (*Observatorio Permanente de la Inmigración de la Secretaría General de Inclusión*) can be found here: https://extranjeros.inclusion.gob.es/ficheros/estadisticas/operaciones/con-certificado/202012/Principales_resultados_residentes.pdf

It is worth clarifying that the number of Britons with a registration certificate as at 31 December 2020 stood at 381,448, almost 22,000 more than a year earlier, showcasing an annual increase of 6%, despite Covid-19 global pandemic and Brexit year. Almost 20% (64,715) thereof have applied for an EIT as of 7 July using the procedure developed in accordance with the provisions of art.18.4 of the Withdrawal Agreement; 75% (48,177) already had a previous registration certificate, i.e. they were already resident in Spain, while the rest are new residents. By type of concession, the greatest relative growth has been concentrated in permanent residence and non-profit residence (Observatorio Permanente de la Inmigración de la Secretaría General de Inclusión, Ministerio de Inclusión, Seguridad Social y Migraciones, 2020).

The age bracket of the resident population is also a major indicator of the difference between the two profiles: the average age of the resident foreign population is around 40 years old and men predominate over women. However, there are more mature groups among those from the EU, such as the British (average age 54) and, to a lesser extent, the Germans (49), and others much younger, such as the Pakistanis and Moroccans (33). With regard to territorial concentration of the foreign population, it is worth noting that two thirds of foreign residents live in four autonomous communities: Catalonia, the Community of Madrid, Andalusia and the Community of Valencia. Seven provinces (Madrid, Barcelona, Alicante, Alicante, Malaga, Valencia, Balearic Islands and Murcia) account for 57% of the total, with all of them exceeding 225,000 resident foreigners.

Resuming the discussion about "social" and "economic immigrants" (Rodríguez et al., 2009, p. 141), it is worth noting that economic migrants relocate to more economically developed countries to lead a more dignified, safe and secure life than in their respective countries of origin. This group is constituted by users of the public health system. Refugees seeking political asylum would also constitute a group of users of public hospitals. Social immigrants, on the contrary, have various reasons for residing abroad: work (employment and self-employment), studies, family related reasons and non-profit residence. Some non-profit residents are elderly people who expatriate in pursuit of foreign retirement. They can still claim their pension in their correspondent country of origin, but they take up permanent residence of another Member State. Spain has become a destination for many such retirees. Affluent expatriates with substantive purchasing power, who settle down and acquire a property in Spain, are either holders of private medical insurance with good coverage or are private patients. They would normally use private medical centres.

2.1. INTERNATIONAL TOURISM

Another very important group is constituted by the tourists. In order to gain a broader perspective, I have decided to consult again the data issued by the National Statistics Institute (INE).

The INE confirms that Spain hosted a record number of 81.8 million tourists in 2017, which is 8.6% more than in 2016. The expected year-end projection was for the figures to approximate the result reached in 2016 by France, the world's leading recipient of international tourists, which constituted 82.6 million. It is also expected that the figures will surpass those of the United States, country which received 75.6 million tourists in 2016.

According to the data displayed by the INE, Catalonia was the main tourist destination in 2017. This community hosted 19 million tourists, which is 5% more than in 2016. It was followed by the Canary Islands with 14.2 million tourists and the Balearic Islands with 13.8 million. Andalusia received 11.5 million tourists, Valencia, 8.9 million, and the Community of Madrid, 6.7 million. In 2017, the main countries of residence of incoming tourists were the United Kingdom, Germany and France.

It is worth nothing that foreign tourists who visited Spain in 2017 spent 86,823 million euros, 12.2% more than in 2016, according to the Tourist Expenditure Survey (Egatur) published by the INE (2018). According to the Spanish Tourism Satellite Account, the tourism sector has constituted 11,2% of GDP per capita in 2016. This sector provides 2,6 million inhabitants with jobs, which corresponds to 13,0% of employment (ABC, 2018).

Spain has beaten another record in 2018 with 82.6 million foreign tourists compared to 81.8 million reached the previous year. According to the data provided by the Ministry of Industry, Trade and Tourism, there was an increase in spending of 3.1%, close to 90,000 million euros (89,678 million euros). The Minister has also pointed out that these data "show the strength of the Spanish tourism sector and the progress towards quality tourism and added value" (Hosteltur, 2019).

Spain has yet again beaten a new record in tourism in 2019 (El País, 2020; Hosteltur, 2020). According to the figures provided by the Ministry of Industry, Trade and Tourism, Spain was visited by 83.7 million international travellers, whose expenditure amounted to 92,337 million euros. The Minister stressed that not only is it a matter of seeking quality tourists outside the traditional source markets, but also of analysing different "profiles" within those countries to deseasonalize[11] (demographic phenomenon whereby the international travellers will not limit their visits to the peak tourist season, but rather gravitate towards travelling throughout the whole year). The profile of the traditional tourist also needs to be analysed to opt for those tourists with greater purchasing power (Molina, 2020).

The figures corresponding to international tourism are clearly not plateaued, in fact they have gradually reached a crescendo in 2019. The figures highlighted in blue colour denote progressive burgeoning of international interest towards Spain. I have consulted the National Statistics Institute data in order to determine the countries of origin of the tourists by whom Spain is massively visited. I also aimed at identifying the autonomous regions which constitute main tourist destinations. I have built on the data provided by the INE and curated the following tables where I included only the most study-relevant information. Thus, in the table on cross-border tourist movements, I have highlighted the figures corresponding to the volume of tourists who visited Spain in 2019 and their respective countries of origin.

[11] Desestacionalizar.

Table 1. Figures of tourists according to their country of residence

	2019	2018	2017	2016
Total	83.701.011	82.808.413	81.868.522	75.315.008
GERMANY	11.176.545	11.414.955	11.897.376	11.208.656
BELGIUM	2.538.829	2.505.146	2.474.720	2.301.628
FRANCE	11.156.671	11.293.323	11.267.269	11.258.540
IRELAND	2.177.106	2.053.385	2.046.123	1.808.469
ITALY	4.542.709	4.389.453	4.222.865	3.969.322
NETHERLANDS	3.701.944	3.855.269	3.704.549	3.355.031
NORDIC COUNTRIES	5.548.745	5.803.535	5.826.548	5.129.025
PORTUGAL	2.440.746	2.344.322	2.137.880	1.996.164
UNITED KINGDOM	18.078.076	18.523.957	18.806.776	17.675.367
RUSSIA	1.311.746	1.227.530	1.150.055	1.004.577
SWITZERLAND	1.824.839	1.883.148	2.059.201	1.703.481
REST OF EUROPE	6.415.281	6.003.629	5.543.011	5.026.962
USA	3.332.654	2.959.487	2.637.484	2.001.813

The highest figure corresponds to the tourists from the United Kingdom (more than 18 million visitors in 2019), followed by Germany (11.176.545), France (11.156.671), Nordic Countries (5.548.745), Italy (4.542.709), Netherlands (3.701.944), USA (3.332.654), Belgium (2.538.829), Portugal (2.440.746), Ireland (2.177.106), Switzerland (1.824.839), and Russia (1.311.746). Thus the main languages spoken by the tourists are English (United Kingdom, Ireland and the US 23.587.836), German (11.176.545+62.6% of German-speaking population of Switzerland), French (11.156.671+22.9% of French-speaking population of Switzerland+40% of French speaking population of Belgium), Dutch (3.701.944+almost 60% Dutch (Flemish) speaking population of Belgium). And Italian is spoken in Italy (4.542.709) as well as in Switzerland by 8.2% of the population. The aforementioned are the main language groups of the tourists.

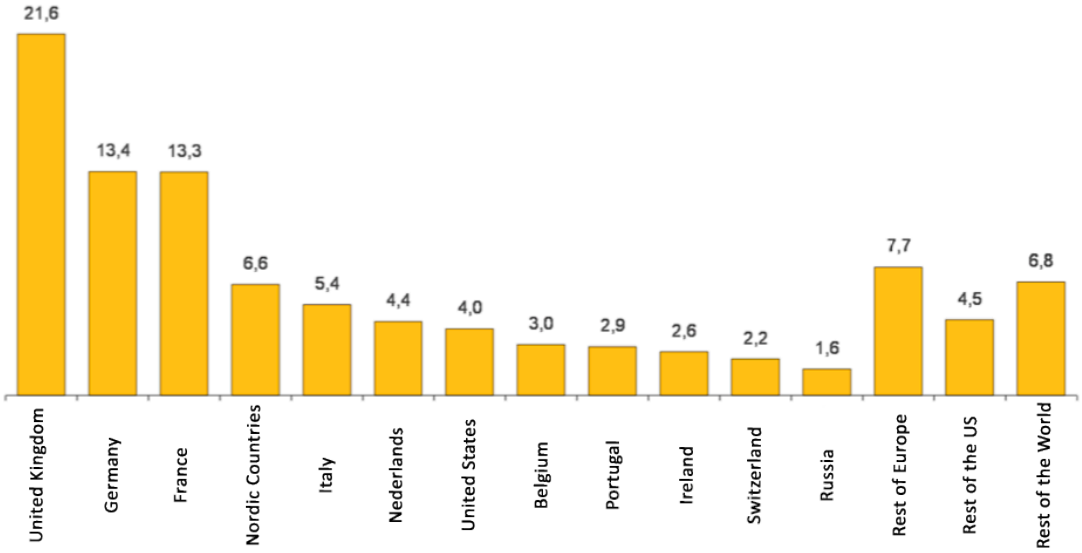


Figure 2. The percentage of international tourists who visited Spain in 2019 according to the respective countries of origin

According to INE (2020) The Autonomous Community of Catalonia constituted the main tourist destination in 2019. This region only hosted 23.1% of the total volume of tourists. Catalonia was followed by Balearic Islands (Illes Balears), which hosted 16.3% of tourists and Canary Islands (Islas Canarias) having accommodated 15.7% of the visitors.

Almost 19.4 million tourists arrived in Catalonia, which is 0.8% more than in 2018. France was the main country of residence of 21.0% of visitors. The number of tourists who visited the Balearic Islands fell by 1.2% to nearly 13.7 million. 33.2% thereof came from Germany and 27.0% from the United Kingdom.

The third main destination is constituted by the Canary Islands. This region has hosted over 13.1 million tourists in 2019. The United Kingdom was the main country of origin in the case of 37.1% of the visitors, followed by Germany (19.1%).

On the other hand, Andalusia received 12.1 million tourists, which denoted a slight increase of 3.4% as compared to 2018, and the Valencian Community (Comunitat Valenciana) hosted 9.6 million visitors which is 3.9% more than the previous year. Finally, the Community of Madrid (Comunidad de Madrid) accommodated 7.6 million travellers (7.0% more that in 2018). The following depiction was extracted from the table provided by INE (2019).

Table 2. Number of tourists according to autonomous community of main destination

	2019	2018	2017	2016
Total	83.701.011	82.808.413	81.868.522	75.315.008
01 Andalusia	12.079.017	11.681.256	11.518.262	10.589.642
02 Balearic Islands	13.680.923	13.851.598	13.792.296	12.997.549
03 Canary Islands	13.147.009	13.752.022	14.214.222	13.259.567
04 Catalonia	19.358.203	19.196.344	19.118.421	18.139.177
05 The Valencian Community	9.566.566	9.206.908	8.925.959	7.731.770
06 The Community of Madrid	7.638.375	7.139.775	6.699.785	5.783.137

Note: Spain is divided into regions called autonomous communities, many of which have self-government and their own laws, as well as transferred competencies in matters of health, justice and education

Spanish government realises the importance of international tourism and medical tourism and its impact on the economy, therefore after new Brexit regulations entered into force Spain did not hesitate to open the door to health tourism with the UK (Laguna, 2020). British tourism is of vital importance for the Valencia Region, the territory with the highest number of British residents and tourists in the whole of the European Union (Laguna, 2020). In this regard, Minister González Laya explained that Spain will seek a bilateral agreement with the British government so that its citizens have access to Spanish healthcare when they come on holiday or to their non-permanent residences (Laguna, 2020).

As soon as the agreement with the United Kingdom becomes effective, Spain will initiate bilateral talks to ensure healthcare for British holidaymakers, in order to ensure the continuity of Spain's largest tourist market (Laguna, 2020). According to the same source, such an agreement would open the door to health tourism that would take advantage of public hospital facilities to sell all-inclusive holiday packages and sun and beach rehabilitation. It should be borne in mind that the free public healthcare system in Spain is not comparable to the co-payment healthcare system in other European countries, but it is comparable to that of the United

Kingdom (Laguna, 2020). Nevertheless, British patients are by far not the only ones interested in Spanish healthcare and captivated by its cultural environment and climate conditions.

2.2. MEDICAL TRAVEL AND MEDICAL INTERPRETING

2.2.1. Introduction to the concepts of medical travel, the traditional model of international medical travel and health tourism

Medical travel *per se* must not be viewed as a newly emergent phenomenon. Since ancient times people belonging to a number of ancient cultures and civilizations have been travelling to hot mineral thermal springs due to the alleged healing properties and therapeutic effects of these health retreats (Health Tourism, n. d.). The hot springs of Sumerians (circa 4000 BC), the Sanctuary of Zeus, Asclepiad Temples, and Epidaurus facility build by the Hellenes (circa 2000 BC), and the thermae constructed by the Romans (circa 750 BC – 470 AD) exemplify some of the major healthcare travel destinations of the antiquity. The Roman term "spa", which stands for "salude per aqua", became widely used to attract potential healthcare travellers to the major Roman baths of Europe during The Renaissance Period (St. Mortiz, Ville d'Eaux, Baden Baden and Bath). The term "spa" came to signify fashionable wellness combined with healthcare. In the Post-Renaissance period spas and health retreats preserved their popularity and became a premiere destination for patients suffering from tuberculosis. In the 20th century medical travel underwent significant changes due to the industrialisation and global commercialisation of healthcare, as well as internationalisation of healthcare marketplace. In view of these globalisation-related changes a number of accreditation organisms were established to ensure that the healthcare facilities of the countries marketed as medical travel destinations conform to international standards. These organisms include the American Board of Medical Specialties, European Union of Medical Specialties and Joint Commission International. Joint Commission International golden seal of quality approval[12] became the quality benchmark *par excellence*, as well as one of the most salient indicators of competitiveness of high-achieving medical organisations.

Medical travel can be subdivided into two categories: 1) the traditional international medical travel and 2) health tourism, which encompasses a) medical tourism and b) wellness tourism.

> In medical tourism, citizens of highly developed nations bypass services offered in their own communities and travel to less developed areas of the world for medical care. Medical tourism is fundamentally different from the traditional model of international medical travel where patients [...] with the necessary resources to do so [...] generally journey from less developed nations to major medical centers in highly developed countries [...] to have diagnostic evaluation and [...] for medical treatment that is unavailable in their own communities. (Horowitz et al., 2007)

To give an example, patients from Russia and some Arab states could be viewed as users of what we came to identify as the traditional model of international medical travel, while Europeans retirees, who enjoy a good financial standing and have no financial burdens would fall within the category of medical tourists (EOI, 2013, p. 113).

[12] All the information regarding Joint Commission International is available here: https://www.jointcommissioninternational.org/about-jci/accredited-organizations

Availability or access to the needed or desired therapy, affordability of care and timeliness are the key pillars of health tourism industry today. Health tourists "feel pressed to balance their health needs against other considerations, and medical concerns may be subordinated to other issues" (Horowitz et al., 2007). There is a series of circumstances under which the patient may be willing to resort to the out-of-country healthcare accepting all the inconveniences and uncertainties of offshore medicine:

1. Cost-conscious patients, who are uncomfortable with spending substantial amounts on a treatment available in their local healthcare market
2. Patients pursuing a treatment which is not covered by their health insurance (cosmetic surgery, dental reconstruction, fertility treatment, gender reassignment procedures)
3. Patients seeking to "circumvent delays associated with long waiting lists", especially in the countries where the "governmental healthcare system controls access to services"
4. Patients seeking to undergo procedures (such as stem cell therapy) "that are not widely available in their own countries"
5. Patients who do not feel confident and are concerned that their privacy and confidentiality may be compromised (especially those who seek to undergo plastic surgery, sex change procedures, and drug rehabilitation)
6. Patients who want to combine their medical treatment with convalescence in vacation-like "exotic locations" with luxurious yet affordable surroundings
7. Patients who seek to undergo wellness treatments

Hence, medical travel is subdivided into several branches of tourism and the graph[13] below (inspired by EOI, 2013, p. 10; Horowitz et al., 2007; Hopkins et al., 2010) represents a broad outline of the major segments thereof.

[13] I drew on the floowing sources: Wikilibro Productos turísticos en Turismo (Escuela Organización Industrial; https://bit.ly/3tPHb76

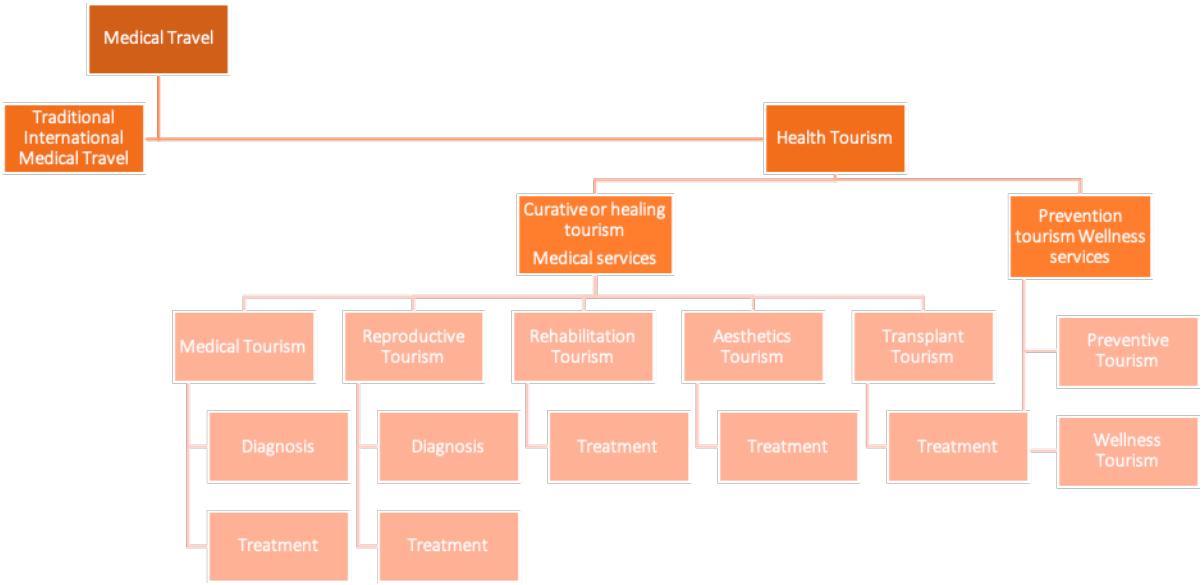


Figure 3. Medical travel subsectors

Even though I will be focusing more on medical tourists, I will still be taking into account all private patient profiles:

- Those who develop a condition or suffer an accident when already abroad (requiring unscheduled emergency medical assistance)
  - Affluent elderly population (expatriates) who seek foreign retirement as long-term residents in Spain
  - International travellers who visit Spain out of the peak tourist season
    - Business tourists
    - Regular tourists
  - Traditional high season travellers
- Those who intentionally seek to undergo a planned elective treatment which became the main purpose for their journey abroad
  - Traditional international medical travellers (travelling from a developing country to a developed country), who are well off patients seeking to receive sophisticated, top quality and high standard treatment unavailable in their local developing communities.
  - Health tourists attracted by affordability of care, high quality standards & infrastructure, highly qualified medical professionals, no waiting lists, lax legislation in infertility treatments, optimal geographical and climatic conditions, rich cultural environment and gastronomy. Woodman defined the health tourism market in the following way:

    > The health tourism market is growing, as the relatively well-off global population ages at a rate that exceeds the availability of quality health care resources. Moreover, additional expenditures on critical and elective medical procedures continue to increase, while countries offering universal health care face an increasing resource burden. These are the

> triggers that force patients to seek cross-border healthcare options in order to save money or to avoid long waiting lists for treatment. We estimate that the global health tourism market is growing at a rate of 15-25 %. (Woodman, 2015)

According to the study on Tendencias, perfiles y motivaciones del turismo de salud y de bienestar [Trends, profiles and motivations of health and wellness tourism], carried out by Ostelea, the determining factors in the choice of a medical tourism destination are highly qualified professionals, services, facilities and infrastructure, the associated costs, as well as the cultural environment (El Economista, 2020).

Health tourists are subdivided into two categories:

- Medical tourists
- Wellness tourists

The next chapter will be dedicated to the analysis of health tourism in Spain.

2.2.2. Health tourism in Spain

According to the study carried out by Escuela de organización industrial (AUREN & Fundación EOI, 2013, p. 18), Spanish healthcare is considered to be one of the best in the world. The World Health Organisation (WHO) ranks it 7th in the world for health. According to data from the Global Wellness Institute provided in 2019, our country ranks fifth in the world in health and wellness tourism and second in Europe, after Germany (Hosteltur Economía, 2019). According to El Economista.es special tourism edition 2020, Spain ranks sixth in Europe and eighth in the world. Newsweek magazine places it in 3rd position, only behind Japan and Switzerland (EOI, 2013, p. 18). Thus, bearing in mind that the Spanish public health system is free and of high quality, it must be considered that private centres are offering very high quality services, which provide great added value and confidence to the user (EOI, 2013, p. 21). For the record, according to the same source private healthcare offers its clients a high technological capacity, accounting for 56% of PET scans, 58% of MRI scans and 37% of CAT scans in Spain. 20% of chemotherapy sessions are carried out in private hospitals (EOI, 2013, p. 21). Spanish private healthcare sphere is constituted by 483 hospitals and 53,985 beds, representing 51% of the hospitals and 33% of the beds in the country (EOI, 2013, p. 21). Also, as discussed earlier, according to the World Tourism Organisation (WTO), Spain is the 4th country in the world in terms of tourist arrivals (EOI, 2013, p. 18).

As maintained by the Círculo Fortuny, Spain has consolidated its position in the international market as a major high-end experiential tourism destination in terms of wellness, cultural and hospitality tourism (Hosteltur, 2019). The main tourism products that complement health tourism are high-quality accommodation at very competitive prices, low flight costs, short duration flights and comfortable flight connections from different Spanish and British cities, Mediterranean lifestyle, gastronomy, leisure, culture, nature (beach and sea), environmental and climatic conditions and sport (EOI, 2013, pp. 47, 112). The same study reports that British patients value Spanish medical professionals' ability to speak English (EOI, 2013, p. 112). 2019 recorded 18.8 million trips and the travellers' spending added up to more than 8.8 billion euros (Hosteltur, 2019). As maintained by the vice-president of Sha Wellness Clinic, Alejandro Bataller: "Spain became an international benchmark in terms of health and wellness, where tourists are looking

for their time to be relevant and for the experience to affect them" (Hosteltur, 2019). Some private hospitals offer "total orientation" of the entire hospital towards the international patient, who "travels, who seeks excellent care with as little bureaucracy as possible, and who must find at their disposal all the amenities for transfer and treatment, including translation services" (20minutos, 2018). Up to 140,000 visitors underwent health treatments or interventions in private healthcare centres of our territory in 2019 ("Turismo de salud: 1.000 millones de euros de impacto económico", 2020). In terms of economic estimates, according to a report by Spaincares, the Spanish Health Tourism Cluster in Spain, this type of tourism accounted for a turnover of 500 million euros in 2017. It was expected that in 2020 this country will have been visited by 200,000 medical and wellness tourists, achieving a contribution to the Spanish economy of around 1 billion euro ("Turismo de salud: 1.000 millones de euros de impacto económico", 2020).

According to EOI (2013), those who are on holiday and require emergency care for an illness or accident and whose care is either guaranteed by the European Health Insurance Card (in the case of European citizens), or by private insurance companies with international coverage are not medical tourists. Neither are patients who take advantage of their sojourn in Spain in order to obtain free treatment from the Spanish public health system (as opposed to the co-payment or payment required in their countries of origin). According to the same source, they commit fraud by spending more than 6 months in Spain to gain access to the Spanish health card or by going to the emergency room in order to get treated free of charge and/or circumvent long waiting lists. As reported by El Economista.es (Vigario, 2018), the government of former prime minister Mariano Rajoy aimed to eliminate this health tourism fraud. The health reform (Real Decreto 16/2012) was put in place in order to put an end to the health paradise that Spain was at that time for foreigners, although it ended up affecting immigrants in an irregular situation as well. Real Decreto-ley 7/2018, of 27th of July, on universal access to the National Health System approved by the new socialist government of Pedro Sánchez is intended to universalise free healthcare for all foreigners in Spain, including undocumented immigrants. Thus, all the immigrants residing in Spain, including those in an irregular situation, as well as all Europeans residing in Spain have been granted by the virtue of the new Royal Decree the health card of Social Security, thus turning the country into a health paradise despite the risk of re-emergence of the health tourism fraud or fraudulent health tourism (*turismo sanitario fraudulento*) (El Economista.es in 2018). According to the Valencian Regional Ministry of Health, the direct charging of foreign patients without coverage will mean a saving of 10 million euros, which could be passed on to the Valencian private health system (EOI, 2013, p. 96). Nevertheless, a report by the Court of Auditors established a difference of millions of euros between what Spain netted for health care to foreigners and what it reimbursed for health care received by Spaniards abroad. In 2009, Spain had a turnover of 441.1 million Euros to 26 EU countries plus Iceland, Liechtenstein, Norway and Switzerland for medical care provided to citizens of these countries, while the cost of care provided to Spanish citizens abroad amounted to 46.2 million. This is a difference that, according to the court, renders Spain as an eminent receptor of foreign tourists and residents (EOI, 2013, p. 96).

On the contrary, private patients who schedule their treatment through medical tourism facilitators, or are sent by international insurers who know that they can offer their subscribers the same service and a holiday for considerably less money than what is paid for therapy in their own countries are indeed medical tourists (EOI, 2013, p. 13). Similarly, European, mainly Nordic, patients sent by their respective countries of origin to Spain through interinstitutional cooperation agreements are also medical tourists being offered this opportunity as a solution to the government's and hospital's inability to cut waiting list (EOI, 2013, p. 13). Lunt and Carrera (2010 in EOI, 2013, pp. 114-115) portray health tourists as middle-aged, in the 40-55 age bracket. Older people tend to have greater financial autonomy (no burdens such as mortgages) and greater freedom to travel (no young children). It is worth noting, without overgeneralising though, that older health tourists focus on medical tourism, whereas younger health tourists are mainly looking for specialities related to cosmetics and mental wellbeing (alternative therapies) (EOI, 2013, pp. 114-115).

It must be pointed out that residential tourists, although they are not health tourists, according to experts they are one of the natural prescribers of the health services offered in Spain, so that it has been observed that, once they have become aware of the excellence of the Spanish health services, they may recommend it to a relative or acquaintance in their country of origin. Moreover, in some ways, they may be health tourists, in that on certain occasions, their main reason for travelling to their residence may be to receive health treatment, with the advantage for them of having a residence (EOI, 2013, pp. 114-115). Thus, their profile may partially coincide with that of health tourist. According to the same source, these residential tourists have availability of free time, possess high level of income and qualifications, and spend most of the year, especially the winter season in Spain and return to their countries of origin in summer. In short:

> The residential tourist can be defined as the "result of a satisfied and loyal holiday tourist" (PDO, 1997,360), who found in the possession of a home during his time as a tourist a mechanism for his location, permanent or seasonal, on the coast as a retired person (Williams et al., 2000). In short, tourism that offers high temporary mobility acts either as a precursor or a substitute for subsequent migration. (Bell & Ward, 2000) (EOI, 2013, p. 114-115)

Assisted reproduction, deserves in my opinion special mention. Ley 14/2006 is one of the most comprehensive and permissive laws to have ever existed in the EU. Apart from surrogacy and gender selection, the following human reproduction techniques are fully authorised and regulated by the above mentioned law: artificial insemination, in vitro fertilisation (IVF), intracytoplasmic sperm injection (ICSI) with own or donor gametes, sperm donation, egg/oocyte donation, embryo donation always safeguarding donors' anonymity, embryo transfer (up to 3 embryos), intrafallopian gamete transfer, embryo cryopreservation, and preimplantation genetic diagnosis (PGD) to select embryos for therapeutic purposes (detection of serious hereditary diseases, of early onset and not susceptible to postnatal curative treatment and detection of other alterations that may compromise the viability of the embryo and therefore result in implantation failure). The law does not specify an age limit for a fertility treatment to be carried out (Ley 14/2006). The Spanish Fertilisation Society (SEF) estimated that the success rate of treatments for both fertilisation and pregnancy in Spain is better than in third countries (32.2% - 40.2% for in vitro fertilisation with own eggs in women between 35 and 39 years of age) (EOI, 2013, p. 26). Spain

is also one of the countries with the highest pregnancy rates, 50-70% (Espiño, 2005 in EOI, 2013, p. 103). Apart from lax legislation Spain offers very competitive prices (an in vitro fertilisation cycle in the USA costs 9,500 euros, whereas in Spain the maximum is 6,000 euros) (EOI, 2013, p. 103). The majority of patients come from Italy, Germany, France, Portugal, Great Britain and Sweden (EOI, 2013, p. 103). Spanish reproductive or fertility tourism is fully adapted to welcome practically all family models (heterosexual couples with male or female infertility, lesbian couples, single mothers, gay couples, single parents).

With liposuction, eyelid surgery, abdominal surgery, breast augmentation, rhinoplasty and reconstructive plastic surgery being the most sought-after specialities, cosmetic surgery places Spain in the 4th position worldwide and 1st in Europe (EOI, 2013, p. 26). It is also worth mentioning that the most common procedure in traumatology is hip and knee prostheses geared towards senior patients (EOI, 2013, p. 26). Medical check-ups are also very popular diagnostic and preventive exploration methods (EOI, 2013, p. 26).

Currently, the private hospital sector amounts to 452 hospitals in Spain with a total of 51,591 beds. According to the data collected by the IDIS Foundation, these figures represent 57% of all medical centres and 33% of all hospital beds in the country . [Tourism constitutes an essential anchor of Spanish economy [...]" (Belinchón, 2020) as it accounts for no less than 13% of the country's total GDP and contributes 12.7% of total employment, with nearly 2.7 million workers (Belinchón, 2020), thereby ranking as the third highest contributor to its economy. In 2019 Spain has beaten a seventh consecutive record in terms of historic figures in international tourism. 83.7 million international travellers were reported to have visited Spain in 2019 (Hosteltur, 2020). Their expenditure amounted to 92,337 million euros (Hosteltur, 2020).

2.2.3. Medical interpreting and medical travel

After having defined the most relevant concepts related to medical travel and after having described the current state of affairs in Spain in this regard, I shall now proceed to analyse the role of interpreting against this backdrop. Woodman (2015) wrote for the *Sun Journal* that "successful hospitals have the basics down when it comes to foreign patients: interpreters, familiar foods, cultural sensitivity. They also have a stellar medical reputation, are easy to get to and, often, have cultural or medical relationships with the sending country".

Many private hospitals located in the Spanish geographical region of Costa Blanca meet the requirements to obtain prestigious international accreditation certificates, however, they neglect the salience of the quality of interpretating in spite of the overwhelming proportions of foreign patients. According to Martínez (2008), some private hospitals in the Valencian Community offer specific services geared towards the nationals or residents of particular countries. These services seek to cater for the idiosyncrasies of care of each nationality treated at the medical facility in question. These services include interpreting delivered by multilingual medical and administrative staff as well as by polyglot interpreters. In such settings, in-house interpreters come from very diverse educational backgrounds meaning that they may have accomplished training programmes other than translation and interpreting, which may include secondary education (Spanish *bachillerato* equivalent to British A-levels) and sometimes higher education (undergraduate and postgraduate university degrees). The personnel hired to undertake other functions, be it of clinical

or non-clinical nature, do have the necessary training to perform these functions, but lack specific training to undertake interpreting assignments (Martínez-Gómez, 2008, p. 1051). Thus, the hospital workers who receive the assignment to interpret are mostly never properly prepared for it.

In addition, the majority of in-house non-professional interpreters consider training in T&I to be totally irrelevant, since in their opinion the best way to learn is on-the-job training. Martínez-Gómez corroborates the above statement by saying that the in-house interpreters currently practicing in the study-relevant field are self-taught (Martínez-Gómez, 2008, p. 1051).

It should be noted that if the hospital administration and the procurement managers decide to hire interpreters, be it graduates in T&I or bilinguals lacking training in MI, this service provision will generate undesirable costs for the hospital to shoulder.

Nevertheless, as maintained by Angelelli:

> The Spanish private sector would "definitely be interested in exploring the potential offered by the Directive and by medical tourism" (ES Inf 9) They would combine medical care and good weather in an attractive formula especially if communication is not perceived as a deterrent (ES Site 11). Interestingly, in private clinics observed there were bilingual staff and professional interpreters as they recognise the importance of communicating with patients in their own language. Their interest in marketing services though is not limited to other MSs, as they also receive many patients from the Middle East and China and they are planning to be more aggressive in attracting patients from those regions. (Angelelli, 2015, p. 35)

The percentage of foreign patients in some private medical institutions of Costa Blanca exceeds 80% (HCB, 2016) this is because these private facilities are specialised centres geared towards foreign-speaking patients[14] (EOI, 2013, p. 101). other private healthcare facilities located in the Valencian Community report that around 50% of their patients are foreigners (IMED, 2016). Other clinics located in the same geographic area publicise a somewhat lower percentage of foreign patients willing to undergo a treatment at their facility, which ranges between 18% and 20% (IB, 2007, IVI, 2016 respectively). One of the above mentioned centres (IVI, 2016) has stated that patients from more than 90 countries have received treatment within their premises. The vast majority of them came from Italy, France, England, Germany and Switzerland (IVI, 2016). Hospital Clinica Benidorm located in the Costa Blanca region has reported that 45% of their patients come from Holland, 22% from the UK, 14% from Germany and Switzerland, 12% from Scandinavia, and 7% from Russia. According to Pellicer-Vidal, in 2016, the privately managed public hospital Marina Salud Hospital of Denia was reported to have treated 25% of patients coming from England, another 25% of patients whose country of origin was Germany, 10% were from Netherlands, 10% were Russians, and another 10% came from the USA, the remaining 20% were from other unspecified countries (Pellicer-Vidal, 2016, p. 4).

Therefore, Angelelli (2015, p. 44) maintains that without language support high quality care is extremely difficult to safeguard. Nonetheless, there were not many examples of in-house professional translation and interpreting services that would meet the expectations of patients and providers (Angelelli, 2015, p. 46).

[14] It was reported by Funes in 2015 (p. 64) that the percentage of foreigners attending some private medical centres in the Western Costa del Sol reaches over 65 %, whereas the public centres reported the figure of 30%.

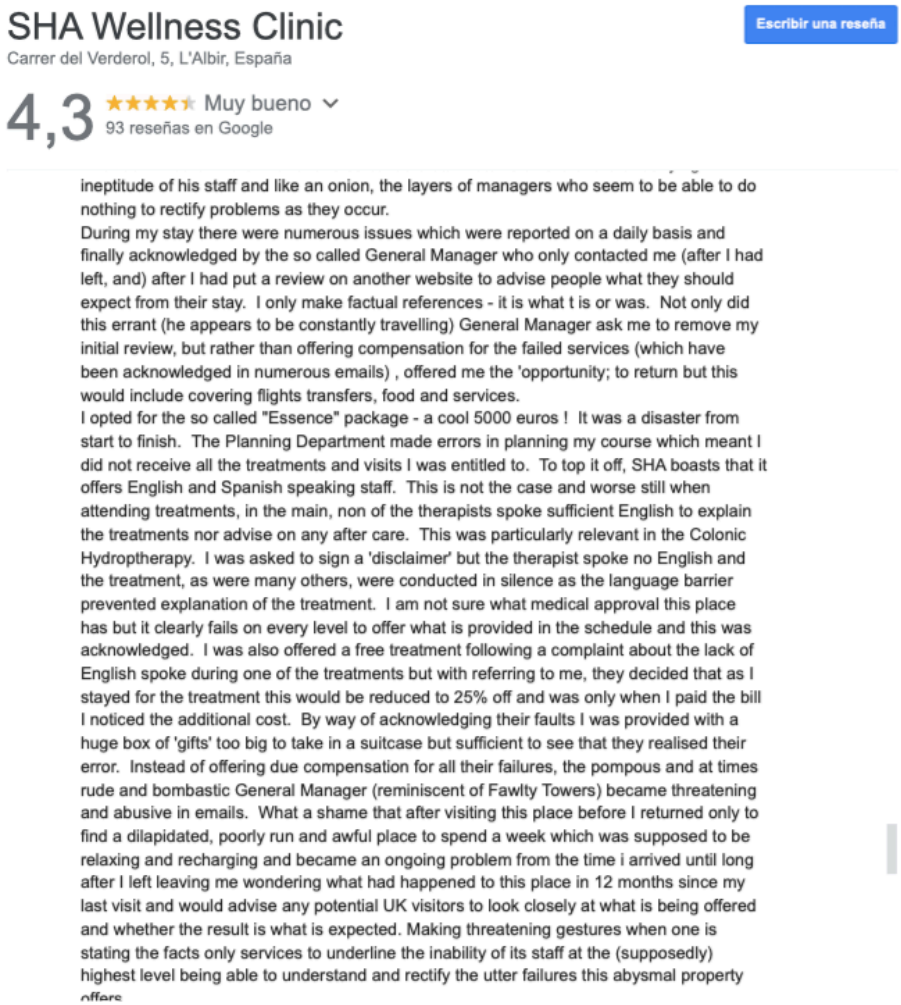
According to EOI report, Alicante –a major receptor of tourists coming from the UK, Nordic countries, Netherlands and France, which belongs to the study-relevant area of the Valencian Community–, has an important infrastructure in private healthcare based on its tradition as an international tourist destination. Therefore, the services that their medical centres offer are not limited to medical procedures, but may also include "*complementary* services typical of tourist intermediation, such as the management of the trip to Spain (booking and contracting of flights, processing of visas, accommodation, transfers, *personal assistant-interpreter*, assistance to family members, excursions, etc.)" (EOI, 2013, p. 42, emphasis added). It is interesting how this report views interpreting as a "complementary service" and how professional identity is being remodelled into "personal assistant-interpreter" to suit the market demand.

The SHA Wellness Clinic positions itself as a "medical hotel" and constitutes a major representative of Spanish wellness tourism. It is a worldwide pioneering wellness clinic located in Albir (Alicante), which is dedicated to improve people's health and wellbeing. In addition to wellness therapies, it includes a clinical area with services in anti-aging medicine, aesthetic medicine, dental aesthetics, sleep medicine and an anti-smoking unit. Its offer is mainly aimed at foreigners (EOI, 2013, p. 26), however some of their patients complain about unsurmountable language barriers. I found several interesting reviews on Google Reviews, but one in particular has caught my attention and I feel it is worth sharing. This excerpt is the most important part of the review:

> To top it off, SHA boasts that it offers English and Spanish speaking staff. This is not the case and worse still when attending treatments, in the main, non of [sic] the therapists spoke sufficient English to explain the treatments nor advise on any after care. This was particularly relevant in the Colonic Hydroptherapy. I was asked to sign a 'disclaimer' but the therapist spoke no English and the treatment, as were many others, were conducted in silence as the language barrier prevented explanation of the treatment. I am not sure what medical approval this place has but it clearly fails on every level to offer what is provided in the schedule and this was acknowledged. (Anonymised Google review, 2019)[15]

[15] https://bit.ly/3EmLtaT

Figure 4. Original screenshot 1


SHA Wellness Clinic

Escribir una reseña

Carrer del Verderol, 5, L'Albir, España

4,3 ★★★★½ Muy bueno

93 reseñas en Google

ineptitude of his staff and like an onion, the layers of managers who seem to be able to do nothing to rectify problems as they occur.
During my stay there were numerous issues which were reported on a daily basis and finally acknowledged by the so called General Manager who only contacted me (after I had left, and) after I had put a review on another website to advise people what they should expect from their stay. I only make factual references - it is what t is or was. Not only did this errant (he appears to be constantly travelling) General Manager ask me to remove my initial review, but rather than offering compensation for the failed services (which have been acknowledged in numerous emails) , offered me the 'opportunity; to return but this would include covering flights transfers, food and services.
I opted for the so called "Essence" package - a cool 5000 euros ! It was a disaster from start to finish. The Planning Department made errors in planning my course which meant I did not receive all the treatments and visits I was entitled to. To top it off, SHA boasts that it offers English and Spanish speaking staff. This is not the case and worse still when attending treatments, in the main, non of the therapists spoke sufficient English to explain the treatments nor advise on any after care. This was particularly relevant in the Colonic Hydroptherapy. I was asked to sign a 'disclaimer' but the therapist spoke no English and the treatment, as were many others, were conducted in silence as the language barrier prevented explanation of the treatment. I am not sure what medical approval this place has but it clearly fails on every level to offer what is provided in the schedule and this was acknowledged. I was also offered a free treatment following a complaint about the lack of English spoke during one of the treatments but with referring to me, they decided that as I stayed for the treatment this would be reduced to 25% off and was only when I paid the bill I noticed the additional cost. By way of acknowledging their faults I was provided with a huge box of 'gifts' too big to take in a suitcase but sufficient to see that they realised their error. Instead of offering due compensation for all their failures, the pompous and at times rude and bombastic General Manager (reminiscent of Fawlty Towers) became threatening and abusive in emails. What a shame that after visiting this place before I returned only to find a dilapidated, poorly run and awful place to spend a week which was supposed to be relaxing and recharging and became an ongoing problem from the time i arrived until long after I left leaving me wondering what had happened to this place in 12 months since my last visit and would advise any potential UK visitors to look closely at what is being offered and whether the result is what is expected. Making threatening gestures when one is stating the facts only services to underline the inability of its staff at the (supposedly) highest level being able to understand and rectify the utter failures this abysmal property offers

Figure 5. Original screenshot 2

This is not to expose the lack of medical interpreters in one of country's largest medical hotels, but to draw the reader's attention to the patient's awareness of the importance of proper communication in medicine. This patient's allegation on the clinic's failure to deliver on English proficiency of their staff is diagnostic of patient's cognisance of the necessity to communicate with the cross-border provider and of the implications such lack of communication may carry.

Despite the exponentially increasing demographic need, only a few private hospitals have interpreters to meet the needs of their cross-border patients. While the public sector is not interested in having interpreters, the private sector is oriented towards health tourism, which means that private hospitals use interpreting services as a PR mechanism to increase competitiveness. Nevertheless, the problem is that some practitioners from the private sphere disregard the availability of interpreting services and opt for conducting the consultation in the patient's language in spite of the fact that they actually struggle to communicate. The free access to profession constitutes another major concern. Candidates who have not successfully accomplished a university training in Translation and Interpreting and therefore lack professional qualifications have no impediments whatsoever to access the marketplace. The lack of professionalisation of interpreting implies leeway as to who can be hired. The lack of control and the lack of awareness regarding

the seriousness of this situation constitute key factors that favour the proliferation of professional encroachment, which in turn spurs and exacerbates devaluation of this occupation.

It is clear that the lack of professional language provision services needs to be contended with as soon as possible, but this problem is just a symptom diagnostic of far more complex socio-cognitive and socio-psychological processes underpinning such lack of professional recognition.

3. MEDICAL INTERPRETING AND THE LAW

In this section I shall focus on determining whether the existing barriers to communication have been taken into account when contemplating the applicability of the domestic and foreign legislative instruments to the current socio-demographic reality. To that end, it is necessary to recap on the main points of the international, EU, domestic and regional legislation.

It needs to be noted that the demand for cross-border healthcare among European citizens and residents has been showing exponential growth up until 2020. During the summer of 2020 Spain lost 83% of international tourists due to the Covid-19 pandemic. It was reported that in 2019 more than 83 million tourists visited Spain, whereas in 2020 this number drastically plummeted to scarcely 17 million (Lara, 2020). Nevertheless, according to some forecasts health tourism might be the first branch of tourism to actually get reanimated and recuperate from the devastating economic consequences. According to a Spanish financial newspaper ("El turismo de salud crece con la pandemia", 2020), medical tourism was expected to grow in the following months. But even though there was a patent decrease in tourism and health tourism, the residential tourists as well as regular residents were still in need of language provision services, although professional interpreters were never hired to deal with this need. The Covid-19 pandemic has not triggered a cognizance of and sensitisation to the problem of language barriers in Spanish healthcare. Thus, the state of affairs before the pandemic remains unaltered today.

Angelelli (2015) and Gavlovych and Blasco-Mayor(2020) claimed that the nihility of all-encompassing pan-European statutory regulations concerning proper language provision, jeopardises equal access to medical information and consequently and seriously challenges patients' entitlement to universalised quality healthcare procurement. A series of vital language support services have been withheld or withdrawn from the patients undermining the accomplishment of cornerstone medical processes including scrutiny of existing medical records, anamnesis, reimbursement paperwork, proper medical examination and medical consultation, thus, downgrading and reducing patient-centrered non-paternalistic care to de-humanised "médécine vétérinaire [veterinary medicine]" (Clark, 1983; Bowen, 2001, cited in Cox & Lázaro, 2016, p. 50), where the patient has no other choice but to defer to the medical team on their wellbeing and pray that they have guessed the diagnose and treatment.

I shall start by unpacking one international document:

1. The Economic and Social Council of the United Nations (The UN Committee on Economic, Social and Cultural Rights, 2000)

A series of documents constituting the EU legal framework:

1. European Charter of Patients' Rights (2002)
2. The Regulation (EC) 883/2004 of the European Parliament and of the Council on the coordination of social security systems lays down "norms and competencies for the provision of healthcare to certain classes of cross-border patients" (Angelelli 2015, pp. 15-20).

3. Europe – Amsterdam Declaration Towards Migrant Friendly Hospitals, Migrant Friendly Hospitals Project (2004)
4. The four principles of the White Paper Together for Health: A Strategic Approach for the EU 2008-2013 presented by the Commission in 2007
5. The Directive 2011/24/EU intends to clarify the legal relationship between patients' rights and cross-border healthcare (Angelelli 2015, pp. 15-20)
6. Charter of Fundamental Rights of the European Union (2012/C 326/02), and more specifically Title III – Articles 20 – 21 and Title VI –Articles 47 – 50. This Charter upholds the rights which the citizens are entitled to.

With regard to Spanish legislation I have curated a list of study-relevant legal norms and provisions encompassing articles from the Spanish Constitution, Royal Decrees, and Organic Laws:

1. Article 43 of the *Constitución Española* (Spanish Constitution, 1978)
2. *Ley Orgánica 4/2000, de 11 de enero, sobre derechos y libertades de los extranjeros en España y su integración social* [On the rights and freedoms of foreigners in Spain and their social integration]
3. *Ley 41/2002, de 14 de noviembre, básica reguladora de la autonomía del paciente y de derechos y obligaciones en materia de información y documentación clínica* [Basic regulation of patient autonomy and of rights and obligations regarding clinical information and documentation]
4. *Ley 16/2003, de 28 de mayo, de cohesión y calidad del Sistema Nacional de Salud* [Cohesion and Quality of the National Health System]
5. *Real Decreto 1030/2006, de 15 de septiembre, por el que se establece la cartera de servicios comunes del Sistema Nacional de Salud y el procedimiento para su actualización* [Establishing the common services portfolio of the National Health System and the procedure for updating it]
6. *Ley 15/2008, de 5 de diciembre, de integración de las personas inmigrantes en la Comunitat Valenciana* [On the integration of immigrants in the Valencian Community]
7. *Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones* [On urgent measures to guarantee the sustainability of the National Health System and improve the quality and safety of its services]
8. *Real Decreto 81/2014, de 7 de febrero, por el que se establecen normas para garantizar la asistencia sanitaria transfronteriza, y por el que se modifica el Real Decreto 1718/2010, de 17 de diciembre, sobre receta médica y órdenes de dispensación* [Establishing rules to ensure cross-border healthcare and amending Real Decreto 1718/2010 of 17 December on medical prescriptions and dispensing orders]
9. *Real Decreto-ley 7/2018, de 27 de julio, sobre el acceso universal al Sistema Nacional de Salud* [On universal access to the National Health System]

In terms of the regional legislation, the following legal provisions will be thoroughly scrutinised:

1. DECRET 93/2009, de 10 de juliol, del Consell, pel qual s'aprova el Reglament de la Llei 15/2008, de 5 de desembre, de la Generalitat, d'Integració de les Persones Immigrants en la Comunitat Valenciana [Approving the Regulations of Ley 15/2008, of 5 December, of the Generalitat, on the Integration of Immigrants in the Valencian Community]. [2009/8340])
2. ORDE 8/2011, de 19 de maig, de la Conselleria de Solidaritat i Ciutadania, per la qual es regula l'acreditació de la figura del mediador/a intercultural i el Registre de Media- dors Interculturals de la Comunitat Valenciana. [2011/6009] [Which regulates the accreditation of the figure of the intercultural mediator and the Registry of Intercultural Mediators of the Valencian Community]
3. Ley 10/2014, de 29 de diciembre, de Salud de la Comunitat Valenciana [On Health of the Valencian Community]

3.1. INTERNATIONAL AND EU LEGISLATION

I would like to start by saying that Directive 2010/64/EU of the European Parliament and of the Council of 20 October 2010 on the right to interpretation and translation in criminal proceedings was a major inspiration for this section. This Directive mirrors the tenets displayed in the European Convention on Human Rights (European Court of Human Rights, 1950), more specifically:

- article 5, which reads as follows: "Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him" (Article 5, Right to liberty and security, p. 8)
- article 6, which reads as follows: "Everyone charged with a criminal offence has the following minimum rights: (a) to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him; [...] (e) to have the free assistance of an interpreter if he cannot understand or speak the language used in court." (Article 6, Right to a fair trial, p. 10)
- article 14 emphasises that: "The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status".

The mentioned EU Directive decrees and stipulates in its article 14 that:

> The right to interpretation and translation for those who do not speak or understand the language of the proceedings is enshrined in Article 6 of the ECHR, as interpreted in the case-law of the European Court of Human Rights. This Directive facilitates the application of that right in practice. To that end, the aim of this Directive is to ensure the right of suspected or accused persons to interpretation and translation in criminal proceedings with a view to ensuring their right to a fair trial. (Directive, 2012/64/EU, art. 14)

Article 2 dilates on the applicability of the right to interpretation by pointing out that upon ascertaining that the suspected or accused party displays limited proficiency of the societal language (art. 21) via specific procedure or mechanism put in place for such purpose (art. 2.1), the party concerned must be provided with the service "without delay" and the areas of intervention encompass "criminal proceedings before investigative and judicial authorities, including during police questioning, all court hearings and any necessary interim hearings". As regards translation, the party with limited Spanish proficiency must be purveyed with "a written translation of all documents which are essential to ensure that they are able to exercise their right of defence and to safeguard the fairness of the proceedings". The translation must be conducted into the native language of the suspected or accused (art. 22).

Interestingly enough, article 5 addresses the issue of quality of the services being provided:

> Member States shall ensure that, in accordance with procedures in national law, suspected or accused persons have the right to challenge a decision finding that there is no need for interpretation and, when interpretation has been provided, the possibility to complain that the quality of the interpretation is not sufficient to safeguard the fairness of the proceedings. (Directive, 2012/64/EU, art. 5)

The language assistance must be purveyed free of charge (art. 17): "Executing Member States should provide, and bear the costs of, interpretation and translation [...]" (art. 15).

The situation in the medical field in Spain, however, is very different. In spite of the fact that many legislative instruments mention the importance of non-discrimination on the basis of language, none specifies how to ensure fair and equitable access to healthcare.

The Economic and Social Council of the United Nations (2000) details that by virtue of the article 12 of the International Covenant on Economic, Social and Cultural Rights every person is entitled to the healthcare procurement of the highest attainable standard. Thus, all health-related discrimination on the grounds of language must be outlawed. This legal document also highlights that: "health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds":

> By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. (United Nations, Economic and Social Council, 2000)

Article 12.2(d) advocates for "*the creation of conditions* which would assure to all medical service and medical attention in the event of sickness" (my italics) and "provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities [...] provision of essential drugs; and appropriate mental health treatment and care".

> The Committee stresses that many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information.

> [...] even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes. (United Nations, Economic and Social Council, 2000)

The authors of the European Charter of Patients' Rights (Cittadinanzattiva-Active Citizenship Network group, 2002, pp. 1-2) decry the fact that: "Despite solemn declarations on the "European Social Model" (the right to universal access to health care), several constraints call the reality of this right into question" as these rights "can be affirmed in theory, but [are] then denied in practice, because of financial limits". The authors went on to say that the reification, materialisation and pragmatisation of these inalienable universal rights, which transcend citizenship cannot be denied, compromised, limited or waived due to "financial constraints" (Cittadinanzattiva-Active Citizenship Network group, 2002, pp. 1-3). The authors also deprecate the fact that despite having been established by law and "asserted in electoral programmes", these rights are "forgotten after the arrival of a new government", and therefore are not respected, delivered on, provided for, subject to transposition, translated into concrete procedures and guarantees or conformed to by the domestic legislation (Cittadinanzattiva-Active Citizenship Network group, 2002, pp. 1-3). All of these rights are aimed at empowering patients by encouraging patient participation in the decision-making process which affects their life, health and wellbeing (Cittadinanzattiva-Active Citizenship Network group, 20022, pp. 1-3). Since all these rights seek to guarantee a "high level of human health protection" (Cittadinanzattiva-Active Citizenship Network group, 2002, Article 35 of the Charter of Fundamental Rights, p. 3) it is essential that they be "rendered applicable" and enacted. Ten out of fourteen rights cannot be safeguarded without professional interpreting service in the case of foreign-speaking patients. Thus, the European Charter of Patients' Rights (Cittadinanzattiva-Active Citizenship Network group, 2002) advocates for a universal and equal right to access a proper preventive care service irrespective of the patients' financial resources, place of residence, kind and severity of illness, etc.; right to access all health services (inpatient, outpatient) that the patient may be in need of irrespective of whether the disease they are suffering from is common or rare; right to access all patient-tailored information related to the healthcare system in general and the patients' state of health in particular; right to receive information conveyed in intelligible, fathomable and cognoscible way without technical verbalism and prolixity, which would enable informed and active participation in the decision-making process; right to free, informed choice of therapies, primary care doctors, specialists and facility; right to the observance of quality standards of care in terms of technical performance, comfort and human relations; right to safety and reification of the main precept in medicine *primum non nocere* through monitorisation of risk factors (such as miscommunication) and (language-related) precedents of medical malpractice, maladvice and medical errors stemming from language barriers (please see Flores, 2006; Moreno et al., 2007; Elderkin Thompson et al., 2001, Meyer at al., 2010; Wang, 2016; Quan, 2010); right to personalised, patient-tailored and patient-centred diagnostic and therapeutic procedures adjusted to the individual patient's needs; right to complain and take legal action and pursue alternative dispute resolution; right to compensation of physical, psychological and moral damage suffered by the patient (European Charter of Patients' Rights, 2002, pp. 3-8). I would like to reiterate that the compliance with these ten rights is in my opinion particularly difficult (not to say impossible) without proper language service.

> The Charter of Fundamental Rights contains many provisions that refer either directly or indirectly to patients' rights, and are worth recalling: the inviolability of human dignity (article 1) and the right to life (article 2); the right to the integrity of the person (article 3); the right to security (article 6); the right to the protection of personal data (article 8); the right to non-discrimination (article 21); the right to cultural, religious and linguistic diversity (article 22); the rights of the child (article 24); the rights of the elderly (article 25); the right to fair and just working conditions (article 31); the right to social security and social assistance (article 34); the right to environmental protection (article 37); the right to consumer protection (article 38); the freedom of movement and of residence (article 45). (Cittadinanzattiva-Active Citizenship Network group, 2002, p. 2)

The Regulation 883/2004 covers cross-border healthcare for those who are willing to undergo treatment abroad and medical assistance overseas for those who sustain injuries or develop a work-related disease residing abroad. Art. 20 on Travel with the purpose of receiving benefits in kind — authorisation to receive appropriate treatment outside the Member State of residence of the Regulation 883/2004 (p. 20) reads as follows:

> An insured person who is authorised by the competent institution to go to another Member State with the purpose of receiving the treatment appropriate to his/her condition shall receive the benefits in kind provided, on behalf of the competent institution, by the institution of the place of stay, in accordance with the provisions of the legislation it applies, as though he/she were insured under the said legislation. The authorisation shall be accorded where the treatment in question is among the benefits provided for by the legislation in the Member State where the person concerned resides and where he/she cannot be given such treatment within a time limit which is medically justifiable, taking into account his/her current state of health and the probable course of his/her illness.

The text of the Regulation further speifies that there shall be no exception for "person who has sustained an accident at work or has contracted an occupational disease and who resides or stays in a Member State other than the competent Member State", as they "shall be entitled to the special benefits [...] by the institution of the place of residence" (Regulation 883/2004, Chapter 2, Art. 36, p. 27). However, this legislative enactment of cross-border healthcare does not foresee possible mechanisms of its successful implementation, thus completely overseeing possible safety contingencies.

According to the Amsterdam Declaration "Towards Migrant-Friendly Hospitals in an ethnoculturally diverse Europe":

> *Health care services are not responsive enough to the specific needs of minorities.* There are many challenges facing both service users and providers. Examples include not only *language barriers and cultural diversity*, but also scarcities in hospital resources and low levels of minority purchasing power and entitlements. All this poses new challenges for quality assurance and improvement in health services - especially for hospitals which play a particularly important role in serving this segment of the population (MFH Project Group in the framework of the European Commission project Migrant Friendly Hospitals, 2004).

The main rationale behind such failure to respond to an exponentially increasing need and an absence of reaction thereto on the part of health policymakers and administration/procurement managers responsible for the compliance with the international and domestic quality standards in health care may be due to the lower levels of health literacy among migrants, language barriers, cultural diversity, scarcities in hospital resources, low levels of minority purchasing power and entitlements (he same document reports that interpreting as well as the acquisition of

cultural competence by the hospital staff via specific training courses may be a successful way to address the problems mentioned above, but the first step towards the implementation of such measures is of course the acknowledgement and recognition of the relevance and germaneness thereof and the preparedness to invest in achieving competency (Amsterdam Declaration, 2004).

The White Paper "Together for Health: A Strategic Approach for the EU 2008-2013" reports that the Council has identified four overarching common values and principles in EU healthcare systems: universality, access to good quality care, equity and solidarity (European Commission, 2007, p. 3).

Angelelli has conducted an extensive investigation into public service translation against the backdrop of cross-border healthcare in 2015 and her report of this transnational research focuses on detailing the current situation of translation and interpreting in the medical field in both public and private sectors against the backdrop of migration, tourism and medical tourism. This study has been conducted within the framework of the EU. Five Member states participated in this project: Germany, Greece, Italy, Spain, United Kindgdom. Angelelli clearly indicated that neither the Directive 2011/24/EU nor other EU legal instruments contemplate *how* exactly foreign-speaking patients are supposed to access information or communicate with medical personnel in a language that they do not understand:

> None of the documents constituting the EU framework (i.e. the Directive, the Charter of Fundamental Rights of the European Union, the Treaty on the Functioning of the European Union or the Regulation 833/2004) explicitly refer to language provision for EU citizens or legal residents pursuing healthcare in Member States in which they cannot access the information. In the absence of a clear EU legislative guidance, the pertinent legislation of each MSs that participated in this study varies considerably. In most cases there is not any legislation that guarantees comprehensive language services to patients. (Angelelli, 2015, p. viii)

Given that "The Charter of Fundamental Rights recognises citizens' right of access to preventive healthcare and the right to benefit from medical treatment" displayed in art. 35 on healthcare (OJ C 364, 2000) and in UN Universal Declaration of Human Rights the UN International Covenant on Economic, Social and Cultural Rights and the European Convention on Human Rights in Biomedicine, the Commission advocates for citizens' empowerment, patient-centredness and individualised care implemented through envisaging the patient as an "active subject rather than a mere object of healthcare" and foregrounding their rights "as a key starting point" (Commission of the European Communities, 2007, pp. 3-4). According to the Commission, these rights are based on an active "participation in and influence on decision-making, as well as competences needed for wellbeing, including 'health literacy' [...]" (Commission of the European Communities, 2007, p. 4).

In the same vein, the Charter of Fundamental Rights of the European Union (2012/C 326/02) suggests in Title III art. 21 that "Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited" (The European Parliament, the Council and the Commission, 2012, title III, art. 21.1).

Thus, private clinics are displaying interest and eagerness to "explore possibilities" by attracting patients from foreign countries, even though "language provision as a line item is only included in some (not all) private sites", whereas "most budgets of observed public administrative bodies managing healthcare neither plan nor allocate funding for language support" (Angelelli, 2015, p. 93). Therefore, one can deduce that the provision of translation and interpreting services is perceived as overpriced and redundant and peripheral splurge rather than an essential instrument to safeguard access, safety and quality of care. Impromptu practices by *ad hoc* bilinguals who perform linguistic mediation rather than professional services do not seem to be a responsible way of addressing the linguistic needs of the diverse population of the European Union. As maintained by Angelelli: "Bilingual staff whose degree of proficiency in both languages and translation/interpreting skills cannot be verified should not be required to perform the duties of translators, interpreters or cultural mediators. They should first be afforded appropriate professional development opportunities" (2015, p. IX). In the absence of proper statutory regulations superintending recruitment criteria and monitoring quality, the foreign-speaking patients (both residing, sojourning and seeking cross-bored care in Spain) remain unprotected against crippling medical errors (Flores, 2006; Moreno et al., 2007; Elderkin Thompson et al., 2001, Meyer at al., 2010; Wang, 2016; Quan, 2010, just to mention a few), which violate patients' right to quality care and non-discrimination. As maintained by Angelelli, "If patients cannot access healthcare services in a language they fully understand, equal access to safe and high-quality healthcare is not guaranteed" (Angelelli, 2015, p. IV).

3.2. DOMESTIC LEGISLATION

In this section I shall be focusing on the national legislative instruments. The article 43 of the Spanish Constitution recognizes the right to health protection, whereby the public authorities are rendered responsible for organising and protecting public health through preventive measures and the necessary benefits and services.

The articles set out in Ley Orgánica 4/2000 were developed against the backdrop of massive international migrations triggered by globalisation and internationalisation of labour markets. Spanish policy-makers sought to be responsive to the needs of its nested assemblages characterised by linguistic and cultural diversity. Led by cognitive proximity, geographic proximity, institutional proximity, informational proximity and social proximity different migrants made their destination choice[16] in favour of Spain. Thus, with Spain being a major destination point for the *Gastarbeiter* and their families who were granted the entitlement to become holders of temporary residence permits by virtue of the family reunification initiative, refugees and residential tourists, Spanish policy-makers had to regulate and regularise the foreigners' access to medical services. Therefore, of 11 January on the rights and freedoms of foreigners in Spain and their social integration was designed to equalise the immigrants' right to access the national the Social Security system. According to the subsection i) of the article 2bis: "equal treatment in terms of working and social security conditions" is essential to outlaw discrimination. Article 14 in its subsection

[16] More information on multi-proximity phenomenon can be found here: https://www.peak-urban.org/publications/how-multi-proximity-affects-destination-choice-onward-migration-nested-logit-model

1 provides that foreign nationals residing in Spain have the right to access Social Security benefits and services under the same conditions as Spaniards. The same article (subsection 2) specifies that foreign residents are entitled to social services and benefits, both general and basic as well as specific, under the same conditions as Spaniards. In any case, foreigners with disabilities, under the age of eighteen, who have their habitual residence in Spain, shall be entitled to receive the special treatment, services and care required by their physical or mental condition. Subsection 3 reiterated again that foreigners, regardless of their administrative situation, are entitled to basic social services and benefits. Nevertheless, does not specify how non-Spanish speaking foreigners can be guaranteed the right to access the above mentioned services when they don't speak or have sufficient command of the official languages.

Ley 41/2002 regulates the autonomy of the patient and the rights and obligations regarding clinical information and documentation, in particular the right to health information. It encapsulates the following points *inter alia* (I curated and translated into English only those excerpts which I deemed the most study-relevant):

Thus, article 4 encompasses the right to healthcare information, whereby:

> 1. Patients have the right to know all the information available on any action [being undertaken] regarding their health [...] The information [...] shall be provided verbally and recorded in the medical record, [it] shall include, as a minimum, the purpose and nature of each intervention, its risks and its consequences (Ley 41/2002, section 4.1)
> 2. Clinical information shall form part of all health care procedures, shall be truthful, shall be communicated to the patient in a way that is comprehensible and appropriate to his or her needs, and shall help him or her to make decisions in accordance with his or her own free will. (Ley 41/2002, section 4.2)
> 3. The physician responsible for the patient [shall] guarantee compliance with the patient's right to information. The professionals attending [the patient] during the care process or applying a particular technique or procedure shall also be responsible for informing him/her. (Ley 41/2002, section 4.3)

Article 5 requires that:

> 2. The patient [...] be informed, even in the event of incapacity, in a manner appropriate to his or her ability to understand, in compliance with the duty to also inform his or her legal representative. (Ley 41/2002, section 5.2)

> 3. When the patient, according to the judgement of the attending physician, lacks the capacity to understand the information due to his physical or mental condition, the information be brought to the attention of the persons related to him. (Ley 41/2002, section 5.3)

Article 8 incorporates guidelines regarding the informed consent:

> 1. Any action in the field of a patient's health shall require the free and voluntary consent of the person concerned, once the information provided in Article 4 has been received, and [the patient] has assessed the options specific to their case. (Ley 41/2002, section 8.1)

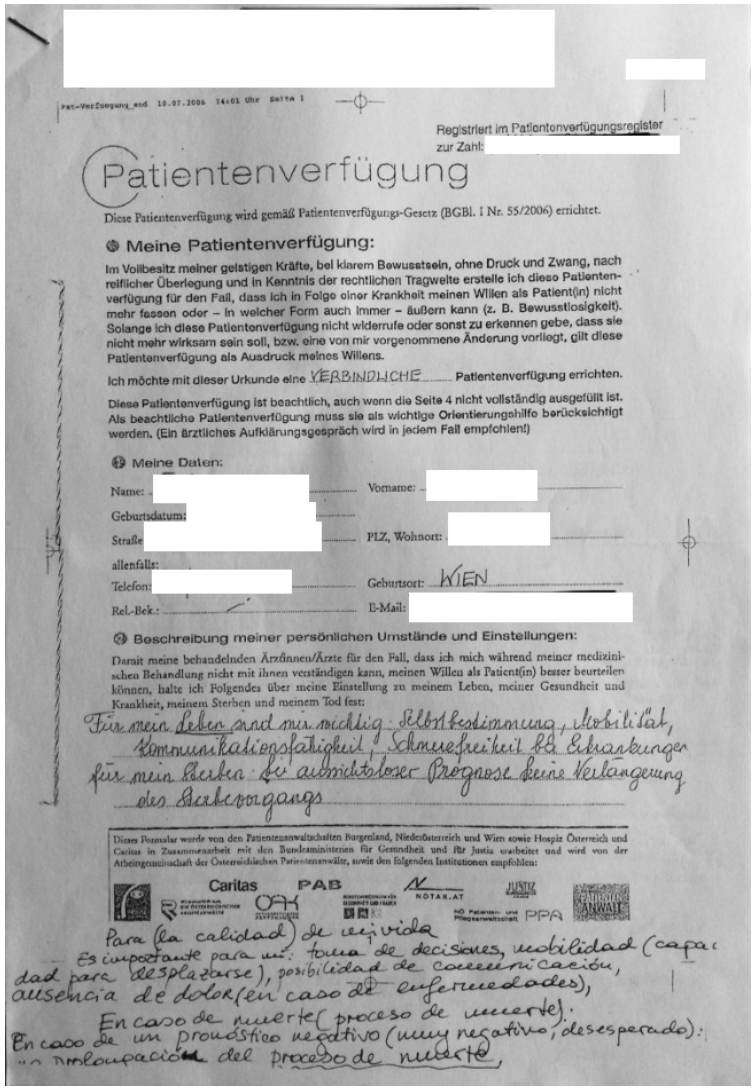
Article 11 encapsulates guidelines regarding advance directives:

> 1. By means of the advance directives document, a person of legal age, capable and free, declares their will in advance, in order for it to be fulfilled at the time when they reach situations in circumstances in which they are not capable of expressing it personally, regarding the care and treatment of their

> health or, once death has occurred, regarding the destination of his or her body or its organs. (Ley 41/2002, section 8.1)

And last but not least, according to the article 22, "All patients or users have the right to be provided/issued with certificates accrediting their state of health" (Ley 41/2002, art. 22).

Before I move on to the next legislative instrument, I would like to lay particular emphasis on art. 11 of the advance (healthcare) directives. I presume that one must realise the magnitude, the importance and the gravitas of the matter concerning this document. An advance directive is not only a medical document, but a legal document as well, which the treating doctors must comply with by law. I would like to share two documents in German: 1) Vereinigung für humanes Sterben and 2) Patientenverfügung. The first one is from a patient from Germany, whereas the second one belongs to a patient from Switzerland. All images were of course anonymised, but the reader can still see how detailed these instructions are and how important it is to convey all the details to the physician. These are drafts, which afterwards resulted in the final copies, but they still work great for comparison and comprehension of the impact and the gravitas of the interpreters' work in the case of foreign advance directives.



Registriert im Patientenverfügungsregister
zur Zahl:

Patientenverfügung

Diese Patientenverfügung wird gemäß Patientenverfügungs-Gesetz (BGBl. I Nr. 55/2006) errichtet.

Meine Patientenverfügung:

Im Vollbesitz meiner geistigen Kräfte, bei klarem Bewusstsein, ohne Druck und Zwang, nach reiflicher Überlegung und in Kenntnis der rechtlichen Tragweite erstelle ich diese Patientenverfügung für den Fall, dass ich in Folge einer Krankheit meinen Willen als Patient(in) nicht mehr fassen oder – in welcher Form auch immer – äußern kann (z. B. Bewusstlosigkeit). Solange ich diese Patientenverfügung nicht widerrufe oder sonst zu erkennen gebe, dass sie nicht mehr wirksam sein soll, bzw. eine von mir vorgenommene Änderung vorliegt, gilt diese Patientenverfügung als Ausdruck meines Willens.

Ich möchte mit dieser Urkunde eine VERBINDLICHE Patientenverfügung errichten.

Diese Patientenverfügung ist beachtlich, auch wenn die Seite 4 nicht vollständig ausgefüllt ist. Als beachtliche Patientenverfügung muss sie als wichtige Orientierungshilfe berücksichtigt werden. (Ein ärztliches Aufklärungsgespräch wird in jedem Fall empfohlen!)

Meine Daten:

Name: Vorname:
Geburtsdatum:
Straße PLZ, Wohnort:
allenfalls:
Telefon: Geburtsort: WIEN
Rel.-Bek.: E-Mail:

Beschreibung meiner persönlichen Umstände und Einstellungen:

Damit meine behandelnden Ärztinnen/Ärzte für den Fall, dass ich mich während meiner medizinischen Behandlung nicht mit ihnen verständigen kann, meinen Willen als Patient(in) besser beurteilen können, halte ich Folgendes über meine Einstellung zu meinem Leben, meiner Gesundheit und Krankheit, meinem Sterben und meinem Tod fest:

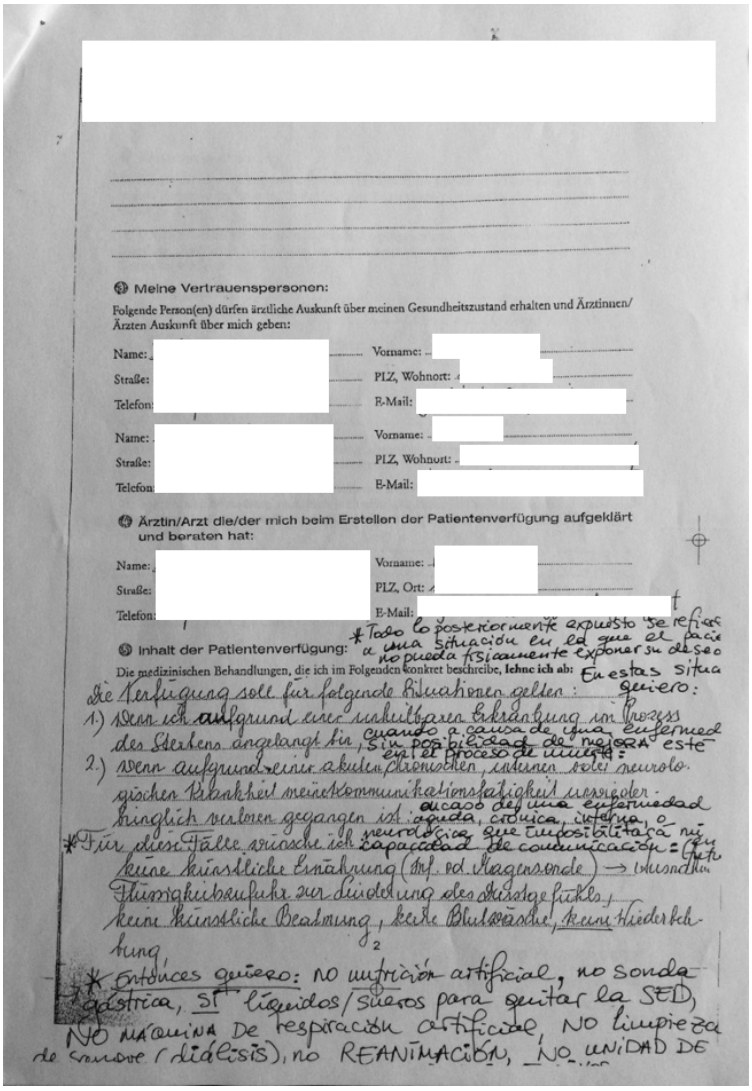
Für mein Leben sind mir wichtig: Selbstbestimmung, Mobilität, Kommunikationsfähigkeit, Schmerzfreiheit bei Einschränkungen
für mein Sterben: bei aussichtsloser Prognose keine Verlangerung des Sterbevorgangs

Dieses Formular wurde von den Patientenanwaltschaften Burgenland, Niederösterreich und Wien sowie Hospiz Österreich und Caritas in Zusammenarbeit mit den Bundesministerien für Gesundheit und für Justiz erarbeitet und wird von der Arbeitsgemeinschaft der Österreichischen Patientenanwälte, sowie den folgenden Institutionen empfohlen:

Caritas PAB NOTAR.AT JUSTIZ ANWALT PPA

Para la calidad de mi vida
Es importante para mí: toma de decisiones, mobilidad (capacidad para desplazarse), posibilidad de comunicación, ausencia de dolor (en caso de enfermedades).
En caso de muerte (proceso de muerte).
En caso de un pronóstico negativo (muy negativo, desesperado):
no prolongación del proceso de muerte.

Figure 6. Patientenverfügung (advance directives) anonymized medicolegal document in German, courtesy of one of my patients



Meine Vertrauenspersonen:

Folgende Person(en) dürfen ärztliche Auskunft über meinen Gesundheitszustand erhalten und Ärztinnen/Ärzten Auskunft über mich geben:

Name: Vorname:
Straße: PLZ, Wohnort:
Telefon: E-Mail:

Name: Vorname:
Straße: PLZ, Wohnort:
Telefon: E-Mail:

Ärztin/Arzt die/der mich beim Erstellen der Patientenverfügung aufgeklärt und beraten hat:

Name: Vorname:
Straße: PLZ, Ort:
Telefon: E-Mail:

Inhalt der Patientenverfügung:

Die medizinischen Behandlungen, die ich im Folgenden konkret beschreibe, lehne ich ab:

Die Verfügung soll für folgende Situationen gelten:

1.) Wenn ich aufgrund einer unheilbaren Erkrankung im Prozess des Sterbens angelangt bin,

2.) Wenn aufgrund meines akuten physischen, inneren oder neurologischen Zustandes meine Kommunikationsfähigkeit unwiderruflich verloren gegangen ist,

* Für diese Fälle wünsche ich keine künstliche Ernährung (Inf. od. Magensonde) → (Mundpflege) Flüssigkeitszufuhr zur Linderung des Durstgefühls, keine künstliche Beatmung, keine Bluttransfusion, keine Wiederbelebung,

* Todo lo posteriormente expuesto se refiere a una situación en la que el paciente no pueda físicamente exponer su deseo

En estas situaciones quiero:

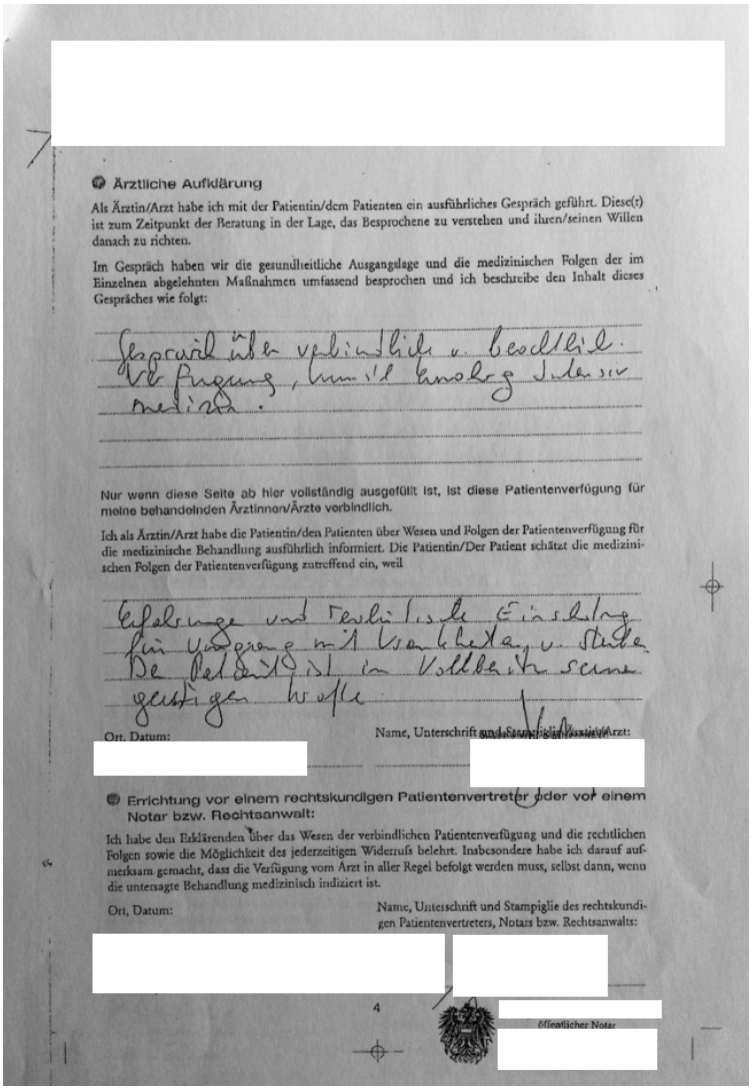
cuando a causa de una enfermedad está en proceso de muerte:

o

en caso de una enfermedad neurológica que imposibilitara mi capacidad de comunicación:

* entonces quiero: NO nutrición artificial, NO sonda gástrica, SÍ líquidos/sueros para quitar la SED, NO máquina de respiración artificial, NO limpieza de sangre (diálisis), no REANIMACIÓN, NO UNIDAD DE

Figure 7. Patientenverfügung (advance directives) anonymized medicolegal document in German, courtesy of one of my patients



Ärztliche Aufklärung

Als Ärztin/Arzt habe ich mit der Patientin/dem Patienten ein ausführliches Gespräch geführt. Diese(r) ist zum Zeitpunkt der Beratung in der Lage, das Besprochene zu verstehen und ihren/seinen Willen danach zu richten.

Im Gespräch haben wir die gesundheitliche Ausgangslage und die medizinischen Folgen der im Einzelnen abgelehnten Maßnahmen umfassend besprochen und ich beschreibe den Inhalt dieses Gespräches wie folgt:

Gespräch über voraussichtl. u. bestätigt. Verlauf, Unmöglichkeit weiterer Intensivmedizin.

Nur wenn diese Seite ab hier vollständig ausgefüllt ist, ist diese Patientenverfügung für meine behandelnden Ärztinnen/Ärzte verbindlich.

Ich als Ärztin/Arzt habe die Patientin/den Patienten über Wesen und Folgen der Patientenverfügung für die medizinische Behandlung ausführlich informiert. Die Patientin/Der Patient schätzt die medizinischen Folgen der Patientenverfügung zutreffend ein, weil

Erfahrung und realistische Einschätzung für Umgang mit Krankheit u. Sterben. Die Patientin ist in Vollbesitz seiner geistigen Kräfte

Ort, Datum: Name, Unterschrift und Stampiglie des Arztes/der Ärztin:

Errichtung vor einem rechtskundigen Patientenvertreter oder vor einem Notar bzw. Rechtsanwalt:

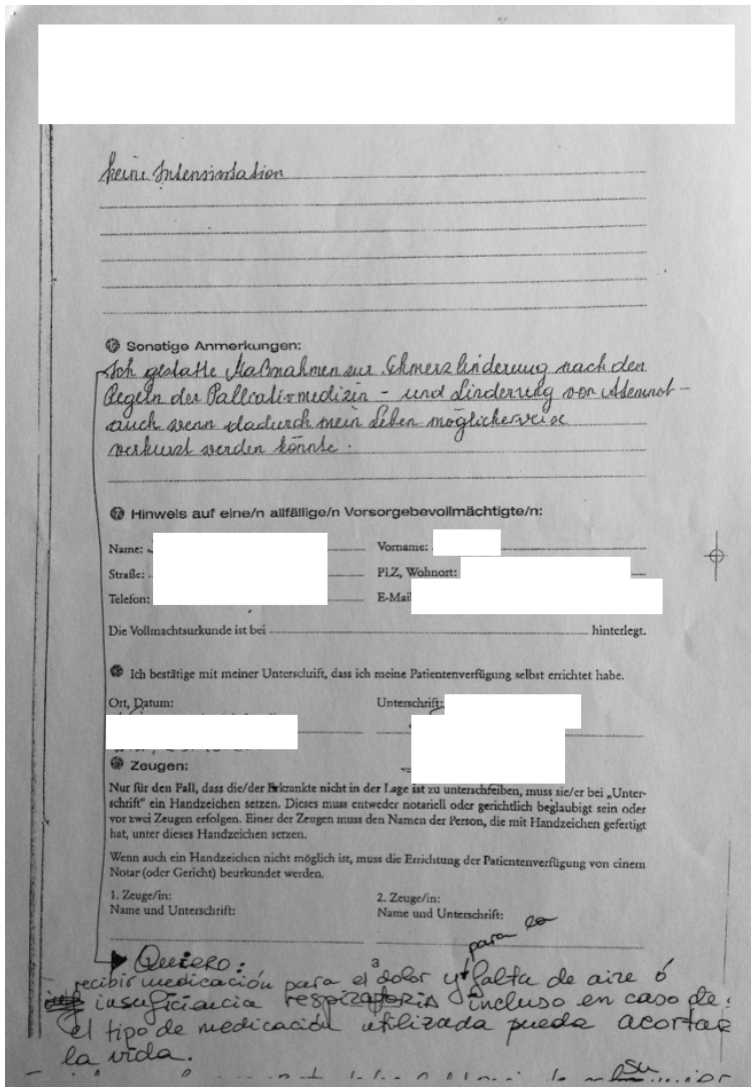
Ich habe den Erklärenden über das Wesen der verbindlichen Patientenverfügung und die rechtlichen Folgen sowie die Möglichkeit des jederzeitigen Widerrufs belehrt. Insbesondere habe ich darauf aufmerksam gemacht, dass die Verfügung vom Arzt in aller Regel befolgt werden muss, selbst dann, wenn die untersagte Behandlung medizinisch indiziert ist.

Ort, Datum: Name, Unterschrift und Stampiglie des rechtskundigen Patientenvertreters, Notars bzw. Rechtsanwalts:

4

öffentlicher Notar

Figure 8. Patientenverfügung (advance directives) anonymized medicolegal document in German, courtesy of one of my patients



keine Intensivstation

⑯ Sonstige Anmerkungen:
Ich gestatte Maßnahmen zur Schmerzlinderung nach den Regeln der Palliativmedizin - und Linderung von Atemnot - auch wenn dadurch mein Leben möglicherweise verkürzt werden könnte.

⑰ Hinweis auf eine/n allfällige/n Vorsorgebevollmächtigte/n:

Name: [redacted] Vorname: [redacted]
Straße: [redacted] PLZ, Wohnort: [redacted]
Telefon: [redacted] E-Mail: [redacted]

Die Vollmachtsurkunde ist bei [redacted] hinterlegt.

⑱ Ich bestätige mit meiner Unterschrift, dass ich meine Patientenverfügung selbst errichtet habe.

Ort, Datum: [redacted] Unterschrift: [redacted]

⑲ Zeugen:

Nur für den Fall, dass die/der Erkrankte nicht in der Lage ist zu unterschreiben, muss sie/er bei „Unterschrift" ein Handzeichen setzen. Dieses muss entweder notariell oder gerichtlich beglaubigt sein oder vor zwei Zeugen erfolgen. Einer der Zeugen muss den Namen der Person, die mit Handzeichen gefertigt hat, unter dieses Handzeichen setzen.

Wenn auch ein Handzeichen nicht möglich ist, muss die Errichtung der Patientenverfügung von einem Notar (oder Gericht) beurkundet werden.

1. Zeuge/in: Name und Unterschrift:
2. Zeuge/in: Name und Unterschrift:

Quiero: recibir medicación para el dolor y falta de aire o insuficiencia respiratoria incluso en caso de el tipo de medicación utilizada pueda acortar la vida.

Figure 9. Patientenverfügung (advance directives) anonymized medicolegal document in German, courtesy of one of my patients

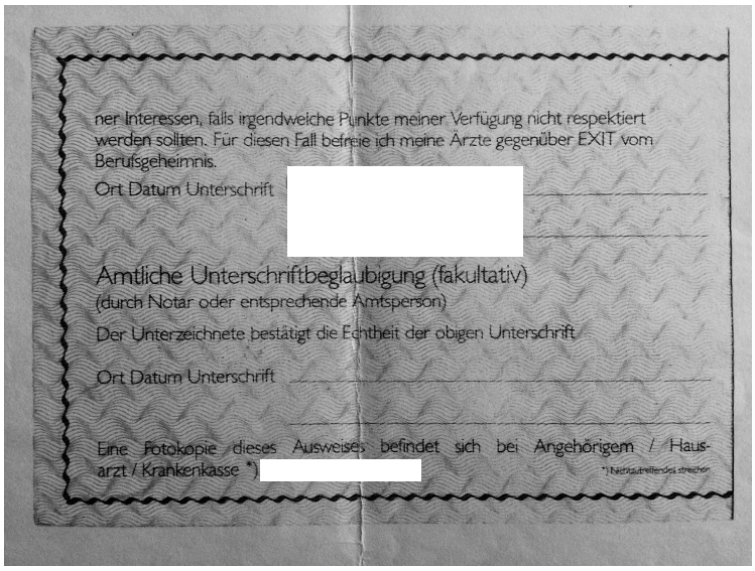
(Deutsche Schweiz)
Vereinigung für humanes Sterben

MITGLIEDERAUSWEIS No. [redacted]

Mitgliederbeitrag bezahlt für [redacted] 2013

Auf der Innenseite meine absolut verbindliche **PATIENTENVERFÜGUNG**

Figure 10.Patientenverfügung (advance directives) anonymised medicolegal document in German, courtesy of one of my patients


ner Interessen, falls irgendwelche Punkte meiner Verfügung nicht respektiert werden sollten. Für diesen Fall befreie ich meine Ärzte gegenüber EXIT vom Berufsgeheimnis.

Ort Datum Unterschrift

Amtliche Unterschriftbeglaubigung (fakultativ)
(durch Notar oder entsprechende Amtsperson)

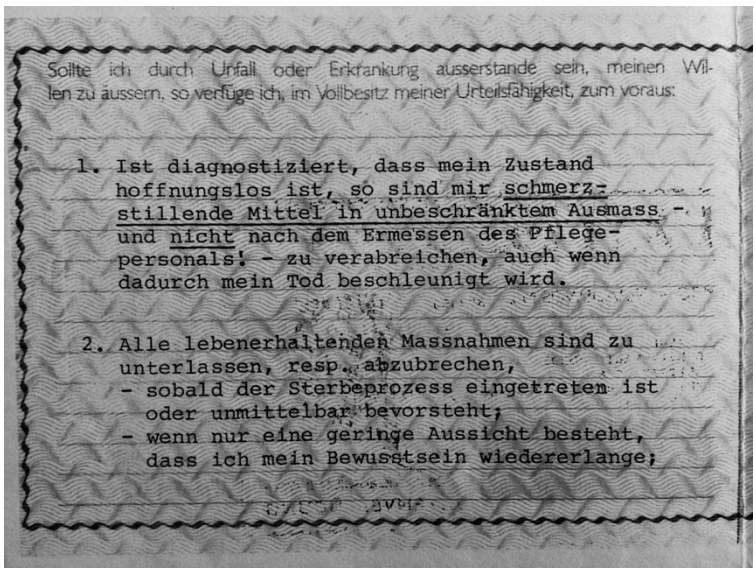
Der Unterzeichnete bestätigt die Echtheit der obigen Unterschrift

Ort Datum Unterschrift

Eine Fotokopie dieses Ausweises befindet sich bei Angehörigem / Hausarzt / Krankenkasse *)

*) Nichtzutreffendes streichen

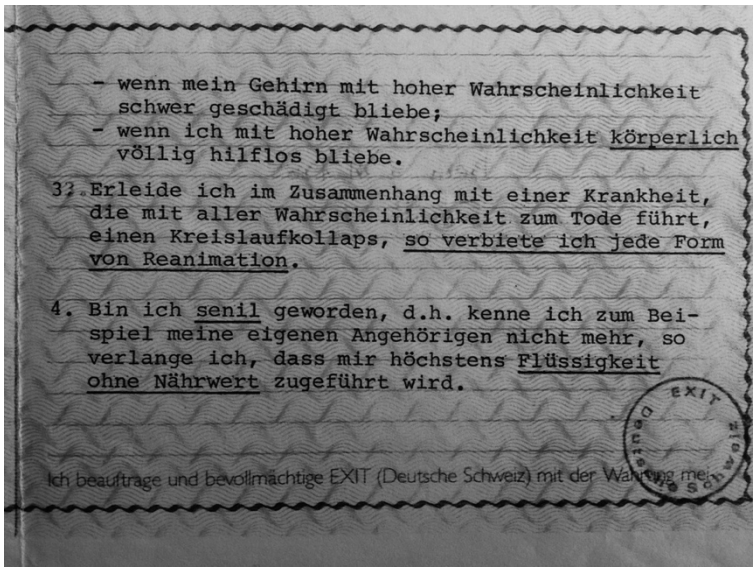
Figure 11. Patientenverfügung (advance directives) anonymised medicolegal document in German, courtesy of one of my patients


Sollte ich durch Unfall oder Erkrankung ausserstande sein, meinen Willen zu äussern, so verfüge ich, im Vollbesitz meiner Urteilsfähigkeit, zum voraus:

1. Ist diagnostiziert, dass mein Zustand hoffnungslos ist, so sind mir schmerzstillende Mittel in unbeschränktem Ausmass - und nicht nach dem Ermessen des Pflegepersonals - zu verabreichen, auch wenn dadurch mein Tod beschleunigt wird.

2. Alle lebenerhaltenden Massnahmen sind zu unterlassen, resp. abzubrechen,
   - sobald der Sterbeprozess eingetreten ist oder unmittelbar bevorsteht;
   - wenn nur eine geringe Aussicht besteht, dass ich mein Bewusstsein wiedererlange;

Figure 12. Patientenverfügung (advance directives) anonymised medicolegal document in German, courtesy of one of my patients


- wenn mein Gehirn mit hoher Wahrscheinlichkeit schwer geschädigt bliebe;
- wenn ich mit hoher Wahrscheinlichkeit körperlich völlig hilflos bliebe.

3. Erleide ich im Zusammenhang mit einer Krankheit, die mit aller Wahrscheinlichkeit zum Tode führt, einen Kreislaufkollaps, so verbiete ich jede Form von Reanimation.

4. Bin ich senil geworden, d.h. kenne ich zum Beispiel meine eigenen Angehörigen nicht mehr, so verlange ich, dass mir höchstens Flüssigkeit ohne Nährwert zugeführt wird.

EXIT

Ich beauftrage und bevollmächtige EXIT (Deutsche Schweiz) mit der Wahrung mei

Figure 13. Patientenverfügung (advance directives) anonymised medicolegal document in German, courtesy of one of my patients

These medicolegal documents (both being binding patient decrees) itemise and clarify what medical action is allowed to be taken under what circumstances. For example, the first document specifies that no prolongation of the dying process must ensue in the event of a bad prognosis, which may result in the lack of self-determination, lack of mobility or lack of communication abilities. Only analgesia must be guaranteed. In the case of terminal illness leading to the patient's death, as well as in the case of acute, chronic or neurological illness, whereby patient's communication abilities have been irretrievably lost, no ICU treatment must be provided, no artificial feeding via the gastric tube must be provided, no mechanical ventilation must be connected, no dialysis must be offered, no resuscitation techniques must be used and only the fluid supply to prevent the feeling of thirst, relief from breathlessness and palliative care and analgesia must be guaranteed, even if it may possibly lead to the shortening of the patient's life. The second document obliges medical workers to administer unlimited amounts of analgesics and to refrain from the implementation of any life-sustaining measures in the case of severe brain damage, when consciousness may no longer be regained, in the event of physical helplessness even if the death of the patient is accelerated. The second document also specifies that once the dying process has started no reanimation must be performed on the patient.

Thus, as we can infer from these documents, an accurate translation of these medical-legal documents is essential to avoid legal implications and to ensure compliance with Ley 41/2002, of 14 November, basic law regulating patient autonomy and the rights and obligations regarding clinical information and documentation. As Quan (2010, p. 10) suggests, "the presence of the interpreter should [...] be noted in the patient's record" in case the physician and the patient are opting for a sight translation of these documents. This would contribute to strengthening of the idea of liability of medical interpreter and translator, foreground the importance of the role of medical interpreter and highlight the salience of the concept of trust in the profession.

These documents have major legal impact on the treatment, they basically determine the treatment and the non-compliance therewith may lead to major legal implications for the hospital.

The unconventionality of these types of medicolegal documents lies in the fact that the translator has either little or no time to translate these documents. Sometimes the patient is admitted to the ICU with a life-endangering condition and the ICU team needs to know what procedures are they legally allowed to perform on the patient.

However, advance decision, living will, end of life care or precautionary mandate are not the only documents that need translation. The following documentation will also need to be translated to ensure safety of care: discharge summaries, (discharge) medication administration instructions, medical reports from the country of origin/residence, which normally include the anamnesis and the results of medical tests that have previously been conducted (diagnostic imaging, genetic testing, blood chemistry tests, molecular diagnostics, physical and visual inspection such as auscultation, palpation, percussion), medical interconsultation reports from the country of origin, and medical reports including the aforementioned data that the patients send before travelling to Spain in order to determine whether the medical facility where they plan to undergo the treatment does these sorts of procedures.

The original Ley 16/2003, of 28 May, on the cohesion and quality of the National Health System, before its amendment in 2012, established, among its general principles universal and public insurance by the State (Gómez-Zamora, 2018, p. 300). One may appreciate that the new provision –Real Decreto-ley 16/2012 – was a piece of drastic backpedalling in an attempt to ensure sustainability. The reform introduced by Real Decreto-ley 16/2012, of 20 April, entailed an involution by distorting the right to health protection, annulling its universal vocation established in , of 28 May (Gómez-Zamora, 2018, p. 300). The ruling of the Constitutional Court 139/2016 upholds that: "The universalisation of access to publicly funded health care benefits has been, since Ley 14/1986 of 25 April, an objective to be pursued in which neither absolute dissociation from the Social Security nor unconditional and free access for all residents in Spanish territory has been achieved" (Gómez-Zamora, 2018, p. 301). The new formulation of Article 3 of expressly recognises the legal entitlement to receive health protection and health care for foreigners who reside in Spain illegally under the same conditions as Spanish nationals (Gómez-Zamora, 2018, p. 306). Now provides that the following categories of citizens are entitled to and eligible for health protection and care: a) Spanish nationals; b) regularised immigrants; c) persons whose right to health care in Spain is recognised by any other legal title; d) Persons who fall within the scope of European regulations or bilateral agreements; e) administrative mutual insurance (special scheme for civil servants, military, etc.) (Gómez-Zamora, 2018, p. 307-308).

Section 3 a of Ley 16/2003 avows that all eligible citizens have a right to information, quality of service and safety *inter alia*. Article 26 provides that the National Health System must make available information on the prospective patients' rights and duties set out in the Basic Law regulating patient autonomy, the portfolio of services and the benefits thereof, access requirements, clinical documentation, etc. According to the article 28:

> The *Autonomous Communities* shall *guarantee the quality of the services* [...] and undertake actions to *humanise care* and to *improve administrative accessibility and comfort*. Newly created health centres must comply with *current regulations on the promotion of accessibility and the elimination of barriers of all kinds that apply to them. Public health administrations shall promote programmes for the elimination of barriers in*

> *health centres and services that, due to their age or other reasons, present obstacles for users with mobility or communication problems*. (Chapter 1, section 3, art. 28, p. 23, my italics)

Article 29 of the same provision reads as follows:

> The *guarantees of safety and quality are applicable to all centres, public and private, regardless of the financing of the services they are offering at any given time*, and it is the responsibility of the Public Health Administrations, for the centres within their scope, to ensure compliance with them. (Chapter 1, section 3, art. 29, p. 23, my italics).

Real Decreto 1030/2006 constitutes a "a pre-existing legislative instrument that is part of the national legal framework for cross-border healthcare in Spain" and comprises a "catalogue of common services" available in the National Health System for natural-born citizens, naturalised citizens, residents and other EU citizens seeking cross-border healthcare in Spain. Article 4 of on the authorised personnel and centres stipulates in section 1 that the health care services, detailed in the list of *common services* of this Real Decreto, *must be provided, in accordance with the rules of organisation, operation and regime of the health services, by qualified health professionals, regulated by Act 44/2003*, of 21 November, on the organisation of the health professions. *All of the above without detriment to the collaboration of other professionals within the scope of their respective competences.* Later on, in article 4 it says that authorised personnel and centres *must offer sufficient and adequate information so that the patients may exercise their right to consent to such decisions*, in accordance with the provisions of Act 41/2002. In article 2 section 3 it is clarified that the procedure for the patients' access to the services that make the benefits thereof effective shall be determined by the health administrations within the scope of their respective competencies. Article 11 specifies that the Autonomous Communities *may include in their service portfolios a technique, technology or procedure not included in the common service portfolio of the National Health System*, *for which purpose they shall establish the necessary additional resources*, nevertheless, *these complementary services,* which shall meet the same requirements established in article 5, *shall not be included in the general financing of the benefits of the National Health System*. Article 5 stipulates that for the definition, detailing and updating of the portfolio of common services, *account shall be taken of the safety, efficacy, efficiency, effectiveness* and *therapeutic usefulness* of the techniques, technologies and procedures, *as well as the advantages and care alternatives*, the care of less protected or at-risk groups and social needs, and their economic and organisational impact, based on the criteria and requirements established in the following sections. Thus, following the instructions of the fifth article, section 3, MI and translation actually do contribute effectively to the prevention, diagnosis or treatment of illnesses, to the preservation or improvement of life expectancy, to self-rescue or to the elimination or reduction of pain and suffering and do Provide an improvement, in terms of safety, efficacy, effectiveness, efficiency or proven usefulness, over other currently available alternatives (art. 5), consequently these services can be viewed as techniques that could/should be included as part of the portfolio of common services of the National Health System.

Ley 15/2008 of 5 December, on the Integration of Immigrants in the Valencian Community provides in its article 13 that the purpose of intercultural mediation is to facilitate coexistence between persons or groups belonging to diverse cultures through dialogue and mutual

understanding. It also prescribes that The Valencian Community shall promote instruments of intercultural mediation as a mechanism for integration:

> La Administración autonómica promoverá instrumentos de mediación intercultural como mecanismo de integración. [...] La Administración autonómica favorecerá la formación especializada de mediadores interculturales, como instrumento de integración. Éstos deberán actuar en todo momento desde la imparcialidad, el diálogo y el acercamiento de posturas.
>
> [The Autonomous Administration will promote intercultural mediation instruments as a mechanism for integration. [...] The Autonomous Administration will favour the specialised training of intercultural mediators, as an instrument of integration. They shall at all times act with impartiality, dialogue and rapprochement of positions]. (art. 14 Ley 15/2008, p. 9)

In spite of the fact that the need for cultural accommodation as a mechanism for integration is explicitly mentioned in Ley 15/2008, the linguistic needs of the non-Spanish speaking foreigners are not being taken into account, since the role of intercultural mediator is viewed through the prism of a social worker rather than an interpreter. The reality is that many mediators come from the professional area of social work and cannot speak foreign languages, so end up needing interpreters in order to do their jobs.

Angelelli observed that in its content and spirit bears similarity to the Directive 2011/24/EU (2015, p. 34). This particular Real Decreto contemplates the principles of patients' freedom of choice, access to high quality health care services and non-discrimination on the grounds of nationality (Angelelli, 2015, p. 34). views healthcare as a service that always maintains the guarantee of a high level of human health protection (Real Decreto 81/2014, p. 10915). It must be clearly understood that: "An essential aspect of the directive is that its requirements *do not constitute either a new regulation of health systems or a substantial modification of them*, even though a new health care scenario is now being considered in the European Union" (Real Decreto 81/2014, p. 10915). This directive calls for an increase in quality and safety guarantees for the prospective patients. Real Decreto 81/2014 along with Directive 2011/24/EU allow for a liberalisation in the healthcare sector, which means an opportunity for private health care and a challenge for the public health sector, which in any case must respect the essential values of universality, access to high-quality health care, equity and solidarity for patients and citizens regardless of their Member State of affiliation (Real Decreto 81/2014, p. 10917). Chapter II of the Real Decreto 81/2014 determines that the guarantees for access to safe and quality cross-border healthcare may be achieved through mechanisms such as information, claims for compensation for possible damages, continuity of treatment and the protection of privacy with regard to treatment (Real Decreto 81/2014). Article 4 on the general principles of cross-border healthcare avows that cross-border healthcare shall be provided in accordance with the legislation of the Member State of treatment, including quality and safety standards and guidelines, and with European Union legislation on safety standards, taking into account the principles of universality, access to high quality care, equity and solidarity. When healthcare is provided in Spain to patients whose State of affiliation is another Member State, the principle of non-discrimination on grounds of nationality shall also apply (Real Decreto 81/2014, pp. 10917-10923). Last but not least, Royal Decree 81/2014 stresses that cross-border patients must have all the clinical reports, the results of diagnostic tests and/or therapeutic procedures at their disposal.

The Real Decreto-ley 7/2018, of 27 July, on universal access to the Spanish National Health System has come to reverse the reform introduced by Real Decreto-ley 16/2012, of 20 April, on urgent measures to guarantee the sustainability of the Spanish National Health System and improve the quality and safety of its benefits by depriving foreigners who were in an irregular situation in Spain of the right to healthcare funded from public funds, thus, entailing a de facto violation of the right to access to the Spanish National Health System under conditions of equity and universality (Gómez-Zamora, 2018, p. 290-291). This reform (Real Decreto-ley 7/2018 was preceded by various rulings of the Constitutional Court (Tribunal Constitucional, TC) on the previous regulation and seeks to recover the principle of universality of healthcare provision in Spain (Real Decreto-ley 7/2018). The concept of holder and the recognition of the right to health protection and health care needed to become more inclusive and integral by incorporating foreigners who are residing in Spain illegally.

With Real Decreto-ley 16/2012, access to the public health system was directly linked to being an insured person and indirectly to being considered a beneficiary of the insured person (for instance, by the virtue of family reunification). Certainly, this circumstance excluded foreigners in a situation of administrative irregularity (neither registered, nor authorised) from the right to receive and benefit from health care at the expense of the regularised tax payers, which was only reserved to foreigners who work and subsequently are registered with the Social Security (Gómez-Zamora, 2018, p. 292-293). Thus, from this category of unregularized foreign residents, free health care could only be offered to minors, pregnant women and persons of legal age in the event of an emergency due to serious illness or accident until they have been medically discharged (Gómez-Zamora, 2018, p. 293). This model was primarily based on the connection between the (tax) contribution to the Social Security system and the right to receive the corresponding health benefits free of charge.

Thus, the new regulation purports to change the policy by progressively extending the benefit of free or subsidised health care to the holders that have previously not been covered by the status of insured person in the Social Security system (Gómez-Zamora, 2018, p. 292). Real Decreto-ley 7/2018, enacted by the new executive, Pedro Sánchez, in 2018 aims to guarantee health protection and access to health care for all persons, regardless of their nationality, who have established their residence in Spanish territory (Gómez-Zamora, 2018, p. 294).

Despite the enactment of the Real Decreto-ley 7/2018, of 27th of July, on universal access to the Spanish National Health System approved by the new socialist government of Prime Minister Pedro Sánchez, intended to universalise free healthcare for *all* foreigners in Spain, and despite the enactment and transposition of the Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, translation and interpreting in the medical sphere seem very far from being declared a patients' and hospital workers' right.

3.3. REGIONAL LEGISLATION

It is worth noting that the Decree 93/2009[17] of July 10, of the Council, whereby the Regulation of the Ley 15/2008 is passed and enacted, views intercultural mediation as an instrument of diplomatic problem-solving and institutional adaptation. Article 19 encompassed in the title IV of the Decree 93/2009 defines intercultural mediation as "a modality of intervention in social situations of significant cultural diversity by third parties, oriented towards bringing the parties together, communication and mutual understanding, learning and development of coexistence and institutional adaptation" (Decree 93/2009, 2009, Title IV, Article 19). No mention of languages is made.

Article 20 delimits the figure of the intercultural mediator in the following way: "a person who provides to the competent authority, which in this case is the Directorate General for the Social Integration of Immigrants, an accreditation of a minimum of 250 hours of training, or a minimum of 150 hours of training in the field of intercultural mediation [...] as well as one year's professional experience with a minimum of 900 hours worked in the field of intercultural mediation (according to the article 2.1 and 2.2 of the , of 19 May, of the Regional Ministry of Solidarity and Citizenship, which regulates the accreditation of the figure of the intercultural mediator and the Registry of Intercultural Mediators of the Valencian Community). This education/training must be provided by a study centre of recognised prestige, such as i) official or officially recognised training entities (public or private universities and university centres attached to them, institutes or foundations which collaborate with the public sector); ii) entities that have established specific agreements or arrangements for the provision of training in Intercultural Mediation with Public Administrations (Article III section 2 a) and b) in the Orden 8/2011[18]). The training must consist in the acquisition of "*specific knowledge, skills and attitudes in intercultural mediation, linguistic and socio-cultural interpretation, areas of intervention of the mediator and inter-cultural communication*" (Article 2 on accreditation of intercultural mediators, p. 21256, my italics). Article 3 section 3 facilitates a detailed training programme in terms of "*specific knowledge, skills and attitudes for the correct exercise of the profession*" (Chapter I, Art. 3, section 3, p. 21256). Please note that is referring to intercultural mediation as a profession. Thus, the intercultural-mediators-to-be must have acquired education and improved employability in the following areas:

a) Linguistic and socio-cultural interpretation
b) International migration
c) Cultural diversity management
d) Intercultural mediation (preventive, rehabilitative and transformative modalities).
e) Techniques, tools and procedures for negotiation and mediation in cultural conflicts.

[17] DECRET 93/2009, de 10 de juliol, del Consell, pel qual s'aprova el Reglament de la Llei 15/2008, de 5 de desembre, de la Generalitat, d'Integració de les Persones Immigrants en la Comunitat Valenciana. [2009/8340] DECREE 93/2009, of 10 July, of the Consell, approving the Regulations of Ley 15/2008, of 5 December, of the Generalitat, on the Integration of Immigrants in the Valencian Community. [2009/8340] https://dogv.gva.es/datos/2009/07/14/pdf/2009_8340.pdf

[18] Full document is available here: http://www.dogv.gva.es/datos/2011/05/26/pdf/2011_6009.pdf

f) Main areas of intervention of the mediator (main areas of applicability)

g) Communication and intercultural competence.

Chapter II (p. 21256) stipulates that in order to get accreditation the applicants must meet the following requirements:

- To be a Spaniard, a national of one of the member states of the European Union or a foreigner with legal residence in Spain.
- Age of majority (being of full age)
- Be in possession of the specific training qualifications in intercultural mediation under the terms of article 2 (spelled out above)
- At least one year of professional experience with a minimum of 900 hours of work experience in intercultural mediation, in those cases in which, in accordance with article 2, this is required.
- Official academic qualifications, approved or validated in accordance with the terms of article 6.4.

As regards intercultural mediators' roles and responsibilities, Article 21 of the Orden 8/2011 (p. 27902) provides that the following functions should be allocated to this figure:

1. To support integration
2. To facilitate the reception of immigrants
3. To accompany [the migrant patients] in order to put at their disposal all information available on the public and private resources
4. To raise awareness by sensitizing the society to the existing cultural gap and bring the immigrant population and the host society closer together in an intercultural way
5. To facilitate encounters between diversified population and to foster the effective communication between social groups pertaining to different cultures
6. To build citizenry by actively fostering integration processes
7. To carry out tasks which would reinforce social cohesion and undertake activities spurring social and citizenry participation.

Article 23 of the IV Title stipulates the cases in which intercultural mediators may deliver their services:

1. At request of any person, institution or entity that requires such service.
2. Intercultural mediator will promote dialogue and communication, making each interested party aware of the positions of the other [interlocutors/participants], their advantages, reducing possible divergent views and proposing solutions
3. Intercultural mediators shall not dictate any resolution on the issue, so that the parties involved remain free to perform actions and exercise rights they deem appropriate

And yet please note that their functions do not include interpreting. Even though Chapter I, Art. 3, section 3, p. 21256 of the indicates that intercultural mediator may be required to carry

out "linguistic and socio-cultural interpretation", in the calls for applications published in the official gazette (DOGV), they never ask for it as a requirement, as the knowledge of languages is only valued as a merit. Call for applications for nine grants for training placements in Intercultural Mediation during 2019 contains a "scale for evaluating personal merits", whereby "knowledge of Valencian", "knowledge of the EU languages", and "other merits [...] knowledge of other officially accredited non-EU languages will be valued up to a maximum of 1 point" appears as a merit or an extra asset rather than a sine qua non requirement (Generalitat Valenciana, 2019). This means that intercultural mediators are actually occupying a niche, whose tasks and competences they do not cover in the end. In an attempt to be deemed suitable for a larger range of job vacancies, the social workers and intercultural mediators purport to cover the need for interpreting, however they fail to provide the actual service as they are not proficient in the foreign languages in great demand. Social workers have seen the opportunity to increase their chances of accessing the labour market by taking on the profile of intercultural mediator, however all they can be is social workers as they lack professional knowledge, skills and competences. These social workers/intercultural mediators severely obstruct the access to workplace and marketplace to the professional MI, and therefore perfectly epitomise Hughes' "occupiers competing for access and struggling to improve their status by new acquisitions [...]" (as cited in Dingwall, 2016, Introduction section, § 10-12).

Orden 8/2011 clearly illustrates that the figure of intercultural mediator is taking over the figure of interpreter in the Valencian Community. This document fully illustrates that the newly emergent profile has already gained recognition at autonomous community, city and municipality level (and as we shall see in the upcoming chapters, at state level as well), and therefore may probably end up usurping medical interpreters' niche due to its popularity and fashionalisation.

Also, according to the Article 11 bis in Chapter I Title III, of the Ley 10/2014, of 29 December, on Health of the Valencian Community (Comunitat Valenciana, 2014), The Generalitat must establish the necessary channels and mechanisms to guarantee healthcare and public health services and benefits for the entire population, and to avoid discrimination for any reason, eliminating [...] communication barriers in all healthcare institutions, facilitating total and real accessibility for all people" (Ley 10/2014, p. 19). Title V Chapter I of the same Law highlights the right to information (Art. 42), informed consent (Art. 43), clinical history (Art. 46) and personalised care (Art. 50). Article 50 (Chapter I, Title V) on the right to personalised care details that:

> Se reconoce el derecho de los pacientes y personas usuarias a recibir información sanitaria en las lenguas oficiales de la Comunitat Valenciana, en la forma más idónea para su comprensión. En la medida en que la planificación sanitaria lo permita, los centros y servicios sanitarios del Sistema Valenciano de Salud implantarán los medios necesarios para atender las necesidades lingüísticas de los pacientes y personas usuarias extranjeros.
>
> The right of patients and users to receive healthcare information in the official languages of the Comunitat Valenciana, in the most suitable form for their understanding, is recognised. Insofar as health planning allows, the health centres and services of the Valencian Health System shall implement the necessary means to attend to the linguistic needs of foreign patients and users (Art. 50, Chapter I, Title V, Ley 10/2014, p. 35, my italics).

From this review one may conclude that Ley 16/2003 was the only legislative instrument at the national level mentioning "elimination of barriers [...] that present obstacles for users with [...] communication problems" (Ley 16/2003, Chapter 1, section 3, art. 28, p. 23), whereas Orden 8/2011 was the only provision at the regional level not only to mention the need to deploy intercultural mediators, but which also provided instructions regarding competencies, education, accreditation and register of intercultural mediators. It is worth noting that fundamental human rights can be only established through organic laws, which have constitutionally and historically been reserved to the Spanish Parliament, therefore being out of the reach of any regional or local parliament. Ordinary laws can only regulate certain collateral elements of the core facets of fundamental rights, not the provisions themselves. Thus, the right to MI for foreign-speaking patients must be conferred only through an organic law passed by the Spanish Parliament. A state-wide legislative instrument must criminalise non-professional encroachment, as well as encompass and clearly itemise different forms of punishment in the event of non-compliance ranging from more lenient ones (such as administrative fines) to imprisonment. When setting out a regime of punishment in an attempt to intensify adherence, legislators must have studied the efficacy forecasts of MI and the degree of imperativeness of its application to the current situation in order to ensure adequacy and proportionality of sanctions. But judging from this literature review, it is my contention that national legislators may perhaps lack the proper degree of technical expertise to assess both the efficacy and the extent of imperativeness of application of this discipline to practice. All legislative provisions on intercultural mediation except for Orden 8/2011 were extremely vague and caused a vertigo of relativity, but in order to enforce a measure on the basis of Organic Law the policy- and decision-making authorities must be knowledgeable and well-versed in the corresponding subject matter in order to successfully navigate the broad scope of discretion that was granted to them by the virtue of their profession. For the time being, the provisions that have been analysed within the framework of this thesis have proven to be riddled with indeterminate and vague legal concepts, that allow for a broad margin of administrative discretion at the point of prospective implementation. The regulatory norms viewed in this section echo that all of the patients are entitled to access medical information and comfortably navigate the Spanish health care system, however the written discourse of the current international and domestic legislation does not mirror any attempt of reification of the stale pledges made in these official documents. Clearly, no law enforcement mechanisms have been put in place to deliver on these pledges and the commitments made therein by ensuring materialisation of the intentions of the policy makers. No *modus operandi* has been foreseen therein, whereby equal access to quality healthcare would be ensured. The lack of clear instructions as to how non-Spanish speaking patients should receive care translates into hospitals being spared the predicament and the expenditures of hiring only professional medical interpreters, especially in the light of scarcity of professionals that have been officially trained in languages other than those offered in the university curricula. Consequently, neither language provision solutions, nor their deployment, nor their implementation have been enshrined in legal norms. From this section we can deduce that the occupation of medical interpreter is almost entirely unregulated by law, which leads to the fact that any person, whether graduate or not, may freely pursue the profession of translator or interpreter. As I shall seek to demonstrate in the upcoming sections of this thesis, it is rather rare to

find job offers as a translator or interpreter, both in the public and private sectors, even though this occupation has been recognised as a professional category (ISCO-08, CNO-11). Instead, the translation and interpretation tasks are subsumed under the administration sector. The lack of proper regulations brings this profession into disrepute and jeopardises those who depend on quality language services.

It seems obvious that a country that purports to develop the field of medical tourism and claims to be one of the major recipients of medical tourists should put forth regulatory guidelines that would narrow down the domain of the exercise of discretion of the existent in house interpreters hired by private clinics, thus, providing a base for professional trust. It is of paramount importance that a consensus be reached regarding the scope of the exercise of professional judgement carried out by medical interpreters practicing in private medical centres. The interoccupational jurisdictional boundaries must not be relativised, but rather essentialised and foregrounded. Such loose and highly evasive regulation results in a failure to properly address and accommodate the needs of foreign speaking patients.

4. INTERPRETING IN SPANISH MEDICAL SETTINGS

4.1. GENERAL INSIGHTS

This chapter will be fully dedicated to the analysis of the current situation of MI in Spanish medical settings. It is meant to serve served as a magnifying glass allowing us to assess the magnitude of the problem against the backdrop of globalisation. A series of newly emergent socio-demographic phenomena described in the previous chapters call for a context-specific study, which should ideally afford a new analysis perspective of the professional identity of MIs in the geographical area of interest. A thorough literature review (Gavlovych, 2017) of numerous studies in the field of healthcare interpreting conducted on international and European level is going to be used as the basis for this chapter, while the "popular beliefs and assumptions" of the EU citizens "on minimum requirements to communicate appropriately" such as the "monolithic and almost unchallenged view that current ad-hoc language provision in healthcare settings is not an issue and does not need coordinated planning (i.e. "language is irrelevant; we manage")" (Angelelli, 2015, p. 9) will be the main point of departure for this chapter.

In Spain there has been an exponentially growing interest in this subject area over the past few years, which has resulted in the emergence of numerous works on interpreting in public services (Niño Moral, 2008; Martínez-Gómez, 2008; Angelelli, 2015; Valero, 2008; Aguilar, 2015, Ortega-Herráez & Blasco-Mayor, 2018 among others). However, there is a paucity of information on the subject of MI in private healthcare against the socio-demographic and economic backdrop of medical tourism in this region.

Quality interpreting services in the public sector are written off as costly, dispensable and time-consuming, therefore, constant regurgitation of the "lack of resources/budget" formulation has now become a self-transplanting tradition for this agenda. The latent rationale may very well be populist generalism[19] – a phenomenon described by Feidson (2001) whereby interpreting would not be considered a complex, esoteric activity, but it is rather associated with language learning and is viewed as something every average adult can understand spontaneously and learn quickly in general public education establishments (Freidson, 2001). Thus, the issue of the necessity of medical interpreters is in enormous contention because of the differences in opinion of different parties and due to other alternative solutions.

Very few social actors seem to consider one caveat: the level of linguistic proficiency, its assessment and accreditation. Many medical professionals are convinced that as long as they have a superficial understanding of the discourse being delivered by the patient and as long as they believe they can surmise the (rest of the) meaning and intention of the discourse from a few words they (might or might not) have understood, they already "know the language". It should be noted that in Spain there takes place a peculiar phenomenon regarding foreign language knowledge and proficiency, whereby numerous medical workers are inclined to misconstrue and

[19] This concept will be discussed in detail in the upcoming sections of this thesis.

overestimate their language skills, while the rest of social actors surrounding them can be seen to hyperbolize these skills.

Undoubtedly, medical staff who work in multicultural and interdisciplinary environments enjoy continuous "exposure to linguistic input, which delays the atrophy of language learning circuitry" (Hartshorne, Tenenbaum and Pinker, 2018, The nature of the critical period for second language acquisition, § 7), but the mounting evidence showcases that prolonged learning trajectory does not imply proficiency, linguistic knowledge crystallisation or mastery. Medical staff who are older or later learners may deploy conscious learning-communication or discourse construction strategies building upon and transferring the knowledge from their 1st or native language. However, this is most likely to lead to all sorts of errors (false friends, calques, unjustified borrowings, wrong evaluation of the recipients' knowledge, etc.). The following excerpts fully cover the points above:

> What is remarkable about language is that we are (nearly) all extremely good at it [...] On a continuum of linguistic ability that includes apes and machines at one end, preschoolers and reasonably diligent late learners are clustered at the other end, near native-speaking adults. Indeed, the question in the critical period literature has never been why adults are incapable of learning a new language—obviously they are—but why adult learners so rarely (if ever) achieve native-like mastery. [...] adult learners rarely, if ever, achieve the same level of mastery as those who started in childhood [...] native speakers did not reach asymptote until around 30 years old, though most of the learning takes place in the first 10–20 years. [...] Thus, even native speakers—who are able to make full use of the critical period—take a very long time to reach mature, native-like proficiency. (Hartshorne, Tenenbaum and Pinker, 2018, The duration of learning section, § 1, 6)

In conclusion, Mora Gómez et al. (2013) states that the average stay and the clinical practice in Spanish public hospitals are affected by non-medical causes such as the language barrier. "The lack of accreditation in the health area, the language barrier, and the lack of social support pose additional difficulties to daily medical practice, which, without being strictly medical problems, do have an impact on clinical care" (Mora Gómez et al., 2013, p. 213). Subsequently, the correct anamnesis, which in the case of non-Spanish speaking patients could only be completed through an interpreter, would render many diagnostic tests and analyses dispensable and even redundant.

4.2. PROFESSIONAL UNDER-RECOGNITION IN PUBLIC CENTRES AMIDST GLOBAL PANDEMIC

Specialised knowledge authority is never an insulated concept, and therefore it cannot be considered a de-contextualised phenomenon. A perfect example thereof would be the unexpected recognition of the indispensability of translation and interpreting services amidst the 2020 Coronavirus pandemic in Spain. Only the essential activities were allowed to take place during the quarantine (lasting form March, 30th until April, 9th 2020), and translation and interpreting activities in legal field were categorised as such. In order to curb further spread of COVID-19, which may have potentially resulted in ICU and hospital bottleneck in Spain, the Government decided to paralyse all inessential and expendable activities, but according to the list of occupations and professions that the Government has drawn up and issued on March, 29th, translation and interpreting in legal field have been both classified as essential activities:

> Lawyers and administration of justice: those who work as lawyers, solicitors, social graduates, translators, interpreters and psychologists and [those] who [will have to] attend the proceedings which have not been adjourned by Royal Decree 463/2020 of 14 March. (Real Decreto-ley 10/2020, my translation)

Please note that this professional recognition ensued in the legal field (Real Decreto-ley 10/2020), but not in the medical sphere. Interestingly enough, the Royal Decree does not mention medical interpreting and translation, or the need for medical interpreting and translation in the middle of a global pandemic.

According to El Diario newspaper (Sánchez, 2020), the lack of interpreters on the hotlines set up to deal with possible cases of coronavirus in different autonomous communities, such as Madrid, Andalucía or Castilla y León, makes it difficult for a part of the foreign population to have equal access to quality care in the event of symptoms of COVID-19.

The NGO *Red Solidaria de Acogida* reports that the existing language barriers hinder access to the essential information regarding COVID-19, thus hampering compliance with the guidelines regarding the measures that are to be taken during the pandemic. The same NGO has launched a campaign "How do you want me to take care of myself if the person taking care of me does not understand me" to demand the Ministry of Health and the Community of Madrid the "permanent activation of interpreter services" in different languages in health centres, administrative telephone lines, hospitals and social services centres.

Martina Corral, who is in charge of the NGO's *Salud Entre Culturas* interpretation and cultural mediation project, indicated that her colleagues reported an alarmingly low number of foreign patients[20]. They feared that isolation, coupled with the language barrier, was hampering access to healthcare for migrant citizens. To avoid this, the organisation has launched a website with information about COVID-19 in different languages (Sánchez, 2020). On May 26, 2020 a campaign "*Intérpretes para Sanar* [Interpreters for Healing]" was launched in Lavapiés district in Madrid (Salud Entre Culturas, 2020). This initiative implied putting up posters on the shopping bags and the shopping trolleys which denounced lack of interpreters in public healthcare. The campaign slogan "*Intérpretes para Sanar* [Interpreters for Healing]" as well as "*Salud Pública y Universal* [Public and Universal Heathcare]" appears on all the banners.

Under the slogan "How do you want me to take care of myself if the person who is supposed to take care of me does not understand me" Red Solidaria de Acogida denounces the lack of translators in the telephone emergency services. The associations Red Interlavapiés and Valiente Bangla also participated in this campaign. Together they have created a network of voluntary interpreters of Russian, Bengali, Wolof, etc. and have launched videos in several languages. They had a list of volunteer interpreters (academy teachers, workers of NGO's such as AGI, CAUTAR) who were available 24/7.

[20] As stated by Orlov (2019), the situation in the UK is similar to that in Spain in terms of the lack of need for certified professional interpreters: "As we know, in today's globalised yet fractured world, each country affected by mass migration flows, which create culturally, linguistically and ethnically diverse societies, has a growing demand for public service interpreting. This need has never been greater in the UK through the Covid-19 crisis and yet, paradoxically, the number of trained, qualified, accredited, registered and regulated public service interpreters listed on the National Register has been in decline. [...] handling communication through Covid-19 ought to have seen an increase, not a decrease, in public services interpreting".

Manique was one of the volunteer interpreters belonging to the Association Valiente Bangla: "I had to wake up at 6 o'clock in the morning until 12 o'clock in the afternoon and I had to keep an eye on the phone during the night[21] [Seis de la mañana tenía que despertar hasta las 12 de la mañana por la noche tenía que quedar con pendiente con movil]" (Salud Entre Culturas, 2020, [00:02:45]). He had to use two phones at the same time in order to attend to the huge volume of calls and messages from WhatsApp asking for information. He highlighted the great responsibility and emotional burden that falls on these volunteer interpreters, who not only translate but also do mediation work, such as informing on ERTES[22], or on how to access different subsidies and aids. Manique highlights that:

> It is not about translating words only, it also about helping [with] many things, helping [to decipher one's way of] thinking because we [belong to] another culture, [helping to understand] how another [healthcare] system works, [how] another [bureaucracy] system works [...] because it differs from our culture [Sí no es solo traducir palabras también tiene que ayudar muchas cosas para ayudar su pensamiento porque somos otra culturas y como y otro sistema de médicos otro sistema de oficinas otro sistema de todo los sistema es distinto que nuestra cultura y aquí][23]. (Salud Entre Culturas, 2020, [00:03:33])

Raquibul Hasan Rasif complains about the fact that: "when a fellow countryman of mine or any migrant has a medical issue or a health issue we call SAMUR or an ambulance and when they hear our voice they know that we are foreigners just by listening to our voice, beyond our ability to speak the language they already know that we are foreigners and so they give us less importance[24]" (Salud Entre Culturas, 2020, [00:05:40], my translation).

Since the beginning of the Covid-19 crisis, the associations have sent letters to the Madrid City Council, the Ombudsman and the Ministry of Health. All of them are referred to the Community of Madrid, which replies that there is a translation service which nobody knows anything about. Meanwhile, the responsibility for many lives is being placed on people who are not professional interpreters working 24 hours a day.

Another initiative of paramount importance and relevance for the present study took place in the Valencian Community around mid-March 2020. This initiative was launched by a group of professional and non-professional interpreters, amounting to fifteen participants in total, who volunteered to telephonically interpret for medical staff. This initiative was endorsed by the James I University in Castellón, Valencian Community. The University lecturers as well as the volunteers agreed upon organising and conducting a training in MI, since many of the volunteers did

[21] Clean verbatim transcription. Spanish original version was transcribed preserving all the errors made by the interviewee. This was done on purpose in order for the competent reader to assess the level of linguistic competence of the interviewee (or lack thereof). The translated version in English needed to be corrected, for the nature of errors would render the excerpt untranslatable.

[22] ERTE stand for "Expedientes de Regulación Temporal de Empleo" or Temporary Lay-Offs and Short-Time Employment Regulations.

[23] The whole audio recording is available on the official Facebook page of Salud Entre Culturas. Clean verbatim transcription. Spanish original version was transcribed preserving all the errors made by the interviewee. This was done on purpose in order for the competent reader to assess the level of linguistic competence of the interviewee (or lack thereof). The translated version in English needed to be corrected, for the nature of errors would render the excerpt untranslatable.

[24] Excerpt transcribed in clean verbatim.

not have previous work experience in this field. After having conducted a three-day-long training course, a list of volunteers was prepared and sent to the relevant and competent local public healthcare authorities: Conselleria de Sanitat (Regional Ministry of Public Health) and the Regional Ministry of Justice, which regulates the emergency operations in the Valencian Community. In spite of all the attempts, we did not obtain any answer or reaction. All the endeavours were in vain as none has produced any results or lead to any responses.

Not even the death of a person which allegedly might have occurred partially due to a language barrier could elicit any type of reasonable response from the regional or national authorities. The case of Bangladeshi restaurant owner from the Lavapiés district located in Madrid had resonated across the country foregrounding the importance of language and the vulnerability of non-Spanish speaking migrants.

According to the newspaper El Diario (Sánchez, 2020), in spite of having called on numerous occasions 112 as well as other telephone numbers specifically activated to deal with possible COVID-19 cases in Madrid, a resident of the Lavapiés neighborhood, Mohammed Abul Hossain, died at his home without having obtained medical assistance he was seeking. The 67-year-old Bangladeshi migrant was suffering from previous cardiovascular pathologies and at the time of dire medical need Hossain presented increasingly serious respiratory symptoms of COVID-19, but neither he nor his family were able to obtain a response until it was too late.

Valiente Bangla denounces that the "language barrier" could have affected the lack of proper healthcare provision. They fear that the current healthcare system might be leaving the non-Spanish speaking immigrants out. Summa[25] on the contrary denied the existence of any problem derived from a language barrier, while the Department of Health merely states that the patient did actually receive advice and treatment both in primary care and in the emergency department without specifying the dates (Sánchez, 2020).

4.3. Terminological fuzziness and alternatives to professional MI in Spain

A number of authors (among them Niño-Moral, 2008; Álvaro-Aranda and Lázaro-Gutiérrez, 2021 *inter alia*) have decried terminological confusion concerning the occupation of MI. The consolidation of the designation of an emerging activity or profession is an indicator of its professionalisation (Álvaro-Aranda and Lázaro-Gutiérrez, 2021, p. 70). It depends on the expectations, demands and subjective perceptions of the relevant social actors. The patients, the institutions and the healthcare personnel play an important role in organising, consolidating and shaping both the boundaries of interpreters' tasks, the skills they should possess and even the appellation they should be given (Álvaro-Aranda and Lázaro-Gutiérrez, 2021, p. 70).

The existing designation confusion mirrors the lack of demarcation of occupational boundaries manifested in the misperception of the role, duties and tasks of medical interpreter: "transmisor de palabras, abogado, proveedor de información, consejero [transmitter of words, advocate, information provider, advisor, counselor]" Niño Moral (2008, p. 1063). This may have been the result of confusing job advertisements and job descriptions aimed at "translators, philologists and

[25] SUMMA is an acronym which stands for Servicio de Urgencias Médicas de MAdrid or Medical Emergency Service in Madrid.

similar", whose only requirement is the completion of the *bachillerato* (equivalent of British A levels) (Niño Moral, 2008, p. 1063, my translation).

Due to terminological fuzziness, it is not uncommon for relevant social actors to verbalise different and often conflicting desiderata as to who is more suitable for this position. It seems to be particularly difficult to reach a consensus on the suitability and effectiveness of different profiles. Despite there being undergraduate degrees in T&I and Master's Degrees in Medical and Healthcare Translation[26], a number of alternatives to professional MI were found to prevail over formally trained candidates.

4.3.1. Community agents in the public hospitals of Barcelona

Burdeus & Arumí (2012, pp. 27-30) reported that language provision services in some public hospitals of Barcelona are provided by the immigrants, who share cultural background with the patient. These may be either autochthonous residents, who purportedly speak the language of the patient, or children of immigrants, who were born in Spain, but who underwent bilingual upbringing (Burdeus & Arumí, 2012, p. 29). These language facilitators are referred to as intercultural mediators, interpreters or "agentes comunitarios [community health workers]" (Burdeus & Arumí, 2012). Such terminological fuzziness indicates a difference in the administrative category that the providers of this type of services have within the organisation chart of each centre. Thus, while at one hospital they are called community health workers, at other hospitals they are called intercultural mediators (Burdeus & Arumí, 2012, p. 28). The figure of the community health worker (*agente comunitario*) is gaining in popularity to the detriment of the figure of medical interpreter (Burdeus & Arumí, 2012).

All of these figures purport to act as a bridge between the health professional and the immigrant patient, although they are also expected to perform other types of functions, which is confusing in terms of role demarcation and qualifications (Burdeus & Arumí, 2012). As suggested by the authors, this may cohere around the fact that the community health agents seem to cover many more functions than the intercultural mediator or the translator and interpreter. Thus, the role of this new breed of bi-/plurilingual profiles is not limited to cross-linguistic re-verbalisation, but rather characterized by multipurposefulness and multitasking abilities in the case of underutilisation of interpreting services (Burdeus & Arumí, 2012). The authors report that some of these tasks have nothing to do with the facilitation of understanding between the participants during medical encounter or with the social services. Some assignments include monitoring of patients, escorting patients across the facility and its premises, detecting problems and referring patients to social workers, offering patients personal counselling, providing information concerning the health system, etc. (Burdeus & Arumí, 2012). This indicates a clear tendency to create hybridised profiles, designed to suit the needs of the hospital management, not the interoccupational boundaries of MI. With regards to training, it is worth noting that it is mainly the private associations or foundations (Salud y Familia, Barcelona Activa, Obra Social "la Caixa" among others) that take the plunge and organise not regulated courses in intercultural mediation (p. 29). Formal

[26] For further information: https://www.uji.es/estudis/masters/traduccio-sanitaria-2013

university education is therefore susceptible of being waived, as some service users posit that intercultural mediators do not lack specialised training:

> All the professionals working in the centres [subjected to research] consider that they are sufficiently trained [to provide interpreting services]. However, they do not see them as qualified to carry out translations that may have an impact outside the centre, arguing that, in order to do so, they need to be able to translate. [...] arguing that a sworn translator would be needed for this purpose. (Burdeus & Arumí, 2012, p. 30)

As regards funding, "Health centres have reportedly other more important needs to which resources should be allocated" (Burdeus & Arumí, 2012, p. 29). This statement showcases that quality MI does not constitute a priority for the management of these medical centres, which indicates a lack of professional recognition. With regard to the professional identity of the above mentioned profiles, the authors report that medical professionals deem interpreting service providers to be auxiliary to other professionals (2012, p. 29).

4.3.2. T&I and Philology graduates and intercultural mediators in the public hospitals in Madrid

Ramón y Cajal Hospital in Madrid is well known for their project "Salud Entre culturas" [Health Among Cultures]. According to the coordinator of the project: "interpreters are usually Translation and Interpreting or Philology graduates and we use them for consultations conducted in vehicular languages such as English, French, Arabic, Chinese or Russian" (Elidrissi, 2018). Intercultural mediators are mainly people of sub-Saharan origin, who speak Spanish, at least one vehicular language and other minority languages, who have been trained to become IM by the Salud entre Culturas team members (Elidrissi, 2018).

Puyol and Martín (2010) report that the Translation and Interpreting graduates who work as intercultural mediators in Ramón y Cajal Hospital provide a 250-hour-long training course, which encompasses theory and practice, in intercultural mediation in healthcare settings. Back in 2010 this training course was geared towards 18 migrants of sub-Saharan, Latin American, Maghreb and Eastern European origin. Six of the attendants were volunteers who worked as medical interpreters in consultation. But according to the same authors, their functions were not confined to interpreting "inside the consultation with a physician". Intercultural mediators may also be requested to travel to the headquarters of the corresponding associations, where they educate non-Spanish speaking population about certain diseases, adapting the information to their needs. According to El Mundo newspaper report (Elidrissi, 2018) both the interpreters and the intercultural mediators are "professional figures", who assist doctors during consultations.

It is worthwhile underlining that both the director and the coordinator of the aforementioned project are neither academically nor professionally linked to translation or interpreting. The director of the project is a doctor, specialist in tropical medicine, and the coordinator is an expert in development cooperation and humanitarian aid.

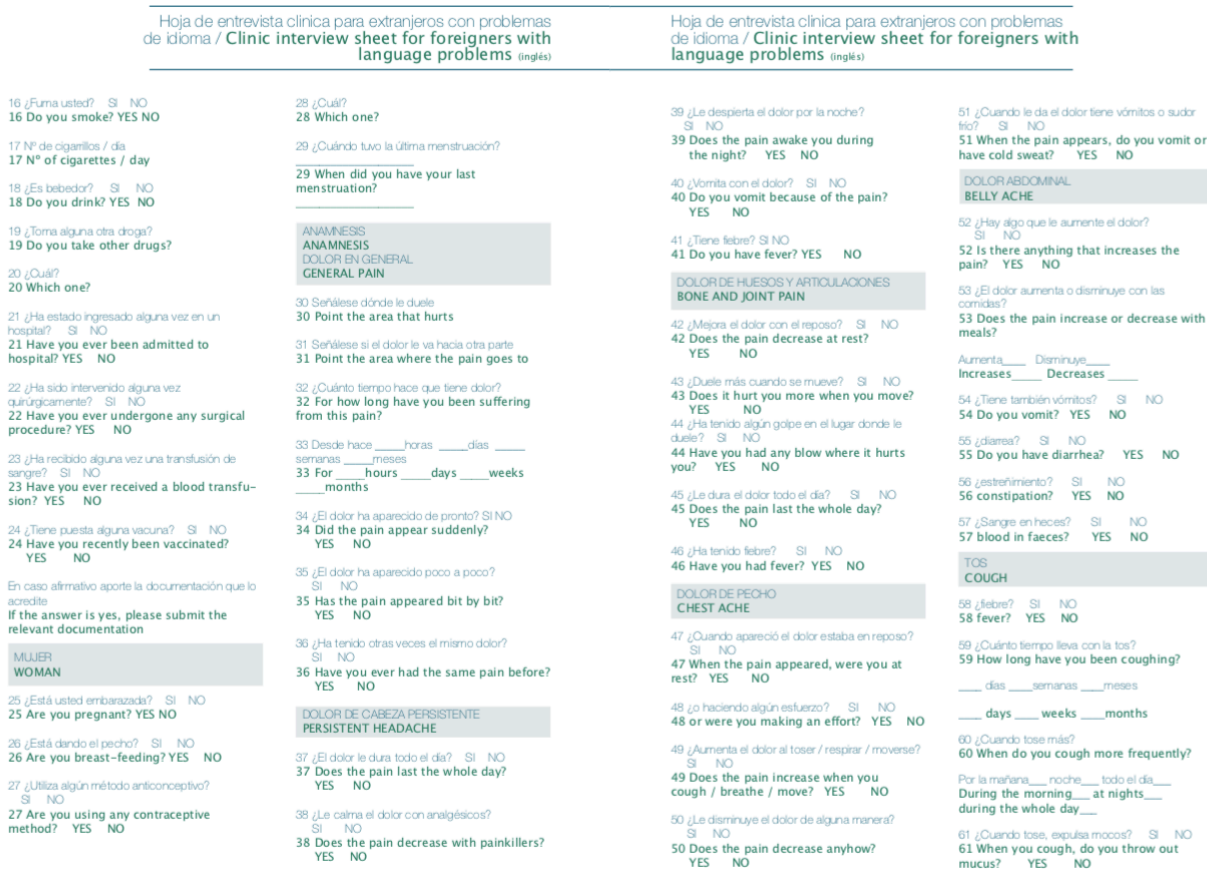
4.3.3. Interview sheets for foreigners in the public medical centres of the VC, Barcelona and Madrid

Sometimes physicians use meta verbal and extralinguistic elements (such as illustrations, visual schemes, or drawings) to explain diagnosis, testing, treatment, and dosage. Nevertheless, this could cause serious misunderstandings. Castillo and Taibi (2005, p. 112) state that in many cases doctors have no choice but to use "illustrations to clarify terminology that can be confusing". Burdeus & Arumí bore out on this occurrence. The authors indicated that: "Healthcare staff members are provided with information brochures on health-related topics translated into several languages to facilitate the understanding of diseases and health care processes by immigrant patients" (2012, p. 31).

The head of department at a Community (public) health centre[27] located in the VC (Gavlovych, personal communication, 2019) decried that[28]: "We have passed on the complaint [regarding the lack of interpreters] to the competent bodies [...] we often find ourselves in need of interpreting services [but all we can do for the time being] is just to muddle through, we do what we can [...]". The same physician revealed that the only thing that local authorities did in response to the complaints was to furnish medical professionals with a sort self-assessment forms in different languages for the patients to fill out, or as the doctor refers to them, "iconografías" [iconographies]: "The laboratories or our [regional] Health Ministry [of the Generalitat Valenciana] or Spanish Paediatric Association or [Spanish Society of] Family [and Community] Medicine provides us with 'iconography' where the most frequently used phrases come in different languages (Personal communication, 2019).

[27] Centro de Salud.

[28] It is worth noting that this particular interview does not constitute a data item forming my data corpus for this thesis as this specific interview was canvassed for another purpose.



Hoja de entrevista clinica para extranjeros con problemas de idioma / **Clinic interview sheet for foreigners with language problems** (inglés)

16 ¿Fuma usted? SI NO
16 Do you smoke? YES NO

17 Nº de cigarrillos / día
17 N° of cigarettes / day

18 ¿Es bebedor? SI NO
18 Do you drink? YES NO

19 ¿Toma alguna otra droga?
19 Do you take other drugs?

20 ¿Cuál?
20 Which one?

21 ¿Ha estado ingresado alguna vez en un hospital? SI NO
21 Have you ever been admitted to hospital? YES NO

22 ¿Ha sido intervenido alguna vez quirúrgicamente? SI NO
22 Have you ever undergone any surgical procedure? YES NO

23 ¿Ha recibido alguna vez una transfusión de sangre? SI NO
23 Have you ever received a blood transfusion? YES NO

24 ¿Tiene puesta alguna vacuna? SI NO
24 Have you recently been vaccinated? YES NO

En caso afirmativo aporte la documentación que lo acredite
If the answer is yes, please submit the relevant documentation

MUJER
WOMAN

25 ¿Está usted embarazada? SI NO
25 Are you pregnant? YES NO

26 ¿Está dando el pecho? SI NO
26 Are you breast-feeding? YES NO

27 ¿Utiliza algún método anticonceptivo? SI NO
27 Are you using any contraceptive method? YES NO

28 ¿Cuál?
28 Which one?

29 ¿Cuándo tuvo la última menstruación?
29 When did you have your last menstruation?

ANAMNESIS
ANAMNESIS
DOLOR EN GENERAL
GENERAL PAIN

30 Señálese dónde le duele
30 Point the area that hurts

31 Señálese si el dolor le va hacia otra parte
31 Point the area where the pain goes to

32 ¿Cuánto tiempo hace que tiene dolor?
32 For how long have you been suffering from this pain?

33 Desde hace ____horas ____días ____ semanas ____meses
33 For ____hours ____days ____weeks ____months

34 ¿El dolor ha aparecido de pronto? SI NO
34 Did the pain appear suddenly? YES NO

35 ¿El dolor ha aparecido poco a poco? SI NO
35 Has the pain appeared bit by bit? YES NO

36 ¿Ha tenido otras veces el mismo dolor? SI NO
36 Have you ever had the same pain before? YES NO

DOLOR DE CABEZA PERSISTENTE
PERSISTENT HEADACHE

37 ¿El dolor le dura todo el día? SI NO
37 Does the pain last the whole day? YES NO

38 ¿Le calma el dolor con analgésicos? SI NO
38 Does the pain decrease with painkillers? YES NO

Hoja de entrevista clinica para extranjeros con problemas de idioma / **Clinic interview sheet for foreigners with language problems** (inglés)

39 ¿Le despierta el dolor por la noche? SI NO
39 Does the pain awake you during the night? YES NO

40 ¿Vomita con el dolor? SI NO
40 Do you vomit because of the pain? YES NO

41 ¿Tiene fiebre? SI NO
41 Do you have fever? YES NO

DOLOR DE HUESOS Y ARTICULACIONES
BONE AND JOINT PAIN

42 ¿Mejora el dolor con el reposo? SI NO
42 Does the pain decrease at rest? YES NO

43 ¿Duele más cuando se mueve? SI NO
43 Does it hurt you more when you move? YES NO

44 ¿Ha tenido algún golpe en el lugar donde le duele? SI NO
44 Have you had any blow where it hurts you? YES NO

45 ¿Le dura el dolor todo el día? SI NO
45 Does the pain last the whole day? YES NO

46 ¿Ha tenido fiebre? SI NO
46 Have you had fever? YES NO

DOLOR DE PECHO
CHEST ACHE

47 ¿Cuando apareció el dolor estaba en reposo? SI NO
47 When the pain appeared, were you at rest? YES NO

48 ¿o haciendo algún esfuerzo? SI NO
48 or were you making an effort? YES NO

49 ¿Aumenta el dolor al toser / respirar / moverse? SI NO
49 Does the pain increase when you cough / breathe / move? YES NO

50 ¿Le disminuye el dolor de alguna manera? SI NO
50 Does the pain decrease anyhow? YES NO

51 ¿Cuando le da el dolor tiene vómitos o sudor frío? SI NO
51 When the pain appears, do you vomit or have cold sweat? YES NO

DOLOR ABDOMINAL
BELLY ACHE

52 ¿Hay algo que le aumente el dolor? SI NO
52 Is there anything that increases the pain? YES NO

53 ¿El dolor aumenta o disminuye con las comidas?
53 Does the pain increase or decrease with meals?

Aumenta____ Disminuye____
Increases____ Decreases____

54 ¿Tiene también vómitos? SI NO
54 Do you vomit? YES NO

55 ¿diarrea? SI NO
55 Do you have diarrhea? YES NO

56 ¿estreñimiento? SI NO
56 constipation? YES NO

57 ¿Sangre en heces? SI NO
57 blood in faeces? YES NO

TOS
COUGH

58 ¿fiebre? SI NO
58 fever? YES NO

59 ¿Cuánto tiempo lleva con la tos?
59 How long have you been coughing?

____ días ____semanas ____meses

____ days ____ weeks ____months

60 ¿Cuando tose más?
60 When do you cough more frequently?

Por la mañana___ noche___ todo el día___
During the morning___ at nights___ during the whole day___

61 ¿Cuando tose, expulsa mocos? SI NO
61 When you cough, do you throw out mucus? YES NO

Figure 14. Example of iconography referred to by the interviewed GP

4.3.4. Universal pain language guide used by paramedics in the VC

Yet another example of an attempt to communicate with non-Spanish speaking patients would be the a universal pain language guide developed by Grupo ASV Transporte Sanitario [ASV Medical Transport Group][29] (Moltó, 2019). It was designed to detect the type of pain experienced by the patient and its intensity through a universal language of symbols. It was created to facilitate the work of healthcare personnel by making it possible to overcome language barriers with patients in a first aid intervention. Reportedly, it allows to identify a condition by overcoming language barriers and by helping healthcare personnel make as accurate a diagnosis as possible in their first contact with the patient. The guide will be distributed among the more than 700 health technicians who operate in ambulances throughout the Valencian Community starting by Alicante, one of the main tourist destinations in the country. Through this tool, Grupo ASV Transporte Sanitario claims to have allegedly found a way to open up a practical and effective communication channel that helps healthcare personnel to identify pain without having to resort to oral language. All of these "solutions" are meant to be something in between the full-fledged professional-interpreter-mediated encounter and quasi-veterinary gesture-based medicine.

[29] Please, consult the website here: https://www.grupoasv.com/noticia/asv-transporte-sanitario-guia-universal-dolor

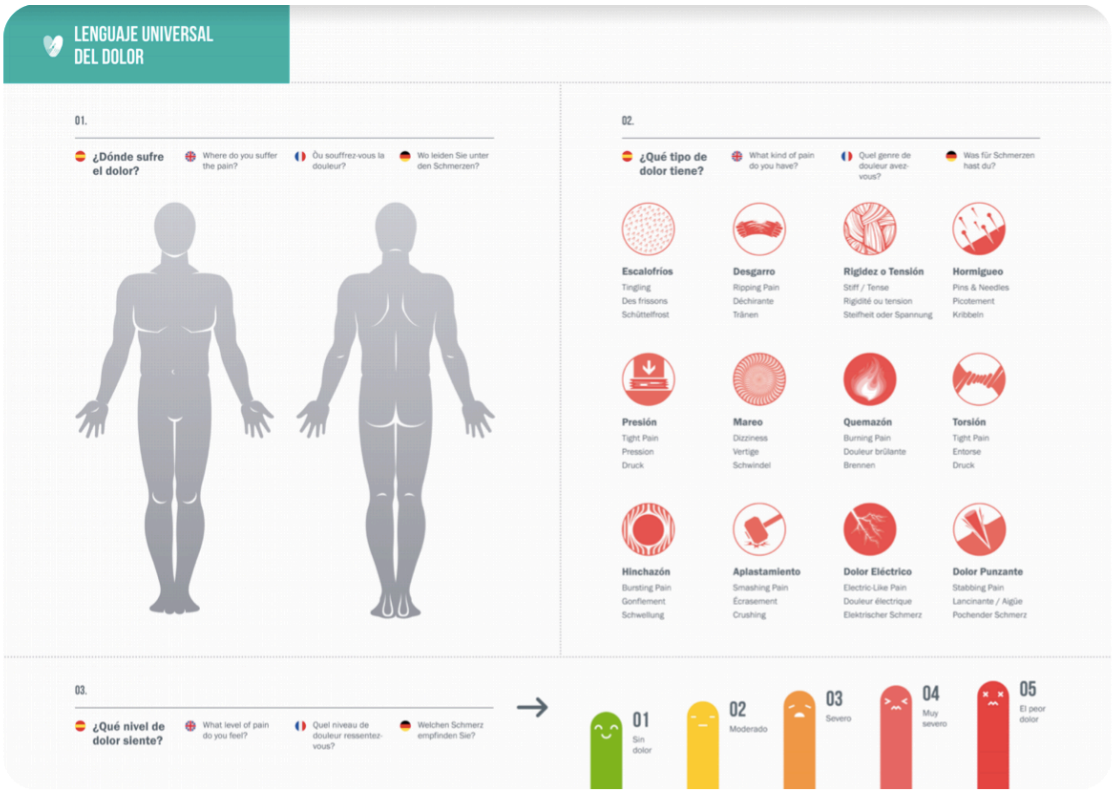


Figure 15. Universal Pain Language Guide by Grupo ASV Transporte Sanitario

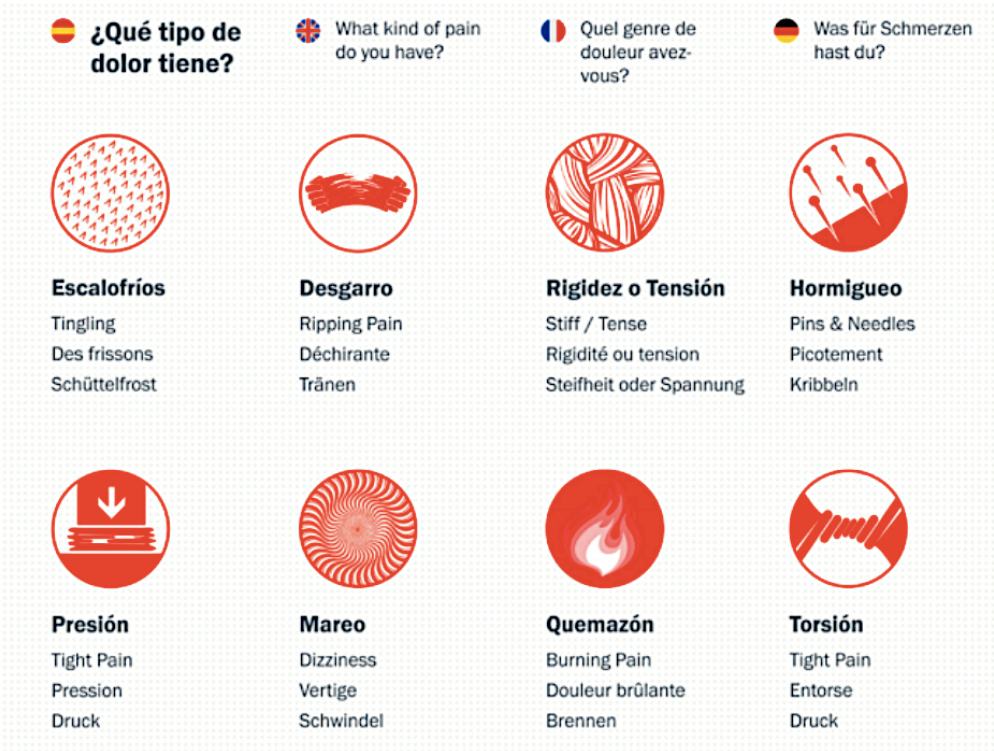


Figure 16. Universal Pain Language Guide by Grupo ASV Transporte Sanitario

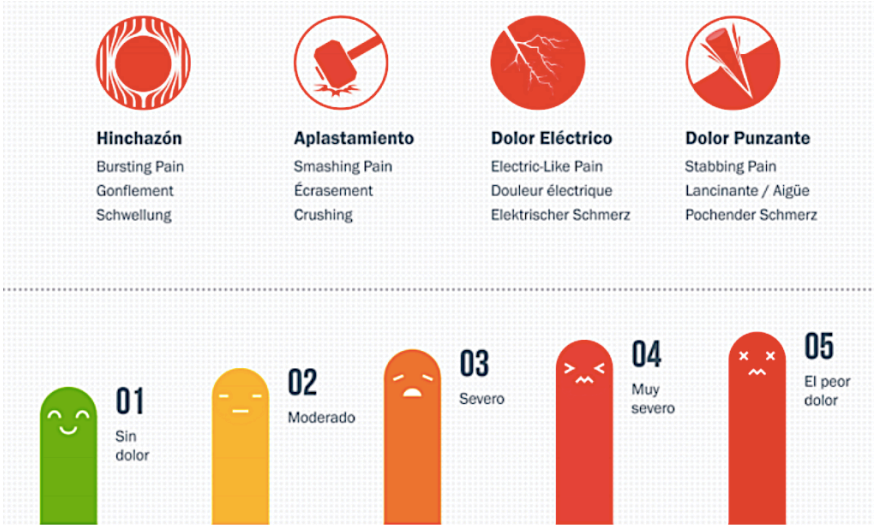


Figure 17. Universal Pain Language Guide by Grupo ASV Transporte Sanitario

Similarly, medical professionals practicing at the public hospital Sant Francesc de Borja de Gandía (Valencian Community) also claimed to have solved communication problems through gestures (Moya-Bataller, 2016, p. 21), which reminds me of the concept of veterinary medicine explored by Cox and Lázaro:

> If no interpreter can be found, or if the doctor prefers not to call in an interpreter, it may be impossible to build rapport with the patient, perform a verbal history, or even simply find out what language the patient speaks. In such a case, a medical interaction may deteriorate to what is referred to as "*médécine vétérinaire*" (veterinary medicine) (Clark 1983; Bowen 2001), implying that only a physical examination can be performed. As Watt (2008) assesses that 80% of the diagnosis tends to depend on oral communication, a communication breakdown is likely to have a strong negative impact on the diagnosis as well as the treatment. (Cox & Lázaro, 2016, p. 50)

It is worth noting that the pain language may vary from country to country and form culture to culture. "Researchers from medicine, sociology and medical anthropology have agreed that ethnic background affects pain perception and that pain is a complex, culturally defined multifactorial experience (Bates, 1987; Greenwald 1991; Ramer et al., 1999; Rollman, 1998; Strelzer, 1997)" (Angelelli, 2012, p. 256). Each culture may have its own verbalisms and phraseology in the common parlance used by the non-experts to detail pain experiences, and it must be made sure that the digit in a pain scale matches the verbal pain qualification/description, non-verbal bodily behaviour (temperature, loos of apetite, verbal complaints encompassing crying, screaming, grimacing, palpation of the sore area, cross-examination of the patient and family members) (Angelelli, 2012, p. 255-256). Angelelli posited that:

> Pain is perceived and communicated differently by members of different cultural communities. Conversations about pain include discussions about intensity of pain based on pain-rating scales as well as discussions of pain management. Healthcare interpreters face challenges in constricting and co-constructing pain while facilitating cross-linguistic communication. (Angelelli, 2012, p. 251)

Additionally, diagnostics are based on multiple factors, which are not limited to pain intensity or location. So, one may wonder how would the team of paramedics or doctors proceed once they have determined the pain location, characteristics and intensity.

4.3.5. The new technologies in the public hospitals of Barcelona and the VC

As early as in 2007 computer programmes were already reported to have been created to be used by Spanish medical professionals. The article issued by El Confidencial (2007) reads as follows:

> A computer programme will allow family doctors to ask their foreign patients about their health state in English, French, German, Portuguese, Romanian, Russian, Arabic, Mandarin Chinese and Urdu. It will be distributed free of charge by the Spanish Society of Family and Community Medicine to 18,800 doctors throughout the country and, subsequently, the aim is to reach everyone (back in 2007 some 35,000 medical professionals. Thanks to this programme, in collaboration with the pharmaceutical company GlaxoSmithKline, doctors will be able to ask an immigrant patient questions without the risk of misunderstandings. The idea came from Dr. Jordi Serrano, who observed the problems of communication with [foreign speaking] patients [...]. The nine languages selected were tested on patients to ensure their effectiveness, and a dozen doctors, a team of engineers and several translation companies were involved in implementing the programme. ("Un médico que habla nueve idiomas", 2007, my translation)

Angelelli (2015) stated that medical professionals from many health centres across Germany, Greece, Italy, Spain and the United Kingdom were using machine- assisted translations to communicate with their foreign-speaking patients. The study revealed that medical professionals in Spain relied on The Universal Doctor Software and Google Translate:

> The technology used includes specialised CAT tools, such as The Universal Doctor Speaker (Spain), specifically designed for the healthcare setting. This tool provides translation of common phrases (e.g., explanations, questions and answers) into over 30 languages (Universal Doctor, 2015). Google Translate was also reported to be an option that institutions use to a certain extent. (Angelleli, 2015, p. 47)

Burdeus & Arumí bear out on the fact of using The Universal Doctor Speaker application, which purportedly "provides translation into several languages of phrases and expressions commonly used during medical visits" (2012, p. 31).

The head of department at a Community (public) health centre[30] located in the Valencian Community (personal communication, 2019) confirmed that the GPs were using "new technologies" to, as they think, enable communication with non-Spanish speaking patients: "I have colleagues who drew on online translators, you know, one of these simultaneous translators [...] a few people bring a translator with them [...] a family member, a neighbour, a friend [would usually] come along with the patient" (Personal communication, 2019).

[30] Centro de Salud.

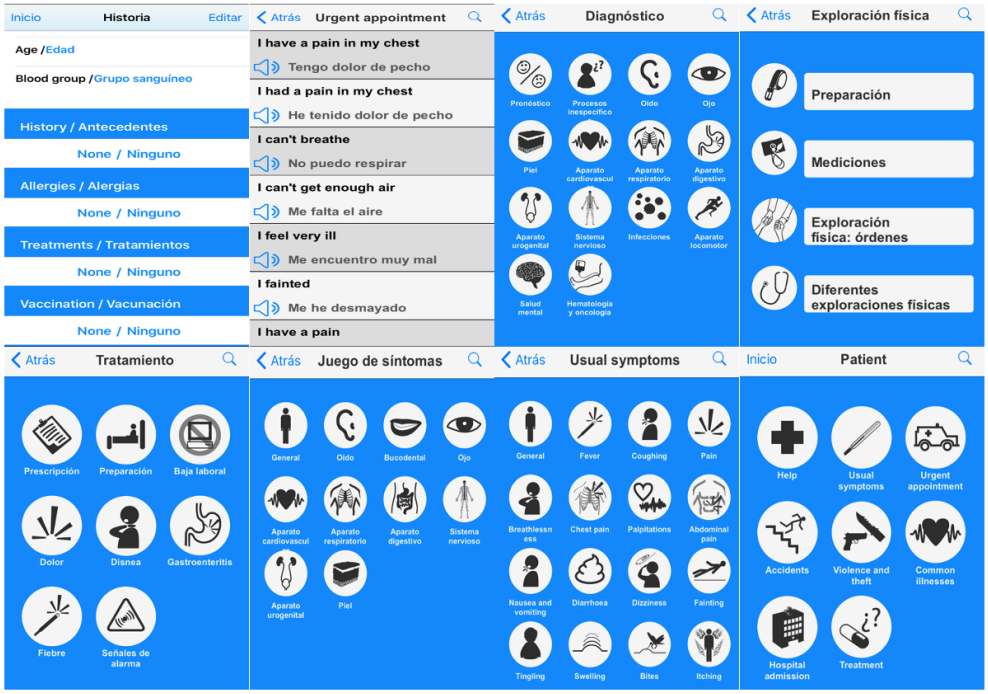


Figure 18. Universal Doctor Speaker App (screenshots)

As one can notice, The Universal Doctor speaker application is very similar to the "iconographies" referred to by one of my informants mentioned above and to the "universal pain language" created by a Spanish medical transport group[31].

4.3.6. MI service advertisements in the VC

In some hospitals of the Valencian Community located in Costa Blanca there can even be found advertisements for interpreting services hanging on the hospital walls or people offering their services on Facebook. None of these adverts indicates whether the announcer has any certification or accreditation in medical interpreting. Please heck the examples provided below.

[31] Grupo ASV Transporte Sanitario.

Figure 19. Image from the Internet, source unknown

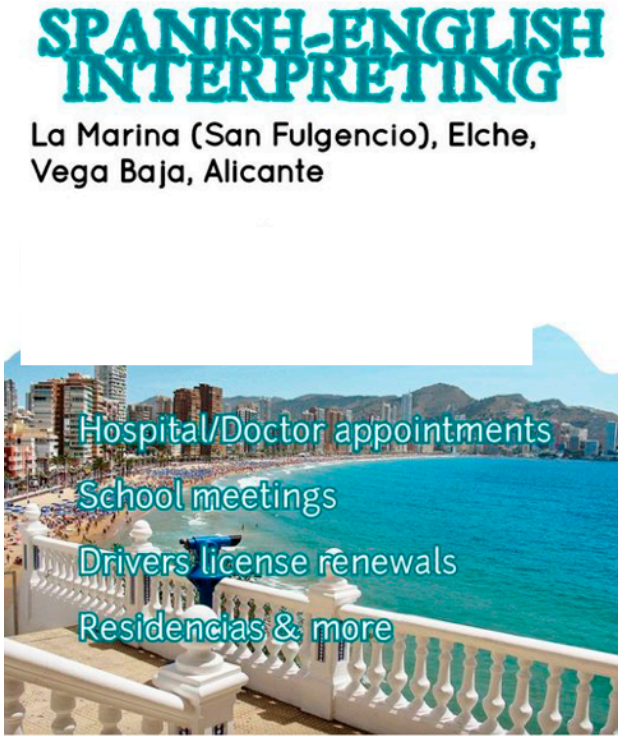


Figure 20. Spanish-English medical interpreting service advertisement. Source: https://www.facebook.com/speech-lessinspain

Figure 21. Spanish-English medical interpreting service advertisement 2. Source: https://www.facebook.com/speech-lessinspain

A student who did an interpreting placement in a hospital of the same geographic area claimed that:

> One of the current problems is that all those who act as translators in the health centre where I have done the placement are people without specific training, who have knowledge of the language and who get by [...] because the terminology is recurrent. For us as translators there is a market in this area, but the low salaries paid to administrative staff are not comparable to what they should pay for a translator with a university degree. (Pellicer-Vidal, 2016, p. 11)

Obviously, the main question that arises in this case is who will be held liable in the case of potential dire consequences of non-professional interpretating? Is the doctor going to put on record that the patient brought with them an interpreter and include the interpreter's details in the patients medical history, which will facilitate the interpreter's localisation if/when needed? And what about the patient's data protection law? What about confidentiality? Professional MI is not only about guaranteeing patient's safety, but also about safeguarding patients integrity in the context of extremely sensitive data being revealed during the medical encounter.

4.3.7. Institutionalised volunteers in Costa del Sol, Andalusia

Even though this section was exclusively dedicated to Aguilar's research, it is appropriate to recall that in 2017 it was publicised[32] that a British volunteer, Candy Wright was awarded the Points of Light prize by the British Prime Minister, Theresa May, for being a dedicated charity worker in Spain with a remarkable 30 year trajectory as interpreter at Denia Hospital in Alicante Province. It should be noted that the article makes the following allusion to Wright's work:

> Candy Wright has spent her adult life dedicated to local charity work in Spain. Most notably she has volunteered with 'Help Denia & Marina Alta' ('HELP DAMA') for 30 years, acting as an interpreter at Denia hospital in Alicante Province [...] playing an instrumental role in developing the charity from a hospital visiting service to a formidable organisation operating several charity shops, funding respite care and running a number of support groups. (Points of Light, 2017)

In some Spanish regions such as Costa del Sol specific non-governmental organisations (NGOs) catering for the communication needs of immigrants have been burgeoning over the past few decades. Favourable economic, social, climatic, cultural, environmental and gastronomic conditions spurred massive arrival of "lifestyle migrants" including retirees from Northern European countries in the 1980s (Aguilar, 2012, p. 135). Thus, an increased number of patients with limited Spanish proficiency spawned "a marked interest in volunteer and charitable work, an activity that is more common in countries such as the UK or Germany than in Spain" (Aguilar, 2015, p. 135). The establishment of non-governmental organisations geared towards non-Spanish speaking patients has ensued. These associations perceived intercultural mediation as the correct way to accommodate communication, convey meaning and facilitate cross-linguistic and cross-cultural exchange. Nevertheless, these mediators purported to build up trust and rapport with and between medical service users and medical service providers by taking on a series of "additional roles such as caretakers and patient advocates (Aguilar, 2015, p. 132).

[32] For full article, please visit: https://www.pointsoflight.gov.uk/championing-charity-spain/

Angelelli indicates that the qualification criteria for volunteers working for non-governmental organisations is practically non-existent: "the selection and training of volunteers is based on a minimum criterion: if you speak the language and want to be a volunteer, you can come. Nothing professional" (Angelelli, 2015, pp. 62-63).

It is not common for volunteer interpreters to achieve the level of institutionalization and recognition described in Aguilar's work, thus, the limitation and the very specific backdrop of this study must be taken into account. Therefore, the findings of Aguilar's study cannot be generalized or extrapolated to other contexts or other settings within the same region or national territory (Aguilar, 2015, pp. 144-145).

Aguilar overviews the particular case of volunteers "organized through the migrant-oriented NGO Asociación de Intérpretes Voluntarios para Enfermos [Organization of Volunteer Interpreters for Patients]", who practice in two medical facilities located in the Costa del Sol region. The medical centres in question are the Hospital Clínico and the Hospital Costa del Sol (Aguilar, 2015, p. 135). The *pièce de résistance* of this study is the iconoclastic institutionalisation of these volunteers within these two articular institutions (Aguilar, 2015, p. 133). The author of the study postulate that the volunteers' self-perception as interpreters burgeoned out of unusual degree of social recognition and unorthodox, unprecedented and curious "legitimization" of their profile "by the healthcare institutions and the regional government" (Aguilar, 2015, p. 133).

> Institutionalization has been an essential factor in transforming the field of PSI in healthcare settings in this very specific Spanish social context. During the process of socialization, the social habitus of the volunteers internalized the structures of their specific healthcare environment and transformed itself into the professional habitus that was required to fill an existing gap in the PSI field structures in healthcare settings in this specific social context. It seems logical that the resulting *socially responsive interpreter role, shaped by linguistic capital, empathy and compassion,* as well as formalized standards of practice was consecrated by healthcare institutions and the regional government. (Aguilar, 2015, p. 145)

It is worth noting that language provision in the above mentioned facilities started with a Dutch physician, Dr. Marko Franke, serving as an interpreter for his fellow providers and non-Spanish speaking patients (Aguilar, 2015, p. 135).

Apart from the dual-role medical staff, the internationalisation and instrumentalisation of English as *lingua franca* has also been reported to have constituted an important alternative to professional medical interpreting:

> And personally I think that doctors are speaking more and more English and some communicate with their patients relatively well, so our job as mediators, as translators, as bicultural, bidirectional interpreters, sometimes happens less frequently. (Excerpt 3 in Aguilar, 2015, p. 139, my translation)

Even though it all started with a dual-role doctor, the figure of medical interpreter or intercultural mediator in the study relevant settings became institutionalised, legitimised and bureaucratised, which denote successful identity positioning:

> 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. (Aguilar, 2012, p. 114)

It is worth noting that institutional legitimisation grounded in recognition endowed upon volunteer interpreters by "those agents with more symbolic capital" determines the "degree of autonomy in shaping the boundaries" and "the extent to which [volunteer interpreters] can position themselves within the wider field of public service interpreting" (Aguilar, 2012, p. 116). As maintained by Aguilar (2012, p. 118): "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". Organisational bureaucratisation in this specific settings implies, according to Aguilar, the consolidation of volunteers as officially affiliated "institutional agents" or "members of the healthcare institution" and "healthcare team" with "bureaucratic properties" and privileges including: ID badges, daily reports, Interpreters' Handbook, office space, the right to eat at the staff canteen, and access to all the administrative offices (2012, pp. 113, 118). Even though the informants have reported sympathy, kindness and confidentiality to be the main pillars upon which recognition was based, the author postulates that the institutionalisation, legitimisation and bureaucratisation processes in this particular case were induced by Doctor Bermúdez, who set up the interpreting team at this hospital (Aguilar, 2012, p. 119). Given that Dr. Bermúdez "had the appropriate symbolic capital" within his own primary institutional sphere (Freidson, 2001), many other agents in the field felt led towards recognising "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" (2012, p. 119). Thus, the author highlights that legitimisation in this particular case was:

> 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. (Aguilar, 2012, p. 119)

To recapitulate, Aguilar's thesis plays a key role in fathoming possible models of professionalisation, and in assessing the importance of being supported by holders of prominent positions in their respective primary institutional sphere, as well as in understanding that in order to succeed members of our occupation should "enjoy prestigious social connections" (Aguilar, 2012, p. 119). Nevertheless, it is my contention that we cannot talk about full recognition of the importance of language capital in multilingual healthcare contexts. The hospital director and Regional Government Delegates[33] as agents with strong habitus and symbolic capital may very well be supportive of the idea of deployment of volunteers to facilitate communication in multilingual health contexts, which is why they have exercised authority to legitimise this position in the field, but in my opinion they do not display an official recognition of the salience and value of this service which, if they did, would translate into an official contract, decent salary and perks. Thus, I do not concur with the fact that, by allowing volunteers in, the holders of high-level, authoritative and

[33] Junta de Andalucía.

influential positions necessarily "attribute volunteer interpreters' linguistic capital a significant value" (Aguilar, p. 119). Thus, the volunteers in this case may very well have achieved a relatively well-established position and certain degree of occupational autonomy, but volunteerism implies that the work is done for one's own satisfaction, whereas professionalism entails active pursuit of profit. Hence, the real institutional support would have implied the willingness to pay in order to obtain an essential service. It may be worth noting that the interest in volunteer interpreting, the understanding of this activity, the appreciation thereof and the attitude towards this non-lucrative practice in this specific institutional setting is not something established and shared by every service user. Some medical professionals were reported to not only value the service provided by volunteer interpreters, but also to "[engage] inexplicit legitimisation of interpreters' position by explaining to hospital staff the value of the service provided by interpreters" and the value of their "linguistic capital" (Aguilar, 2012, pp. 123-124). The newcomers, on the contrary, were reported to be "more reluctant to accept the field structures the way volunteer interpreters have known them in the past" (Aguilar, 2012, pp. 123-124). These "new agents began to question and challenge interpreters' position and their linguistic capital as a valuable asset that can be transformed into symbolic capital" (Aguilar, 2012, pp. 123-124). This situation highlights the non-generalisability of the institutionalisation of volunteer interpreters in this particular case, and showcases the irregularity of the status of MI in general.

4.3.8. Recruitment of allegedly English-speaking medical professionals in the public hospitals of Costa del Sol and the VC

This "reluctance" may be explained by allegedly good command of English language displayed by physicians:

> Although they're here [16 years and] they learnt all English [and they say: "I'm not] quite sure", I always let them speak and if they, you know, you jump in, I admire this, they do this really (.) but the new ones, the younger ones they think they can do it all. I mean some do speak very good English. (Extract from excerpt 6, Aguilar, 2012, p. 124)

Nevertheless, we may want to be very careful when we talk about Spanish doctors being allegedly able to communicate in foreign languages as they may be often berated for not being proficient enough to bring their message across despite claiming the opposite. Several interviewees, who are volunteer interpreters in two public hospitals located in the Costa del Sol region, were cross-examined by Aguilar (2012, pp. 131-132) and revealed 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" (Aguilar's translation), however:

> Well, they are also hiring more doctors who speak English, who speak other languages [...] Well, mind you...Some do, but let's face it, a lot of the problem is that they think they speak English but they don't really, and as I was saying to you before it's not their fault, 'cos they're trying and they shouldn't have to speak English, I mean, it's their country, but by the same token they should say: "Look! My English is not great, I need an interpreter" (Dorothy) And often what happens is that the patient says I don't understand a word and so you've got to be very diplomatic with the doctors obviously, you know? I mean not all of them are like that, but some of them are... (Cordula) [...] And then also you get the situation where a lot of the doctors here don't really care that much for us here,

> so the patient could be asking for an interpreter and the doctor would be saying, NO, NO, NO, NO!!! They don't bother" (emphasis in the original) (Julianne). [...] [Or we speak enough English] or whatever and the problem is that they don't speak that well [...] (Julianne). (Excerpt 10 featuring three informants as cited in Aguilar, 2012, pp. 131-132)

One of the informants tries to explain the phenomena publicised above by saying that medical professionals, especially the newcomers, think that volunteer interpreters are intruders (Aguilar, 2012, p. 125), even though Aguilar, who authored this study, elucidated further by postulating that "new agents" as she calls them (doctors and nurses): 1) fail to accept the volunteer interpreters' position as part of naturalised, routinised and normalised order of things; 2) fail to acknowledge interpreters' linguistic capital as a valuable asset; 3) claim to possess same linguistic capital, which leads up to non-recognition of the interpreters' position in the field (Aguilar, 2012, p. 126). Thus, on the one hand there may be medical professionals who indeed hold sufficient linguistic capital to be able to communicate with their patients, on the other hand there may be many medical workers who are convinced of their linguistic proficiency and self-sufficiency in terms of but whose eligibility has never been subject to scrutiny and the truthfulness of their claims – never verified.

Therefore, many times when patients are treated by doctors who have (hyper) inflated perceptions of self-sufficiency and self-reliance in terms of foreign language proficiency and degree of FL command, the patients:

> They won't say to the doctors but they will say it to us [volunteer interpreters], so of course they (.)- and whenever the doctor comes in, you know what it's like, we do the same thing in our own languages, you know, you're so sort of in awe of this doctor that comes in, and you, and it's like he's God right, and you know, I see the patients, going: "Yes, yes, yes!", but then, I understand but they don't understand a word. (Aguilar, 2012, pp. 124-125)

In conclusion, Aguilar demonstrates that the longed after and sought after legitimisation of volunteer layperson interpreters in the Costa del Sol region may be undermined, challenged and rebutted by both the doctor and the patient. In order to reaffirm their leading role and their control over the situation, doctors have been reported and proven to interrupt the interpreter by proclaiming command in English and therefore access to the same value (linguistic capital) in furtherance of self-affirmation (Aguilar, 2012, pp. 138-139). As maintained by Aguilar the interpreters' position was challenged straight after having gained recognition of the patient:

> 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. (Aguilar, 2012, p. 139)

Angelelli (2015) addressed the role of the English language in the recruitment process for hospital staff be it medical, administrative, admission or nursing staff. According to the data canvassed by her, it is clear that one of the essential criteria for hiring hospital staff is their alleged

knowledge of English. Angelelli described this alleged English proficiency as a "wildcard", which is believed to solve all the possible communication problems:

> Doctors and nurses are recruited also because they understand and speak two or three languages. For less common languages, we contact foreign consulates… who sometimes refuse to help. In most cases, communication is not a major problem… We manage in English. We always manage. English is like a wild card (comodín). For consent forms for example, we simplify the language to make it more accessible, especially when the "translator" is a child who then needs to explain it to the family member (ES Inf 7). (Angelelli, 2015, p. 61)

It is worth clarifying that despite claiming that "most primary care physicians read English and speak enough to be able to communicate with the patient" (Angelelli, 2015, p. 62), "neither the language proficiency nor the interpreting skills of these ad-hoc interpreters were tested. Rather, they were taken at face value" (Angelelli, 2015, p. 63). Angelelli's informants argue that "this type of care is optional for the patient and that, when deciding whether or not to apply for healthcare outside their MS of affiliation, they should take language barriers into account" (Aneglelli, 2015, pp. 68-69). This attitude is endorsed by the assumption that English "can be understood by many patients" and therefore English must be used as lingua franca de facto (Angelelli, 2015, p. 69). Similar phenomena can also be attributed to Germany in that according to Borde "sociocultural diversity has changed the job description of hospital staff" (2002, p. 7).

Private hospitals located in the Levante area (Valencian Community) tend to:

> Hire some interpreters on a full-time basis for the languages most in demand; for the others, they manage with bilingual or trilingual receptionists and telephone operators. When asked about the qualifications of the interpreters they hire, they said they would prefer someone with a university degree and education in interpreting but if that is not the case the person needs to show that she is a native speaker. (Angelelli, 2015, p. 62)

These findings are absolutely consistent with those reported by Funes-Chica in 2015, who conducted her study on the "social interpreting" in the medical field in Costa del Sol. In her study she explained that:

> Generally, health centres have stated that there are no communication problems or cultural conflicts. With the exception of a few isolated cases where the language of the patients is not very common and they cannot communicate in English. (Funes, 2015, p. 64, my translation)

English was reported to be "one of the least problematic languages, since in many of the centres, knowledge of English is required of staff as a basic communicative requirement" (Funes, 2015, p. 65).

Angelelli's and Funes's data (2015) also concur with the findings presented by Niño Moral in 2008, who within the framework of her study "Proyecto de estudio de campo sobre las necesidades de mediación lingüística en los hospitales públicos de la provincia de Alicante" researched market demands and employment trends and patterns in (privately managed) public/state hospitals as well as private hospitals in the area of the Costa Blanca (Valencian Community). Thus, she found that one of the alternatives to professional medical interpreting and one of the ways in which these medical facilities were reacting to the current situation of multilingualism in the province was the tendency to recruit staff with foreign language skills:

> Another type of measure being taken by the hospitals is the tendency to hire personnel with foreign language skills, a hiring policy which seems to be the norm for the new hospital in Torrevieja where, among the minimum requirements for registering for the job vacancies, knowledge of English is required in all cases and German in many of the job categories. Several press reports also point out the hiring of health personnel from Eastern European countries in this same hospital. The case of this particular health centre is very specific, since it is a privately managed public hospital, which allows its procurement managers to include the command of foreign languages among its staff selection criteria. Apparently, foreign language proficiency as an imperative application criterion cannot be imposed in the case of public hospitals managed by the Conselleria de Sanitat, as it would be considered discriminatory. (Niño Moral, 2008, p. 1066, my translation)

There are two other excerpts regarding different tactics and strategies used by public hospitals in Spain to deal with linguistic diversity of their patients:

> Doctors and nurses are recruited also because they understand and speak two or three languages[34]. For less common languages, we contact foreign consulates… who sometimes refuse to help. In most cases, communication is not a major problem… We manage in English. We always manage. English is like a wild card (comodín). For consent forms for example, we simplify the language to make it more accessible, especially when the "translator" is a child who then needs to explain it to the family member. (ES Inf 7). (Angelelli, 2015, p. 61)

Ortega-Herráez and Blasco-Mayor have already deprecated the huge credibility gap, lack of trustworthiness and plausibility of these types of statements, because in ensuring that all practitioners speak English the hospital administration renders communicative problems involving foreign patients as inexistent and categorically denies the problem caused by the lack of instruments (qualified medical interpreters) that would enable multilingual speech events to occur duly (Ortega-Herráez & Blasco-Mayor, 2018, p. 188). Moreover, the official narrative of the healthcare officials purports to persuade those concerned that all the hospital staff has advanced linguistic competence in English which enables them to communicate safely with English-speaking patients without imperilling the accuracy of the diagnosis and the evolution of the state of the patient. Nevertheless, although this statement is extremely widespread in healthcare settings, it poses a threat because no evidence was found to substantiate its veracity (Ortega-Herráez & Blasco-Mayor, 2018). A number of alternative sources decry lack of interpreters. According to a primary care physician, despite the employment of the "simplest terms possible" during the consultation and despite "giving the treatment in writing" to the patients in order for them to "better understand the instructions", "language does indeed constitute a problem, especially in the consultation room, where we find ourselves under time constraints which imply delays" (Ortega, 2018).

4.3.9. Translation of informed consents

Translation of informed consents is also a possibility. In her research "Studies on translation and multilingualism. Public service translation in cross-border healthcare" (2015) Angelelli informs that: "in the public and private healthcare sites visited in this project[35] there were not many examples of professional in-house translation services that fulfil the requests of patients, providers

[34] This was also corroborated by Niño-Moral (2008, p. 1066).
[35] Germany, Greece, Italy, Spain, United Kingdom.

or staff" (Angelelli, 2015, p. 46). Angelelli maintains that "translation needs are most often judged to be the responsibility of the patient" (Angelelli, 2015, p. 46). Even though ad hoc translation has been reported to be the most frequently used solution, which has already become commonplace in many MSs, sight translation and machine-assisted translation have also been reported to be occasionally used for informed consent forms, check-in forms and informative materials such as information brochures, posters and websites (Angelelli, 2015, pp. 46-47):

> Professional translation service is not the norm in the MSs of this study. Ad-hoc translation of documents is the most common solution for the public and private health centres and hospitals observed in Spain, Italy and the UK. Bilingual staff members translate documents and patients are also asked to perform this task for themselves. [...] These translations are usually done only for the most common language combinations in a particular country. The most common language combinations vary between the institutions of this study and depend on the demographic profile of the population that each institution serves.

To conclude, I would like to share a testimony of Pellicer-Vidal, who completed a placement at a privately managed public/state hospital in the study-relevant area:

> Despite being a hospital that receives many foreign patients, written information is not usually translated. However, many of the medical documents and the website were already translated but had not been published. These translations are usually done by administrative staff who have foreign language skills and who also interpret for the hospital. However, the wording or the terminology of the translations into English was often error-ridden. This is because they neither had a professional translator, nor did they send the translations for proofreading, which indicates that the translations could have ended up being published with errors. (Pellicer-Vidal, 2016, p. 5)

The informed consent is a medico-legal document, which is extremely important for the compliance with Ley 41/2002, of the 14th of November, on basic regulation of patient autonomy and of rights and obligations regarding clinical information and documentation. By not providing all the relevant information needed for the informed decision in a language comprehended by the patient, the clinic is definitely breaching the Ley 41/2002, however the breach of this legislative instrument on account of linguistic gap has not been foreseen and addressed by the current national legislation, which allows for practices described in Pellicer-Vidal (2016, p. 5) to take place.

4.3.10. Translators and interpreters in the private centres of the VC

I would like to provide a screenshot of the website of one of the private hospitals of the Valencian Community, which does offer interpretation service. Please note how the term "translator" is being used to refer to "interpreter" and how the two term are thought to be interchangeable synonyms.

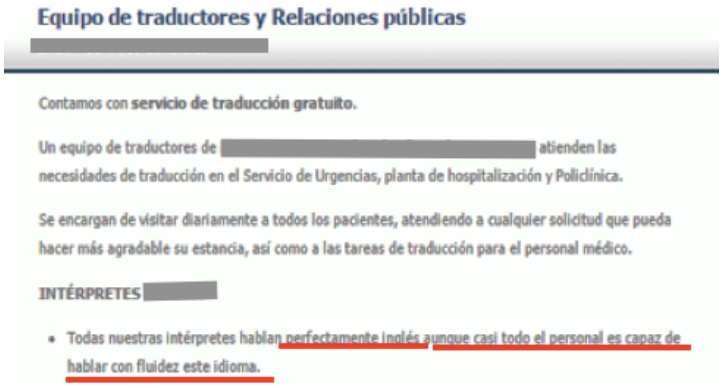


Figure 22. Screenshot of the website belonging to a private centre whose name is not being disclosed for confidentiality reasons

Another very important problem described by Martínez-Gómez (2007, p. 1049) is the lack of demarcation of the occupational boundaries, which leads in-house interpreters practicing in the private sphere to carry out tasks which should not fall within their remit. Thus, the tasks undertaken by both in-house interpreters and trainee interpreters were reported by Martínez-Gómez to cover a much wider field than interpreting *per se*. It was observed that in-house interpreters in the study-relevant private facilities were frequently called upon for the translation of documents including medical reports and even menus. They were also attributed with administrative tasks including communication with foreign insurers, invoicing, etc., as well as lending personal support to patients and relatives by paying at least one daily visit to the inpatients (which consisted of talking to the patients, commenting the press) or by spending hours accompanying the relatives of patients admitted to the ICU.

According to the participants of the survey, this is where the "work of a quasi-psychologist" comes into play. It is worth noting that:

> The question that does not seem to be clear to either group is the appropriateness of the practice of cultural mediation in the event of conflict. Despite the fact that many experts have been advocating for some years now for intercultural mediation by the interpreter, the reality is that around 50% of the professional interpreters and most of the students are reluctant to participate in the communication *qua* intercultural mediators and state that they limit themselves to interpreting what each party says "as literally as possible" (with the linguistic and cultural clarifications they consider appropriate). (Martínez-Gómez, 2007, pp. 1049-1050)

Drawing on my own professional experience in the field, I know that the taks of Mis in the private healthcare may include escorting patients and family members across the facility and its premises, bringing a blanket or an extra pillow, bringing a newspaper and commenting news in the press, bringing a remote control/ a book, sight translating menus for each patient individually, finding a TV channel, etc.

This bears similarity to the figure of flight attendant ensuring comfort of the patients in the same way as a flight attendant would ensure comfort of the airline passengers. Moreover, even the uniform of the interpreters practicing in some private facilities in the study-relevant areas is similar to the uniform worn by cabin crew: scarf, heeled shoes, skirt, etc. It should be noted that in one of the private clinics of Costa Blanca even a *compulsory* make-up tutorial was organised

geared towards interpreters and reception staff[36]. With regard to education, the surveyed interpreters believe that the training is "irrelevant":

> Regarding the respondents' assessment of their own training, it is worth noting that most of them consider it to be irrelevant, since the only way to learn is through professional experience as a healthcare interpreter. Only one student and one staff interpreter (in fact, the only one with a degree in translation and interpreting) consider that their training has not fully prepared them to carry out these tasks. (Martínez-Gómez, 2007, p. 1050, my translation)

It is the author's contention that: "Although most of the interpreters surveyed claim that training is irrelevant, which may stem from the fact that they have been self-taught, many experts believe that, as in any other field, it is essential" (Martínez-Gómez, 2007, p. 1051).

4.3.11. Multilingual staff in the private hospitals of the VC

This screenshot showcases the existence of several serious problems apart from the terminological confusion. First thing worth mentioning is the sentence highlighted in red, which reads as follows: "Todas nuestras intérpretes hablan perfectamente inglés aunque casi todo el personal es capaz de hablar con fluidez este idioma [All our interpreters speak perfect English, even though almost all members of our staff are able to speak this language fluently]". On the one hand, this formulation implies that almost all of the staff is bilingual, which implies 1) that the procurement managers must have hired many professionals from abroad and 2) that English has been consolidated as *lingua franca*. It also implies that all of their interpreters are duly qualified and certified professionals. However, as far as I know no study has been conducted on how applicants' alleged language command is assessed, and whether there exist criteria to determine the newcomers' ability to communicate in a language they *claim* to be proficient in. This statement also corroborates the fact that private facilities do take advantage of their status as private hospitals/clinics and hire people with languages so to say (*gente con idiomas)*, which in the case of public healthcare would be unacceptable and considered discriminatory (Niño Moral, 2008).

Another problem with dual-role (clinical and non-clinical) staff interpreters is that interpretation is their secondary duty, which means that if the volume of foreign speaking patients is fairly high it may pose an insurmountable difficulty for them to keep up with both assignments/roles. For example, if a hospital hired a German speaking doctor he would not be able to always serve as an interpreter for fellow providers due to 1) tight schedules (encompassing activities such as visiting inpatients, writing discharge reports, conducting consultations at the outpatient clinic, etc.); 2) the constraints of his/her specialty: a German-speaking nephrologist cannot see all German-speaking gynaecology patients; 3) work overload; 4) impossible 24/7/365 reliance due to vacation, medical leaves, etc., which will imply that a *locum* will be covering and backfilling clinician's absence. Basically, a German-speaking doctor may not be able to leave a German-speaking patient in his outpatient consultation in order to attend to another German-speaking person who is being rushed to the emergency room, for example. According to Martínez-Gómez:

[36] Datum extracted from my own personal experience.

> Private healthcare, as a company, opts for those solutions likely to ensure a better service, with a view to greater competitiveness. The clinics with the highest volume of [foreign-speaking] patients (San Jaime, Medimar, Vistahermosa) have in-house interpreters, while the smaller clinics (Centro Médico, Moraira) usually have staff (especially nurses and administrative staff) with a sufficient command of foreign languages who, if necessary, add interpreting to their specific tasks. On the other hand, in the public health system the figure of in-house medical interpreter does not exist, nor are we aware of other staff members performing such tasks, with the exception of the Villajoyosa hospital, where an employee performs only interpreter functions, even though, for administrative purposes, she is not an interpreter. (Martínez-Gómez, 2007, p. 1049, my translation)

Members who were recruited to double as interpreters were not specifically trained to perform interpreting tasks (Martínez-Gómez, 2007, p. 1050). Resuming the analysis of Martínez-Gómez' study, it should be noted that the in-house interpreters she has been shadowing have a very diverse education background, which encompasses both higher education (a diploma in tourism, a degree in mathematics and a degree in translation and interpretation) and secondary education (bachillerato equivalent to Advanced Level Qualification (A levels) in Britain) (2007, p. 1050). It was also found that staff.

4.3.12. Conclusion

Generalised confusion over the definition of interpreting, the difference between interpreting, translation and intercultural mediation, the delimitation of occupational boundaries, the education and training and the role of medical interpreter.

As maintained by Angelelli, private assistance providers should undertake initiatives that would guarantee proper language services, but for the time being they clearly lack criteria for monitoring the quality of the improvisation practices being delivered by *ad hoc* bilinguals or volunteers (Angelelli, 2015, p. 93). The procurement managers, the hospital administration, the patients, the general public and the state need to understand that having volunteers ad-libbing, dual-role medical staff extemporizing, and ad hoc bilinguals providing autoschediasms along with other questionable impromptu solutions such as Google translate and other cognate software alternatives or pictograms is not the correct way to cater for language needs of their foreign-speaking clients. Furthermore, all these "solutions" are totally unreliable, and when minimum quality standards cannot be guaranteed, there may be serious implications. I would like to conclude this chapter by citing Angelelli:

> If, as we have seen in this study, access to public services (such as healthcare) requires language provision (when there is no shared language), but language provision is not provided under the guise that it is cumbersome, costly or "not *really* necessary", then it follows that equal access to the highest degree of health protection is not for *all* EU citizens, but rather for *some*. It is time that we ensure that it is available for *all.* (Angelelli, 2015, p. 98, italics in the original)

Thus, in case of medical interpreting in both public and private fields, the demand is not well calibrated to supply. This means that there is an exponentially growing demand for language provision in both sectors, but the supply is very poor. This situation is excacerbated by the fact that the predatory competition cannot be tempered by an economic monopoly guaranteeing that all qualified members of a discipline gain at least a modest living, because the competition is

between the professional and non-professional groups, both contesting ownership of tasks and ability to carry these tasks out.

Thus, the constant exoterisation of English as universal, one-size-fits-all solution, as well as certain gravitation towards dismissing competent and professional language provision as dispensable and unnecessary, the lack of recognition of the value of medical interpreting (in other words, the state and the general public turn the blind eye and fail to see the immediate functional value of this activity) contribute to devaluation, depreciation and write-down of medical interpreting. The whole society is gaslighted and conditioned into thinking that learning languages is something easy everyone can do and that interpreting is just parroting words, ad-libbing, something everyone who speaks a language can naturally do.

PART II. SOCIOLOGY OF THE PROFESSIONS

5. A PROFESSION: RELEVANT CONCEPTS

An adequate definition must provide itemised "referents by which the phenomenon may be discriminated in the empirical world - that is, specifying attributes, traits or defining characteristics" (Freidson, 2016, p. 22). Freidson argues that the lack of definition of the structure of "profession" will result in the loss of significance of the process of "professionalisation" (2016, p. 22). "In order to think clearly and systematically about anything, one must delimit the subject-matter to be addressed by empirical and intellectual analysis. We cannot develop theory if we are not certain what we are talking about" (Freidson, 2016, p. 21). What stratum within the current social stratification system does the translation and interpreting niche occupy? "How well does the interpreter's societal function fulfil the criteria of being a profession?" (Skaaden, 2019, chapter 3 Ethics and Profession, § 1).

This chapter of the study will look to map the setting of medical interpreting through a sociological lens, building on the sociology of professions as the main point of departure. Sociology of professions constitutes a research area "rooted in ethnographic and comparative-historical methods" (Liu, 2014, Foreword section, § 7). It is noteworthy that most of the empirical studies spawning theories of professions are grounded on occupational parochialism, since in their majority they spotlight stereotypical high-status professions, such as medical and legal, playing down other professions and occupations (Liu, 2014, Foreword section, § 11). Sociologists acknowledge that "there has been little effort to expand the scope of empirical studies to a wider range of professions in order to advance theory" (Liu, 2014, Foreword section, § 11) and therefore the aim of this chapter of the thesis is to tackle the theoretical and empirical stagnation and stigmatisation in the field of translation and interpreting, and more specifically medical interpreting and hospital in-house translation, and thus to further the development of the sociology of professions applying it to a new field. This study will seek to examine the current state of affairs of in-house medical interpreting and translation within the burgeoning socio-demographic phenomenon of medical tourism in Spain. In the acclaimed article "The Theory of Professions: State of the Art" by Eliot Freidson the author states that "the task for a theory of professions is to document the untidiness and inconsistency of the empirical phenomenon and to explain its character in those countries where it exists" (Freidson, 2016, Pursuing the Folk Concept section, § 1). Thus, in this thesis I will delve deeper into the empirical phenomenon of medical interpreting in the private sector as an emerging occupation being sought by cross-border medical tourists in the Valencian Community in Spain.

5.1. PROFESSION AND PROFESSIONALISATION

Thus, this section will seek to expand its scope by fruitfully cross-fertilising two different realms of expertise: "Sociology" pertaining to the academic discipline of Social Sciences, and "Languages" which encompasses Translation and Interpreting Studies and belongs to the academic branch of Humanities. In other words, as the author of this thesis I will seek to apply occupational sociology to the case of medical interpreting in order to elicit insights into how different social

actors grade the *status quo* of this discipline in particular according to its immediate functional value (Freidson, 2001) and to reveal "how well does the interpreter's societal function fulfil the criteria of being a profession" (Rudvin et al. 2019, Chapter 3 Ethics and Profession, § 1).

The reader must be aware of the fact that this study views medical interpreting as an autonomous and self-contained discipline or ramification and therefore its process of professionalisation must be viewed separately from other adjacent branches such as conference interpreting (consecutive and simultaneous modality), public service interpreting encompassing police interpreting and court interpreting, sworn translation and interpreting, literary translation, multimedia or audio-visual translation, scientific and technical translation, etc; as well as juxtaposed disciplines such as medicine, law, etc. nor can medical interpreting and translation be compared against the occupations (used here as an umbrella term) which have long ago completed their transition from mere occupations through to fully-fledged professions.

Thus, the locus of research must be shifted from parochial views merely focusing on medical interpreting as a detached or isolated activity to an interdisciplinary approach constituting a meta-reflexion on interconnectedness and embeddedness between languages and society. A thorough professionalization process analysis would come in particularly useful and insightful for a comprehensive understanding of the current state of affairs.

This study aims to delve deeper into two scenarios that might unfold in the future regarding the trajectory of translation and interpreting in Spanish medical settings:

1. Pursuing professionalisation or attaining the coveted status and sophistication of a fully-fledged profession
2. End up regressing towards de-professionalisation without ever having become a duly established profession. This worst case scenario may be spurred by deployment of new technologies such as neural machine translation, statistical machine translation, universalization of English establishing it as lingua franca, globalized and multilingual societies, bilingual upbringing as a benchmark of quality, role hybridisation amongst other factors.

One of the relatively few forays into the investigation of the status signals in the translation occupation has been made by Pym et al. in 2012 within the EU framework.

It is worth noting that Pym et al. (2012) used the term "profession" in the title of the study "The status of the translation profession in the European Union". The terms "profession" and "status" have become so deeply entrenched in our vocabularies that laypeople use them in their common parlance without trying to fathom the actual denotations that these convey. The label of "professional" became frequently misused in colloquial speech in modern societies coming to denote multi-layered workplace reality[37] of those occupations which cannot be attributed to professions (yet). According to Freidson "profession" is not a "generic concept", but rather "a changing historic concept" (2016, p. 22). This assertion ties flawlessly in with the analytical framework of this thesis: social constructionism, which argues against the pre-existence of ideas (Burr, 2015) supporting the view of an *a posteriori* conceptualisation of discursively and intersubjectively

[37] Reality – [...] quality appertaining to phenomena that we recognize as having a being independent of our own volition (we cannot "wish them away"), and to define "knowledge" as the certainty that phenomena are real and that they possess specific characteristics (Berger, 1966, p. 13).

constructed ideas, identities and realities and their posterior embeddedness and normalisation in the society. Thus, medical interpreting in this thesis will be X-rayed within the scope of the sociology of knowledge, a discipline which has for a long time remained only a peripheral concern for many sociologists and philosophers, and yet turned out to be the only one "concerned with the relationship between human thought and the social context within which it arises" (Berger & Luckmann, 1966, p.16). In other words, the sociology of knowledge "painstakingly" investigates "the concrete relationships between thought and its historical situations" (Berger & Luckmann, 1966, p. 17). According to Berger and Luckmann (1966, p. 15):

> 'Sociology of knowledge'[38] will have to deal not only with the empirical variety of 'knowledge' in human societies, but also with the processes by which *any* body of 'knowledge' comes to be socially established *as* 'reality'. It is our contention, then, that the sociology of knowledge must concern itself with whatever passes for 'knowledge' in a society, regardless of the ultimate validity or invalidity (by whatever criteria) of such 'knowledge'. And in so far as all human 'knowledge' is developed, transmitted and maintained in social situations, the sociology of knowledge must seek to understand the processes by which this is done in such a way that a taken-for-granted 'reality' congeals for the man in the street. In other words, we contend that *the sociology of knowledge is concerned with the analysis of the social construction of reality.* (Emphasis in original)

Therefore, in this chapter as well as in the following chapters I shall seek to ascertain what types of knowledge come to be socially established as those necessary for obtaining the label of "professional". For this purpose I shall seek to cross-pollinate Berger's and Luckmann's (1966) concept of the sociology of knowledge, Freidson's (2001) notion of expert or professional knowledge, and Burr's (2015) depiction of social constructionism. Thus, the idea of "profession" is not a static ever-existent notion, but rather an artificially (be it consciously or unconsciously) plus intersubjectively constructed and *a posteriori* socially underpinned concept, subject to fluctuations in meaning spawned by historical backdrop.

> The option that can lead to a coherent and systematic method of analysis is one that requires forsaking the attempt to treat profession as a generic concept and turning instead to formulating a generic conception of occupations within which we can locate analytically the particular occupations that have been labelled professions. To advance a theory of professions, however, requires a rather different option, which treats the concept as an historical construction in a limited number of societies, and studies its development, use and consequences in those societies without attempting more than the most modest generalisations. (Freidson, 2016, p. 20)

I find it truly thought-provoking to expand the scope of the sociology of professions by cross-fertilising the empirical research thereof, that has been focusing so far on very few overexposed professions in the field of law and medicine, in order to spawn fruitful and insightful results in the barren field of medical interpreting when it comes to analysing its, for the time being, truly fetal stage of occupational development. If academics "shift[ed] the focus of research from high-status occupations to occupations at the middle range of the status hierarchy, such as nurses, technicians, teachers, librarians, flight attendants, and so on" (Liu, 2016, Foreword section, § 12) they would greatly contribute to spotlighting the work and the merit of these underexposed occupations. I sincerely believe that my attempt to inspect the field of medical interpreting through

[38] Wissenschaftsoziologie as it was coined by Max Scheler in 1920 (Berger & Luckmann, 1966).

the prism of the sociology of professions will "greatly enrich theories of occupations" (Liu, 2016, Foreword section, § 12).

A number of academics who authored a series of works on T&I would employ the designation of "profession" when referring to the adjacent occupations comprising T&I realm regardless of the occupational differences among them. The empowerment, the service formalisation, and the social representativeness being given to e.g. sworn translators and interpreters or literary translators cannot be stacked up against the disenfranchisement and underestimation of other branches such as public service translation and interpreting. It could be argued that interoccupational boundaries in this case should not be blurred or disregarded. The branch of medical interpreting might tantalise undergraduates, but they will end up disenchanted after they have learned that the workplace reality mismatches the future that they have envisaged.

Having said that and contextualised the field of research, I believe that it is of pivotal importance to determine what historical and contemporary meaning does the term "profession" actually have in order to minimise the surrounding obscurity. I will be looking into "profession" as a folk concept within the paradigm of the division of labour. I believe that these theories are the most relevant to the subject matter.

5.2. DIVISION OF LABOUR

I would like to start off unpicking the concept of the division of labour as an underlying backdrop for using knowledge as a key to power. As summarised in Dingwall (2016, Introduction section, § 10-12) Hughes treats the world of work "as an analogue to the social [or urban] ecological theory" (Dingwall, 2016) visualising "division of labour" as a "terrain" (Dingwall, 2016) of demand for goods and services characterised by the compartmentalisation of the assignments or tasks allocated to each worker. These clusters of tasks might burgeon, revamp or cease to exist. Each of these clusters or "blocks" (Dingwall, 2016) is constituted by workers or "occupiers competing for access and struggling to improve their status by new acquisitions or the relinquishment of less attractive properties" (Dingwall, 2016). If we just zero in on medical interpreting for a moment, and ponder about the current state of affairs, we will immediately see how this theory perfectly mirrors the modern day reality. The division of labour in the medical sphere, which is the secondary institutional sphere for interpreters, because the professional authority is hierarchically distributed and exercised by the medical staff, is indeed a terrain where the assignments are compartmentalised and allocated to each worker according to the knowledge and skill that these workers possess. As I shall reveal in the following chapters of this thesis, Halliday (1987 as cited in Dingwall, 2016) talks about the necessity of sufficiently codified and very distinctive knowledge and tasks in order for the compartmentalisation to take place which subsequently will allow for the establishment of clear jurisdictional boundaries. Medical interpreters do have distinctive tasks, nevertheless other social actors can easily contest and claim ownership of these tasks. Medical workers claiming language proficiency may consider they do not need an interpreter in the consultation, because they already speak the language. Thus, there are two possible scenarios that could take place, and both will lead to de-professionalisation:

1. Due to the lack of immediate functional value, scepticism and indifference towards our profession it will disappear, as it will end up being perceived useless.
2. The interpreters are going to be repurposed and hybridised (also due to lack of immediate functional value, scepticism of the masses, indifference of the society and of the state): "occupiers [doctors in this case] [are] competing [...] and struggling to improve their status by new acquisitions [they are more competitive if they are bi- or multilingual] or the relinquishment of less attractive properties" (Hughes, cited in Dingwall, 2016, Introduction section, § 10-12), whereby other unattractive tasks are going to be allocated to professional and/or self-proclaimed interpreters, who will end up carrying out this unattractive tasks. The "interpreters" will end up being called "assistants", "multilingual personnel", "international assistants", etc. And this second scenario is where medical interpreting is at now.

All of the supply-side social actors are subject to "evolutionary process" which is triggered by changes in "demand and technology either from clients or from internal attempts to influence the market" (Hughes, cited in Dingwall, 2016). "Some occupiers" enjoy prestige and power while others (medical interpreters is a good example) remain "disregarded" (Hughes, cited in Dingwall, 2016). Some occupations "have an implicit or explicit license to carry out certain activities which are different from those of others, in exchange for money, goods and services" (Hughes, cited in Dingwall, 2016). The members of an occupational community may "claim a mandate" in order to formalise, universalise and bring to the fore the proper workplace conduct which would determine those assignments they have been commissioned, granted authority and officially sanctioned to undertake, those they should refrain from and variants of delivery of their services based on "the patterns of public demand and response" (Hughes, cited in Dingwall, 2016). The aforementioned traits ("prestige", "power", "licence to undertake certain activities", "mandate" to determine workplace conduct and "sense of community") are attributable to profession, which Hughes "regards as the prime illustration of the possible legal, intellectual and moral scope of a mandate" (Hughes, cited in Dingwall, 2016.). Moreover, according to Hughes professions seek to secure monopoly position on the market by delimiting its "task ownership" and its responsibilities and by "delegating purposely or by default many related tasks and responsibilities to other occupations" (Hughes, 1994, p. 71 as cited in Liu 2014, Foreword section, § 4).

Returning back to the analysis of the term "profession", what *mystifying* power does a concept of profession have over modern society and how does this power manifest in the society? According to Hughes:

> Not only do professions presume to tell the rest of their society what is good and right for it: they can also set the very terms of thinking about problems which fall in their domain. They exemplify in an extreme form the role of trust in modern societies with an advanced division of labour. The professions are licensed to carry out some of the most dangerous tasks of our society - to intervene in our bodies, to intercede for our prospects of future salvation, to regulate the conflict of rights and obligations between social interests. Yet in order to do this, they must acquire guilty knowledge - the priest is an expert on sin, the doctor on disease, the lawyer on crime - and the ability to look at these matters in comparative and, hence, relative terms. This is the mystery of the professions. Their privileged status is an inducement to maintain their loyalty in concealing the darker sides of their society and in refraining from exploiting their knowledge for evil purposes. (Hughes, cited in Dingwall, 2016, Introduction section, § 10-12)

5.3. FREIDSON'S CONCEPT OF PROFESSION AS MULTIFACETED HISTORICAL FOLK CONSTRUCT

According to Freidson (2016), the notion of "profession" is "an intrinsically ambiguous, multifaceted folk concept, of which no single definition and no attempt at isolating its essence will ever be generally persuasive" (p. 32). He perceives it as an "historical construction in a limited number of societies" (p. 20). Up until recently professionals have been perceived as "honoured servants of public need" oriented towards meeting the needs of the public "through the schooled application of their unusually esoteric knowledge and complex skill" (Freidson, 2016). However, in recent academic literature the scholars tend to pinpoint the political influence of professions.

As posited by Liu (2014, Foreword section, § 11), Becker regards the concept of profession as an "honorific symbol" that is conferred upon certain coveted types of work. The title of "profession" was connected with the gentlemanly/gentry status of the traditional learned professions, which are medicine, law and clergy spawned by the medieval universities of Europe (Freidson, 2016, The parochialism of the institutional concept of profession section, § 3). It is crucial to note that in Anglo-American culture the professions used to gain "their distinction and position in the marketplace" through their identity as "occupations to which specialised knowledge, ethicality and importance to society are imputed".

If "profession may be defined as a folk concept then the research strategy appropriate to it is phenomenological in character. One does not attempt to determine what a profession is in an absolute sense so much as how people in a society determine who is a professional and who is not, how they "make" or "accomplish" professions by their activities, and what the consequences are for the way in which they see themselves and perform their work (Freidson, 2016, p. 27).

As stated by Macdonald (1995, p. 7), "lay members of society" such as "customers, patients, and clients" do sort of profiling or reeling off the "traits" of different occupations. Laypeople are "continuously aware of the performance in all manner of aspects of members of occupations: they monitor, assess and evaluate [them] and thereby" (Macdonald, 1995) build up their opinion on how high or low ranking each occupation is and thus, engineer the pecking order in accordance with the stratification system of their society. This evaluation "provides the background for "professional" standing and at certain junctures may become quite crucial". The corresponding professional bodies also assess the profiles of occupational groups and "make specific decisions which affect their "professional" standing" (Macdonald, 1995). In conclusion, the society is viewed as an active participant of this continuous contest for professional leadership, power and importance, and "the relevance to society" might be a cornerstone factor when it comes to sorting out each profession or occupation within the pecking order of the occupational system. Undoubtedly, there are occupations that have already been labelled as professions, whose members happened to have habitualised roles "of great strategic importance in society, since they [these roles] represent not only this or that institution, but the integration of all institutions in a meaningful world" (Berger & Luckmann, 1966, p. 93). Roles are accomplished in different domains within which the professional (the interpreter) exercises discretion (Skaaden, in Phelan et al., 2019, chapter 3 Ethics and Profession, § 1-2). The authors were referring to the judges, who "may, on occasion, in some particularly important case, represent the total integration of society in this

way", or the monarch, who is a "'living symbol' for all levels of the society" (Skaaden, in Phelan et al., 2019). The interpreter may not be "of great strategic importance in a society" *per se*, but this profession or role may definitely help in accommodating the newcomers' needs, which will help burgeon their integration "in the consciousness and conduct of the members of the [apparatus of the] society" (Berger & Luckmann, 1966, p. 93).

Freidson (2016, The Parochialism of the Institutional Concept of Profession section, § 1-6) pinpoints the bifurcation in usage and meaning that the very nature of the concept of "profession" has historically undergone. The first and quite fuzzy concept of profession mirrors an educational status encompassing a relatively broad social stratum whose members are identified by their higher education status rather than by the occupational skills. In other words this usage of the term profession and the derivatives was built on the assertion that a higher education diploma was a sort of *laissez-passer* to the club of professionals or professional occupations. An individual who had been conferred a diploma of a higher education institution automatically gained entry into a prestigious occupation. In other words, the prestige of the educational institution which one receives one's credentials from plays a paramount role in the case of numerous professions. This concept stems from the nineteenth-century when "primary identity was not given by occupation, but by the status gained by élite education" (Freidson, 2016, The Parochialism of the Institutional Concept of Profession section, § 6).

The second concept of "profession" mirrors a restricted number of occupations which have "particular institutional and ideological traits" (Freidson, 2016, The Parochialism of the Institutional Concept of Profession section, § 1), and it is this second concept which enables the sociologists to view the "professionalisation" process as an indispensable scaffolding to build, organise and establish the institutional concept of profession. The "profession" cannot be regarded as solely an educational or academic status in that as opposed to other occupational groups, it encapsulates broader social, political and market traits such as exclusionary market shelters in the open market, distinctive occupational identities and politicisation, whereby the members of an occupation seek state support in order to secure a privileged position within the economy thus attempting to revoke the competition with rival occupations spawned by the passive attitude of the state apparatus and its detrimental *laissez-faire* philosophy. It is worthwhile mentioning that in England and in the United States a solid rationale is needed to justify a state-sanctioned market shelter formation (Freidson, 2016, The Parochialism of the Institutional Concept of Profession section, § 1-6). It is a bottom-up initiative which stems from the members of an occupation willing to gain state protection and recognition. In Europe, however, the state used to play a rather active role "in organising both training and employment" (Freidson, 2016). Thus, in order for an occupation to become eligible for the adjudication or official allocation of the application of the label of "profession" and its concomitant privileges such as higher rewards it needs to be institutionalized (Ben-David, 1971)[39] throughout the process of professionalisation, which includes organising

[39] "Institutionalization will mean the acceptance in a society of a certain activity as an important social function valued for its own sake; the existence of norms that regulate conduct in the given field of activity in a manner consistent with the realization of its aims and autonomy from other activities; an finally some adaptation of social norms in other fields of activity to the norms of the given activity. A social institution is an activity that has been so institutionalised. This definition is to be distinguished from that usage, which also includes in "institution" the

a training system and credentialing institutions (Freidson, 2016, The Parochialism of the Institutional Concept of Profession section, § 1-6).

Freidson (2016, The Inevitability of Apologetics and Polemics section, § 2) postulates that the term "profession" became a label denotating social value which entails "social, economic, political or at the very least symbolic rewards accruing to those so labelled". (2016, The Inevitability of Apologetics and Polemics section, § 2). Thus:

> It seems inevitable both that disagreement about its application to particular persons or occupations will exist, and that disagreement will exist about the propriety of the special rewards accruing to those to whom it is applied. Because of the nature of the concept, any enterprise of defining and analysing it is inevitably subject to the possibility of being employed to direct the assignment and justification of rewards to some, and the withholding of rewards from others.

He also states that:

> If X means to refer only to those few occupations recognised by almost everyone as professions, possessing very high prestige and a genuine monopoly over a set of widely demanded tasks, while Y means to refer as well to occupations which try to ameliorate their low prestige and weak economic position by referring to themselves as professions, then each is talking about incomparable categories. (Freidson, 2016, The Obligation of Definition section, § 2)

But who can provide an unadulterated and decontextualised definition of the essence of "profession"? Always following Freidson (2016) each of the following groups will advance different concepts of profession:

a) the members of the occupation "seeking the rewards of a professional label"
b) the members of those occupations which have already secured a privileged place in the economy as well as an exclusionary market shelter and the label of "profession"
c) the employers and the clients "seeking to control the terms, conditions and content of the jobs they wish done"
d) the "government agencies seeking to create a systematic means by which to classify and account for the occupations of the labour force"
e) the general public

Each of these social actors may endeavour to manipulate the self-concepts of the members of an occupation and tailor their own definition in a way that it suits their self-interest. The idea of construing "profession" as a phenomenologically, intersubjectively and contextually grounded concept, rather than endeavouring to fathom out the meaning of "profession" in an absolute sense, –as if it was a static pre-existing notion–, links to social constructionism (Burr, 2003, 2015). Phenomenology of professions studies "how people in a society determine who is a professional and who is not, how they 'make' or 'accomplish' professions by their activities, and what the consequences are for the way in which they see themselves and perform their work" (Freidson,

actual organization of social activity in a given field. In the case of science, institutionalization implies the recognition of exact and empirical research as a method of inquiry that leads to the discovery of important new knowledge, which is distinct and independent of other ways of acquiring knowledge such as tradition, speculation or revelation" (Ben-David, 1971).

2016, The Phenomenology of Profession section, § 1). In fact, some scholars such as Dingwall argue that:

> Rather than define professions by fiat, sociologists would do better to devote themselves to the study and explication of the way ordinary members of particular occupations invoke and employ the term during the course of their everyday activities, to study how such members 'accomplish' profession independently of sociologists' definitions. (Dingwall 1976, pp. 331-349, cited in Freidson, 2016, The Phenomenology of Profession section, § 2)

This thesis precisely seeks to gauge how ordinary members of an occupation *in statu nascendi*, medical interpreters in this case, and those who interoperate or interact with them, medical and paramedical staff, discursively construct their conceptions regarding the occupational identity of medical interpreters. Freidson endorses this approach by positing that an interpersonal "accomplishment of a profession" cannot be confined solely to the members of this occupation, but must include "the conception of members of other occupations with whom interaction takes place" and must take into account the process of negotiation of "some workable agreement on usage and the activities and relationships it implies" (2016, The Phenomenology of Profession section, § 2).

5.4. PROFESSIONAL AUTONOMY AND SOCIAL CONTROL OF EXPERTISE

5.4.1. Professional Autonomy

As Freidson (2001) has pointed out, the "profession" cannot be regarded as solely an educational or academic status, so the process of disciplinarisation that an occupation might have undergone does not guarantee that these disciplines have acquired a status of expert knowledge that would allow its holders to exert self-control and full professional autonomy. Freidson (1970a, p. 343, in Rueschemeyer, 2016, section IV, § 1-5) holds that "the special knowledge of the profession justifies its autonomy" and distinguishes it from other occupations. The concept of professional autonomy is grounded in "the special character of [...] services" (Rueschemeyer, 2016, section III, § 13).

The author distinguishes two different categories of professional autonomy: "autonomy in the immediate execution of work" and "autonomy in the institutionalised regulation of the relations between experts and clients" (Rueschemeyer, 2016). I believe that we can safely draw a parallel between the autonomy in the immediate execution of work and the discretionary application of highly sophisticated expertise and experience, and the autonomy in the institutionalised regulation of the relations between experts and clients and task discretion. Both types of discretion are anchored to the concept of expertise and professional knowledge. The "irreducible core of autonomy in the actual delivery of expert services" is an absolute indicator of socio-professional "power and influence".

However:

> Even the greatest degree of autonomous self-control is typically secured by legal intervention and government guarantees in the form of licensing, inhibition of unauthorised competition and publicly stipulated minimum standards of professional training. Major client groups exercise varying degrees

> of 'lay control' through their choice of practitioners in the market and through the terms of employment of professionals in their organisation even where the professions have secured a large measure of autonomy for themselves. In turn, even in bureaucratic employment or under third-party supervision, expert practitioners derive from the special character of their services a core of autonomy which, though different from profession to profession, is greater than the irreducible autonomy found in other occupations. (Rueschemeyer, 2016, section III, § 13)

5.4.2. Professional autonomy and medical interpreting

Medical interpreters in the VC experience a massive occupational depreciation because their expertise is equated to mere foreign language proficiency, which is not considered expert knowledge *per se*. To make the matter even worse, the MIs professional language command is equated with the knowledge of any self-proclaimed bilingual or polyglot both *de iure* and *de facto*. The concept of "interpreting" and the concept of "*alleged* foreign language knowledge" are considered undistinguishable. Credentials are trivialised as the concepts of "language learning", "interpreting" and "translation" carry the undertone of generally accessible knowledge. The regulation of interpreting services is held in abeyance as this activity is construed as something that can be dispensed with, which ineluctably derives from the lack of recognition of interpreting as expert knowledge. The orthodox belief of modern society is that language learning, translation and interpreting are natural processes, which means that any person who claims to be able to speak a language or interpret cannot be prevented from doing so. Accordingly, in Spanish society, interpreting in medical settings is not allocated exclusively to T&I graduates. Language is something inherent to human beings, so everybody can start to learn languages from any age as opposed to law or medicine. Interpreting and translation are construed and socially embedded as effortless activities, just like speaking in foreign languages. Consequently, no license or credentials are being required to use one's linguistic skills.

This was also corroborated by Hsieh and Kramer (2012), who investigated the role, responsibility and professional identity negotiation between physicians and interpreters in the US hospitals. It was revealed that the interpreters who participated in the study had no control over their professional expertise. They were instrumentalised as people providing a "utility" –a "simple one-to-one machine-like process"– lacking the capacity to influence the content or alter the dynamics of communication (Hsieh & Kramer, 2012, p. 158).

In other words, MIs were viewed as the embodiment of the well-known and often referred to concept of walking dictionaries. This "utilitarian approach" objectifies interpreters and reduces them to mere instruments of the provider. This approach implies total compliance with the providers' or physicians' expectations, which may range from the doctors' preference for literalism, whereby the interpreter is reduced to a mere voice, to the interpreter becoming an "extension" or "duplication" of the clinician, his/her role, functions, tasks and duties (Hsieh, 2010, cited in Hsieh & Kramer, 2012, p. 158). "Tension may result if a provider suspects an interpreter did not provide word-for-word interpretation" (Hsieh, 2010, cited in Hsieh & Kramer, 2012, p. 158). That would be a typical example of a physician trying to monitor and exercise control over interpreter's expertise. Interpreters have also reported on "being under pressured to skip [...] introduction because providers do not have time to listen to them" (Hsieh & Kramer, 2012, p. 159).

Aternatively stated, the MIs comments were reported to be neither expected, nor need, nor desired (Hsieh & Kramer, 2012, p. 159).

Another informant reported that some providers would normally refuse to follow the instructions for the specific mode (liaison or dialogue interpreting), modalily (face-to-face session) and model (conduit), which can be for example using the first person to address and communicate with the patient directly: "Some of [the providers] just refuse to do it. They get mad at you, because they think you are telling them what to do. [...] They don't want to be told" (Hsieh & Kramer, 2012, p. 159).

Some physicians were reported to have been perceiving a professional interpreter as somebody who would work only for them: 'I consider them colleagues, but ancillary services to mine. Ultimately [I am] in charge, so they're functioning underneath my umbrella'' (Hsieh & Kramer, 2012, p. 160). This attitude was also corroborated as common by Rudvin, who reported that in Italy "the interpreter is called in to put the judge in a position to understand that information" (Rudvin, 2005, p. 169). Moreover, the judge may either require that the interpreter deliver a rendition of the entirety of the interlocutor's utterances, or that the interpreter deliver only "what the judge him/ herself selects as relevant" (Rudvin, 2005, p. 169). All the above mentioned examples demonstrate a clear lack of autonomy in the immediate execution of work.

Hsieh and Kramer have also highlighted that physicians dictate interpreters what to do (e.g. filter information) and ignore their code of ethics: "Vicky said, 'Sometimes, doctors say, 'Okay, I am going to ask a question, you give me the answer. If it doesn't deal with my question, I don't want to hear it'" (Hsieh & Kramer, 2012, p. 160). Other tasks may range from explaining to the patient how to get to different departments across the facility and/or premises to going over the consent form/process with the patient. In some cases interpreters pursue the accomplishment of providers' goals, thereby seriously interfering with the delivery of optimal care, which should be the main goal of all participants.

Just as the doctor who chooses to communicate in broken English may compromise a patient's life, health or wellbeing, an interpreter who chooses to "accept assignments beyond their professional skills" (IMIA, 2006) may also severely harm the patient:

> Because interpreters may not have the skills to differentiate what is medically meaningful (to the specific illness or the specialty), they may feel uncomfortable to filter ''irrelevant'' information. However, the utilitarian approach renders them powerless to resist providers' expectations. In addition, as interpreters preemptively filter out information, providers miss the opportunity to evaluate the quality or the meaning of the information they never received. (Hsieh & Kramer, 2012, p. 161)

These would be clear examples of situations, where the interpreter would fail to exercise their task discretion in accordance with the correspondent code of ethics, which is an indicator of lack of autonomy in the institutionalised regulation of the relations between experts and clients.

The fact that other professionals consider themselves fully capacitated to dictate the actions that interpreters need to take indicates that medical interpreters are very far from becoming fully professionalised. The fact that interpreters are being silenced, marginalised and put into ethically problematic positions means that their code of ethics is not being recognised or respected by colleagues. Therefore, by seeking to satisfy doctors' desiderata, medical interpreters dishonour and neglect patients' needs and thus fail to deliver on patient centred and culturally sensitive

care. By compromising care they flout the main tenet of medicine *primum non nocere*, thus contributing to their own de-prefessionalisation.

5.4.3. Social control of expertise

Rueschemeyer argues that the functionalist approach of the sociology of professions, which focuses on the traits an occupation must display to attain the coveted label of "profession", views social control of professional work as a thorny issue.

> Professional interests do affect the knowledge base itself as well as its public acceptance. Exaggerated claims of validity and effectiveness, selective development of knowledge, protective maintenance of mystique and complexity, over-education with the aim of professional respectability and limitation of access to the profession are more or less common. Furthermore, the professions do have, in varying degree, a special voice in determining normatively what constitutes a problem fit for, and in need of, expert intervention. (Rueschemeyer, 2016, section IV, § 11-12)

Rueschemeyer's "critique" of the sociology of professional knowledge seeks to define the very nature of the concept of "the expert knowledge" and how/why certain value or importance is being attributed to the problems, which this expert knowledge is meant to be applied to. Rueschemeyer (2016, section IV, § 1) suggests that the "material and immaterial interests" as well as the "values" underlying the problems which constitute the subject matter of the applicable expert service (for example, the necessity to address the linguistic needs of non-Spanish speaking patients), are determined by the "enterprising groups of self-proclaimed experts" –in this case medical interpreters–, to a very significant extent.

In other words, the author suspects that occupational groups pursuing professionalization promote their knowledge as pragmatic expert knowledge, shape the interest and the importance of the problem their knowledge is meant to be implemented to, and secure their position by claiming social control of expertise. Basically, the self-proclaimed experts intend to determine the extent of the relevance of a social problem they are volunteering to tackle, they allocate certain social value or importance to what they consider to be a problem which they would tackle using what they claim to be "scientific" knowledge (Rueschemeyer, 2016). The ultimate goal thereof is to anchor or secure their claims to be recognised and viewed as professionals or experts across a series of political or socio-economic institutions.

The self-proclaimed experts would call for social control of expertise seeking statutory recognition and regulation, state protection, and enactment of legal barriers that govern entry to a certain occupation by barring access to undesirable competition. So they would artificially fabricate this need for social control of expertise so that they may achieve exclusionary market shelters and substantial increase in remuneration among many other privileges. Although Rueschemeyer (2016, section IV, § 1-5) views this theory as an overstatement, he nevertheless holds that it raises important questions as to what the real nature of "expert knowledge" is. So what is the nature of scientifically established knowledge and why is it important? As maintained by Rueschemeyer scientific knowledge ineluctably derives from socially and culturally determined preoccupations and "the demands and interests crystallising in professional practice constitute one of the mechanisms through which such determination takes place" (Rueschemeyer, 2016).

5.4.4. Social control of expertise and medical interpreting

Social control of expertise depends on four historically variable reference points "the character of expert knowledge, its recognition as pragmatically useful [...], as well as the interests and normative considerations involved in the problems to which expertise is applied" (Rueschemeyer, 2016, section V, § 4). Graduate interpreters do not hold the social control of their expertise because medical interpreting has not been socially recognised as an activity that requires discretionary application of expert knowledge. And this is not a question of what the real nature of their expert knowledge is, but what the relevant social actors think the nature of their knowledge is. To make matters worse, language provision in cross-border healthcare does not seem to constitute a major social preoccupation or interest, as the relevant decision-makers are convinced that "this type of care is optional for the patient and that, when deciding whether or not to apply for healthcare outside their MS of affiliation, they should take language barriers into account" (ES Site 5)" (Angelelli, 2015, p. 69).

Angelelli, Martínez-Gómez and Niño Moral *inter alia* have certainly demonstrated that social control of expertise is in the hands of everyone but the professionals. Angelelli averred that the employers:

> Hire some interpreters on a full-time basis for the languages most in demand; for the others, they manage with bilingual or trilingual receptionists and telephone operators [...] bilingual service providers (e.g. medical assistants, laboratory technicians, receptionists) as well as ad hoc volunteers [...] patients' relatives and friends [...] (including minors) [...]NGO volunteers [...] who are asked to step in and to help broker communication with various degrees of success or software (such as Google Translate). (Angelelli, 2015, pp. 62, 69, 131)

Martínez-Gómez Gómez decried that "interpreting tasks in public hospitals and health centres in the province of Alicante are left to the patient's relatives or friends, although it is true that, in certain centres translation and interpreting students are sporadically present as trainees" (2007, p. 1047). Niño Moral (2008, p. 1066) also informed that privately managed public hospitals exhibit a tendency to hire staff with foreign language skills as an alternative measure. Apparently this procurement-recruitment policy has been normalised in many hospitals of the Valencian Community. English and German language skills have been reported by Niño Moral to have been constituting one of the minimum and most basic requirements in the applicant selection criteria, rendering a job application or a *résumé* without a description of the aspirants' language skills unworthy of consideration, negligible and inconsequential. Thus, such curriculum vitae or job application form is bound to end up being dismissed (Niño Moral, 2008, p. 1066).

English has been definitely chosen as the *lingua franca de facto* (Angelelli, 2015, pp. 55, 60). Apparently many employers, procurement managers, hospital administrators, doctors, receptionists, etc., are convinced that:

> In most cases, communication is not a major problem... We manage in English. We always manage. English is like a wild card (comodín). For consent forms for example, we simplify the language to make it more accessible, especially when the "translator" is a child who then needs to explain it to the family member [...] we all read English. (Angelelli, 2015, pp. 61, 81)

However, in spite of the fact that many relevant social actors prefer to believe that "it can be understood by many patients [...] in reality many patients do not speak English at all" (Angelelli, 2015, pp. 68-69). Despite this fact, poor command and the presence of professional interpreters in the consultation medical professionals' intransigent position to express themselves in English proves to be a disquieting yet ubiquitous attitude. Medical professionals' language competence is not subject to any verification criteria or professional screening. Even in the case of very poor foreign language abilities medical professionals' attempt to communicate will rather be praised than condemned by other social actors. Moreover, some doctors or patients with evident communicative struggles may feel that they are treated disrespectfully when the interpreter present at the consultation offers to assist.

Same scenario may be seen with specialised medical translation. It is a hotly debated issue in specialised translation to determine who will translate a specialised text better: a subject matter expert who happens to speak a foreign language or a qualified translator who studies specialised translation or is specialised in the particular field.

Both the doctors and the patients tend to overestimate their foreign language skills and underestimate the complexity of communicating in a foreign language. The role of medical interpreters as well as their duties and competencies are being constantly contested by the parties and even though an interpreter may perceive need for a professional service, the problem is that the parties do not detect such need. It is paradoxical how from a professional interpreters' perspective the demand for the service as well as the need are very real, especially taking into account the crippling errors cross-referenced in Quan, 2010, Flores, 2005, 2006, 2017 and Singh 2018 *inter alia*. Interestingly enough, this history of devastating consequences and implications is not enough to convince the relevant decision-makers of the indispensability of professional MI service.

The patients' right to access medical information may be compromised by determination not to trust the interpreter with the conveyance of the mystified expert knowledge on the one hand, and by physicians' implausible self-assessment of their foreign language proficiency on the other hand. Apparently, medical workers do not find themselves in breach of the Hippocratic oath when communicating in a language they display a poor command of. It is an interesting phenomenon how the communication in a language a person is not actually proficient in is not considered medical malpractice.

I believe that in this case it is very clear that altruistic motivation to safeguard collective benefit and wellbeing is what galvanizes professional interpreters into action, as it is far more critical then individualistic motivation to pursue self-interest.

Mungham and Thomas (2016, Solicitors and Clients: Altruism or Self-Interest? section, Descriptions of the legal profession subsection, § 3), averred that the altruistic motivation played an important role in the establishment of the legal profession in that the language used by The Law Society to publicly describe their profession mirrored "general visions of altruism and service": "'public protection', 'willing to serve the public', 'public confidence', 'trust', 'special skill', 'the supply of professional services is very much more than a business transaction'". The authors clarified that "no profession worthy of the name has ever been impelled merely by the monetary

reward", but it is true though that "it expects, and has a moral right, to be paid properly for its skills and services. (Conveyancer 1972, pp.81-2)" (The profession's response subsection, § 2).

It must be understood that the goal of medical interpreters and community or public service interpreters is not to incapacitate the clients in order to "increase their power at the expense of the ordinary people whom they purport to serve" by having a "disabling effect" (McKnight, 1989, pp. 38-40 in Andrews, n.d.) on their freedom of linguistic choice, but rather guarantee their right to quality healthcare and safe practice of medicine.

We do not need to manufacture the sense of need, but due to the fact that the parties involved are unknowledgeable about this occupation, the employers, procurement managers, the state and the legislators manufacture the sense of false language fluency in their parsimonious alternative approaches. As reported by Angelelli, many healthcare providers in the EU share a:

> Monolithic and almost unchallenged view that current ad-hoc language provision in healthcare settings is not an issue and does not need coordinated planning (i.e. "language is irrelevant; we manage [...] language is not by law a priority... we have other urgent problems and we can manage in English [...] but ... we always manage. They [the patients] come with someone from the community who can interpret for them [...] Sometimes there are difficulties with language and culture... then we put a lot of question marks on the medical records. Sometime as in the case of a Turkish patient, we use Google Translate, but just for some terms" [...] "language is never central", "it is not so important", or that "it is more difficult to follow a patient through an interpreter". (Angelelli, 2015, pp. 9, 56, 57, 81)

Thus, the fact that no attention is being paid to the language needs and the fact that the communication is being reduced "to some improvised and not-shared set of gestures and drawings" and "unedited output of machine translation" (Angelelli, 2015, p. 81) indicates that a false sense of safety and security is being manufactured and conveyed, which may potentially lead to misdiagnosis, medical malpractice and maladvice, litigation, unnecessary repeated visits, needless time loss, unequal access to universal services, non-pecuniary losses such as tarnished reputation of the healthcare professionals, patient health deterioration and even loss of life. Therefore, in my opinion it is not –the interpreters– who are manufacturing a sense of need to pursue personal benefit, but it is rather the healthcare providers who manufacture a false sense of safety and language fluency to pursue cost savings.

Even though layperson ad hoc interpreters may seek to serve the client by purporting to "minimis[e] their pain, maximis[e] their opportunities and enable[e] them to cope with the difficulties they face" (Andrews, n.d.), professional graduate interpreters seek to adhere to their professional role orientation, which "implies a high degree of concern with professional values and standards" (Rothman 1974 in Andrews, n.d.). Even though the monetary reward may not be the overriding objective of professionalisation, all members of occupations coveting the label of profession will still pursue higher financial rewards. Professionals are not volunteers or charity workers and they need to recoup their investment in skill acquisition.

Exogenous factors such as demographics, politics, historical background and economics certainly dictate labour market demands, trends and vacancies, which will end up locating certain occupations in higher or lower stratum. Medical interpretation will need to undergo an upgrading in terms of institutionalisation strategies including licencing, credentialing, certification, unionisation and representation by associations (Weeden, 2002, p. 57). The author claims that only

the combination of the restriction of labour supply, demand stimulation, service monopolisation and state-endorsed signal of quality may improve occupational rewards (Weeden, 2002).

In my opinion it is only through occupational closure mirrored in the indispensability of the institutional assistance into the profession (in other words the imperative character of university education) that the eligible practitioners can guarantee maximum benefits in the form of public protection, public confidence, trust in the profession, altruism and respect. Otherwise, no conscious adherence to the main principles of the profession and its code of ethics and conduct can be guaranteed. The exclusion of ineligible and the inclusion of highly qualified recruits will sensitise the public and the prospective consumers to the salience of a conscious and informed choice as to who they seek to purchase labour from: legitimated practitioners or outsiders. Thus, the closure may be sought as a mechanism of public protection, but end up as a mechanism of professionals' protection in terms of higher occupational rewards, which may benefit both parties.

5.5. THE EXERCISE OF PROFESSIONAL DISCRETION AND CREDENTIALISM

5.5.1. Task discretion

Task discretion (Zhou, 2014) may be viewed as a manifestation of job autonomy. The decision latitude is the extent to which members of an occupation are able and allowed to exercise independent initiative, judgement and control over the repertoire and delimitations of their tasks. Task discretion is based on the corresponding codes of conduct and codes of ethics. The higher the level of job autonomy that the members of an occupation are being granted and enjoy, the stronger reliance is being placed by the employer(s) on the creativity unleashed by the employees. Task discretion is an indicator of professional trust that the employer puts in the employee. The decision latitude in the case of task discretion does not refer to manifold choices that professionals make during their working hours. It rather refers to far-reaching dilemmas concerning the profession itself, professional ethics and ideology. The right that the professionals claim "to judge the demands of employers or patrons and the laws of the state, and to criticize or refuse to obey them" forms part of task discretion (Freidson, 2001, The Soul of Professionalism section, § 2). It is worth noting that such refusal is by no means premised on "personal grounds of individual conscience or desire but on the professional grounds that the basic value or purpose of a discipline is being perverted" (Freidson, 2001, The Soul of Professionalism section, § 2).

In the case of medical interpreting, the interpreters practicing in the study-relevant geographic area are not given the possibility to "refrain from accepting assignment[s] beyond their professional skills, language fluency, or level of training", as suggested in IMIA (2006). This is an indicator that the discipline of medical interpreting is being "perverted" (IMIA, 2006) and hybridised. These interpreters feel obliged to embrace all the tasks they are required to perform, even if they are underqualified to undertake some of them.

The paradox is that these anxious-to-be-labelled-as-uncooperative interpreters cannot exercise task discretion, however, when it comes to discretionary application of professional expertise, which many of them lack, no quality control is being carried out to ensure safety of practice. My explanation of this paradox is that graduate interpreters do not exercise task discretion because they practice in private facilities and they fear being ostracised. Non-professional interpreters, on

the contrary, remain largely oblivious to the salience of task discretion and discretionary application of expertise, because they lack proper university education and training. University education is absolutely essential for knowledge acquisition and its discretionary application.

5.5.2. Discretionary application of expertise

Discretionary application of individualised expertise and experience is a competence grounded in a vast corpus of abstract theories and concepts attainable only through a special university training. It refers to the manifold decisions, which interpreters make about their interpreting during the comprehension (understanding input) and production (rendition of the code) processes, as an inextricable part of their interpreting assignments.

Discretionary judgement denotes skilled practical thinking grounded in the flexibility and leeway to choose a strategy which in the professional's estimation is the best suited for the solution of a particular problem (Freidson, 2001, Working Knowledge section, § 5). The ideology of professionalism foregrounds the relevance of "a firm, [exhaustive academic] grounding and concepts" (Freidson, 2001, The Professional Curriculum section, § 1) for the professionals to build their discretionary judgement on. Accordingly, the ideology of professionalism "claims that the work of a specialist with professionally controlled training is both superior to and more reliable than that of someone who may have experience but lacks training" (Freidson, 2001, Specialisation and Productivity section, § 3).

> However, not only today but in any time or place, surely a large proportion of specialized knowledge is more reliable and valid than everyday or popular knowledge. True inequality of knowledge and judgment in specialized affairs exists by virtue of the very existence of a division of labour. Those who have had intensive training and then work full-time at a specialty can hardly fail to know more about that work than others. (Freidson, 2001, Elitism section, § 3)

However, many do not think that professional interpreters are entitled to possess exclusive niche ownership and cognitive authority (Freidson, 2001) over this discipline. Many people believe that the layperson interpreters' unaccredited ability to speak the patients' language or dialect and understand their culture based on their belonging to a certain ethnicity is more reliable than professional interpreters' training and credentials.

Spanish society at large, and relevant social actors in particular, do not seem to perceive dialogue interpreting as a discipline based on the discretionary application of complex knowledge. Interpreting is often associated with unselfconscious, popular, everyday use of foreign language to communicate or interpret. Globalisation and multilingualism became promoters of language learning on a global scale. This and other corollary factors, such as lack of professionalisation, might have resulted in perceiving foreign language acquisition as well as interpreting as activities characterised by utmost simplicity, cognitive effortlessness and monotonous homogeneity, which can be performed by virtually anyone who claims competence and preparedness to do so. We, as professional interpreters, need to concede that this is how we are portrayed and perceived by lay public is a modern, globalised and multilingual society. There is this shibboleth that allegedly everybody can learn a language and that everybody who presumably knows a language can interpret.

Therefore, the extreme self-awareness and the cognitive load imposed on professional interpreters during the task execution are often believed to be minimal. Interpreters are not viewed as specialists who render professional service in linguistic knowledge, but rather as *gente con idiomas* or people with foreign language knowledge, who can help with translation.

The heavier the cognitive load, the more sophisticated discretionary application of expertise. In this case, the exercise of professional discretion requires university education, which makes credentials absolutely essential for recruitment. The vast majority of the above mentioned factors (except for the personal traits and perhaps environmental factors) are addressed by the university curricula, and are essential for the interpreter to be able to render a professional service in language knowledge. Nobody can purport to do a job without fully understanding the underlying process of the activity they are performing. The popular(-ised) language knowledge of any bilingual person cannot be compared with the sophisticated linguistic expertise of a trained professional, who in addition to the verifiable foreign language proficiency also masters highly specialised translation and interpreting techniques.

5.5.3. Credentialism

Phelan et al. (2020, p. 181) argue that: "all professionals engage in fallible activity", and therefore the "credential testifying to the successful completion of professionally controlled training" (Freidson, 2001, chapter 9 The Soul of Professionalism, § 2) is essential to guarantee the practitioners' competency and competence to yield quality services within their corresponding area of expertise. The professional's credentials, granted upon completion of education which lasts at least several years, validate the applicant's eligibility, aptness and fitness for position or placement. Credentials guarantee that specific knowledge and skills have been acquired and that "certain functions" are monopolised and no longer accessible to laypeople. Credentials also imply that professional identity has been developed throughout the education process. Hence, "organised education" safeguards the status of a *profession* by replacing market-related *caveat emptor,* whereby all responsibilities are being shuffled off onto the inexpert lay client unable to control the quality of the service being provided, with *professional* trust.

Rueschemeyer (2016, section II, § 2) argues that the "recipients of expert services are not themselves adequately knowledgeable" to evaluate or assess the quality of the service provided by the expert. The clients, who in their majority are unacquainted with the specificities of a given profession, are vulnerable to "professional incompetence, carelessness and exploitation" of the experts. It is difficult for consumers to police the expertise, the professional competence, the probity and the integrity of the service provider. There is clearly a "competence gap" (Rueschemeyer, 2016, section II, § 2) between the provider and the recipient of the service. Furthermore, the outcome of the expert performance cannot be construed as a clear indicator of the quality of that performance or render the experts' deeds as either overperformance or underperformance. It may be tempting for lay people to subject routinised or standardized to a certain extent expert performance to "a judgement of its quality", even though such evaluation of the outcome of expert intervention may be highly inaccurate and misleading.

> Professions 'strike a [mutually beneficial and advantageous] bargain with society [by offering] 1) competence, [...] 2) integrity, 3) careful recruitment, 4) [education and training], 5) formal professional organization [to secure both] privilege and autonomous position, 6) codes of ethics and 7) professional courts as guarantees of self-control [in exchange for] the trust of client and community, relative freedom from lay supervision and interference, protection against unqualified competition as well as substantial remuneration and higher social status. (Rueschemeyer, 2016, section II, § 2)

It is extremely important to pinpoint that consumers put their trust in the professionals' moral involvement and commitment to exercise their discretionary judgement professionally and in the best interest of the customer/consumer. Credentialism is absolutely essential if we want to guarantee the successful discretionary application of expertise, competency and competence by a person who is morally committed to providing a service in the best interest of the customer. The fact that "critical personal services" (Freidson, 2001, The Soul of Professionalism section, § 1), whose provision requires complex esoteric knowledge and skill, are provided by underqualified workers means that the patients are subject to potential maladvice, negligence, malpractice, or wilful neglect. Without proper credentials there will always be a risk that such consumer confidence may be shaken by serious implications.

> That exception to the rule should be made for services dealing with life-threatening conditions such as those provided by surgeons, if not also physicians in general. Implicitly or explicitly, they [economists espousing the neo-liberal market ideology] accept the professional argument that some kinds of work are too complex or esoteric for the untrained to understand, so that in circumstances where the wrong choice can be fatal, the range of choices must be limited to safe ones. (Freidson, 2001, Credentialism section, § 3)

The problem is that the relevant social actors do not seem to agree that medical interpreting is actually a "critical personal service". They do not seem to be aware that complex esoteric knowledge and skill are required to guarantee safety. Therefore, academic credentials in this case do not guarantee that the applicant will be put on the shortlist of candidates. In other words, medical interpreting is viewed as a métier rather than the work requiring complex formalised scientific knowledge base.

> Credentialism, the device that sustains monopoly and social closure in the professional labor market, has also spawned a shibboleth enabling attacks on professionalism. But a social closure is intended to include only those who have effective command over a defined body of knowledge and skill, so that some method must be used to determine qualifications for admission and the right to practice. The characteristic method of selection for professionalism is the training credential. Its possession earns both inclusion in the ranks of the elect and exclusive right to practices or jobs requiring a defined set of skills. [...] considering contemporary controversies over the value of educational testing, one must ask what alternatives to credentialism exist for selecting workers to consult or employ. Trial and error consultation or employment of anyone who offers to perform a particular set of tasks is at the very least expensive in time and money, and in some cases, such as surgery or bridge construction, very risky. Nor is credentialism as vulnerable to the charge of injustice, exploitation, or inefficiency as is the use of such common criteria for employment as kinship, ethnicity, gender, race, sexual orientation, political persuasion, personal recommendations, highly doctored and undocumented résumés or, what is the same thing, attractive advertising. For all its failings, credentialism is far less likely than its alternatives to be an unfair basis for exclusion from particular jobs. (Freidson, 2001, Credentialism, § 1-2)

Accordingly, selecting and hiring layperson interpreters only on the basis of their ethnicity, personal recommendations or undocumented résumés (which is often the case in Spain) may not only be considered inefficient and unjust, but also extremely dangerous (see Flores, 2005, 2006, Flores et al., 2017, Singh, 2018. Quan, 2010). The relevant social actors are not sufficiently educated in terms of language acquisition, translation and interpreting, and therefore they fail to competently assess the performance of the person who is providing language services. Many Spanish healthcare providers do not believe that excellent academic credentials should be considered as a prerequisite for hiring language service providers. The majority of customers do not invest time and effort in learning about the advantages of professional MI service provision. Very few healthcare providers fathom the actual processes underpinning this activity, and therefore their recruitment criteria are not based on fully informed decisions, as they are not knowledgeably "equipped to choose among available goods and services in their own best interest" (Freidson, 2001, Credentialism section, § 3). Also, the inclination towards cost saving may result in them opting for cheaper labour:

> Much of the change taking place in the organization and direction of professional work today is economically inspired and reflects the material interests of both private capital and the state [...] But it is politics that advances and protects such change. (Freidson, 2001, chapter 9 The Soul of Professionalism, § 2)

The information on professional MI and other alternative solutions (and most importantly, the difference between the two) is very scarce in the empirical marketplace, while the available information is "attractively distorted" and presented as commercial advertising, thus rendering its validity as unreliable. This would be the case of private hospitals and clinics, who advertise the availability of multilingual medical professionals and staff members in their facilities.

In essence, credentialism has not yet been established as a *sine qua non* prerequisite for the calibration and recruitment of language provision services in the VC. This is resulting in a complete task incoherence and role imbroglio. The deficient discretionary application of experience and expertise –precisely due to the lack of expertise along with unrealistic assessment of one's own capacity, preparedness and competence– is leading to serious deficiencies in quality of performance. The implementation of credentialism as the only reliable socio-professional control instrument would grant the MI a monopoly over the privileged and exclusive entitlement to offer their services and perform a particular kind of work in the marketplace. This safeguards access to the labour market shelter only for those who are knowledgeable about the subject matter they operate with.

5.6. SOCIAL CLOSURE AND MONOPOLY

5.6.1. The concept of social closure

According to Weeden (2002) occupational closure, also known as social closure, has been designed to generate "an artificial scarcity of individuals who have the legal, technical, or socially recognized ability to perform the bundle of tasks provided by that occupation (Weber, 1978; Larson, 1977; Freidson, 1994, pp. 80-83; Parkin, 1979, pp. 44-71; Collins, 1979, pp. 56-58; Sørensen and Kalleberg, 1981, cited in Weeden, 2002, p. 61).

Monopoly restricts 1) consumers' choice to qualified members of the occupation; and 2) workers' "freedom to offer their services to consumers, for only those who are qualified may do so" (Freidson, 2001, Ideological Shibboleths Surrounding Monopoly, § 2; ISO 13611, p. 11). To sum up, the monopoly of professionalism rests upon the idea of guaranteeing high quality service being provided exclusively by those who are eligible by virtue of a university degree diploma attesting to successful completion of training, logically, excluding from practice of a discipline all those who fail to meet relevant requirements and demonstrate eligibility in the aforementioned way. Monopoly must be enforced either by law or by administrative regulation. According to Freidson (2001) social closure is a primordial mechanism for the survival of an activity as a distinct discipline. Social closures are normally created by members of an occupation who:

1. share a common economic interest or in other words who pursue profit-focused growth;
2. have successfully accomplished common vocational training/schooling, which lasted longer that an average training;
3. carry out complex discretionary work;
4. share a common set of tasks, techniques, concepts, working problems and distinctive experiences;
5. are enthusiastic about, fascinated by and interested in what they are doing;
6. view work as a long-term career;
7. are committed to advancing the body of knowledge and skill underpinning their profession and protecting its integrity (Monopoly, Social Closure, and Disciplinary Community, § 1-4).

Obviously, this mechanism bears the character of exclusivity, in that it excludes from membership all those who are not eligible to join in:

> According to Weeden (2002), closure is achieved through three processes, namely restricting the supply of labour into an occupation, creating and solidifying demand for the occupation's output, and securing the occupation's territory through task demarcation. (Williams and Koumenta, 2019, pp. 711-737)

Social closure plays an indispensable role in

a) the formalisation of knowledge;
b) institutionalisation of work by formation and mapping out jurisdictional boundaries by means of task discretion in order for the profession to acquire coherence and distinctness. Institutionalisation will inextricably lead to the ritualization of work habits, traditions or routine. Jurisdictional boundaries are necessary to create a social "shelter or environment" as Freidson calls it, which is like a niche in a stratum formed by the division of labour;
c) consequently, these strategies will end up resulting in a transformation of a set of skills into a coherent and recognisable discipline and burgeoning of formal knowledge distinguishable from other disciplines (Freidson, 2001, Monopoly, Social Closure, and Disciplinary Community, § 1-4).

5.6.2. Social closure applied to medical interpreting in VC

Having defined the concept of social (also called occupational) closure, I shall now proceed to delve deeper into the possible rationale for the failure to establish such closure in the case of medical interpreters in private healthcare centres located in the Valencian Community in Spain. For the reasons mentioned above (formalisation of knowledge, institutionalisation by means of mapping jurisdictional boundaries out, creation of the medical interpreters' own occupational niche in the occupational stratum governed by the division of labour, recognition of the discipline by its distinguishable formal knowledge), the social closure mechanism is the cornerstone for the occupation's survival as a distinct discipline. As maintained by Freidson:

> If disciplines could survive at all without shelter, therefore, they would be popularized and lose some if not most of their disciplinary character and value. It is economic monopoly that reduces this necessity for modifying or at least diluting disciplinary knowledge and skill so as to gain a greater resemblance to everyday knowledge. (Freidson, 2001, Monopoly, Social Closure, and Disciplinary Community, § 4)

Thus, occupational or social closure underpinned by the duly regularised and reinforced economic monopoly serves to preserve disciplinary knowledge and skill without alterations to its abstract essence, preserving its disciplinary character and value, and, of course, safeguarding its detachment and isolation from unspecialised everyday knowledge.

We have the completely opposite situation with medical interpreting in Spain. There is demand for medical interpreting in both public and private spheres, nevertheless, apparently, as Angelelli (2015, p. 43) has also stated in her study: "only in the UK do policymakers report a budget for language support/provision to patients who do not speak English. In the remaining countries respondents believe there is no budget [allocated for public healthcare settings]". Moreover, according to Angelelli: "In public healthcare sites in the Levante area, we were told: "most primary care physicians read English and speak enough to be able to communicate with the patient" (Angelelli, 2015, pp. 61-62). These two excerpts clearly epitomise that not only is the importance of medical interpreting downgraded to a dispensable, unspecialised activity characterised by its ordinariness, but its worth or value is also being devaluated as well as its highly specialised and sophisticated knowledge and skill are being popularised and degraded. It is being reduced to *sweeping the floor and driving the car type of everyday knowledge and skill* every normal adult can have.

On the other hand, we have the private healthcare settings, some of which do actually recruit medical interpreters, but the majority of the newcomers constitute a non-professional *ad hoc* solution, as the empirical part of this thesis will seek to demonstrate. The fact that "critical personal services" (Freidson, 2001, The Soul of Professionalism section, § 1), whose provision requires complex esoteric knowledge and skill, are provided by underqualified workers means that the patients are subject to potential maladvice, negligence and malpractice, although it might not be explicitly deliberate or intentional. Moreover, it is worthwhile stating, heavily drawing on my own experience as medical interpreter in a number of private medical centres in the Valencian Community, that many non-professional interpreters perceive the interprofessional interference (see part III) in a range of different tasks, duties and responsibilities as a tremendous help they are

proud to offer. I insist, the in-house non-professional medical interpreters are proud of being "helpful" to both doctors and patients by means of active intervention, overinvolvement and interference in the strictly medical processes. The non-professional in-house interpreters desperately seek to disassociate themselves from the role of mere translator, alienate themselves from this insignificant role assimilating the roles belonging to other professionals, such as doctors, which is how they sort of conceptualise "promotion". I am convinced form my own professional experience that this readiness and disposition "to help" should be regarded upon as a sort of virtue signalling mechanism, whereby the non-professional interpreters seeking validation from their employers and co-workers embrace any type of tasks, duties, assignments and responsibilities. The rationale behind it might be the fact that they do not want to lose their job on one hand, and their unfamiliarity with the code of ethics which strongly advises against undertaking assignments beyond the interpreters professional skills, language fluency, or level of training on the other hand (IMIA, 2006).

This encroachment on the doctors realm of expertise is of course approved by the medical staff, employers and hospital/clinic management themselves, because this apparently facilitates their work in terms of time saving and cost saving. I dare to speculate, judging from what I have been told by my informants, that the initiative for such intervention must have burgeoned gradually and not drastically, that is to say, the so-called interpreters went increasingly expanding their range of tasks embracing them and being proud of this sort of career ladder "promotion", instead of lambasting this interprofessional intrusion and rejecting its undertaking. Yet again we can see as ad hoc non-professional interpreters in private sector, as well as intercultural mediators in public spheres, denigrate the very essence of interpreting by stating that they are not just mere translators/interpreting or it is not just a matter of interpreting/ I am not just an interpreter, I am a personal healthcare assistant/international medical assistant/public relations, etc. They are convinced that by encroaching on the medical staff's realm of expertise they are doing a great favour to all the involved parties. The fact that the non-professional interpreters are overburdened with undue tasks and responsibilities placed upon them, which according to the IMIA code of ethics and ISO 13611 must not fall within the medical interpreters' remit, is viewed by non-professional interpreters as a sign of appreciation, trust and recognition of their motivation and attitude towards autonomous, self-reliant, self-sufficient and independent troubleshooting and problem-solving initiatives, which they lack appropriate medical qualifications for. Being entrusted with carrying out highly sophisticated medical tasks, which basically means deputising for medical staff, is not regarded as encroachment or interference, but rather as help for doctors, for patients and excellent promotion prospect. The fact that an interpreter has refused to carry out a task which they are not qualified for could be misinterpreted as a uncongenial attitude. Thus, the fact that many practitioners in both public and private sector claim to be proficient in languages proves the popularisation of our discipline which may eventually result in its de-professionalisation. This popularisation, decline in value and "exoterisation" are more sharply defined in the private healthcare sector, because the fact that many medical workers who are put on the payroll in the study-relevant geographical area are expected and required to be proficient in English at the very least:

> The demand for health professionals who speak several languages is expected to rise by 40% in 2017 alone [...] Fluency in English is a basic requirement. However, offers requiring a third language are increasing. Russian, Arabic, Chinese, German and French are the most demanded. Adecco points out that this increase in job offers for health professionals with different languages may be a way back for expatriates during the economic crisis. (Pascual & García, 2017)

Thus, the overriding rationale behind the ideation of overloading medical interpreters with tasks other than interpreting may come from the fact that their merely linguistic services within the consultation in the form of the traditional triadic communication are no longer needed, since the doctor, be it expatriate, bilingual resident, *brain drain* phenomenon representative, or just someone who claims to be fluent in a language, speaks the language of the patient. Consequently, the employers do not need interpreting services during the consultation where the doctor (allegedly) speaks the language of the patient, and nobody is going to be paying for the interpreter who is (all day long) sitting and waiting to be called to interpret. What they need is a multilingual staff outside the consultation, whose linguistic skills constitute a sort of bonus or transferable skills, which have ultimately contributed to their employability. Thus, the interpreters instead of facilitating triadic communication in the consultation by adopting a conduit role, assume the role of consultant and co-diagnostician. In her study "Interpreters as co-diagnosticians: Overlapping roles and services between providers and interpreters" Hsieh (2006) clearly showcases how interpreters sometimes tend to "help" the clinicians by blurring the lines between the roles and taking over the provision of "services typically associated with providers".

The information elicited in this thesis (Part III) showcases how interpreters are expected to get intimately involved in the patient's treatment process instead of remaining deferential and displaying professional behaviour by denoting emotional and "medical" detachment. Hsieh (2006, p. 925) states that the criteria she has found to be determining in identifying the co-diagnostician role displayed by interpreters constitute systematically and intentionally "deviating from the conduit role and [...] assuming responsibilities typically associated with providers (e.g. diagnosing the illness, educating patients, or providing support)", which comes to be what the doctors who participated in our study want. Some of the tasks that interpreters had been found to perform included history taking, giving medical instructions and providing medical advice without the doctor giving any recommendations at all (Angelelli, 2004 cited in Hsieh, 2006, p. 925). The rationale and justification that apparently motivated such behaviour is the interpreters' perception of themselves as part of a team and their willingness to contribute to the joint effort by "aiding" the team they belong to (Hsieh, 2006, pp. 924, 935).

Thus, the patients run the risk to be misdiagnosed or receive erroneous treatment, but they are "not in a position to evaluate the quality of the information and may still believe that the advice is given by the provider, rather than the interpreter" (Hsieh 2006, p. 936). Consequently, the patient's access to safe, high quality healthcare is jeopardised (Angelelli 2015, p. 44). Such practices must clearly be outlawed since the interpreters do not receive any "training in soliciting, screening, and evaluating medical information" (Hsieh, 2006, p. 925). Nonetheless, such demeanour remains obscured by the fact that patients are unaware of the interpreter's taking over provider's responsibilities, and they think that the instruction or advice comes from their doctor rather than interpreter. "There is no system in place to ensure the quality of information that is

independently provided by the interpreters, which may increase the risk of malpractice lawsuits" (Hsieh, 2006, p. 936). Thus, the lack of monopoly and social closure, which implies drawing of jurisdictional boundaries underpinned by task discretion contribute to the creation and establishment of hybridised or mutated profiles.

In conclusion, there can be no social or occupational closure neither in the field of medical interpreting in public health spheres, because it is practically inexistent, nor in the private sphere, because it is constituted by non-professionals. The mechanism of social closure is difficult to establish in the case of medical interpreting in the private medical centres in the Valencian Community. On the one hand, "economically successful goods and services are those that satisfy what consumers understand, desire, and are interested in" (Freidson, 2001, Monopoly, Social Closure, and Disciplinary Community, § 4), but in our case the potential consumers (both patients and doctors) do not grasp the difference between professional and non-professional services. Thus the consumers neither understand, nor desire, nor are interested in medical interpreting. The promotion of multilingualism contributes to the perception of language proficiency and interpreting as transferable skills and knowledge that may boost employability rather than a separate, independent, autonomous profession. This is why (pseudo)bilinguals, (pseudo)multilinguals, or those who claim good command of the given language apart from their primary education and training are preferred over T&I graduates. Besides, hiring T&I graduates would imply the risk of social closure, as the graduates would adhere to the international codes of ethics and ISO 13611, critique and reject inappropriate tasks they are neither competent, nor qualified to undertake, whereby the division of labour is organised. The graduates would display lower compliance with (or rather acquiescence to) the inappropriate requests and expectations of the employers, as well as aloofness underpinned by what Collins calls a "consciousness community [...] formed on the basis of common and distinctive experiences, interests, and resources" (Collins, 1979, pp. 58, 134 in Freidson, 2001, Monopoly, Social Closure, and Disciplinary Community section, § 2), as opposed to sycophantic meekness and conformity displayed by non-professionals who are unacquainted with the norms expressed in the international codes of ethics, unfamiliar with realistic self-assessment and who do not share common professional consciousness as they come from different professional/occupational backgrounds and, most importantly who fiercely compete with one another, because obviously, there is no economic security due to lack of monopoly and competitiveness of free market. According to Freidson:

> A monopoly may assure that all qualified members of the discipline gain at least a modest living. If the qualified compete with each other for work with some economic security assured, competition is less likely to be predatory. (Freidson, 2001, Monopoly, Social Closure, and Disciplinary Community section, § 5)

It is worth stressing yet again that virtually anybody who claims proficiency in a language or a series of languages has access to the marketplace, but the question is who is going to guarantee the quality of medical assistance if those whose work is meant to enable this assistance are underqualified. As I have already stated above, the economic monopoly is yet to be established in the medical interpreting market. At the moment the situation can be described as free market struggle where:

> Economic survival requires that price competition be central and that work always be calibrated to the demands and desires of consumers. Prices must be kept as low as possible and, in so far as cost is associated with the quality of work, quality must be as low as it can be and still sell. (Freidson, 2001, Monopoly, Social Closure, and Disciplinary Community section, § 4)

The social or occupational closure has a broader scope than monopoly and, therefore, implies privileged economic position (Freidson, 2001, Ideological Shibboleths Surrounding Monopoly, § 2), which allows the qualified members of a profession to stand on their professional dignity and make at least a modest living. Nevertheless, given its exclusionary character and the strong dependence of general population upon the "advice and assistance" being provided by specialised experts, social closure always comes up for discussion and scrutiny as a mechanism of domination and exploitation (Parkin 1979, p. 71, Murphy, 1988, p. 48 and Bauman, 1987, pp. 19–20 in Freidson, 2001 Ideological Shibboleths Surrounding Monopoly section, § 3). According to Freidson:

> Economists consider monopoly to be by definition a conspiracy against consumers, assuming that the primary intent of those who establish it is to keep prices and their own incomes higher than they would be under free competition. Sociologists link social closure, on the other hand, to inequality by the fact that it involves exclusion. (Freidson, 2001, Ideological Shibboleths Surrounding Monopoly section, § 3)

Hence, some critics deprecate social closure in that they believe that experts conspire together to monopolise jobs and services with a view to seeking financial gain. They claim that economic self-interest constitutes the main motivation for social closure. Nevertheless, social closure is the only strategy that helps maintain high standards of work performance, guarantees commitment to the quality of service being delivered, enables consumers to rest assured that the experts they seek advice and assessment from are competent enough to provide them with a flawless performance of tasks belonging to their specific expertise (Freidson, 2001). This being said, "no one can deny that all professions, like all workers, have an economic interest in making what they regard as a good living [...]" (Freidson, 2001, Ideological Shibboleths Surrounding Monopoly section, § 4). Moreover, economic reward is a sign of recognition, therefore demanding higher remuneration and better job conditions should be viewed as standing on the profession's dignity and seeking payoff for commitment to quality and sunk costs in extensive and exhaustive training rather than explosion towards customers by means of exclusionary market monopolisation resulting in contrivance to raise service prices. The authors of the EU documents (such as High Level Group on Multilingualism) are fully cognisant of the fact that "quality has its price", of the fact that it is higher education institutions who must "remain responsible for training of the highly qualified interpreters", of the fact that becoming interpreter is a time-consuming, "arduous" and expensive process (European Communities, 2007, p. 16). Moreover, High Level Group on Multilingualism report attributes high value to the translation and interpreting, and calls it a "highly demanding profession" (European Communities, 2007, p. 17), so there is no reason for professional highly specialised medical interpreters to settle for being a selfless expert. Altruism and free-of-charge inter-lingual transfer provision by those with bilingual proficiency as well as by T&I graduates only because they feel obliged or are compelled to *help* should *never* be the motivation behind interpreting. "Brokers may view brokering as an unencumbering instantiation of social

responsibility" (Hlavac, 2017, p. 200). Nevertheless, social responsibility and solidarity must never be the motive and the stimulus behind interpreting for free, instead high remuneration and professional recognition must be the incentive sought after if the goal is to professionalise.

5.7. LICENCING ACCORDING TO WEEDEN

Licencing is one of the most efficacious, efficient and effective exogenous mechanisms intended to achieve and entrench occupation closure of a given profession. According to Redbird (2017, pp. 600-624), it is a state-enforced mechanism enacted through licensure to spur limitation of entry by meritocratic method of entry/the principle of academic meritocracy, and quality-driven increase in demand. This mechanism consists in external authority granting legitimacy to practitioner who becomes entitled to use a state-endorsed signal of quality and competence. Occupational closure allows to bypass initial questions regarding employability such as age, race (ethnicity), and gender.

> The magnitude of the closure effect is likely to be even stronger where in addition to educational credentials, licensing regulations make stipulations regarding formal continuous professional training and regular re-testing as a condition to maintain one's license to practice. (Koumenta and Pagliero, 2018; Kleiner, 2015 as cited in Williams & Koumenta, 2019, pp. 711-737)

The licence is granted under the aegis of the state itself to the profession that thereby enjoys state patronage and endorsement, as well as law enforcement strategies safeguarding its licencing status, whereas the non-state mandated voluntary certification or educational credentialing turns occupational incumbents into exclusionary gatekeepers of their profession (Redbird, 2017, pp. 600-624). According to Weeden: "Educational credentialing refers to the use of the familiar symbols or markers of knowledge (e.g., grade levels, diplomas) conferred by formal educational institutions to monitor entry into occupations" (2002, p. 61).

> While other forms of closure such as certification and educational credentialing are voluntary in nature, only licensed occupations have a legal underpinning such that *only those* that meet the criteria can practice (or undertake certain occupational tasks). To achieve the supply-side restrictions described by the theory, occupations engage in boundary-setting activities over occupational tasks and commit considerable resources in their attempt to persuade the public, the state and legislators that licensing is in the public interest. (Williams and Koumenta, 2019, pp. 711-737)

According to Weeden: "Licensure is often justified to lawmakers and the public on the grounds that it protects consumers from incompetence or malfeasance in occupations where incompetence and malfeasance are difficult for consumers to judge and can threaten consumers' health, wealth, homes, or other valued 'goods'" (2002, p. 62). Nevertheless, I would like to clarify that there are two different standpoints on credentialling, which I believe are extremely important for the subject matter of this work and, which I shall get back to in the third part of this thesis, but at this stage of investigation it is important to distinguish that there is clearly a disjunction as to what credentials actually guarantee:

> One view posits that educational credentials certify the acquisition of real skills, and, as a result, any restrictions on opportunities to attain these credentials—whether through the influence of accrediting boards, the scarcity of native ability, or the "considerable expenses and long period of gestation"

> (Weber 1978, p. 1000) training entails—will shrink the pool of candidates who have the skills necessary to perform an occupation's tasks (Parkin 1979; Sørensen 1996; Wright 1979). [...] An alternative perspective argues that educational credentials are only loosely, if at all, related to the knowledge a person needs to be competent or productive in an occupation (Collins 1971, pp. 1005–7; 1979, pp. 12–21; Berg 1970; Jencks 1979, p. 192). Instead, these credentials serve as a largely arbitrary "cultural currency" that buys membership into a particular club (Collins 1979, p. 189; Bourdieu 1984; Parkin 1979). (Weeden, 2002, p. 61)

Collective initiative, action, enthusiasm and ambition play an absolutely essential role in achieving public and state recognition and anchoring its position, status and prestige to a higher socio-professional stratum. The state accreditation and licensure would allow medical interpreters to exercise "task discretion"[40], in other words "control over the nature of work activities", to "dictate skill requirements", a "job demands" (Williams and Koumenta, 2019, pp. 711-737). In this regard, according to the authors, "occupational licensing can be viewed as a form of career insurance in that by prohibiting aspiring practitioners from entry, it shields incumbents from competition" (Williams and Koumenta, 2019, pp. 711-737). Apart from upgrading the status of the members of a given occupation within the stratification system, licensure substantially improves job quality or the quality of working life and, subsequently, job satisfaction. According to Williams and Koumenta (2019, pp. 711-737) licensure is a multidimensional approach in the sense that it provides a "*de facto* incentive for [...] incumbents to engage in human capital acquisition", optimizes the perks or benefits, improves "the contractual status" of the incumbent, provides job stability, enables career development and professional growth, provides financial, psychological and emotional security, grants the possibility to control the work process, its nature and scope, confers professional autonomy and empowers workers in professional occupations to demarcate their job tasks (Williams and Koumenta, 2019, pp. 711-737). According to Abbott (1988) and Larson (1977) as cited in Williams and Koumenta (2019, pp. 711-737) licensure places professionals in advantageous position which allows them to "resist work intensification associated with technological change". I believe that the effects of licencing go even further and immunise professions against the amplification or swelling of their range of tasks, roles and duties by providing them with maximum leverage in terms of and reinforcing their monopoly over knowledge. All of the aforementioned facets of job related wellbeing increase productivity, reduces turnover and absenteeism, and produces a feeling of satisfaction. Licensure also increases the "minimum fees" or the "going wage" that Freidson is talking about (2001).

> Since occupational closure strategies (strategies associated with institutional and legal barriers to enter occupations) have repeatedly been shown to be successful in creating and capturing 'economic rents' for occupational members (additional pay on top of what 'would have' prevailed in the counterfactual occupational labour market without such barriers), it is possible that gains might also be extended to non-pay aspects of job quality. (Williams & Koumenta, 2019, pp. 711-737)

[40] Here I am referring to the task discretion at the macro level, in other words, task discretion in terms of *forbearing to accept tasks beyond incumbents' qualification, resisting work intensification and amplification of the range of tasks.* It is worth noting that the study conducted by Williams and Koumenta (2019) concludes that the licencing may lead to lower task discretion (at what I call a micro level) and "more intense work and a wage premium—all of which tend to be restricted to the most stringently licensed occupations" due to an effort to "homogenise quality standards and also standardise production methods".

Nevertheless, in order for the licensing to have a "strong closure effect on the job quality" the incumbents must be required to demonstrate that they have an outstanding performance level, remarkable skills and excellent vocational education (Williams & Koumenta, 2019, pp. 711-737). The prospective employees must be subject to a highest-level eligibility requirements in order to be able to practice. These requirements must include a broad range of "entry hurdles" to clear, as well as "the substantive nature of these hurdles" (Williams & Koumenta, 2019). Again, see how important the concept of knowledge and skill is. Its complexity and onerous character, as well as its unfathomable nature in terms of being only available to the initiated ones plays the key role in licencing.

Interpreting therefore, must be perceived as a remarkable feat of cognitive effort instead of an easy quasi mechanical task. On the other hand, I believe that the entry hurdles should already start at the university enrolment level highlighting the sophistication of the Translation and University Degree. The eligibility criteria for admission must not allow for indiscriminate acceptance. The diploma must be associated with quality, but there exists a dichotomy between the practitioners' interests, and the higher education institutions. There is an "inherent conflict between the practitioners' collective interest in limiting supply and the countervailing interest in increasing supply created by the institutionalization of formal schooling" (Freidson, 2001, Professional Control of Supply section, § 2).

NAATI[41] (national standards & certifying authority for translators and interpreters in Australia) epitomises a sophisticated and highly demanding specialist healthcare interpreter accreditation. The adaptation thereof to Spanish T&I labour market should definitely become one of the professionalisarion priorities for the foreseeable future.

[41] For more information, please visit the official website: https://www.naati.com.au

6. FREIDSON'S TYPOLOGY OF PROFESSIONAL KNOWLEDGE APPLIED TO MEDICAL INTERPRETING

So are the cognitive processes and mechanisms underlying interpreting activity more scientific or artistic? Does interpreting entail "esoteric knowledge and complex skills" (Freidson, 2016, The Theory of Professions: State of the Art, § 1)? May translation and interpreting processes involve "guilty knowledge acquisition" (Dingwall, 2016 Introduction section, § 12)? Neither the physicians, nor the patients, nor the unqualified personnel who undertakes interpreting assignments construe medical interpreting as "an occupation to which specialised knowledge, ethicality and importance to society are imputed" (Freidson, 2016, The Parochialism of the Institutional Concept of Profession section, § 7).

So the first key question is, is there any expert or scientific knowledge underlying the exercise of medical interpreting, or is it just a natural, innate and effortless activity? In case interpreting does actually take some sort of knowledge as foundation, the seconf question would be what type of knowledge are we talking about? In case the first two answers are affirmative, the third and last question is why this knowledge, which would be a decisive factor to anchor professional power and autonomy is still unrecognised (Freidson, 1970a as cited in Rueschemeyer, 2016, section V, § 1).

As Carvalho and Santiago (2016) maintain, many scholars who theorised within the field of the Sociology of Professions have foregrounded knowledge as a *Büchner funnel* mechanism, of course in a figurative sense, of the occupational closure – indispensable strategy of the professionalisation process (Johnson, 1972, Freidson, 1994, 2001, Larson, 2013 as cited in Carvalho and Santiago, 2016, p. 144). Carvalho and Santiago (2016) view knowledge as a "basic condition to perform highly specialised work" and as a mechanism of "rationalisation of tasks and solutions to solve complex problems" (Carvalho & Santiago, 2016, p. 144). With the exponentially increasing complexity of tasks being carried out in the context of the division of labour, the salience of "scientific knowledge", duly "legitimated through formal credentials" issued by "higher education institutions", gained even more "prominence" in the pursuit of "qualified workforce" (Carvalho & Santiago, 2016). However, the concept of knowledge may lead to a series of controversies: "first, expert knowledge is increasingly contested by different social actors (Jensen et al., 2012 in Carvalho & Santiago, 2016, p. 145)", and second "democratisation of higher education" has led to acknowledgement of new professions by means of institutionalisation of their codified knowledge (Carvalho & Santiago, 2016). The division of labour became more rationalised, more intellectualised and more compartmentalised due to growing differentiation by means of incorporation of "specialised science and technology" (Freidson, 2001, Larson, 2013 and Brint, 1994 as cited in Carvalho and Santiago, 2016, p. 145), fostering recognition of "formal and abstract knowledge, obtained through higher education training, formally attested to by a diploma" and anchoring it in the society as a cornerstone condition for those occupational candidates willing to professionalise. The recognition of knowledge allowed for exclusionary access to and control of market shelters (Freidson, 1986 as cited in Carvalho and Santiago, 2016, p. 145) which

resulted in "social, cultural and economic power and privileges" as sated by Larson (2013 in Carvalho and Santiago, 2016, p. 145). I have curated the following stages of professionalism according to Freidson (2001 as cited in Carvalho and Santiago, 2016, p. 145):

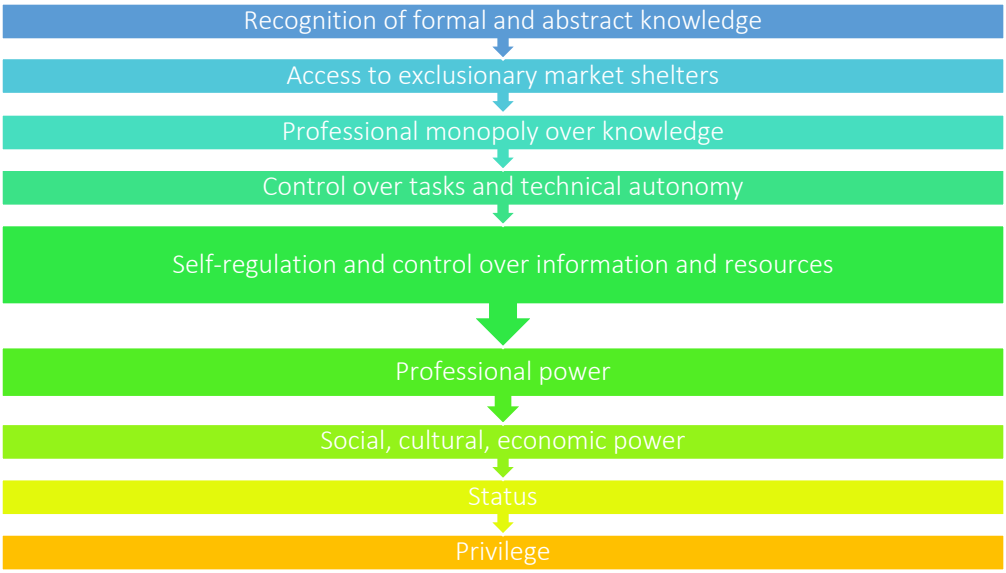


Figure 23. Stages of Professionalisation following Freidson (2001)

According to Ovretveit, many different sociologists have presented different models of stages of professionalisation, as well as different typologies of professions, such as "would-be-professions", "new professions", "near professions" and "professions" (see Carr Saunders, 1955 as cited in Ovretveit, 1992, pp. 191-195), "new professions" as opposed to "traditional professions" (Marshall, 1965 as cited in Ovretveit, 1992, pp. 191-195), "aspiring professions" (Goode, 1969 as cited in Ovretveit, 1992, pp. 191-195), "professions", "near-professions", "enterprises", "missions", "arts", "crafts", and "jobs" (Hughes, 1958 as cited in Ovretveit, 1992, pp. 191-195). However, almost all of the sociologists of professions agree on the "typical five-stage historical process of professionalization" (Ovretveit, 1992, pp. 191-195) constituted by the following phases:

1. Occupations become full-time occupations
2. Then acquire training schools and university schools
3. Subsequently form local and national professional associations
4. Afterwards become protected by law
5. Ultimately adopt formal codes of ethics

Regarding the traits of a profession:

> Millerson in The Qualifying Associations took the work of twenty-two scholars on the professions, including Carr-Saunders, Marshall, Parsons, the Webbs, Tawney and Whitehead. He extracted the constant characteristics of their work to see which were considered essential to a profession. The common features were found to be: skill based upon theoretical knowledge; training and education; demonstration of competence by passing a test; integrity maintained by adherence to a code of conduct; a professional organisation and service for the public good. Underlying these definitions is the sentiment that the professional is a noble, independent individual who places public duty and honour before all else. (Ovretveit, 1992, pp. 191-195)

Nevertheless, in this thesis I shall be using Freidson's model (2001), according to which all stages of professionalisation and the success of professionalisation depend on recognition of formal and abstract knowledge as the cornerstone of every profession. It could be said that the lack of recognition of the knowledge underlying medical interpreting is the main obstacle to completing professionalisation, therefore Freidson's approach (2001) which rests upon the identification of the underpinning typology of knowledge as the main indicator of potential professionalisation or de-professionalisation will be my point of departure for this thesis. It is worthwhile noting that Freidson developed the most comprehensive system of knowledge classification, which I will use as a toolbox for my analysis of knowledge for medical interpreting.

6.1. THE CONCEPT OF KNOWLEDGE: PROVIDING GENERAL INSIGHTS USING THE SOCIOLOGICAL SCOPE

I would like to begin this section by defining the connection between "professionalism" and "knowledge". Freidson pointed out that "ideal-typical position of professionalism is founded on the official belief that the knowledge and skill of a particular specialization requires a foundation in abstract concepts and formal learning and necessitates the exercise of discretion" (2001, section I, Professional Knowledge and Skill, subsection Specialization, § 4).

Skaaden (2019, chapter 3.2 What is a profession?, § 4-6) argues that every professional activity consists in offering a service (rendering someone else's discourse in another language) to clients (patients and healthcare providers or speakers and listeners, double allegiance) who hinge upon the professional's specialised skills to solve a "how to" problem (how to verbally communicate) by applying specialised skills in unique situations that are difficult to standardise. Therefore, the professional must exercise discretion by applying a codified body of knowledge (systematised and standardised only up to an extent according to Freidson, 2001) to unique cases and situations. Consequently, professional activity may be qualified as a fallible activity due to the exercise of discretion. The exercise of discretion implies "constantly mak[ing] judgements and on-the-spot decisions in real life situations that are each unique" when applying their knowledge and skills in practice (Skaaden, 2019, chapter 3.2.1 Professions and the exercise of discretion, § 1). Of course, some situations, protocols, procedures, etc. may bear typological similarities, but "no two situations are identical":

> Above all else, the ideology supporting professional training emphasizes theory and abstract concepts. This is justified by claiming that whatever practitioners must do at work may require extensive exercise of discretionary judgment rather than the choice and routine application of a limited number of mechanical techniques. Hence, it is more important to have a firm grounding in basic theory and concepts to guide discretionary judgment than to gain practice in what can only be a selection from among all the concrete practical and working knowledge that particular work-settings may require. (Freidson, 2001, The Professional Curriculum section, § 1)

As Freidson (2001, The Professional Curriculum section, § 1) clarifies, the existing body of literature fails to address the gaps concerning a "systematic rationale [or method] for distinguishing" classifying and cataloguing disciplines or different kinds of work by their "content", tasks, knowledge and skills required for its performance. I conducted an exhaustive literature review

for the purpose of finding convincing and very well founded facts and evidence concerning the typology of knowledge underlying the academised, intellectualised, disciplinarised but not yet professionalised process or activity of translation and interpreting. But I could not find anything written by translation and interpreting scholars that would explain why medical interpreting is being played down, trivialised and devoid of occupational dignity. I could not fathom either why translation and interpreting scholars would keep calling "translation" and "interpreting" a profession, when it has never been consolidated as such. So after a thorough deliberation I decided to draw on the sociology of knowledge as I believe it provides unique and exceptional insights into how the typology of knowledge and skill and its perception by the general public influences occupational development.

In his book "Professionalism The Third Logic" Freidson categorises different typologies of knowledge and skill. He foregrounds "discretionary specialisation", which is grounded in "abstract concepts and theories", as the "ideal-typical professional knowledge" (2001, section 7, § 1). This special type of professional knowledge and skill, even though it may have been officially recognised, may not achieve full endorsement and promotion on political, social and economic level culminating in official establishment and consolidation of professionalism. It may depend on the variation in the substance or content of knowledge and skill (which may constitute a "contingency" of the process geared towards reaching the "position of professionalism"), as well as on the institutional requirements for the undertaking of tasks it claims ownership for (Freidson, 2001, section 7, § 2).

6.2. MACRO STRUCTURE OF KNOWLEDGE

This section will purport to introduce some general notions regarding the theory of professional knowledge, how it differs from profession to profession, and what role it plays in reifying and materialising professionalisation. I will start by analysing the seventh chapter of the book *Professionalism The Third Logic* by Freidson (2001) called

Bodies of Knowledge (subsection Professional Knowledge, § 1-4), which would introduce the reader to what I think might be called the macro structure of knowledge, and then I shall proceed to unpick the first chapter of the same book called *Professional Knowledge and Skill*, which in my opinion will provide the reader with the more concrete notions of knowledge and the micro structure of the concept. In this section I shall try to fathom out why some professions are dignified, idealised and even adulated, whereas other professions or occupations are dismissed as not only unsophisticated, unnecessary, redundant, unimportant, replaceable, but even uncalled for. My aim is to ferret out why some professionals display peremptory behaviour or attitude and expect the non-experts to defer to them on important life-altering matters, whereas other professionals need to become invisible in order not to encumber others with their presence. In other words, the main question that this section will seek to answer is why physicians' knowledge is considered irreplaceable, unattainable and unfathomable to the uninitiated, whereas anyone, be it a doctor, a patient or a family member can replace the figure of professional interpreter by making them squeeze into a corner and yield their slot to those who claim to possess analogous knowledge. This phenomenon was widely reported on by Castillo and Taibi in 2005. Thus, the

interpreter is being allowed in and tolerated rather than welcome, their knowledge is not considered to be *the* expert knowledge and skill, and anyone can step in and have one's say when it comes to speaking a language as well as contest their proficiency and task ownership. Therefore, for the reasons set forth above, I shall try to understand why the professional knowledge underpinning medical interpreting does not seem to have quite the cachet of the knowledge underlying other more recognised professions such as medicine or law.

6.2.1. Ideal type of knowledge

According to Goode (1969, p. 277 as indicated in Freidson, 2001, section 7, § 3) in order to uphold its position within the desired social milieu, knowledge must be endowed with "abstraction" as its key feature, and it must systematise "a codified body of principles" or "must be formalised and codified enough to allow standardisation" (Larson, 1977, p. 31 as cited in Freidson, 2001, section 7, § 3). The notion of abstraction according to Abbott cannot play a decisive role of a litmus test, or be subject to a golden standard, it must be "effective enough to compete in a particular historical or social context" (1988, p. 9 as cited in Freidson, 2001, section 7, § 3-4). Nevertheless, according to Freidson, it must not be regularised or methodised to such an extent as not to allow discretionary judgement. "Uncertainty or indeterminacy" must be inherent to the "complexity of the task" or work (Abbott, 1988, p. 9 as cited in Freidson, 2001, section 7, § 3-4). It is difficult to develop and fix a set of objective benchmarks or criteria by which knowledge and skill for certain work may be characterised. These criteria are subject to personal perceptions of different social actors:

> The criteria are not fixed and objective. Furthermore, they vary by social perspective: both consumers and managers are prone to perceive less indeterminacy and complexity in work than are those who actually perform it. (Freidson, 2001, section 7, § 4)

Furthermore, Freidson maintains that the assumption of "esoteric" and "schooled theory" being crucial for appropriate performance of work is highly disputable. Theorists peddle this idea to practitioners, consumers and managers. They force-feed its indispensability from their ivory towers while not having to dirty their hands with workplace reality. Having said that, Freidson warns us that even though these criteria are biased, they serve the purpose of "justification for the social status attributed to some kinds of work" and thus although not "timeless" and absolute they came to be socially and culturally underpinned (Freidson, 2001, section 7, § 4).

6.2.2. Epistemological status

As maintained by Halliday (1987, pp. 28-55 in Freidson, 2001) the epistemological foundation of disciplines may impose a "knowledge mandate", extolling knowledge supremacy of certain types of professions while imposing mediocrity and subjugation on other more disadvantaged occupations in terms of knowledge and skills. In this light, the scientific grounding of knowledge and skill employed in medicine endows this discipline with "cognitive authority".

Nevertheless, according to Freidson (2001, section 7 subsection Epistemological Status, § 1), to conceive of medicine as a prototypical profession might be misleading as such gravitation towards this assumption implies that "the prototypical professional knowledge is scientific in

character", which is a delusion and can be disputed on the ground of perceiving law as a fully-fledged, established profession as well. Both professions have acquired a traditional status of profession, however, the types of knowledge and skill employed in these professions are widely differing. Science is the cornerstone of medicine, while law has no scientific foundation at all, instead it applies abstract concepts partially relying on the "systematic body of abstract theory" (Merryman, 1985 as indicated in Freidson, 2001, section 7, subsection Epistemological Status, § 1). Halliday and Rueschemeyer both hold that: "neither legal nor clerical profession is based on positive science [...] (§ 3). Consequently:

> Scientific foundation is not an essential characteristic of professional knowledge. This conclusion immediately raises the possibility of distinguishing different bodies of professional knowledge by their epistemological status. (Freidson, 2001, section 7, subsection Epistemological Status, § 1)

Halliday (1987, pp. 28-55 as cited in Freidson, 2001, section 7, subsection Epistemological Status, § 3) suggests that a more "catholic" approach to "distinguishing bodies of knowledge and skill" would yield a better understanding and compartmentalisation or systematisation thereof. According to this author, an optimal "cognitive basis for a discipline" would entail a) a sufficiently codified knowledge; b) tasks that are sufficiently distinctive as to draw clear jurisdictional boundaries of this discipline; c) standardisation of the codified knowledge, skill and tasks which would in spite of its routinisation still allow discretionary judgement. I have curated the following graphic down below for a better apprehension (Halliday, 1987).

Figure 24. Cognitive basis for a discipline according to Halliday (1987 in Freidson, 2001)

It is worth noting that scientific knowledge is not the only type of knowledge that endeavours to gain insights into different "facts", however, scientific methodology is perceived as the most reliable when it comes to demystification of different phenomena. Halliday subsumes all different academic specialties under one single academic profession, which is inaccurate because what they teach and research "sharply divides them into quite different specialties". Freidson argues that:

> The knowledge of some of those specialties is scientific in character, and most of the others are concerned with discovering and refining substantive knowledge rather than consciously analysing and expounding values or norms. At best a minority of the professorial disciplines has an essentially normative or syncretic focus. (Freidson, 2001, section 7, subsection epistemological Status, § 5-6)

Freidson (2001, section 7, subsection Epistemological Status, § 5-7) distinguishes 3 forms of knowledge:

Descriptive forms claiming technical authority	Prescriptive forms claiming moral authority	Artistic forms claiming normative aesthetic/cultural authority
a) Scientific group b) Scholarly or humanistic group (according to this classification, translation and interpreting would fall within this category)	c) Secular group (law) d) Sacred (religion) concerned with: - behavioural norms - social norms or morality e) Ethics (concerned with social norms)	f) Arts concerned with aesthetic norms

Figure 25. Difference between professions with official status and unrecognised occupations according Freidson (2001)

In terms of the scope of the authority, scientists, for instance, may confine their influence to the relatively limited areas of their scientific interest. Those groups pertaining to normative knowledge may exercise authority in wider social contexts. Nonetheless, these distinctions are not empirically mutually exclusive for it is possible to combine technical expertise with moral authority, for example.

Illich (1976, as cited in Moskop, 1980, pp. 35-41), on the other hand, distinguishes three branches of professional authorities:

1) *Sapiential authori*ty to advise, instruct and direct
2) *Moral authority* which professionals are granted based on their formal commitment to client welfare. Moral authority seeks to help the clientele receive the benefit they are pursuing. This type of authority is grounded in trust which in medical profession, for example, manifests when patients confide in their physician and follow the treatment despite the difficulty, rigorousness and elevated costs.
3) *Charismatic authority* implies involvement in "events or situations of special import for human beings" such as "birth, nudity, trauma, anxiety, disease, death" (Moskop, 1980). The aforementioned processes constitute the "existentially charged" and "emotionally laden situations" in which patients have to deal with "suffering and loss". The practitioners find themselves "in the unique position to provide guidance", to counsel, and to comfort the patients and the families. In other words, the practitioners main task is to care for those involved (Moskop, 1980, pp. 35-41).

Thus, professionals are expected to exhibit a) strong interpersonal skills; b) psychological strength; c) technical competence; d) commitment to client welfare; e) sensitivity to the needs of suffering individuals (Moskop, 1980, pp. 35-41). Please note that medical interpreting is clearly a *mélange* of all three branches of professional authorities, therefore I believe that this occupation makes an excellent candidate to professionalisation.

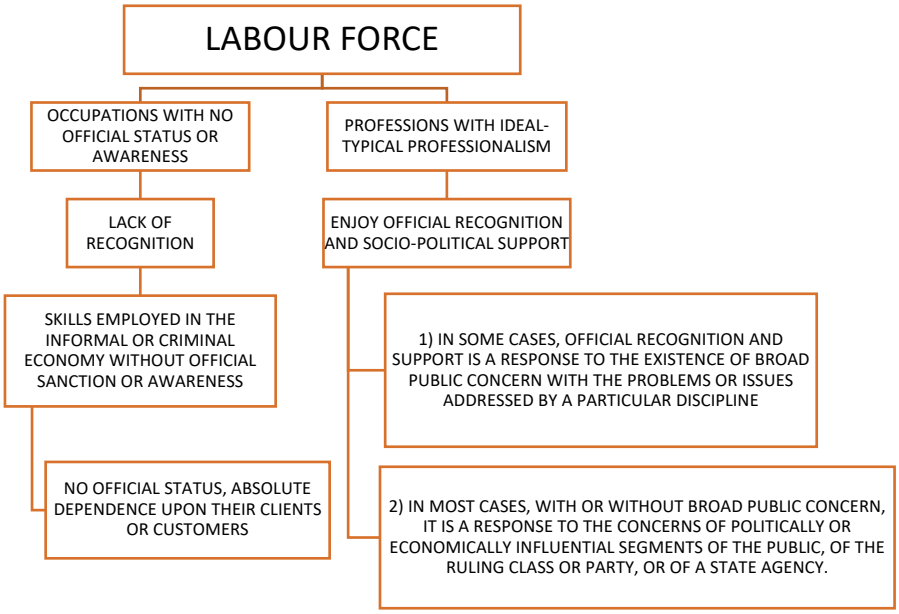


Figure 26. Labour Force. Source: Freidson, 2001, section 7, subsection The Contingencies of Knowledge, § 1-8

I have curated the schema inserted above with the purpose of illustrating a clear divergence, or bifurcation if you will, between recognised and unrecognised occupations, showcasing the relevance of public backup and/or state endorsement and promotion in gaining prominence and professional status.

It is worthwhile noting that the authority that a body of knowledge or a discipline exerts is not an everlasting, timeless, unceasing intangible asset. The discipline which may potentially end up engineering social behaviours and social tastes and preferences as well as scientifically control socially relevant issues, is totally contingent upon "the concrete historical circumstances surrounding its position".

According to Freidson (2001, section 7, subsection The Scope of Epistemological Authority, § 2) "the degree and the scope of the authority of a given body of knowledge" is liable to depend on "its relationship to other disciplines" within the theoretical framework of "social division of labour". Freidson clarifies that to fathom out the dynamics and the rationale behind the logic by which bodies of knowledge gain and lose influence we need to examine the situation through a historical and social lens, paying close attention to "the spirit of times", "historic and national circumstances in which they are practiced" (Freidson, 2001).

Freidson states that the "specialised knowledge" and "skill" are not insulated and decontextualised concepts, but facets to be envisaged within the overarching context of the "universe of work", for both constitute a part of the "labour force" (2001, The Contingencies of Knowledge section 7, § 1-9)

But now the question arises as to what reasoning do the public in general and the "politically and economically influential segments of the public", "the ruling class" or "a state agency" in particular adopt to classify occupations. In other words, why do some occupations get furthering and patronage while others remain unacknowledged?

Freidson has an explanation which I believe ties in perfectly with my theory as to why medical interpreting remains unacknowledged:

> There are a few disciplines whose tasks bear on issues of widespread interest and deep concern on the part of the general population. They might be called core disciplines, bodies of knowledge and skill which address perennial problems that are of great importance to most of humanity. Although they have quite different epistemological statuses, medicine, law, and religion exemplify such disciplines [...] With official support, one version or another of those disciplines can become very securely established so long as it also has the support of the general population. But when general support from the population is fragmented by sectarianism or weakened by general scepticism or indifference, the official position of disciplines purporting to serve those concerns may become an empty shell and crumble over time, their position ultimately usurped by another more popular discipline or by schismatic movements which fragment if not dissolve the original. (Freidson, 2001, section 7, subsection The Contingencies of Knowledge, § 1-3)

Following this logic, stakeholders must convince society in general and relevant decision-makers in particular that medical interpreting is of "widespread interest and deep concern" in that it deals with issues of great importance to any multilingual and multicultural society, not just isolated non-Spanish speaking minorities. This standpoint was also defended by Phelan et al.:

> A first step towards comprehensiveness hinges on society's political will and its readiness to see that 'poor communication not only threatens minority speakers' legal safeguard, but also poses a threat to the professional integrity of the healthcare workers, police officers, or judges in charge of the institutional dialogue' (Skaaden and Felberg 2012: 8). Consequently, ethical principles of a wider range than those governing the interpreter function are at stake. (Phelan et al., 2020, Organised education for interpreters: an international spectrum of response section, § 8)

I italicised the wording throughout this written discourse that I consider to be quite self-explanatory and meaningful. I think that Freidson was envisioning or gravitating more towards prescriptive cognitive knowledge claiming normative authority when elucidating the rationale behind the establishment of occupations. Yet this explication can be perfectly applicable and attributable to any occupation in my opinion.

So, according to the aforementioned reasoning (widespread interest and deep public concern), the state ought to grant official approval, sanctioning and independent niche within the labour force not only to the core disciplines, but also, for instance, to "schoolteachers, social workers, and professors" in that these occupations "provide services directly to the general population" and the general public is acquainted with their work.

It is important that we are fully aware and cognizant of the fact that many disciplines are granted professional status due to "their importance to special segments of society or to the state itself", even though their functions have "little relationship to the interests and felt needs of the broad public":

> But *not all disciplines* likely to gain special status in the labour force *are believed to be of immediate functional value* to either the powers of the political economy or the public at large. Conspicuously *without such value* but privileged nonetheless are most of the academic disciplines. If clear functional value alone were invoked, a privileged professoriate would be composed solely of those disciplines directly related to the training of engineers, chemists, accountants, and physicians. (Freidson, 2001, section 7, subsection The Contingencies of Knowledge, § 4)

It is worthwhile mentioning that according to Freidson (2001), the members of certain specialisations are not always willing to remain faithful to the "jurisdictional boundaries" of their respective occupations. Sometimes they dispute the boundaries by "contesting" tasks or duties as

if it was a free occupational interaction, even though these were categorised and systematised by "managerial authority" by which specialised members were not given leeway to blur official limits.

But the division of labour in a hospital, for example, bears on complex *apparatus* of hierarchically arranged technical specialties "both within medicine itself" and those which are not subordinated to medicine.

In his subsection on Institutional Spheres (2001, section 7, § 1, 3-4) Freidson pinpoints the importance to take into account, when analysing knowledge and skill, the institutional environment in which concrete "knowledge is exercised". The practitioners of both, professions as well as occupations, operate in "particular institutional spheres", geographically and physically delimited areas like a hospital catchment area, court of law, police station, interpreting booth at an international organisation, translation bureau, etc., which may be considered as their sphere of influence. But not all the members of a particular occupation or profession engage in their corresponding professional or occupational activities in their "primary institutional spheres, where the authority of their discipline's knowledge is central" (Freidson, 2001). Many times they practice in what Halliday calls "secondary spheres, where the authority of their discipline's knowledge is not central" or subsidiary (Halliday as indicated in Freidson, 2001, section 7, subsection The Variety of Institutional Spheres, § 1). This would clearly be the case of medical interpreters as they have *colonised*, if you will, private healthcare, [unsuccessfully] struggling to delimit their occupational jurisdiction or areas of responsibility/accountability in an unacquainted territory or interdisciplinary working climate, where their knowledge is conceived of as secondary if not expendable. In this case coexistence does not always result in fruitful occupational cross-fertilisation and mutually beneficial collaboration. Thus, I agree with Freidson that such "institutional relations" may critically influence the level of leverage of the authority (or lack thereof) of their occupation.

More research needs to be conducted into the criteria which help classify the character of knowledge and skill of different disciplines, particularly if scholars aim at examining emerging occupations, in order to gain insights into how the typology of knowledge and skill predetermines the essence of a particular discipline. This would help researchers understand how "the character of disciplines bears on the gaining of economic or political privilege". Freidson suggests that "we must go beyond epistemology to the substance or content of the tasks that disciplines perform and the conditions required for their performance" (Freidson, 2001, section 7, subsection The Variety of Institutional Spheres, § 3).

6.3. MICRO STRUCTURE

In the first chapter "Professional knowledge and skill" located at the very beginning of the first part of the book "Professionalism: the Ideal Type" Freidson states that the main objective he pursued was an ambitious endeavour to "establish the essential framework of distinctions that defines the type of knowledge and skill at the core of professionalism" (Freidson, 2001, Introduction section, § 1). The very rudimentary, or as Freidson calls it, "elementary" definition of "professionalism is a set of institutions which permit the members of an occupation to make a living while controlling their own work" (Freidson, 2001). This is a very privileged, advantaged and

favoured socio-professional position, but it is also highly preferential because the state of professionalism can be achieved only by those people, whose expertise is envisaged as intrinsically unique or heterogeneous due to its complexity. In other words, the concepts of "profession" and "professionalism" would be rendered irrelevant if society was not conditioned to think that the particular tasks performed by the professional elite are "so different from those of most workers that self-control is essential". As stated by Freidson:

> The two most general ideas underlying professionalism are the belief that certain work is so specialized as to be inaccessible to those lacking the required training and experience, and the belief that it cannot be standardized, rationalized or, as Abbott (1991b: 22) puts it, "commodified". (Freidson, 2001, section 1, Introduction, § 1)

If we want to fathom why most of the translation and interpreting activities are not professionalised we must first and foremost understand what kind of knowledge underlies these activities and how this knowledge is perceived by the society within a given historical context. But in order to be able to do that, we must understand how the process of definition of particular kinds of knowledge works, why certain types of knowledge are considered preferential and are granted social and economic privileges imperative for the accomplishment of professionalism. Those scholars who are staunch and ardent advocates of professionalisation of translation and interpreting must draw on Freidson's conceptual tool-box in order to understand why is it that these disciplines still remain socially unrecognised. It is essential to clearly distinguish between the importance of the "function" of translators and interpreters and the "degree and kind of specialisation required by particular jobs" to "establish their social, symbolic, and economic value and justify the degree of privilege and trust to which they are entitled" (Freidson, 2001, section 7, subsection The Contingencies of Knowledge, § 1-3). Thus not only the function or the role must be taken into account, but also the kind of knowledge and the degree of specialisation, and of course, there must be a belief of inaccessibility, mystique, complexity of training, "belief that [this knowledge] cannot be standardised [or] rationalised. The general support from the population is absolutely imperative, if the general attitude towards the concerns, the function, the role and most importantly the knowledge and skill of a discipline or work may be described as "sceptical" or "indifferent" then the position of these disciplines is an "empty shell" and it will "crumble" or be absorbed or "usurped by another more popular discipline" (Freidson, 2001, section 7, subsection The Contingencies of Knowledge, § 1-3). One could even say that the occupation would deprofessionalise without having even become a profession.

6.3.1. Typologies of specialisations: mechanical vs discretionary

I shall now proceed to unpack Freidson's notion of specialisation (2001, section 1, subsection The Growth of Specialisations, § 1-2). He basically distinguishes two major overarching or macrostructural groups of specialisations: "manual specialisations" (working class) and "intellectual specialisations" (preserved for the middle class). In his book "The Wealth of Nations" (1776 as cited in Freidson, 2001, section 1, subsection Manual Specialisations, § 3-4) Smith maintained that "specialization increased productivity". Industrial proletariat (or industrial class of workers) exemplifies and represents those workers with manual specialisation. The second type of

specialisation is intellectual and it started to increase exponentially since the second half of the nineteenth century "in the pursuit and application of complex, formal knowledge and technique" (Freidson, 2001). According to Freidson:

> Scholarship and scientific research, [...] developed into full-time, paid occupations during the nineteenth and especially the twentieth centuries. [...] The practice of most was sustained by the host occupation of university teaching, but those who could practice in the marketplace became self-supporting occupations, whether self-employed (physicians, lawyers), employed by the state (jurists, engineers), or by industrial enterprises (chemists and most engineers). The development of that form of specialization, which involved the middle rather than the working class, led to the coming of the "expert" and the "technician," along with the English words (which did not exist earlier) to designate them conveniently. (Freidson 1986, 12–13)

Freidson distinguishes two types of specialisations: mechanical and discretionary. The mechanical specialisation entails performance of "simple" and "repetitive" in perfunctory and automaton-like or robotic fashion. All these qualifiers convey the idea of an utmost simplicity, cognitive effortlessness and monotonous homogeneity. As stated by Freidson, these adjectives transmit "the idea of the exclusive performance of tasks that are so simple and repetitive that they can be performed by virtually any normal adult [...]" (Freidson, 2001, section 1, subsection Types of Specialisation, § 1-4). Moreover, there is "little or no opportunity to vary the tasks [...] or the way" in which these tasks should be carried out.

> A mechanical specialization is thought to employ largely everyday knowledge and skill, some of which is of course tacit, and a fairly small proportion of practical knowledge connected with work in particular settings. A discretionary manual specialization employs a large proportion of practical knowledge, and moderate proportions of everyday, formal, and tacit knowledge. A mental discretionary specialization, on the other hand, is distinguished by its reliance on a relatively small proportion of everyday and tacit knowledge, a moderate amount of practical knowledge, and a high proportion of formal knowledge. (Freidson, 2001, section 1, subsection Specializations, § 3)

Discretionary specialisation, on the contrary, encompasses the mental exercise of deliberation, "fresh judgement", circumspection, "however narrow, minute, detailed, or "specialized" the task. In other words, in order for the task to be undertaken successfully the performer must make a cognitive effort of discernment, assessment of the situation, deliberation on action, rational forethought, they must exercise "discretion". According to Freidson:

> What underlies it is not the use of the mind instead of the body but rather the kind of knowledge and thought that is believed to be used in different kinds of work. Mechanical specialization by definition requires primarily the knowledge and concepts that normal adults learn during the course of their everyday lives. Discretionary specialization, on the other hand, is thought to require the employment of a body of knowledge that is gained by special training – which is why its practitioners are called experts or specialists and pinmakers are not. (Freidson, 2001, section 1, subsection Types of Specialisation, § 1-4)

Fox (1974, pp. 26-35 as indicated in Freidson, 2001, section I, Professional Knowledge and Skill, subsection Specialization, § 4) highlights that the right to employ discretionary knowledge or judgement implies consumers putting trust in the specialist, but it also implies the worker's commitment and moral involvement in the work they do. Thus, the failures that might happen during the work process should not be considered as a result of "wilful neglect", negligence,

malpractice or maladvise. The role of trust is to scale down the "externally imposed" policies, norm-setting and "rules governing work".

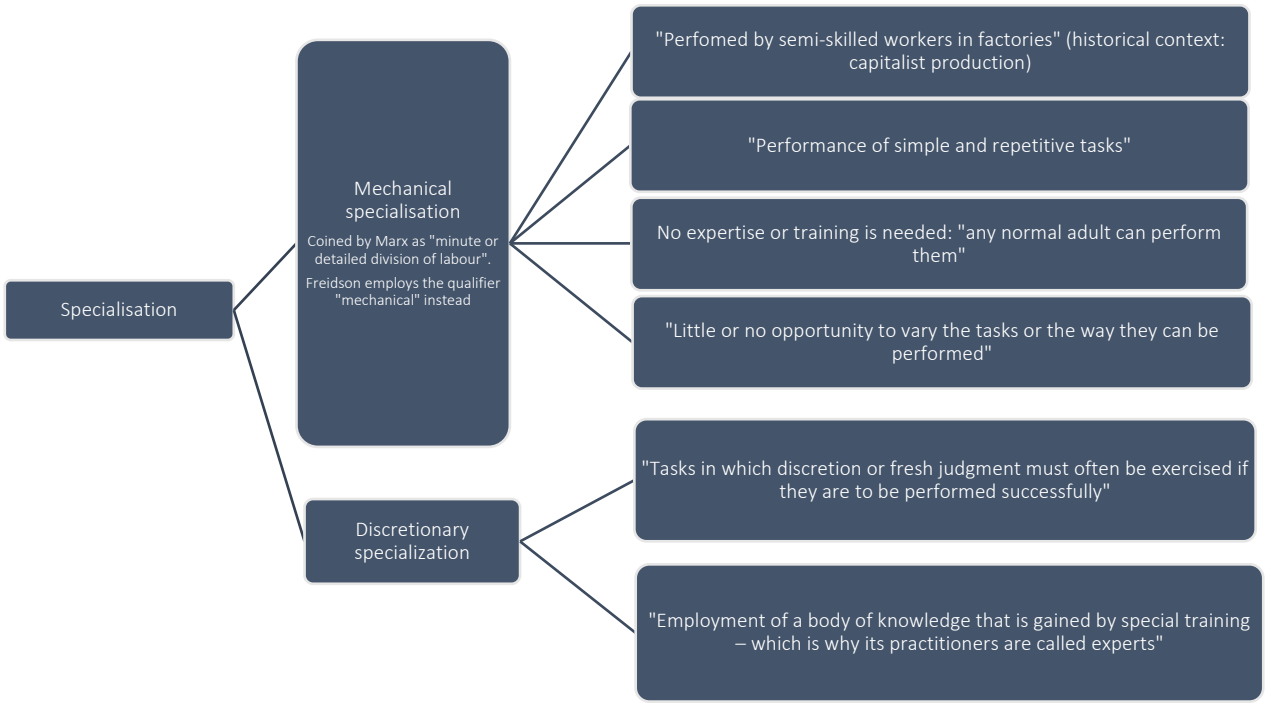


Figure 27. Mechanical and Discretionary Specialisation. Source: Freidson, 2001, section 1, subsection Types of Specialisation, § 1-4

6.3.2. Definition of skill

As maintained by Freidson (2001, section 1, subsection Skill and the Tacit, § 1), the term "skill" in official statistics betokens "the amount and kind of specialised training" that the members of different labour forces are displaying when performing corresponding tasks. Freidson cites Attewell (1990, p. 423) who arrives at the conclusion that the notion of "competence" and "proficiency" compound the marrow of the term "skill", as the main idea of all definitions of "skill" mirrors "the ability to do something well". Moreover, the concept of "skill" subsumes both "mental" or cognitive "understanding or knowledge" and "physical dexterity" or patent adroitness. Nonetheless, sometimes during an employment screening, for example, the term "skill" may be downgraded to the mere "capacity to accomplish a task which may be kept analytically separate from the substantive knowledge connected with the task itself" (Freidson, 2001, section 1, subsection Skill and the Tacit, § 1-3). According to Freidson:

> While skill is itself a kind of knowledge, namely, of the techniques for using or applying substantive knowledge, it is facilitative in character. Thus, to solve an abstract problem, one must not only have command over the body of knowledge connected with the problem, but also the rules of discourse (that is, logic, mathematics, rules of evidence), and the capacity or skill to employ them so as to arrive at an acceptable solution [...] People with the same substantive knowledge can differ in their skill at solving abstract problems. (Freidson, 2001, section 1, subsection Skill and the Tacit, § 1-3)

6.3.3. Typology of skills: codified and tacit skill and knowledge

According to Freidson, skill application is a transition phase from the body of knowledge to the actual performance of the task whereby this knowledge may be displayed. There are two different types of skill application: formalised or prescribed and "tacit" or "unverbalisable". Those skills which are prescribed by rules, stipulated in "codified texts", conventionalised, formalised or as Freidson calls it "formal in character", "clearly and systematically" specified "in the course of training for work" are predetermined and must be abode by in accordance with the applicable provisions. However, the second type of skill is called "tacit", which Freidson qualifies as "unverbalised" or "perhaps even unverbalisable", which means that it is not stipulated by any "formal corpus of codified technique". Those skills simply cannot be "codified or described systematically; they must be learned by practice, become part of the eye, ear, and hand". In other words, tacit knowledge is grounded in experience instead of formal knowledge "learned in classrooms".

> According to Polanyi (1964), [tacit knowledge] is also the case for such exalted enterprises as scientific research. He argues that skills are an essential component of *scientific discovery and knowledge*, and that they are exercised according to a tacit art that is based on experience rather than formal theory [...] The same *tacit intellectual skills are involved in writing a research grant, an essay, a scholarly or scientific paper, a poem, or a novel*. Formal rules of grammar, spelling, and discourse can be specified and learned (some reduced to a computer program), but *no set of rules can specify*, for example, *how much to emphasize or repeat a point, [...] when ordinary rules and conventional forms can be fruitfully violated, [...] and what words or phrases, should be used to characterize a point.* (Freidson, 2001, section 1, subsection Skill and the Tacit, § 3-4, I italicised the key points)

Having defined the concepts of "codified knowledge and skill" and "tacit knowlwdge and skill", we shall now proceed to focus on the difference between "everyday knowlegde" and "formal knowledge".

6.3.4. Everyday vs formal knowledge

Large numbers of people worldwide contest the knowledge of languages as they claim to be proficient enough to translate and interpret as though it was as easy as "sweeping a floor, using a shovel or driving an automobile" (Freidson, 2001, section 1, subsection Everyday and Formal Knowledge in Work, § 2). Apparently and judging from the famous Pöchhacker's and Kadric's paper on *The Hospital Cleaner as Healthcare Interpreter* (2014) – there is no difference between sweeping the floor and interpreting. The hospital staff featured in this seminal paper believe that the hospital cleaner does not need specific knowledge and skill employed by those who work at particular jobs and occupations (professional translators and interpreters), she just needs her knowledge of being a regular user, a native speaker of Serbian language to interpret. So the difference between communication in one's own native tongue and arrangement or accommodation of communication for third parties in a multilingual setting has been blurred.

An article authored by Krol-Hage and Kircher (2020) perfectly exemplifies the fact that people are inclined to consider language learning as something easy and undemanding to accomplish rather than something sophisticated and time-consuming. The authors of the article imply that 1) every person or every migrant *can* learn a foreign language or dialect as long as they are willing

to, but in most cases only to a certain extent; 2) they *do not* need to be proficient, but rather be able to employ their basic skills; 3) migrants need these skills to further their career. Thus, the general public worldwide does not perceive translation and interpreting, as well as language learning as activities grounded in a particular "kind of knowledge that establishes the foundation for the institutions of professionalism" (§ 1), in other words they conceive of it as knowledge and skill which all normal [educated middle class] adults [of the globalised and multilingual society] "can possess in order to perform everyday tasks of daily life" (Krol-Hage and Kircher, 2020). As a matter of fact, a large number of people use languages to communicate on a daily basis "unself-consciously" or "without reflecting on it and [therefore they] may not even be able to verbalise it". It (especially the phenomenon of English becoming *lingua franca*) just became part of the "corpus of everyday knowledge", in other words, knowledge acquired empirically or phenomenologically in/throughout everyday life. The fact that contemporary society regards language proficiency, language learning and the derivative activities, such as translation and interpreting, as exoteric knowledge and skill or "corpus of everyday knowledge and skill", proves outsiders eligible and entitled to opt for the very coveted and unprotected role of interpreter. If anyone feels free to claim proficiency to communicate in a given language, and if nobody calls into question their knowledge, how they acquired that knowledge and whether any criteria were used to verify it and what criteria (if any) were employed and why – chaos may ensue. Many medical professionals plead ignorance regarding the education that an interpreter should receive because they simply do not view interpreting as an activity one would need to acquire a *formal* knowledge for, which substantiates the necessity to fathom Freidson's distinction between formal and everyday knowledge. So, basically, there are two groups jockeying for the position of medical interpreter: qualified and unqualified candidates.

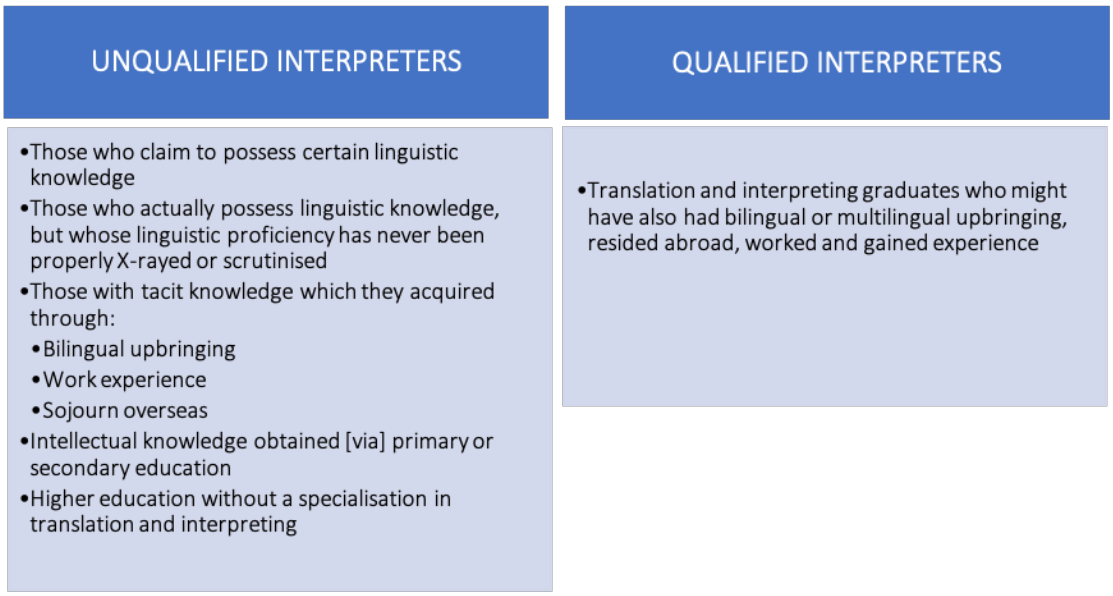


Figure 28. Position, expertise and task ownership claimed by professional vs layperson interpreters

Unqualified applicants would normally win the competition, because the diploma certifying completion of undergraduate or postgraduate education in T&I conferred upon the candidate

by the university does not constitute a seal of quality, it has not set as a benchmark for selection of aspirants. So interpreting, be it in public services or private health sector, is indifferently regarded upon as some perfunctory, unsophisticated, customary, effortless and undemanding activity, a "taken-for-granted activity" as it was coined by Schutz (1970) and Garfinkel (1967), or "common sense" activity as it was called by Geertz (1983a, pp. 73–93) as cited in Freidson (2001, section 1, subsection Everyday and Formal Knowledge in Work, § 3). Thus, it is absolutely imperative to:

> Distinguish the knowledge and skills which all normal[42] adults [..] possess in order to perform the everyday tasks of daily life from the knowledge and skill needed only by those who work at particular jobs and occupations. (Freidson, 2001, section 1, subsection Everyday and Formal Knowledge in Work, § 3)

Needless to say, the knowledge required to carry out certain specific tasks is more respected than commonly-held knowledge (Freidson, 2001, section 1, subsection Working Knowledge, § 3). I believe that the following excerpt is worth reproducing as it will help the potential reader to get a better idea of knowledge distribution in modern society from the point of view of the sociology of professions:

> It is important to note that some of what is taught in the primary and secondary schools that all children must attend is formal in character, is based on abstract theories and concepts created by the intellectual classes. While that formal knowledge (see Freidson 1986: 2–16) becomes part of everyday knowledge, it is only a part, and a small part at that, of a much larger corpus. Some of it – what Machlup (1962: 21–2) calls "intellectual knowledge" – is taught to children who obtain a higher education, and becomes incorporated into the everyday knowledge of the educated middle class. The largest part of it, however, is taught only to those seeking specialized vocations. Unlike everyday knowledge, formal knowledge is institutionalized into what Foucault (1979) called "disciplines" and Holzner (1968: 68–70) "epistemic communities." [...] *The formal knowledge of particular disciplines is taught to those aspiring to enter specialized occupations with professional standing.* For actually performing work, formal knowledge may be needed in some cases, *but so also are specialized knowledge and skill of a more concrete nature and*, of course, everyday knowledge. (Freidson, 2001, section 1, subsection Everyday and Formal Knowledge in Work, § 4-5)

I want to elaborate more on the fact that only a *small* section of formal knowledge becomes entrenched in the corpus of empirically acquired everyday knowledge. So, translators and interpreters did not manage to blackbox their knowledge, to mystify it until an extent where it is no longer considered exoteric but esoteric instead. The scepticism and the indifference of society and policy-makers is one of the key factors that would explain the lack of interest towards medical interpreting, the lack of broad public concern with the problem or issue addressed by a particular discipline is another pivotal factor. Turning a blind eye on the immediate functional value medical interpreting would have if it were applied in a proper manner is another factor of paramount importance. But the main latent underlying pitfall is that the knowledge that interpreters use is considered unspecialised, customary, standardised, dispensable and expendable. Anyone who speaks the language can easily deputise for interpreter. Therefore, language related occupations

[42] Educated, middle and upper class adults.

are becoming extremely vulnerable because no hurdles are to be cleared in order to access these uninstitutionalised domains of competence.

In order to thrash out this complex situation, all social actors involved in it (qualified interpreters, unqualified interpreters, society, state, employers and co-workers from primary as well as secondary institutional spheres) must lucidly distinguish everyday knowledge used by amateurs from specialised, vocational and formal knowledge institutionalised (academically disciplinarised) into disciplines which teach skills of specific or concrete nature.

6.3.5. Working knowledge

Freidson distinguishes another important type of knowledge, the "working knowledge" which encompasses all the knowledge and skill employed to undertake assignments at work independently of its "content" or "source". This rather general category of knowledge encapsulates both formal and everyday variations of knowledge. The working knowledge consists of two elements: diagnostic and prescriptive. The former incorporates the "background information", interiorised insights and vast groundwork that allows the workers to identify the source of the problem. The latter integrates a "repertoire" or repository of "tested procedures" and "techniques" that allow the workers to successfully solve or at least partially contend with the previously diagnosed problem (Kusterer 1978, p. 138 as cited in Freidson, 2001, section 1, subsection Working Knowledge, § 1-2). Nevertheless, Freidson states that this standpoint is too restricted (§ 3). Abbott (1988, pp. 40-52 as cited in Freidson, 2001, section 1, subsection Working Knowledge, § 3-4) incorporates the notions of "diagnosis, inference, and treatment" and denominates them "the three acts of professional practice".

Freidson introduces another variation of working knowledge – "practical knowledge". Acquired through work experience it may be described as instrumental in character, for it resembles a toolbox which allows workers to undertake specific tasks under concrete circumstances (Freidson, 2001, section 1, subsection Working Knowledge, § 4). The point of departure of Scribner's theory cited in Freidson, is that "*practical thinking [...] developed and learned situationally or on the job involve[s] little formal knowledge*" and constitutes the cornerstone of working knowledge and skill (Scribner, 1986 as indicated in Freidson, 2001, section 1, subsection Working Knowledge, § 4-6). Part of that practical knowledge may be "tacit, and therefore neither verbalized nor codified". Scribner highlights "the discretionary character of the practical thinking" which has an "artful aspect" to it: its "flexibility" allows workers to solve the same problem each time in a different way by applying "a preferred mode of problem-solving", which best matches the changing circumstances this problem is surrounded by. "All forms of work thus require both everyday and practical knowledge and skill in varying degrees, *but only some* require the specialized formal knowledge that has not been incorporated into everyday knowledge", but unfortunately medical interpreting as well as other forms of translation and interpreting (see following sections) are not considered to be the case (Freidson, 2001, section 1, subsection Working Knowledge, § 4-7). The *specialised formal knowledge* by no means constitutes everyday knowledge, but is grounded in and achieved by means of arduous, gruelling work, predisposition to life-long learning, and according to Freidson, also "special vocational schooling":

> Discretionary specializations which do include a large component of formal knowledge in their training are identified with the historic professions. Those specializations which embody values held by the public at large, the state, or some powerful elite are given the privileged status of monopoly, or control over their own work. This monopolistic control is the essential characteristic of ideal-typical professionalism from which all else flows. (Freidson, 2001, section 1, subsection Working Knowledge, § 7)

6.3.6. Formal knowledge

Freidson (2001) manages to pinpoint the knowledge allocated to professionals who enjoy a privileged status and who were given the leeway to control their own work themselves. He draws a clear distinction between the knowledge and skill that endow an occupation with professional characteristics or professional skeleton if you will, and some baseline, "informal knowledge of everyday life" (Freidson, 2001, section 1, subsection Specializations, § 1). Freidson (2001) views skill as an ability to use the knowledge in way that would allow to accomplish the task that is being undertaken in an appropriate and successful fashion. "Like substantive knowledge, it can be tacit, embedded in experience without being verbalized, codified, or systematically taught" (Freidson, 2001, section 1, subsection Specializations, § 1). Before I delve deeper into the characteristics of the type of knowledge I am looking for, I would like to recapitulate on the main types of knowledge I have presented and broken down so far.

All of the adult members of a community are fully acquainted and familiarised with the informal knowledge of everyday life. This type of knowledge "taught in schools and by the media" may integrate "abstract theories and concepts" (Freidson, 2001, section 1, subsection Specializations, § 1-2) thus generating a bedrock for further entrenchment in the specialised bodies of formal knowledge, but it is not the specialised knowledge.

Working knowledge, as we have seen in the previous section of this chapter, "has [certainly] narrower scope than everyday knowledge" (Freidson, 2001) because it is geared to the successful accomplishment of the task. It is not shared by general population. This type of knowledge is compartmentalised into "conscious and tacit [...] bodies of practical knowledge and skill" shared by all those people who carry out the same type of work.

The third type of knowledge is denominated formal knowledge and this is the definition thereof:

> [Formal knowledge] is composed of bodies of information and ideas organized by theories and abstract concepts. Some of it inevitably rests on the taken-for-granted (which is to say, tacit) assumptions stemming from both everyday and working knowledge, and some of it becomes part of everyday knowledge in advanced industrial societies, but most of it is divided among specialized disciplines practiced by different groups of specialized workers. (Freidson, 2001, section 1, subsection Specializations, § 2)

In conclusion, we have three major specialisations categorised in accordance with the degree or extent to which these specialisations are considered to operationalise the aforementioned types of knowledge. I recreated the skeletal representation that Freidson used in his book, because I think it is very clear and straightforward, and there is also a very schematic description that precedes the table, which I do not want to alter and which I believe is worth reproducing as it is:

TYPE OF SPECIALISATION	EVERYDAY KNOWLEDGE	PRACTICAL KNOWLEDGE	FORMAL KNOWLEDGE	TACIT KNOWLEDGE
MECHANICAL	High	Low	Low	Moderate
MANUAL DISCRETIONARY	Moderate	High	Moderate	High
MENTAL DISCRETIONARY	Low	Moderate	High	Low

Figure 29. Adaptation of Table 1.1 Relative proportion of each type of knowledge and skill in each type of specialization extracted from Freidson, 2001, Specializations section, § 4

Accordingly, MI falls within the mental discretionary specialisation, which implies low levels of everyday and tacit knowledge, moderate level of practical knowledge and high level of formal knowledge.

6.4. HOROBIN'S CONCEPTS OF "MYSTERY" AND "CHARISMA" APPLIED TO MEDICAL INTERPRETING

The knowledge and the skill underlying every profession and the perception thereof are intimately interlinked with the concepts of "mystery" and "professional charisma". Both concepts form powerful mechanisms stimulating public recognition, which is an absolute must if professionalisation is being pursued.

I presume that these notions are remarkably relevant for this study, especially taking into account the exponential vulgarisation and generalisation of the specialised knowledge underlying MI. Interpreting certainly has mystery surrounding it, but this mystery is being detracted from by the generalised nullification of the merit of language professionals. This section will seek to determine why mystery and professional charisma are so important for the consolidation of our profession.

6.4.1. The importance of mystery

In order to entrench the perception of value of a particular profession in the society, its members must protect their professional interests, which include: exaggerated claims of validity and effectiveness, selective development of knowledge, protective maintenance of mystique and complexity, over-education with the aim of professional respectability and limitation of access to the profession (Rueschemeyer, 2016, section IV, § 12).

> Outsiders are irrational, dangerous and potentially corrupting to the purity of the rational *cognoscenti*. The threat of corruption is ever present, however, in the form of the competitive forces in society at large – rival organizations, sub-professions, the dissemination of hitherto reserved knowledge through mass media. (Jackson,1970, pp. 1-17)

Mystery is important for the recognition of an occupation as a profession on social and state levels. Each occupation or profession is judged, and:

> These judgements use a variety of cross-cutting (and often contradictory) criteria, including productiveness, social importance, scarcity value, degree and type of mystery. We also judge work performance by the quality of the product (in so far as we can assess this) and by the work style of the

> performer. The amount of trust we feel justified in placing on the work done for us is a measure of both the moral status of the occupation and of the work performance we can expect. (Horobin, 2016, Profession as Morality and Mystery section, § 1)

Professional "mystique is [...] compromised by the contact [the professional] must make with the profane world" (Horobin, 2016, Profession as Morality and Mystery section, § 1). MIs continuously find themselves in contact with the profane world, in that they are bridging the gap between medical professionals and patients.

Also, the knowledge underlying language learning, and consequentially interpreting, has been debased and turned into everyday knowledge taught at schools, courses, different university faculties, etc. Language learning and interpreting, both have been universalised until becoming everyday non-specialised knowledge. These activities have lost the prestige along with the esoteric value. Both interpreting and language learning became secularised activities, included into mass education. The mystique of these activities is compromised by the fact that the tasks are considered to be within the general competence.

The lack of exclusive discretionary specialisation, professional autonomy and occupational self-control denote lack of social, symbolic and economic value, which would justify the degree of privilege, socio-economic relevance, prerogative to assume control over all aspects of the occupation, special entitlements pertaining to professional elite, and authority. The occupation of MI does have the moral superiority as MIs similarly to the doctors are never off duty, and the inspection of the private lives of the patients whose utterances they interpret is also part of their undertaking. Therefore, the concept of service in the sense of duty, assistance and help rather than self-interest pursuing financial benefit only is also inherent in MI.

However, MI lacks supra-authority displayed by adopting a "paternalistic stance" in the expert vs nonexpert dichotomy, in that MIs are often expected to advocate for one of the parties (Hsieh, 2013) and to bridge the gap between the expert and non-expert knowledge by the implementation of certain techniques. Interpreters are often expected to deliver an interlingual as well as intralingual rendition of discourse, which would include a re-expression of the utterances (from more specialised to less specialised). Such adaptation may include synthesis of information, terminological simplification (otherwise known as determinologization of complex medical terms), paraphrasis, use of synonyms, common sense explanations of difficult concepts, explication, personalisation of the language being used by expanding relevant information and by making key meanings explicit, by adjusting tenor or register to achieve more customised information, by simplification of syntax and lexis, as well as by substitution, omissions and additions. However, the professional knowledge needed to exercise professional discretion in this case is not surrounded by mystery or enigma, because this occupation has been vulgarised and its tasks oversimplified, deskilled and mainstreamed in the eyes of the general population. Interestingly enough, there is certain mystery and enigma surrounding polyglotism and hyperpolyglotism though, nevertheless often it is not the level of proficiency that is being extolled, but the sheer quantity of foreign languages that the alleged polyglot can allegedly speak.

With regard to professional jargon, neologisms, and the creation of knowledge by means of research as processes of mystification, it is worth noting that these remain reserved only to the

academic realm and perhaps are more noticeable in the case of more professionalised branches of interpreting.

6.4.2. The definition of "mystery" and its application to medical interpreting

According to Kosa (1970 as cited in Horobin, 2016, Professional Charisma section, § 1) the notion of professional mystery is strongly correlated to the idea of professional charisma. In the case of medicine, for example, "the original [...] charismatic authority" (Kosa, 1970) manifests as "powers to heal sickness and cast out devils" (Mark 3:15 in Kosa, 1970) and in a unique "aura" not shared with other professions enshrined in the Hippocratic Oath based on the principle of *primum non nocere*. In a collective consciousness and public sentiment the term "doctor" and its synonyms are instantly associated with the alchemical "ability of healing" using magical portions (Horobin, 2016) and the domination over, supremacy of and "mastery" over death itself. These seem like superpowers, and although there is nothing magical about them (as people still die and doctors use informed consents as a way to wash their hands of undesired complications) the public still "invokes" these powers in times of distress (Kosa, 1970, p. 31 in Horobin, 2016, Professional Charisma section, § 1). This happens because medicine encompasses highly specialised fields of knowledge which are meant to solve widely experienced social problems. These problems affect all individuals, but only a few can actually end up becoming experts in these fields of knowledge. Such knowledge requires training, which "represents an [institutionalised] initiation into mysteries" (Jackson, 1970, p. 7). This training will allow the professional to solve certain problems by engaging in "taboo" activities placed "in the central value system of the society", such as "the cutting up of cadavers", "the examination of the body", or the examination of "inner secrets" (Jackson, 1970, p. 7).

The medical profession deals with human beings, their personality, fights off a common adversary, which is the disease, and deals with "circumstances which are beyond human control" (Kosa, 1970, p. 27, in Horobin, 2016, Professional Charisma, § 2).

> Goode (1969) proposed that that there were limits to the extent to which certain occupations could "professionalise", mainly because society did not accept that some occupations had sufficient of the two core elements of knowledge base and service ideal. [...] he argued that the "four great person professions" of law, medicine, the ministry, and university teaching, in an important sense, "get inside the client". (Ovretveit, 1992)

In accordance with this statement, the society in Spain does not seem to accept that MI is sufficiently complex to require the special knowledge base for practice. It is rather viewed as a "semi-profession", which lacks "knowledge, skills or service value to exchange for the public trust" (Goode, 1969, p. 307, cited in Ovretveit, 1992, pp. 191-195). For Goode:

> The crucial difference is whether the substance of the task requires trust and therefore autonomy, and therefore some cohesion which the occupation can in fact impose ethical controls on its members. (Goode, 1969, p. 307, cited in Ovretveit, 1992, pp. 191-195)

Horobin (2016, Professional Charisma, § 6) states that the esoteric character (in other words, the mystery) of a profession consists in tackling the problems "which seem beyond [the] control of general population and comprehension". Due to the universalisation and de-specialisation of

language learning and acquisition, and owing to the fact that interpreting is viewed as a natural activity, any person can self-identify as proficient language user capable of interpreting. Therefore, interpreting is no longer perceived as a skill beyond the control and comprehension of general population. The problem is that very few people are aware of the difference between amateur language knowledge and natural interpreting and the actual language proficiency and professional interpreting. If language acquisition can still be viewed as a process that requires talent, giftedness and is therefore mystical, interpreting is seen as an effortless activity.

We must not forget that "profession" is a folk concept (Freidson, 2016) and it cannot be decontextualised and isolated form the social, political, economic and historical backdrop. Therefore, in spite of having once had these historically underpinned "mystical roots" or "mystical authority" we have suddenly started to lose them due to the deployment of new technologies, globalisation and promotion of multilingualism. The universalisation of English also exacerbates the situation. However, with "more than a billion people speak[ing] English as a first or second language, and hundreds of millions more as a third or fourth [...] the demand for English proficiency [still] far outpaces supply" (EF EPI English Proficiency Index, 2019, pp. 4-5). The report concludes that this is due to the fact that the speed at which English started to exponentially and dramatically gain value in the workplace and the speed at which it ended up becoming a valuable asset for an applicant to possess was too fast for the society to catch up with (EF EPI English Proficiency Index, 2019, pp. 4-5).

The 2019 EF EPI report indicates that "English is, by far, the most widely studied second language in the world [...], yet despite these massive public and private investments in teaching English, results are frustratingly uneven. Pupils with years of classroom instruction often cannot hold a conversation" (EF EPI English Proficiency Index, 2019, p. 40). Thus, those employees who were attending school in 1989 constitute today "the core of the global workforce" (EF EPI English Proficiency Index, 2019, p. 40), but many thereof do not speak English.

As regards other foreign languages, Spanish public administrations may think that with time everything will sort itself out on its own because the immigrants will have already learnt Spanish and the EU expatriates residing here, if they do not learn it, it is because they do not need it (Niño Moral, 2008, p. 1068). Nevertheless, the reality and experience of the countries that have traditionally been recipients of migrants shows that the language problems will not end up sorting themselves out just like that.

The advocates of life-long learning may claim that "the idea that adults cannot learn English has been thoroughly disproven" (p. 40), however, this statement clashes with the opinion of the experts in the field of neurocognition, who state that:

> In 2016, more than 60% of adult European citizens were able to speak at least one foreign language (FL; European Commission—Eurostat, 2016). With multilingualism on the rise, learning foreign languages (FLs) is so common these days, it is often taken for granted. Yet, regardless of how ordinary it might seem, mastering a new language is and always will be an immensely complex task. Being able to formulate sentences in any language requires knowledge of its words and grammatical structures, all of which have to first be encoded, and then consolidated and integrated into long-term memory. (Mickan et al., 2019b)

In addition, we cannot turn a blind eye and choose to ignore the fact that, as Garber (1998 in Niño Moral, 2008, p. 1068) points out, community interpreting is characterised by the fact that it emerges precisely in a situation of crisis in the life of the user. Which means that the individual finds him/herself probably in a state of emotional distress and dismay, which will encumber their ability to express themselves accurately in a language that is foreign to them (Barclay 2002, p. 503, cited in Niño Moral, 2008, p. 1068).

De-mystification, exoterisation and mainstreaming of knowledge underlying language acquisition and interpreting, and the promotion of English as lingua franca is clearly detracting from the complexity and mystery of language learning and interpreting. The fetishization of multilingualism in modern societies nullifies the merit of the language professionals, completely stripping the discipline from mystery.

6.4.3. The definition of charisma and its application to medical interpreting

MIs enable doctor-patient rapport, however, their work remains unacknowledged. The figure of interpreter as perceived by service users is stripped from the professional merits, professional dignity and value of professionality. The role that is being attributed to the interpreter in Spanish medical settings is that of a *doctor's assistant,* rather than an autonomous professional in the sense of a separate professional figure. MI has been fully instrumentalised and adapted to meet the needs of those who exert the highest authority in their primary institutional sphere.

The main difference between the charisma of a doctor and the charisma of an interpreter is that the physician has a *professional charisma*, whereas the interpreter is expected by the employers to exhibit a *personal charisma*, which encompasses rather personal traits and attitudes such as *empathy*. Doctors are perceived as heroes and saviours, while interpreters are viewed as empathetic, over-involved multilingual and multitasking *do-gooders* with some taken for granted linguistic knowledge, and whose outstanding professional merit is being nullified by the popularisation, de-specialisation and exoterisation of specialised knowledge they possess. MI are expected to help medical staff and patients, but the concept of "help" in this case is extremely vague.

These wordings misinform the populace about the range of tasks which fall within the remit of an interpreter, so by trying to be empathetic and willing to "help" sometimes interpreters themselves blur the jurisdictional boundaries of their own expertise, which is one of the worst things the members of an occupation can do, as according to Halliday (1987 as cited in Freidson, 2001) the sufficiently distinctive tasks are essential for the correct distribution of work within the division of labour.

7. WIDELY-HELD PERCEPTIONS OF THE KNOWLEDGE UNDERLYING INTERPRETING, LANGUAGE ACQUISITION AND POLYGLOTISM

The concepts of "proficiency", "fluency", "command / mastery / knowledge of a (foreign) language", "to speak a language" are intricate and complex to disentangle. Many people both experts and non-experts in the field use these terms interchangeably as if they were synonyms, but the real meaning behind these terms remains obscure for both initiated and uninitiated. Nevertheless, the main problem resides in the fact that very few people seem to consider one caveat: the level of linguistic proficiency, its assessment and accreditation. Drawing on my own professional experience I believe many medical professionals are convinced that as long as they have a superficial understanding of the discourse being delivered by the patient, and as long as they believe they can surmise the [rest of the] meaning and intention of the discourse from a few words they [might] have understood, they already know the language.

Thus, the main point of departure of this thesis is the perception of "profession" as "an intrinsically ambiguous, multifaceted folk concept" or "a historical construction" (Freidson, 2016, pp. 20, 32). Accordingly, the bedrock of every profession is the ability of its members to make a living while controlling their own work by curbing competence and monitoring jurisdiction over particular tasks. In order for an occupation to be granted exclusive regulative authority over a series of tasks it claims ownership over, these tasks and the knowledge underlying them need to be envisioned by the state and by the society as intrinsically unique, inexhaustible, unparalleled and most importantly, absolutely unfathomable, mysterious/mystifying, obscure, esoteric and indecipherable to those who did not successfully complete the training necessary to acquire this knowledge which will allow them to accomplish the tasks.

The society and the state must be conditioned to conceive of the tasks and the work an occupation performs as something very different from the rest of the undertakings carried out by other occupations, so that occupational self-control is acknowledged as an absolutely ineluctable condition for correct functioning. Only when the general public is convinced that the work being done is so specialised as to be inaccessible to all those lacking the required (university) training, will it attain the necessary social, symbolic and economic value which would justify the degree of privilege, socio-economic relevance, prerogative to assume control over all aspects of the occupation, special entitlements pertaining to professional elite, and authority. Consequently, the general public's stance on this occupation is pivotal for its recognition.

> The prerequisite for all other institutions of professionalism is official recognition that the occupation uses in its work a complex body of formal knowledge and skill that commands abstract concepts or theories and requires the exercise of a considerable amount of discretion. The general public's views of that occupation can facilitate and support such recognition, as can the views of some influential elite, but recognition and support from the state or some other paramount power is essential. When so recognized, an occupation is in a position to control its own work rather than be controlled by consumers or managers. (Freidson, 2001, Training Programs section, § 1)

Therefore, in this section I shall proceed to examine the extrinsic, widespread and streamlined perceptions of the knowledge base undergirding the seemingly interchangeable concepts of "interpreting", "language acquisition" and "polyglotism". Many people seem to misconstrue these intrinsically correlated concepts as they have apparently internalised them as synonyms. Therefore, I shall attempt to ferret out the rationale behind the general public's definition of each of the above mentioned concepts by analysing the current situation from the perspective of Freidson's theory of the typology of professional knowledge. This section sets out to determine the key features or facets whereby medical interpreting, a concept which became mired in confusion, may be distinguished from other similar concepts. The relevant decision-makers as well as the society at large need to experience cognitive and conceptual awakening and de-patterning[43] from the deeply entrenched misunderstandings by breaking the previously conceptualised and internalised concepts or ideas and reconstructing them all over again.

7.1. KEY EXTERNAL PLAYERS, KEY INTERNAL PLAYERS AND THE SOCIETY AT LARGE

Apart from the passive or rather detached general public's view on interpreting, there is a number of social actors or players whose opinions and actions exert a major impact on the development of a profession. García-Beyaert (2015, pp. 45-46) established the taxonomy of key "external" and "internal players". Following her ideation, I curated the following graph:

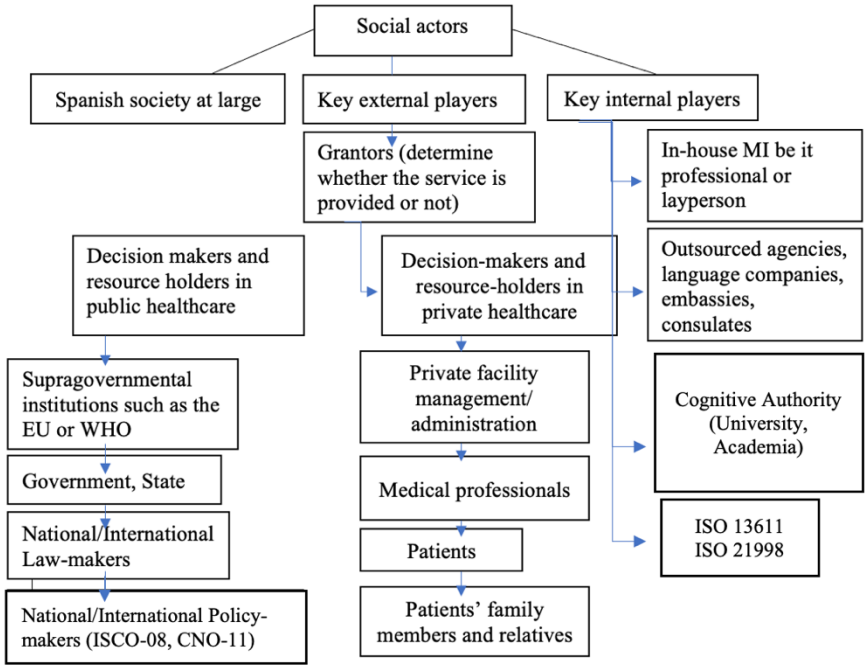


Figure 30. Adaptation of the table displayed in Key external Players in the Development of the Interpreting Profession, (García-Beyaert, 2015, p. 43)

The following sections will be dedicated to analysing how such concepts as "interpreting", "polyglotism" and "language acquisition" are viewed by the supragovernmental institutions such

[43] In figurative sense.

as the EU, by the EU citizens, by the representatives of Spanish government, by the national and international policy-makers (ISCO-08 and CNO-11), and by the ISO 13611 and ISO 21998. Part III of this thesis will be narrowed down to a detailed analysis of the situation in the private healthcare.

7.2. KNOWLEDGE UNDERLYING INTERPRETING LANGUAGE ACQUISITION AND MULTILINGUALISM AS PERCEIVED BY THE EU

The main conundrum which hinders professionalisation of MI is fuelled by the promotion of multilingualism and language learning. This tendency may engender a fallacious perception of languages and interpretation creating an illusion of language proficiency being sufficient to become an interpreter, thus, proliferating the use of bilinguals as interpreters. The EU initiatives of popularisation and stimulation of multilingualism might be, although not by deliberate intent, contributing to downgrading and oversimplification of language learning. Although unpremeditatedly, this promotion automatically may lead to generalisation or universalisation of knowledge, and what is most important de-specialisation of the knowledge and skill underlying language learning, depicting it as unspecialised knowledge accessible to literally everyone and no longer reserved exclusively for those who are willing to undertake vocational training to become experts, specialists and professionals. The notion of effort, talent or innate predisposition intrinsic to both language learning and interpreting might be unwillingly played down. Promoting multilingualism unintentionally strips mystique, specialisation, complexity and inaccessibility from language learning leaving it devoid of charisma, secrecy and preternatural dimension.

The spirit of multilingualism promoted by the EU documents might contribute to instilling or ingraining the idea of naturality, simplicity and innate ability of language learning. This tendency creates an illusion that knowledge underpinning language proficiency is within everybody's reach, that it is universal and achievable for widespread use. Multilingualism may be misunderstood as the ultimate utopian solution to all language problems by some member states' law makers and decision-makers. The Commission has a long-term objective "to increase individual multilingualism until every citizen has practical skills in at least two languages in addition to his or her mother tongue" (European Commission 2005, p.4). However, The Council and Parliament realise that "an individual's level of proficiency will vary [...] according to that individual's social and cultural background, environment, needs and/or interests" (European Parliament and Council of the European Union 2006, p. 14). The EU distinguishes between different levels of competence that an individual might acquire in a given language ranging from "partial skills competence to full literacy" (European Communities, 2007, p. 6).

English is viewed as "a means of non-mediated intra-European and international communication" (2007, p. 7). It became the most demanded foreign language at schools across the EU being learnt by a "90% of all pupils in secondary education (Eurydice 2005, p. 11, cited in European Communities, 2007, p. 7):

> It is doubtful that the benefits of language learning highlighted by the EU will convince Europeans at large. The appeal English holds for young people is a well-researched topic. However, what is perhaps even more important is that for a variety of reasons many policy-makers and decision-makers –

> including parents – firmly believe that all that children at the beginning of the 21st century need to acquire is a good command of English. (European Communities, 2007, pp. 8-9)

High Level Group on Multilingualism suggests that language learning at school age ought to be combined with "extracurricular and out-of-school activities [...] and contacts with speakers of other languages", so that the children are given bilingual upbringing (European Communities, 2007, pp. 10, 19-20). "Early Language Learning" as well as "Content and Language Integrated Learning (CLIL)" were implemented as strategies promoted by the EU (European Communities, 2007).

However, the report does not view multilingualism or the universalisation of English as a replacement for professional interpreting. It rather prognosticates an exponential increase in demand for "highly qualified language specialists" (European Communities, 2007, pp. 10-11). The report emphasises that "quality has its price" and therefore higher education institutions in the Member States "are and must remain responsible for the training of the highly qualified interpreters and translators required in the European institutions and bodies" (European Communities, 2007, p. 16). Thus, it is absolutely unacceptable that there be a decline in quality. The EU document attributes high value to the translation and interpreting, and calls it a "highly demanding profession" (European Communities, 2007, p. 17). The EU highlights the need and demand for both the "language learning" and the creation, expansion and preservation of T&I services of "unparalleled size, complexity and quality" (European Communities, 2007, p. 6). The EU acknowledges that the acquisition of a high level of linguistic competence is "an arduous and time-consuming task", especially when it comes to languages such as Arabic, Chinese, Korean or Japanese (pp. 16, 22). The report goes on to unpick the current situation of the interpreting profession and it is worthwhile to reproduce an excerpt I believe clearly showcases *the value* that the EU ascribes to the knowledge and skill required to work as interpreter:

> In spite of increasing demands in certain sectors, the interpreting profession seems to be particularly vulnerable. Training for high-quality interpreting requires major investment in terms of time and money; interpreting is a highly demanding profession. Whereas in the past, it was possible to expect adequate returns on the investment made, the market has now become much more volatile, requiring increased flexibility in terms of languages, directionality, the immediate work environment, and modes of delivery. [...] The European Commission should encourage the launch of European projects for the joint development of higher education programmes in legal / court translation / interpretation and community translation / interpretation. Projects should focus on the identification of the competences required in carrying out the respective professions. [...] The programmes to be developed should also equip students with competences sought after in related sectors of the labour market. (European Communities, 2007, pp. 17-18)

In spite of all the value that is being attributed to interpreting in these excerpts, some EU texts can be difficult to fathom out. The logic and the ideation of the following extract is extremely difficult to grasp, as it exemplifies a glaring inconsistency in terms of offering two completely different solutions to the same problem:

> Legal interpretation: In certain situations it is crucial to have proper language assistance to protect essential rights. Increased mobility means that lawsuits in Europe frequently involve people with limited skills in the language of the court. [...] the Reflection Forum on Multilingualism and

> Interpreter Training [...] recommended ways of spreading best practice and improving the quality of legal interpreting training in Member States.
>
> Languages in the health services are also vital to citizens' wellbeing. Greater mobility for work or leisure means health professionals increasingly need to understand patients in a language other than their own. The emergency situations involved and the very specific vocabulary are a major challenge. This is a very clear example of why the Commission encourages Member States to 'mainstream' multilingualism, i.e. include it in other policy areas. (European Commission, Directorate-General for Education, Youth, Sport and Culture, 2009, p. 15)

Note how the authors of the document acknowledge the need for "proper language assistance" in legal realm, and how multilingualism is viewed as a viable solution for the health services. The authors do not even mention medical interpreting! They highlight that healthcare professionals "need to understand patients in a language other than their own", implying that medical professionals and the patients need to figure it out on their own. In my opinion, the document clearly indicates that healthcare professionals must learn foreign languages in order to communicate with their patients. Moreover, the authors go on to say that this need to understand the foreign-speaking patient is "a very clear example of why" the multilingualism should be encouraged and mainstreamed across the EU Member States. This statement is just self-explanatory.

7.3. INTERPRETING AS ENVISIONED BY SPANISH POLITICIANS

The attitudes or personal opinions that some decision-makers on the national level display towards interpreters are an important source of information, however very few national politicians have expressed their views on this particular occupation in this particular context. Therefore, the example that I am about to share is not generalisable, but it showcases how some political figures perceive interpreters and how their discourse mirrors the current state of affairs in the field of interpreting in Spain in terms of constructing an occupational identity.

I came across a newspaper article (García, 2015) issued back in 2015 about the initiative launched under the aegis of the Valencian Regional Government (La Generalitat) to open a sea corridor in order to bring 1,100 Syrian refugees from the Greek island of Lesbos to Valencia. The Martí i Soler boat with a total capacity of 1,200 people should have been made available to transfer Syrian refugees under the supervision of NGO staff and technicians. Thus, during the press conference with a view to getting the official authorisation form the Ministry of Foreign Affairs in Madrid, the Vice President of The Generalitat, Mónica Oltra, has assured that the Valencian Community is fully prepared to receive Syrian refugees and that "even translators have been made available [tenemos hasta los traductores]" for this purpose (Chiva-Flor, 2017, p. 15). She said "even translators", as if it was some little, expendable, but still a nice detail. It seems as though she wanted to emphasise that everything was taken into account, down to the very last detail.

This wording accessorises the interpreters' critical role in communication and totally ignores the fact that the term "translator" is used to refer to rendering written texts from the source language into the target language. From a beholder's stance the whole wording depicts the availability of interpreters as a expendable luxurious detail, unnecessary splurge instead of an urgent and dire need. And just for the record, according to Chiva-Flor (2017, p. 15), a form was created

on the Valencia City Council website, so that the population could offer collaboration in the process of reception of Syrian refugees. Among a series of voluntary actions displayed in this form there was a field corresponding to interpreting for the volunteers to tick. This allows us to get an idea of who would have been in charge of the interpreting tasks during the reception had this initiative not been rejected by the Ministry of Foreign Affairs. Due to the fact that interpreting was thought to be carried out by volunteers and NGO's, no budget was allocated to cover the costs of these services. It is worth noting that the volunteers would have also been in charge of classifying the refugees by assessing their ascents and thereby determining whether they truly come from Syria (Chiva-Flor, 2017). So, apparently, apart from (possibly defective) interpreting the volunteers would have been responsible for "cross-examining" and playing the decisive role of experts witnesses in these refugees' lives.

7.4. TRANSLATION PROFESSION AS ENVISIONED BY THE EU CITIZENS

In this section I shall proceed to analyse what role do the EU citizens attribute to interpreting in different social milieux. Subsequently, I shall proceed to examine how the general society in the EU member states views the knowledge and skill underpinning interpreting. The aim of this section is to determine whether and to what extent interpreting can be considered a topic of deep interest and social concern and a solution to problems of universal nature. This will allow for the assessment of the value that is being allocated to this occupations by the general public.

> There are a few disciplines whose tasks bear on issues of widespread interest and deep concern on the part of the general population. They might be called core disciplines, bodies of knowledge and skill which address perennial problems that are of great importance to most of humanity. Although they have quite different epistemological statuses, medicine, law, and religion exemplify such disciplines [...] With official support, one version or another of those disciplines can become very securely established so long as it also has the support of the general population. But when general support from the population is fragmented by sectarianism or weakened by general scepticism or indifference, the official position of disciplines purporting to serve those concerns may become an empty shell and crumble over time, their position ultimately usurped by another more popular discipline or by schismatic movements which fragment if not dissolve the original. (Freidson, 2001, section 7, subsection The Contingencies of Knowledge, § 1-3)

Drawing on the Special Eurobarometer 386 (Directorate-General for Communication [European Parliament] & Directorate-General for Education, Youth, Sport and Culture [European Commission], 2013), the social screening thoroughly X-rays the standpoints on the "importance of the role that translation from and into foreign languages plays in different scenarios" (p. 124). The results (pp. 124-125) showcase that the participants consider that translation plays "an important (very or fairly) role" in the *area of health and safety (e.g. mediciens or safety instructions)*:

> "Europeans are most likely to perceive translation as playing an important role in health and safety and in education and learning [...] In relation to health and safety, where respondents were given the examples of medicines and safety instructions, seven in ten respondents (71%) say that they consider translation to have an important role to play, with a similar proportion four in ten (41%) perceiving this role as very important [...] A somewhat lower proportion of respondents - around six in ten - view the role of translation as important in relation to [...] accessing public services (59%) [...] accessing public services is most likely to be seen as one [of the areas] where translation has a very important

> role to play (26% of respondents)" (Directorate-General for Communication [European Parliament] & Directorate-General for Education, Youth, Sport and Culture [European Commission], 2013, p. 124).

The frame of reference of the aforementioned findings is the EU, which comes in extremely useful and helpful to get a general idea of the extent of professional value being attributed to translation by Europeans in general, but the research agenda of this thesis is to examine the Spanish context, which is an underexplored but fruitful avenue for research.

7.5. TRANSLATION PROFESSION AS ENVISIONED BY SPANIARDS

Spain offers a particularly interesting testing ground in terms of its unique concatenation of socio-demographic factors such as migration and medical tourism. However, the Special Eurobarometer Report does not estimate a detectable difference in proportion between Spanish and European informants who consider translation in health and safety spheres to play a major role. The figures representing perceptions on both levels, national and European, remain practically identical with only slightest variations. Please compare:

Table 3. The importance of translation profession as envisioned by Europeans vs Spaniards

Health and safety (e. g. medicines or safety instructions)	
Europeans	Spaniards
41% translation plays very important role	41% translation plays very important role
30% translation plays a fairly important role	35% translation plays a fairly important role
12% translation plays a role but it is not important	12% translation plays a role but it is not important
14% translation does not play a role	10% translation does not play a role

With regard to the extent of importance being allocated to translation in the field of public services, 34% of participants from Spain think it plays a very important role, 35% believe translation plays a fairly important role, 15% argue that translation does actually play a role but it is not significative, and 13% indicate that translation does not play a role in ensuring equal access to public services (Directorate-General for Communication [European Parliament] & Directorate-General for Education, Youth, Sport and Culture [European Commission], 2013, pp. 132-133). The report concludes that 71% of participants on European scale do actually recognise that translation is important in health and safety sphere (p. 124). That is an indicator of social recognition, which is a necessary component of professionalisation.

I am fully aware that these findings exclusively echo the effect that the concept of translation has upon Europeans in general and Spaniards in particular, but to the best of my knowledge, no similar studies on interpreting have been carried out yet. After an exhaustive literature review I failed to find a study of this magnitude which would seek to address social attitudes towards interpreting in different social areas.

However, I am deeply convinced that this Special Eurobarometer research has succeeded in eliciting insights into how Europeans perceive translation, which may beneficially contribute to fathoming the degree of social support and social concern regarding the function and the role of translators in modern globalized society.

7.6. LANGUAGE KNOWLEDGE AND LEARNING AS PERCEIVED BY EUROPEAN AND SPANISH CITIZENS

According to Special Eurobarometer 386 Report (Directorate-General for Communication [European Parliament] & Directorate-General for Education, Youth, Sport and Culture [European Commission], 2013, p. 28) over 40% of European citizens claim to be able to "understand at least one foreign language well enough to listen to or watch the news, and a similar proportion to read newspapers or magazine articles". The internationalisation or universalisation of English is patent, since 67% of Europeans view English as the most useful language for themselves and 79% of participants state that they consider this language to be the most useful one for their children followed by French, German, Spanish and Chinese; 25% of informants from 19 Member States claim to be able to "follow radio or television news in English" with the highest percentage thereof belonging to Malta (85%), Cyprus (63%), Denmark and the Netherlands (57% in each) and Finland (50%) (p. 29). What about Spain?

> The Member States where respondents are least likely to say that they understand English well enough to follow radio or TV news are Spain and Hungary (12% in each), Slovakia (14%), Bulgaria and Poland (17% in each) and the Czech Republic (18%). (Directorate-General for Communication [European Parliament] & Directorate-General for Education, Youth, Sport and Culture [European Commission], 2013, p. 29)

84% of Europeans believe that one language should be universalized to an extent as to become everybody's second language in the EU; 72% of informants consider that EU citizens should be able to communicate in more than one foreign language; and 69% of participants support the idea of commonising one language across the EU. In the same vein, 53% of the respondents "agree that EU institutions should adopt a single language to communicate with European citizens" (pp. 141-142). Nevertheless, "Whilst just over half of all Europeans are able to speak at least one other language, there are no signs that multilingualism is on the increase" (Directorate-General for Communication [European Parliament] & Directorate-General for Education, Youth, Sport and Culture [European Commission], 2013).

Regarding the language learning process, the survey is reported to have identified five main barriers to learning a new language. The survey found that 34% of respondents do not feel motivated enough to start learning a new language since they fail to find any stimulus or mainspring that could incentivize them do embark on a language learning process and therefore they feel discouraged to do so. In addition, I deduce that 28% of participants acknowledge that language learning process requires time, effort and dedication, for they state that they lack time to study properly. The third main reason that refrains 25% of informants from starting to learn a new language is the fact that it is too expensive. Another important rationale behind unwillingness to become engaged in the language learning process for 19% or one fifth of all informants is the reasoning or ideation that they are "not being good at languages". For 16% of respondents the main ground for keeping themselves aloof form a new language acquisition is the lack of further development given that they face difficulties in terms of finding someone to practiec this language with (p. 93). Thus, "only a minority of Europeans are actively engaged in learning new languages (p. 143).

In conclusion, I infer from the aforementioned data that Europeans are perhaps not fully, but still partially cognizant of the fact that language learning is a difficult process requiring investments, commitment, dedication, perseverance, diligence, effort and time.

7.7. POLYGLOTISM AND LANGUAGE FLUENCY

Polyglotism is yet another highly controversial concept that raises questions regarding language fluency, false fluency, language knowledge and language proficiency. All these intimately interwoven concepts cause confusion and tend to conjure up a rather distorted image of the (typology of) knowledge underlying language proficiency and interpreting.

I would like to begin the discussion with a brief case study on polyglotism, and most importantly on the public perception of polyglotism and polyglots. The purpose of the following situation analysis is to analyse the mystery surrounding the term "polyglot" and to fathom out how that mystery allows the polyglots to pass the unverifiable (and often superficial) language knowledge off as language proficiency so sophisticated as to allow them to interpret in potentially life-altering scenarios. Put simply and following Freidson's concept of everyday knowledge I would like to know why a person needs a licence to drive a car for example, but they do not need a license to interpret at an ICU?

The mayor of South Bend, Indiana, and a Democratic presidential candidate, who can reportedly speak Norwegian, Spanish, Italian, Maltese, Arabic, Dari, and French), has been reported to have undertaken a "translation" assignment (English-Arabic) at one of the US hospitals. According to The Atlantic Newspaper (Erard, 2019):

> A South Bend emergency-room doctor sent a message on Twitter to the *BuzzFeed* writer Ashley C. Ford about the time the mayor materialized in a local hospital and translated in Arabic for a patient. According to the message, Buttigieg had been listening to the police scanner and had heard that an Arabic translator was needed.

The following is the screenshot from a Facebook page[44] containing the original message posted by D. F. Zimmer[45] :

[44] Visit: https://www.facebook.com/415722869192138/posts/this-is-the-story-in-case-it-got-lost-under-the-repost-of-a-post/416542812443477/

[45] Visit: https://twitter.com/billyeichner/status/1109286129000341504?lang=en

Figure 31. Screenshot of the original D. F. Zimmer post on Facebook

This self-explanatory story just highlights the image that is being ingrained in the general public regarding medical interpreting services. Of course, I am not even questioning that the government official meant well: given the shortage of interpreter services he offered his help in a difficult situation, which just proves him to be an empathetic and good-hearted person, but let us concede that if his (or anybody else's) intention were to substitute a medical worker they would not have been allowed to do so. But, for some reason, if someone claims to be "fluent" in a given language that automatically qualifies them to perform as *medical* interpreters.

But what does it mean to be fluent? What does it mean to speak a language? Here is what the Mayor has to say:

> When former US Senator Claire McCaskill asked Buttigieg to comment on his language-speaking ability in a 14 February instalment of MSNBC's Morning Joe, he replied: "it depends what you mean by speak!" and added that he can "still kind of read a newspaper in Norwegian… but only slowly" and that *he has gotten "rusty" in his Arabic and Dari*. That shows humility, but not so much that Buttigieg and his camp definitively dismiss the polyglot rumours. (Sandoval, 2019)

Let us parse some of the key elements of the message posted by D. F. Zimmer. Apparently there are "official translators", but they were not available at that moment. Thus the public official overhears the police scanner request to send down an official "translator" and rushes to the hospital to "help". Without the doctor knowing who this person is and without introducing himself, the Mayor "just started translating". The doctor himself recognises that he did not bother to ask who this person was, assuming that it must have been the new translator. The patient, who

happened to be a little boy, "was gravely ill", this fact seriously aggravates the situation, because the risk of potential translation error potentially claiming the child's life escalates given the already exacerbated state of the patient on admission. The patient ends up admitted to the ICU from the ER, which only corroborates the gravity of the situation. The crux of the matter is that many times being fluent (even though the government official said he "has gotten rusty in his Arabic", the doctor assures the readers of his post on Facebook that the Mayor indeed "speaks fluent Arabic") is sufficient to be allowed to interpret in a setting as complex as the medical setting. The public officer's comments on him gotten "rusty" in his Arabic spawned a groundswell of opinions in the media questioning the very concept of "fluency" and "polyglot" or "polyglotism".

Sandoval (2019) inquires into what does the word "fluent" actually mean: "in lay circles, this term has come to equal "native-level proficient", with no grey area between the bumbling beginner and the mellifluous master" (Sandoval, 2019). The writer who authored this article highlights the failure to accurately assess language proficiency or language fluency on the part of non-professionals: "An outsider overhearing a conversation in a foreign language only hears a fog of sounds, thus perceiving anyone who can cobble together a sentence as 'fluent'" (Sandoval, 2019). Many learners do not have a realistic process of self-assessment either, they do not undergo a shrewd self-evaluation, as they "fall into the trap of assuming that because they are understood, their speech is 'perfect'". The learners may be surrounded by such friends or teachers, who would usually extol and compliment the L2 learners' new endeavours in order to encourage them to further their knowledge, but this may lead to "inflated" self-assessment and low self-awareness (Sandoval, 2019).

Drawing on my professional experience I can corroborate this phenomenon. I have eye-witnessed many patients and hospital staff sycophantically exaggerate doctors' linguistic abilities, which resulted in doctors' self-assurance and self-confidence built upon such compliments, which does not correspond with their real foreign language skills. It is worth noting that de Jong, senior lecturer at the Leiden University Centre for Linguistics, as stated in Sandoval (2019), explains that "grammatical errors won't usually prevent [mutual] comprehension", because the listener is "automatically able to 'edit out' [grammatical] mistakes" of the interlocutor (Sandoval, 2019). Thus, the listener's politeness and appreciation of the effort made by the speaker to communicate in a foreign language render the speaker's grammatical mistakes unnoticeable, inconspicuous and irrelevant. But the question about fluency still remains unanswered.

> De Jong describes the unconscious process any speaker goes through before speaking: conceptualising what to say, formulating how to say it, and, finally, articulating the appropriate sounds. All of this takes place in roughly six syllables per second. *A speaker of a second language who needs to convert their thoughts into an unfamiliar language faces an even greater challenge in meeting these strict time constraints*. They must also [...] overcome inhibition and pronunciation challenges. Accuracy may still be lacking at this stage, but make no mistake – achieving L2 fluency is a colossal feat. (Sandoval, 2019)

Daniel Morgan as cited in Sandoval (2019) argues that the concept of "fluency" is abstract in character and therefore we need to "assign observable variables" or transition the concept from metaphysical to more concrete, quantifiable and gaugeable. According to Morgan "speech rate" and "utterance length" are the "most reliable" strategies to measure fluency (Sandoval, 2019).

The speech rate gauges the volume of effective discourse that the speaker is producing within a given time frame, for instance, "syllables per minute" (Sandoval, 2019). The "utterance length", on the other hand, measures the quantity of discourse produced by the speaker "between disfluencies", such as "pause or hesitation" (Sandoval, 2019). However, language dominance is extremely difficult to define and measure:

> *There is no general agreement on which measures best express language dominance*; indicators [that are normally] used include Mean Length of Utterance (MLU) [which measures linguistic productivity in children by dividing the number of morphemes by the number of utterances (normally 100)], Upper Bound (i.e., the longest utterance in a given transcript), the number of (multimorphemic) utterances, vocabulary size, and number of words per minute. Amount of exposure has also on occasion been used as a proxy for language dominance. In general terms, the frequency of use of a language and the amount of input received have repeatedly been found to be good predictors of children's language proficiency (Gathercole & Thomas, 2009; Gutiérrez-Clellen & Kreiter, 2003; Hoff, Core, Place, Rumiche, Señor, & Parra, 2012). (Serratrice & Hervé, 2015, p. 321)

It is worth noting that fluency, although it may denote a degree of knowledge, does not encompass accuracy and proficiency (Sandoval, 2019). In conclusion, the answer to the question whether someone speaks a language may need a maieutic approach by counter-questioning how well? (Sandoval, 2019) rather than seeking a yes or a no answer. Thus, the question of when and who can say that they speak a language is actually a pysma because of its multilayered complexity.

This "fluency" phenomenon is intrinsically linked to the "polyglotism" phenomenon or rather to the polyglot mythmaking (Erard, 2019), whereby "commentators, journalists, and bystanders loosely apply terms such as 'fluency', 'proficient', 'speaks', 'knows'" discursively constructing a fata morgana without the proper academic grounding substantiating their words. These statements without any grounding or verification have plagued our society indoctrinating it into not even questioning what "proficient" actually means and whether it is a synonym of mastery (Erard, 2019).

Higher education institutions (under the aegis of governments) have already developed and established "fine-grained" frameworks based on objective mechanisms to classify and categorise the hierarchy of knowledge and skill underlying all language related and language relevant activities such as reading, speaking, writing, listening and translating. Nevertheless, the polyglot mythmaking is undergirded by a "belief in language as a form of magic" (Erard, 2019). Sometimes, polyglots tend to be viewed as people with superpowers. Erard (2019) states that there is a great deal of mystique surrounding the whole theme of languages: "Witnessing a conversation in a language you don't understand confirms words' esoteric power. In that light, someone who speaks lots of languages can't avoid being regarded as a prodigious magician". Therefore, sometimes the assessment of language aptitudes carried out by non-professionals or lay public may lead to discredited reputation of language professionals owing to the fact that lay masses have been conditioned to think that linguistic proficiency should be measured by a specific count of languages. However, a diversified linguistic repertoire claimed by some unverified hyperpolyglots may often be "an unreliable credential" (Erard, 2019), as only very few people were scientifically confirmed to have possessed a peculiar inborn brain architecture (more specifically cell structure in Broca's area) that would have facilitated their atypical FLA aptitude (Amunts et al., 2004, cited

in Biedroń, 2015, p. 19). Consequently, the employers are not willing to settle for less and are therefore nonconforming and disappointed with the relatively low count of languages of their applicants.

7.8. FOREIGN LANGUAGE SKILLS AS THE MAJOR ASSET IN TERMS OF EMPLOYABILITY

The Commission issued a communication in 2005 where the capacity to "understand" and "communicate in more than one language" is portrayed as "a desirable life-skill for all European citizens [...] necessary for personal fulfilment, active citizenship, social cohesion and employability in a knowledge society" (European Commission 2005, p. 3, cited in European Communities, 2007, p. 8). The Commission also found in 2005 that "skills in several languages" may boost not only the "competitiveness of individual companies" and the "employment of individual workers", but also the performance of the EU "economy as a whole" (p. 13).

A study on the Effects on the European economy of shortages of foreign language skills in Enterprise conducted in 2005 demonstrates that enterprises opt to hire employees with already acquired language skills (for instance, migrants) rather than invest in their training (European Communities, 2007, pp. 13-14). In the same vein, the ELAN study highlights "the added value of language skills in enhancing employability", especially taking into account the creation of new job profiles and new employment opportunities (p. 15). Thus, multilingualism is viewed as a ferment of economic prosperity and therefore the EU construes multilingualism as a "general education good" necessary for sustainable employability (European Communities, 2007), which prompts people to construe language learning and multilingualism as the grist to the mill which they can capitalise on when applying for a position. The need for the higher education institutions to adapt to the employment market demands is reportedly reaching a crescendo.

The Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions clearly foregrounds the need to reach the "Barcelona objective", which consists of "communication in mother tongue plus two languages" (2008, p. 5). The "ability to use several languages" will allow EU citizens to "benefit from better communication, inclusiveness and wider employment and business opportunities" (Commission to the European Parliament, 2008). According to the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions:

> Concrete measures are also needed for a large part of European society, which is still *missing out on the advantages of multilingualism*, e.g. those who are monolingual or still struggle with their first foreign language, school dropouts, senior citizens and other adults no longer in education. New learning solutions are called for to reach these specific groups through *edutainment*, the media and technologies, but also suitable translation and interpretation services. (Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions 2008, p. 5)

The EU multilingualism initiatives may ultimately end up contributing to the establishment of English as *lingua franca*, which may automatically lead to an even greater detraction from the

complexity of knowledge and skill underlying language learning. The internationalisation of markets leads to trans-nationalisation of English as the one world language.

Nevertheless, this report draws a clear distinction of the levels of linguistic proficiency, which broadens the cleavage between language experts and amateurs. Thus, the EU is fully cognisant of the fact that in order to eschew occupational anomie, where both amateurs-outsiders and highly qualified professionals contest the right and the authority to assume the role of interpreters in a wide spectra of contexts, we must learn to distinguish these "contestant" figures. We need to separate the two concepts, for amateurs, as this very word indicates, are in theory not supposed to make a living with a full-time job because they did not acquire the knowledge that would qualify them as specialists, experts or professionals. The problem is, however, that the society, the state and the businesses dissociate interpreting in international institutions from interpreting carried out at a police station, in court of law, in a public hospital or in the private clinic. They just do not conceive of medical interpreting as highly specialised and complex task. Therefore, as also indicated in Torroba (2015) the language knowledge and the interpreting skills are considered an extra asset, a bonus, an added value, a tool to perform primary tasks which have technically nothing to do with interpreting. Thus, language knowledge and interpreting skills are gradually becoming transferable:

> In order to make students aware of the importance of key transferable skills in this exercise, they are made aware that language accuracy represents only about one third of the final mark. Accuracy and communication skills are equally important in the assessment scheme for International Management and Languages students, as what they are aiming for is a range of skills that they can use in various management and international career paths (rather than training to become professional interpreters). [...] Language graduates present a skills profile that differs from that of other graduates. They opt for a much wider diversity of posts (transferability) and local markets. (Chouc and Calvo, 2010)

Chouc and Calvo (2010) maintain that according to the Cámara de Comercio e Industria de Barcelona, the ability to communicate in "at least two foreign languages" is an essential skill sought after by the main five Spanish industries. This confirms and undergirds the ongoing hybridisation of profiles and roles. Employers realise that it is highly convenient to hire an applicant with the ability to communicate in foreign language/s, since they can double up as secretaries, assistants, etc.

> As noted by the employers' panel during a conference on employability in October 2009, it is always possible to train a graduate for a specific post through an intensive in-house training scheme in a few weeks or months, but it is not possible to develop a working knowledge of a foreign language on a similar time-scale. It takes many years of effort to acquire a foreign language and become sufficiently fluent to use it for work purposes, which is why language students have an edge on other graduates when it comes to recruitment. (Chouc and Calvo, 2010)

This tendency may become a slippery slope leading towards downmarket services, as professional and highly qualified interpreters might not be willing to embrace the market demands in terms of using their linguistic skills not only to interpret, but also to carry out other types of tasks of either lower competence level or higher competence levels which they lack qualification for. The employers might even prefer to put on the payroll unqualified plurilingual personnel in order to ensure better compliance and lower task discretion. Thus, language skills help expand

the career options boosting one's competitiveness, but they also lead to fiercer competition: "[Graduates] in their own country they will be competing with other EU graduates, who will be equally qualified in their specialist field, but will bring language skills (i.e. English and their own languages) and an intercultural perspective to the job (Chouc and Calvo, 2010).

Hence, specialists who pursued expertise in fields other than languages or T&I may also access the hybridised positions in Spain as long as they claim they speak the required languages. No verification criteria are being used prior to the onboarding of prospective candidates to ensure the veridical nature of such claims.

> Language-related and applied languages courses are in high demand among Spanish students, especially Translation and Interpreting courses". The prospective students are willing to pursue language studies because they "increase graduates' value on the job-market. (Chouc and Calvo, 2010).
>
> However, courses are only available in the three main European languages (French, English, and German) in most cases and curriculum design has failed to diversify into better adapted courses and more combined, interdisciplinary studies. (Chouc & Calvo, 2010)

On the other hand, universities

> should provide realistic information about career prospects [...] in order to recruit motivated students and avoid frustration later", because apparently many Spanish students "do not actually enter Languages or Translation and Interpreting courses with a very realistic view of the objectives involved. (Chouc & Calvo, 2010).

7.9. CLASSIFICATION OF INTERPRETING BY ISCO-08

This section will be dedicated to the official classification of interpreting according to the International Standard Classification of Occupations (ISCO-08). The aim of this section is to understand how the Experts of Labour Statistics on international level classify the knowledge, the skill and the expertise underpinning interpreting. The International Labour Organisation officially recognises interpreting as a profession and acknowledges its scientific and intellectual nature. The following graph based on the information retrieved form the International Standard Classification of Occupations (ISCO-08) website[46] illustrates the occupation stratification and the position of interpreting therein:

[46] Avaliable in: https://www.qualificalia.com/terms/ciuo/?tema=213

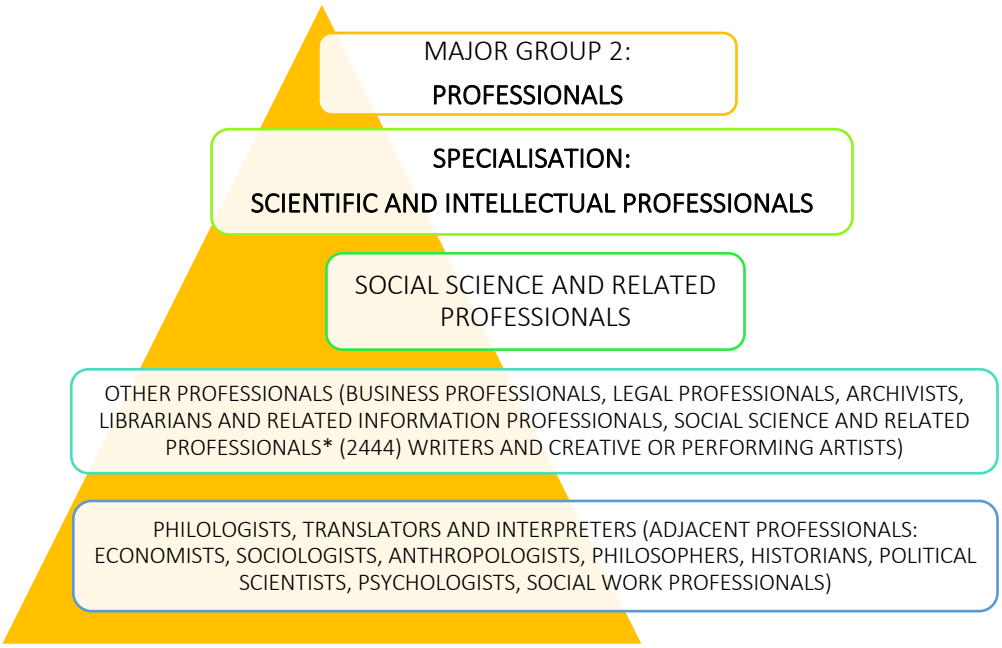


Figure 32. ISCO-08 Profession classification

The definition of "Philologists, Translators and Interpreters" may be found on the International Labour Organisation website and reads as follows (International Labour Organization, 2008):

> Philologists, translators and interpreters study the origin, development and structure of languages, and translate or interpret from one language into another.
>
> Tasks include:
>
> (a) studying relationships between ancient parent languages and modern language groups, tracing the origin and evolution of words, grammar and language forms, and presenting findings;
>
> (b) advising on or preparing language classification systems, grammars, dictionaries and similar materials;
>
> (c) translating from one language into another and ensuring that the correct meaning of the original is retained, that legal*, technical* or scientific* works are correctly rendered, and that the phraseology and terminology of the spirit and style of literary works are conveyed as far as possible;
>
> (d) develop methods for the use of computers and other instruments to improve productivity and quality of translations;
>
> (e) interpreting from one language into another, in particular at conferences*, meetings* and similar occasions*, and ensuring that the correct meaning and, as far as possible, the spirit of the original are transmitted;
>
> (f) preparing scholarly papers and reports;
>
> (g) performing related tasks;
>
> (h) supervising other workers.

Interpreting is mostly associated with institutional settings where simultaneous and consecutive modalities are preferred. The document does not mention community or public service interpreting. I consider that this constitutes a big problem for professionalisation, because the

overall complexity of liaison interpreting is being downgraded. The lack of visibility enjoyed by the interpreting in international institutions detracts from the complexity of medical interpreting.

As regards the level of competencies allocated to this professional category in terms of the type of work, the specialisation and the ability to perform tasks required to carry out this work, interpreters fall within the fourth and the highest level of competence:

> Occupations at Skill Level 4 typically involve the performance of tasks which require complex problem solving and decision making based on an extensive body of theoretical and factual knowledge in a specialised field. [...] Occupations at this skill level generally require extended levels of literacy and numeracy, sometimes at a very high level, and excellent interpersonal communication skills. These skills generally include the ability to understand complex written material and communicate complex ideas in media such as books, reports and oral presentations. The knowledge and skills required at Skill Level 4 are usually obtained as the result of study at a higher educational institution for a period of 3 – 6 years leading to the award of a first degree or higher qualification [...] In many cases appropriate formal qualifications are an essential requirement for entry to the occupation. (ISCED[47] Level 5a or higher). (International Labour Organization, 2008, pp. 4-5)

The following section will be dedicated to the National Classification of Occupations, which is the Spanish equivalent of the ISCO-08.

7.10. CLASSIFICATION OF INTERPRETING BY CNO-11

I shall now continue to analyse the National Classification of Occupations (Catálogo Nacional de Ocupaciones, 2011; Gavlovych & Blasco, 2020). It is a system for the organisation and aggregation of data related to the existing occupations in the national territory. Although it almost fully matches the ISCO-08 classification, I would still prefer to insert a diagram showcasing the similarities and the interrelatedness between the two classifications.

[47] ISCED: The International Standard Classification of Education.

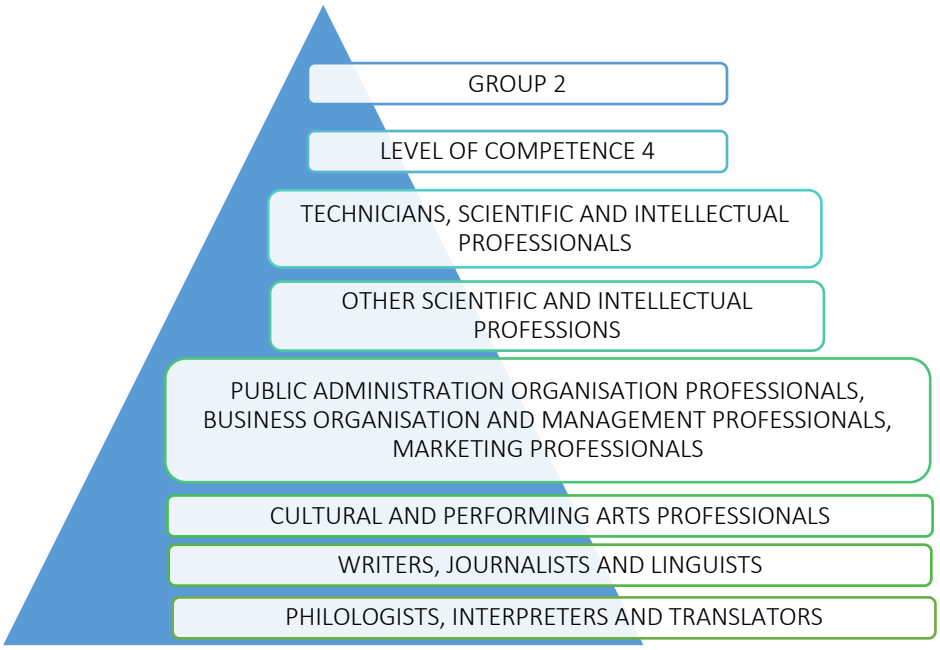


Figure 33. CNO-11 Profession classification

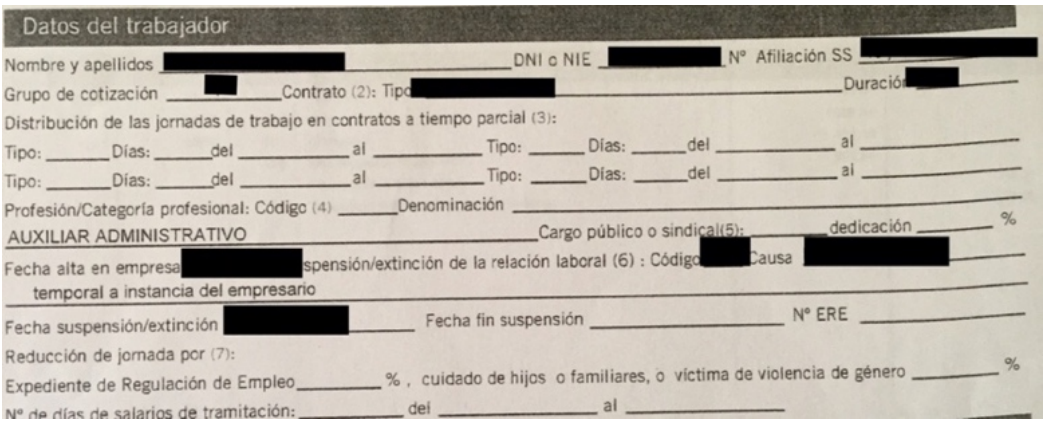
As we can see when comparing the two classification systems, the overarching categories remain the same. Both organisations attribute interpreting to the 4th and the highest of competence. From these data I can conclude that my approximation to the knowledge and competence underlying interpreting is much more accurate than that of medical workers practicing in the study-relevant geographical area and Spanish society. In fact the definition given by CNO-11 just happens to completely mirror my perspective on the topic of knowledge and skill underlying interpreting.

7.11. CLASSIFICATION OF ADMINISTRATIVE ASSISTANTS BY CNO-11 AND ISCO-08

Having reviewed the official classification of the interpreting profession provided by national and international Experts of Labour Statistics, I feel the urge to compare the professional category of interpreters with the occupational category of medical assistants. I feel it is important to draw this comparison because the status that is being been assigned to medical interpreters practicing in the private medical centres located in the area of interest is that of administrative assistant. One of my informants has kindly provided me with a copy of a labour contract negotiated between themselves and a private healthcare centre situated in the VC. The professional category that had been allocated to this medical interpreter is "auxiliar administrativo" (Conselleria de Economía, Industria, Turismo y Empleo Dirección Territorial de Economía, Industria, Turismo y Empleo, 2014), which stands for "administrative assistant" or "administrative support specialist" instead of the existent category of interpreter.

The Council of Economy, Industry, Tourism and Employment defines the category of administrative assistant as a worker who without an initiative and without responsibility carries out

ancillary tasks at the administration department (Conselleria de Economía, Industria, Turismo y Empleo Dirección Territorial de Economía, Industria, Turismo y Empleo, 2014).[48]


Datos del trabajador

Nombre y apellidos [redacted] DNI o NIE [redacted] Nº Afiliación SS [redacted]

Grupo de cotización [redacted] Contrato (2): Tipo [redacted] Duración [redacted]

Distribución de las jornadas de trabajo en contratos a tiempo parcial (3):

Tipo: _____ Días: _____ del _____ al _____ Tipo: _____ Días: _____ del _____ al _____

Tipo: _____ Días: _____ del _____ al _____ Tipo: _____ Días: _____ del _____ al _____

Profesión/Categoría profesional: Código (4) _____ Denominación _____

AUXILIAR ADMINISTRATIVO Cargo público o sindical(5): _____ dedicación _____ %

Fecha alta en empresa [redacted] spensión/extinción de la relación laboral (6) : Código [redacted] Causa [redacted]

temporal a instancia del empresario

Fecha suspensión/extinción [redacted] Fecha fin suspensión _____ Nº ERE _____

Reducción de jornada por (7):

Expediente de Regulación de Empleo _____ % , cuidado de hijos o familiares, o víctima de violencia de género _____ %

Nº de días de salarios de tramitación: _____ del _____ al _____

Figure 34. Excerpt of a job contract where administrative assistant is stated as the professional category

The National Classification of Occupations allocated the occupational category of administrative assistants to the third level of competence:

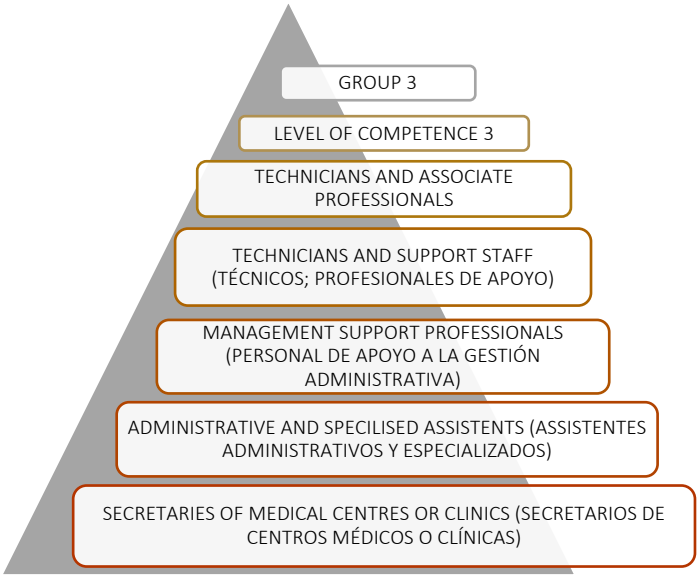


Figure 35. CNO-11 Classification of the category of administrative assistant

According to the ISCO-08 The third level of occupational competence corresponding to the Skill Level 3 typically involve:

> The performance of complex technical and practical tasks which require an extensive body of factual, technical and procedural knowledge in a specialised field [...] high level of literacy and numeracy and well developed interpersonal communication skills. These skills may include the ability to understand complex written material, prepare factual reports and communicate with people who are distressed. The knowledge and skills required at Skill Level 3 are usually obtained as the result of study at a

[48] The following figure is a personal communication and the courtesy of an employee, who had kindly agreed to provide their contract on the condition that the rest of the data contained therin will remain confidential and anonymised.

> higher educational institution following completion of secondary education for a period of 1 – 3 years (ISCED Level 5b). In some cases extensive relevant work experience and prolonged on the job training may substitute for the formal education. (International Labour Organization, 2008, p. 4)

As we can see from the excerpt inserted above, competence level 3 does not imply the necessity to have previously acquired a theoretical body of abstract knowledge as in the case of the competence level 4. Another important difference resides in the fact that although the education is normally acquired at a higher education institution, as well as in the case of interpreting, it is the secondary education, not the first degree qualification. Also the duration of the training varies from 1 to 3 years in the case of administrative assistants and adjacent occupations, whereas the professions pertaining to group 2 and competence level 4 encompassing interpreting imply education lasting from 3 up to 6 years. But most importantly, the appropriate formal qualifications only constitute an essential requirement for entry to the occupation in the case of group 2 professionals, which encompass interpreters. The following is the delimitation of the tasks, duties and responsibilities carried out by the administrative assistants according to CNO-11:

> The secretaries of medical centres or clinics assist the head of the unit and other employees in performing and supporting administrative functions of communication, documentation and internal coordination. They apply specialised knowledge of medical terminology and procedures, in order to support health personnel in medical centres and other healthcare organisations [...] assist with the preparation of budgets and the drafting of contracts and purchase or procurement orders; maintain medical files and records and the technical library; interview patients to fill out forms, documents and medical records; arrange and confirm medical appointments and relay messages to medical staff and patients; compile, record and review medical records, reports, documents and correspondence; complete health insurance and other claim forms; prepare financial statements and bills. (CNO-11, 2011, my translation)

In conclusion, the tasks that some interpreters have to carry out downgrade the profession of interpreter, as they clearly belong to groups of occupations with a lower level of competence.

7.12. INTERPRETING ACCORDING TO THE OFFICIAL UNIVERSITY EDUCATION SYSTEM

It is worthwhile noting that Real Decreto 1659/1998 of 24 July 1998 regulates the Article 8 (section 5) of the law on the statute of rights for workers, on the provision of information to workers on the essential elements of the employment contract. In the labour relations included in the scope of application of this Royal Decree, the employer must inform the employee in writing about the essential elements of the labour contract and the main conditions for the performance of the work. This obligation will be understood to have been fulfilled when such elements and conditions already appear in the written contract of employment held by the employee. If the employment contract formalised in writing contains the information relating to the aforementioned elements and conditions only partially, the employer must provide the employee with the remaining information in writing, under the terms and within the deadlines established in this Real Decreto. Thus, one of the things that must figurate in the job contract is:

> d) La categoría o el grupo profesional del puesto de trabajo que desempeñe el trabajador o la caracterización o la descripción resumida del mismo, en términos que permitan conocer con suficiente precisión el contenido específico del trabajo

> [d) The category or professional group of the job held by the worker or the characterization or summary description of the job, in terms that allow the specific content of the job to be known with sufficient precision]. (Real Decreto 1659/1998, Article 8, section 5)

According to this Royal Decree, there is an inconsistency between the designation that the employers are assigned (administrative assistants) and the tasks that they are expected to carry out (interpreting *inter alia*). Thus, the people who sign the employment contract agreeing to carry out interpreting assignments even though they do not have the necessary qualifications and the employers, who agree to hire applicants lacking the necessary professional qualifications, should both be in breach of law.

However, according to the Real Decreto 967/2014, interpreting is not a regulated profession as its practice is not regulated by the requirement of a university degree and its practitioners are not required to be in possession of an official university degree. Thus, the university diploma or title is in this case not a "título habilitante" or a diploma/certification that qualifies the holder to exercise a regulated profession in Spain. Consequently, this qualification is not being recognised as a prerequisite for the admission to practice. Professional effects are those provided by official university degrees that enable access to the exercise of any of the regulated professions (Real Decreto 967/2014, p. 6), however this is not the case of MI in Spain. According to Real Decreto 1393/2007, interpreting is not a regulated profession, as this university diploma is not necessary to gain access to the profession:

List of branches of knowledge according to Real Decreto 1393/2007 of 27 October 2007 and the specific fields based on the document "Fields of education and training" for the purpose of declarations of equivalence to qualifications

Please, note: All diplomas enabling access to a regulates profession on the basis of a university degree are excluded from this annex

Branches of knowledge Real Decreto 1393/2007	
Arts and Humanities	021 Arts 022 Humanties except for languages 023 Languages

Figure 36. Language related disciplines being allocated to non-regulated professions

The following chapter will be dedicated to the analysis of international standards ISO 13611 and ISO 21998.

7.13. INTERPRETING AS SPECIFIED BY ISO 13611 AND ISO 21998

International standards ISO 13611 (2014) and ISO 21998 (2020) are of paramount importance and great relevance for this thesis. Both standards aim at educating service providers and end users about the role boundaries of interpreters (task discretion) and about the knowledge and skill that these professionals require to exercise their discretionary specialisation successfully. The fact that a major emphasis is laid on the delimitation of the body of formal and specialised knowledge and skill constitutes an essential step towards sensitisation to the complexity of the profession. The gravitas of role delimitation is also key for the occupation's professional development. The following are the collated excerpts extracted from the section on competences of the ISO 13611 (2014) and ISO 21998 (2020) and my analysis thereof:

1. Linguistic proficiency competence is described as *"high enough level of linguistic competence"* (ISO 21998, 2020). The standard does not specify what *"high enough level of linguistic competence"* actually denotes and what level of linguistic proficiency can be considered a benchmark which other levels of competence can be stacked up against. According to ISO 13611 community interpreters should demonstrate excellent command in their respective working languages in accordance with "accepted standards of language proficiency" (ISO 13611, 2014). Interpreters should be able to accommodate the discourse taking into account age, gender, race, ethnicity and socio-economic status of the speakers and listeners (ISO 13611, 2014). Linguistic proficiency in working languages is meant to encompass speaking (production of messages), listening comprehension of different linguistic varieties such as regional accents/varieties or dialectal varieties, idiomatic expressions, colloquialisms and slangs, reading comprehension skills, recognition of registers (formal and informal), knowledge of relevant subject areas and terminology (ISO 21998, 2020, p. 6; ISO 13611, 2014, p. 8).
2. Intercultural competence is being viewed separately from linguistic proficiency despite the oneness of the two concepts in the hermeneutics of both oral and written discourse. "When necessary, healthcare interpreters shall bridge the cultural and conceptual gaps separating participants" (ISO 21998, 2020, p. 7). Apparently, intercultural competence encapsulates identification of cultural nuances in speech and their correct conveyance, as well as correct interpretation of gestures and tone.
3. Interpersonal competence capsulises broad-spectrum forbearance-related principles of professional interoperability and even social interaction: proper verbal and non-verbal behaviour, flexibility, patience, ability to work in a multidisciplinary team and problem-solving (ISO 21998, 2020 p. 7), as well as politeness, respect, tact, self-control, impartial behaviour, cross-cultural competence, ability to build rapport, ability to manage and keep up the flow of communication through effective interjection skills (ISO 13611, 2014, p. 8). The phrase "healthcare interpreters shall be able to build therapeutic rapport with the main participants [...]" (ISO 21998, 2020, p. 7) should not be glossed over. Therapeutic rapport incorporates three major aims: the feeling of safety, respect and empathy in the therapist-client/patient relationship.

Presumably, the interpreter's attitude must invite the service users to confide in him/her. This goes in line with the current market demands, however, this statement may clash with the precept of neutrality manifested in deferential, yet emotionally detached behaviour. I am certain that by displaying professional competence and extensive expertise their presence would emanate safety and trustworthiness. Service receivers may distrust medical interpreters because they do not know what to expect from their performance, especially if they have not had the opportunity to work with professional interpreters before. The end-users are hesitant as to whether they can feel safe in a situation where interpreter has to be availed of. The physicians do not know whether they can entrust their highly specialised and sophisticated knowledge to somebody's interpretation. No interpersonal competence can be truly reified until there is professional trust and recognition.

4. Technical competence stands for the interpreters' ability to avail themselves of interpreting equipment "(such as microphone, audio- and video-conferencing technology). Technical competence also includes image management, volume control, microphone etiquette, and signals for meta-communication" (ISO 21998, 2020, p. 7; ISO 13611, 2014, p. 8).
5. Competence in health-related terminological research implies keeping abreast of the healthcare terminology by researching relevant terminology resources (ISO 21998, 2020, p. 7), as well as retrieving "additional linguistic, terminological, and specialised knowledge necessary to interpret in specialised cases" such as databases or parallel texts (ISO 13611, 2014, p. 8).
6. Healthcare related competence is constituted by the specialised knowledge intrinsic to different medical settings. The interpreter needs to understand the organisational systems of institutions where healthcare services are delivered and adhere to the "protocols and norms" which operate in different medical specialisations such as mental health, assisted reproduction, end of life, emergency care, etc. (ISO 21998, 2020, p. 7) Interpreters must "be familiar with the appropriate protocols and mechanisms of difficult case post-conferences", be able to cross-linguistically navigate through complex medical terminology across all hospital departments or specialised clinics, "be able to ensure their own safety", be alert to "common cultural health traditions and beliefs of their patient populations" (ISO 21998, 2020).
7. Communicative competence essentialises non-verbal cues and non-verbal communication. Many times there is no designated place for the interpreter in the consultation, even in the medical facility which does offer interpreting services to their clients. In numerous occasions the interpreter is being allowed in and tolerated rather than welcome and awaited. Sometimes the figure of medical interpreter is so invisible that they often feel obligated to literally squeeze themselves into a corner where they cannot even rest their elbows and their notepad to take notes. There is lack of appropriate infrastructure in the facility to accommodate them. Nevertheless, according to ISO 21998 (2020, p. 7) interpreters should know how to introduce themselves to the

participants, how to choose the best positioning by "physically position[ing] themselves in such a manner as to maximize the quality of the interpreting and directness of communication between parties" (ISO 21998, 2020, p. 7). The interpreter has to ensure that they are able to both hear and see non-verbal cues, gestures, gazes, etc. in order to yield the most accurate rendition of the verbal and non-verbal discourse (ISO 21998, 2020). Communicative competence is also related to dexterous turn taking and knowledge when and how to intervene, and whether it would be acceptable to ask for a clarification (ISO 21998, 2020, p. 7).

8. Interpreting competence according to ISO 21998 (2020, p. 8) encompasses the ability to bidirectionally render oral discourse using appropriate interpreting mode. This competence includes:
   - The ability to successfully reckon with the meaning of complex language structures
   - The ability to factor in the communicative function thereof
   - The ability to convey rendered utterances with maximal accuracy
   - The ability to "apply situation-specific interpreting strategies of clarification and intervention"
9. According to ISO 13611 (2014), interpreters must be competent at:
   - utilising consecutive, simultaneous, and chuchotage modes of interpreting
   - bidirectionally sight-translating written materials
   - using note-taking techniques,
   - applying active listening skills
   - providing effective delivery skills
   - relying on strong memory skills
   - using professional judgement to intervene effectively without disturbing the flow of communication
   - showing self-awareness by understanding one's own role
   - respecting the jurisdictional role boundaries when interoperating with other professionals
   - respecting client autonomy (for example, by refraining from interjecting personal remarks and counselling)
   - adhering to applicable practice ethics mechanisms such as standards of practice and codes of ethics
   - upgrading performance trough continuous professional development, self-education and life-long learning
10. Entrepreneurial competence consists of "**the practical, financial and legal background to set up, plan, market, and run their professional activity**" (ISO 21998, 2020, p. 8).

The authors of ISO 21998 (2020, pp. 7-9) recommend "that interpreting service providers or healthcare organizations use third party testing for non-certified interpreters, and not rely on an interpreter's self-assessed competence for liability and patient safety reasons".

7.14. FOREIGN LANGUAGE KNOWLEDGE AND SKILLS AS VIEWED FROM THE LENS OF NEUROPHYSIOLOGY, GENETICS AND COGNITIVE SCIENCES

This section will aim to explore the topic of talent in foreign language acquisition (henceforth FLA) from the lens of neurophysiology and genetics. FLA may be considered the core of the abstract and esoteric body of knowledge underpinning interpreting, and also the core of the profession's mystique. "Second-language learning in adulthood is becoming increasingly prevalent as globalization advances" (Mamiya et al., 2016, p. 1). Foreign language knowledge (henceforth FLK) is being promoted as a transferable asset accessible for everyone willing to attain it in order to improve their employability. However, this section will seek to demonstrate that L2 language acquisition is not only subject to the persons willingness to master a language, but to their biological predisposition to do so.

A study conducted by Hartshorne et al. (2018) gathers evidence from 2/3 million (669,498) native and non-native English speakers on the critical period for 2nd langage acquisition. It revealed that that native and foreign learners require around 30 years spent in immersion settings to reach asymptotic performance, otherwise referred to as near-native proficiency. According to this study children are proficient at learning a second language up until the age of 18, roughly 10 years later than earlier estimates (Smith, 2018).The study also showcases that "it is best to start by age 10 if the learner wants to achieve the grammatical fluency of a native speaker" (Smith, 2018). The study showed a slight improvement—roughly one percentage point—in people who have been speaking English for 30 versus 20 years" (Smith, 2018). Therefore, "people who learned a second language in childhood are difficult to distinguish from native speakers, whereas those who began in adulthood are often saddled with an accent and conspicuous grammatical errors" (Hartshorne, Tenenbaum and Pinker, 2018, Introduction section, § 1).

In this thesis I tried to focus on the theme of the ultimate attainment (the optimal level of performance of the advanced learners), and more specifically on the meaning of the term "proficiency" and on how long does it take to achieve the native-like proficiency in a foreign language. Also, Hartshorne et al. distinguish between "proficiency" and "native[-like] proficiency", which denotes "extreme levels of accuracy" in the usage of the following syntactic phenomena: "passivization, clefting, agreement, relative clauses, preposition use, verb syntactic subcategorization, pronoun gender and case, modals, determiners, subject-dropping, aspect, sequence of tenses, and wh-movement (Hartshorne et al., 2018, Materials section, § 1). It is true though that later learners may deploy conscious learning-communication or discourse construction strategies by building upon and transferring the knowledge from their 1st or native language to the 2nd foreign language. However, it can often result in all sorts of errors such as false friends, calques, unjustified borrowings, wrong evaluation of the recipients' knowledge, etc.). Physicians and medical staff who work in multicultural and interdisciplinary environments enjoy continuous "exposure to linguistic input, which delays the atrophy of language learning circuitry" (Hartshorne, Tenenbaum and

Pinker, 2018, The nature of the critical period for second language acquisition, § 7), but the mounting evidence showcases that prolonged learning trajectory does not imply proficiency, linguistic knowledge crystallisation or mastery.

Therefore, the authors of the study indicate that there is no consensus as to how long "long enough" really is, as there are different stages of language acquisition which are interrelated with different ways to use the language or the acquired linguistic knowledge. As put by Hartshorne, Tenenbaum and Pinker, the language can either be produced (production) or understood (comprehension). Both written (writing and reading) and oral (speaking and listening) modalities can be either produced or comprehended. But production and comprehension have different cognitive demands: "listening places high demands on speed and memory (one can re-read but not re-hear), and the speech must be analyzed by non-native acoustic phonetics and phonology [...]. Written tests require literacy" (Hartshorne, Tenenbaum and Pinker, 2018, Test modality section, § 2). These are undoubtedly long-term learning processes, but the authors claim that relatively little is known about how long it actually takes learners to reach asymptotic performance, and:

> Even less is known about how long non-native speakers continue to improve on the target language. While a few studies found limited continued improvement for immersion learners after the first five years (Johnson & Newport, 1989; Patkowski, 1980), these studies had minimal power to detect continued improvement [...] In contrast, analysis of US Census data suggests that learning continues for decades (Stevens, 1999), though the validity of this self-report data is uncertain. Analysis of foreign language education suggests learning in that context may continue for a couple of decades, though this may merely reflect the slower pace of non-immersion learning (Huang, 2015). In the absence of any clear evidence, researchers have chosen a diverse set of cut-offs, ranging anywhere from three (Birdsong & Molis, 2001; McDonald, 2000) to fifteen years (Abrahamsson, 2012). (Hartshorne, Tenenbaum and Pinker, 2018, The duration of Learning section, § 4-5)

Of course, this particular finding has its proponents and detractors. Charles Yang, a computational linguist at the University of Pennsylvania, is one of the advocates of these findings. He is not surprised at this outcome due to the sophisticatedness of grammar rules (for instance nominalisation of an adjective) that the learners can only pick up from adolescence onwards. Yang calls these linguistic details "fine-grained". "Elissa Newport, a professor of neurology at Georgetown University who specializes in language acquisition, remains a skeptic" (Smith, 2018). She claims that: "Most of the literature finds that learning the syntax and morphology of a language is done in about 5 years, not 30 [...] [t]he claim that it takes 30 years to learn a language just doesn't fit with any other findings" (Smith, 2018).

Schumann (2004b, in Biedroń, 2015, p. 17) distinguished five cognitive determinants or sources of brain variation which may eventuate in variances in FLA aptitude. He maintains that:

1. "Genes are the most influential factor in the development of cognitive ability" (Schumann, 2004b, in Biedroń, 2015)
2. The chemical environment during the embryonic stage of development
3. Idiosyncratic environmental stimulation galvanises the increment and interconnectedness among neurons and engages in additional microstructural variations in the neural structure.

4. Degeneracy implies brain pluripotentiality and spawns changes in brain microstructure leading to functional diversification of the same brain structures
5. The individual appraisal system (Scherer, 1984 in Biedroń, 2015, p. 17) is responsible for idiosyncratic preferences and aversions. The brain pliability resulting from such an inborn predisposition also affects career choice (Biedroń, 2015, p. 20). The genetically predisposed brain anatomy conditions the burgeoning of what lay public labels as "talent" (Biedroń, 2015, p. 20). The interpreters-to-be feel drawn to a language-related career because they are genetically coded and programmed to become successful in using certain abilities, therefore they end up seeking environments fitting their genotype where they can best self-actualise (Jensen, 1997, in Biedroń, 2015, p. 17).

Schumann (2004b, cited in Biedroń, 2015, p. 17) maintains that the formation of foreign language aptitudes "might be a consequence of evolutionary selection processes [...] which means that individuals can be differently prepared to respond to environmental changes, and, consequently, to survive and to transmit their genes".

7.14.1. Neurophysiological factors

It is worth noting that it was scientifically substantiated that the special aptitude for foreign language learning goes hand in hand with the "inborn functional and structural characteristics as well as an individual brain response to an idiosyncratic experience of learning a language" (Biedro, 2015, p. 16). The foreign language aptitudes are subject to highly individualized functional (brain activity) and anatomical (brain structure) patterns, which condition the development of specific talents (Perani, 2005, cited in Biedroń, 2015, p. 31).

As pinpointed by Schumann (2004b, p. 7 in Biedroń (2015, p. 16): "all brains are different—as different as faces . . . and these differences have consequences for learning".

With regard to phonological aptitude it was found (Biedroń, 2015, p. 29) that highly proficient L2 speakers have been born and favoured with an "increase in grey matter in the mid-body of the corpus collosum" (Van den Noort et al., 2006), hypertrophied grey and white matter in left parietal cortex (hypermyelination), which accommodates phonological verbal working memory (Heschl's gyrus) (Golestani et al., 2011, Wong et al., 2011), neurocognitive flexibility (Reiterer, Hu, Sumathi, & Singh, 2013), "enhanced hemodynamic responses in the speech-motor neural network and speech-auditory perception areas responsible for the aptitude for pronunciation" (Hu et al. (2013), enhanced hemodynamic in "mirror neurons" responsible for speech comprehension, prosody, phonetic coding ability, language pronunciation aptitude and empathy (Hu et al., 2013), "larger articulation space", which allows "access to a wider range of sounds", making FL learners "better sound imitators" (Reiterer et al. (2013), very developed "pre-supplementary motor area and head of the caudate nucleus" responsible for the "performance on phonetic fluency" (Grogan et al. (2009).

The lifelong learning advocates' statement that: "children's brains are particularly well adapted to learning languages, but the idea that adults cannot learn English has been thoroughly disproven [as] we cannot possibly hope to learn everything we need to know in the first quarter of our lives" (EF EPI English Proficiency Index, 2019, p. 40) cannot possibly be taken seriously

because it has already been scientifically determined that "only 15% of adult or late-onset second language learners can imitate sounds to a high degree" (Hu et al., 2013, Nardo and Reiterer, 2009, Reiterer et al., 2011a). Hypermyelination (enlargement of the white matter volume) guarantees faster and more efficient neural processing, which is essential for learning the phonetics of a language (Biedroń, 2015, p. 20).

With regard to vocabulary and the ability to sound natural when conversing in a language, it was scientifically determined that "the proficiency in learning new words depends on correlated amplitude changes between the left hippocampus and neocortical regions" Breitenstein et al. (2005). Semantic memory is "correlated with grey matter volumes in a predominantly left hemisphere" (De Zubicaray et al., 2011). "Performance on semantic fluency is linked to grey matter in the left inferior temporal lobe" (Grogan et al. (2009).

This ability denotes successful management of competition between "translation equivalents in distinct languages that share a common concept [...] which affects online [discourse] production in bilinguals" (Mickan et al., 2019a; Hermans et al., 1998; Colomé, 2001 in Mickan et al., 2019b). Immediate bilingual access to the needed lexical units denotes successful executive control, whereby the speaker "inhibits the non-target language [lexicon] during [the discourse]", thus eschewing undesirable wording selection errors (Mickan et al., 2019b). The cross-linguistic influence hypothesis within the context of Paradis' Activation Threshold Hypothesis (ATH) highlights the interconnectedness and interrelatedness of all elements comprising a language. The process of word or term retrieval is conditioned by an activation threshold. "The [activation threshold] is lowered after successful retrieval but is increased again either gradually through disuse or through top-down inhibition during access of other, competing words" (Mickan et al., 2019b).

With regard to syntax, it was found that: "integrity of white matter fiber tracts arising from Broca's area is linked with the ability to extract grammatical rules" (Flöel et al., 2009). "Subjects with an increased impact of dopamine are better at grammar learning" (Wong et al. (2012). Particular characteristics of the inferior frontal gyrus were reported to influence learners' grammar learning (Nauchi and Sakai (2009). Thus, the ability to extract grammatical rules, systematise them, commit them to memory by rote memorisation and apply them in practice is also determined by the brain anatomy of the learner (Biedroń, 2015, p. 15).

7.14.2. Genetically-driven factors

The interdependence of the COMT genotype and the white matter strongly affects the success in foreign language learning (Mamiya et al., 2016, pp. 7249-7253). Subjects with the Methionine (Met)/Valine (Val) [as 1° variation of COMPT genotype], and Val/Val [or 2° variation of COMT] genotypes showcased that a white matter changes were elicited as a response to language immersion they were experiencing within specific time frame, whereas those with the Met/Met [3° variation of COMT] genotype did not display similar brain response in spite of undergoing the same environmental stimulation. Apparently, these finding are not confined to adults, "polymorphism in the catechol-O-methyltransferase (COMT) gene" as well as increased fractional anisotropy (FA) and decreased radial diffusivity account for better reading skills in children and adolescents (Mamiya et al., 2016).

Variation in the FOXP2 gene is also "strongly associated with the ability to learn a foreign language during adulthood" (Chandrasekara et al., 2015), as those adult participants who happened to have a particular genetic alteration on the FOXP2 gene were found to be able to learn "the foreign speech sounds faster and more accurately". "Contrary to the idea that adults have difficulty in learning new languages, we find that some adults are exceptional at learning them" (Chandrasekara et al., 2015).

Thus, individuals seek self-actualisation[49] (Pauchant & Dumas, 1991, p. 58) through innate metamotivation (Goble, 1970) in terms of fully materialising and realising one's own genetically predetermined potentialities and capacities in a way that would fit their genotype. Albeit possessing genetic predisposition and experiencing environment in one's own idiosyncratic ways defined by brain's anatomy, individuals may only achieve linguistic proficiency by training and learning, in other words, by acquiring the knowledge underlying language command or proficiency.

7.14.3. Training and learning from the lens of neurophysiology

All the above knowledge is acquired through procedural memory, declarative memory and semantic memory. Procedural memory was found to be related to the learning of morpho-phonological grammar, which implies comprehension of complex grammatical rules governing phoneme and morpheme pattern creation and combination (Ettlinger et al., 2009 as cited in Wong et al., 2012, p. 1094), as well as syntax rules and sentence formation process (Morgan-Short, Farreta-Stutenberg, Brill, Carpenter, as cited in Wong et al., 2012, p. 1094). This is done through feedback and memorisation of rules for pattern formation (Frank et al., 2004; Schultz et al., 1997, cited in Wong et al., 2012, p. 1094). These patterns are systematized (although only partially owing to manifold exceptions and nuances) into rules and formulas. Such formulas regulate the cohesion and coherence among different linguistic components, and are relatively difficult to interiorise and implement (Abrahamsson and Hyltenstam, 2009; Johnson and Newport, 1989; Weber-Fox and Neville, 1996 as cited in Wong et al., 2012, p. 1096). As opposed to lexicon, which can be acquired by adult learners through the declarative memory "with nearly native-like proficiency" (Weber-Fox and Neville, 1996 as cited in Wong et al., 2012, pp. 1092, 1096), grammar produces unsurmountable difficulties for many adult learners even after many years of learning. Semantic memory encompasses all the declarative knowledge acquired throughout our life and through our language about the world Binder and Desai (2011, pp. 527-536), and allows us to retrieve this conceptual knowledge.

Thus, Successful language proficiency acquisition requires exercise of phonetic and acoustic abilities (language specific nonnative sound discrimination predetermined by phonological short-term memory; non-interference with native sounds and excellent sound/speech imitation abilities/utterance articulation/pronunciation, which in 66% percent of cases is predicted by working memory); excellent attention span; grammatical and syntax sensitivity; rote memorization and retention of lexicon (self-monitoring or executive control over the lexical access and inhibition of the non-target terms during discourse, immediate word retrieval in case of interpreting, avoidance

[49] https://en.wikipedia.org/wiki/Abraham_Maslow#Goble

of wording selection errors during between-language lexicon competition); excellent noticing ability; outstanding semantic and phonemic fluency; and exceptional working memory as well as long-term memory (Biedroń, 2015, pp. 13-32). All of these aptitudes can be subsumed under declarative and procedural memory (Biedroń, 2015). Semantic and phonemic fluency, two variations of verbal fluency, encompass processing speed, attention, working memory, access to and retrieval of the lexicon stored in the learners' semantic memory as described above, ability to generate words within a very limited time window, and executive functioning or executive/cognitive control ability, "which has been found to be implicated [...] in bilingual processing" (Linck et al., 2008, cited in Mickan et al., 2019b).

On the top of all of the declarative and procedural memory, interpreters need to be trained on how to use their memory in terms of retaining all the relevant information and rendering it in a way that would accurately and faithfully relay the original message:

> One of the most stark contrasts between a qualified interpreter and a bilingual staff person trying to interpret is the interpreter's trained capacity to focus on the important details of a healthcare conversation, retain the information, and convert it to the target language accurately without requiring multiple repetitions and without omitting important details. This is a refined skill that takes untold hours of guided practice. (Foster, 2022)

The long-term effects of the acquisition of a very advanced linguistic skill in interpreters causes hypermyelination in: bilateral putamen, the inferior and superior colliculi, and the bilateral dorsomedial thalami (Green et al., 2006, cited in Biedroń, 2015, p. 19).

> In 2016, more than 60% of adult European citizens were able to speak at least one foreign language (FL; European Commission—Eurostat, 2016). With multilingualism on the rise, learning foreign languages (FLs) is so common these days, it is often taken for granted. Yet, regardless of how ordinary it might seem, mastering a new language is and always will be an immensely complex task. Being able to formulate sentences in any language requires knowledge of its words and grammatical structures, all of which have to first be encoded, and then consolidated and integrated into long-term memory. (Mickan et al., 2019b)

Another challenge in language learning and linguistic proficiency acquisition is the fact that, due to the risk of foreign language attrition, these processes are meant to be a life-long processes.

In conclusion, a flair for languages is based on inborn neuromorphological idiosyncrasies, genetic predisposition, COMPT genotype eliciting better brain response during environmental stimulation, FOXP2 predetermining development of 1) striatum (forebrain region) responsible for procedural memory and learning, as well as 2) frontal cortex governing declarative knowledge. The final stage of language learning is the proceduralisation of declarative knowledge (Fakhraee Faruji, 2012, p. 37), whereby the accumulated experience through conscious learning becomes internalised and, thus, no longer dependent on the declarative learning, but on the procedural automatised memory (Ullman, 2001 in (Fakhraee Faruji, 2012, pp. 37-39).

Unlike in case of other professions and occupations, learning and training in translation and interpreting does not guarantee proficiency if the learner lacks all the biopsysiological and genetic factors. This is the rationale behind the exclusive character of linguistic knowledge acquisition: the abilities required to obtain this professional knowledge is not accessible for everyone and not achievable by everyone. The willingness and readiness to learn does not imply successful language

acquisition leading to proficiency. Thus, the patent promotion of multilingualism and the expectations verbalised by Dame Louise Casey in 2018 ("UK should set date for everyone to speak English, says Casey", 2018) (a "target date" by which the government wants "everybody in the country [UK] to be able to speak a common language"), might be impossible to fulfil. A person is not born linguistically proficient, a person is not made linguistically proficient, polyglot or interpreter, but a person is definitely born to be made linguistically proficient, or polyglot or translator or interpreter.

7.15. INTERPRETING ACCORDING TO THE COGNITIVE LOAD THEORY

Apart from foreign language proficiency, professional interpreters need special skills to implement their specialised knowledge by exercising their discretionary specialisation in order to achieve "pragmatic equivalence" (Crezee et al., 2020). In other words, MIs must have "pragmalinguistic" competence and know that the linguistic expression of the pragmatic intention differs from language to language (Hale, 2014, p. 323 cited in Crezee et al., 2020). They must also have "socio-pragmatic" competence and know what types of behaviour are considered appropriate in what settings in different languages and cultures (Hale, 2014, p. 323 cited in Crezee et al., 2020).

The cognitive load (hereafter CL) theory (Sweller et al., 1998, 2011, 2019; Paas and Van Merriënboer, 1994; Yin et al., 2008; and Meshkati, 1988 in Zhu and Aryadoust, 2022) views interpreting as an activity requiring major cognitive resources to deal with task demands (mental effort). Zhu and Aryadoust (2022) postulate that the CL of professional interpreters, is intrinsic (inherent complexity of information and the skill to process this information), extraneous (the manner in which the information is presented), and germane (processing and cross-linguistic reconstruction of information).

Gile's (1995, 2009 as cited in Zhu and Aryadoust, 2022) "assimilates interpreters to a tightrope walker who has to utilise nearly all their mental effort during interpreting, which is available only in limited supply" due to a limited capacity of their working memory. Giles identifies 3 major mental efforts: comprehension of the input, production of the rendition or "articulation of the translated code" and short term memory or capacity to store limited bits of information (as cited in Zhu and Aryadoust, 2022). The vital decisions or the discretionary application of individualised expertise and experience is happening during the time lag (otherwise referred to as ear-voice-span) between the comprehension and articulation of the rendition. However, the short timeframe left for the exercise of discretion is not the only challenge faced by interpreters. It is the multidimensionality or multifacetedness of factors that need to be taken into account and processed while exercising professional discretion in that short timeframe. Zhu and Aryadoust (2022) identify the following factors[50]:

- Linguistic factors
  - Turn duration
  - Directionality (L1 – L2, L2 – L1)

[50] The original table is available here: https://www.frontiersin.org/files/Articles/899718/fpsyg-13-899718-HTML/image_m/fpsyg-13-899718-t001.jpg

    - Lexical density, domain-specific terminology, acronyms, conversion of units of measurement
    - Syntaxis (simple vs compound sentences)
    - Semantics (culturally loaded expressions)
    - Pragmatics (intention, implication)
    - Sociolinguistics (dialect variety, register)
    - Textual organisation (genre, cohesion)
- Paralinguistic factors
    - Delivery speed
    - Accent
    - Body language
- Environmental factors
    - Hospital setting, different hospital departments, different medical specialties
    - Psychological pressure and stress due to hospital emergencies
    - Medical professional reputation and patients' wellbeing is in play
- Interpreter factors
    - Linguistic knowledge (foreign language discourse competence)
    - Cultural knowledge (political, economic, social, ethnic, literature, arts, etc.)
    - Interpreting modes and techniques
    - Interpreting strategies (understanding of the underlying process of interpreting is essential to apply the optimal solutions, skills to comprehend and produce language)
    - Personal traits (motivation, anxiety, stress resistance)
    - Meta-cognitive processes such as the ability to build up a mental representations and monitor speech production

Interpreting requires extremely high degree of metacognitive awareness Bravo, 2019, p. 148 as cited in Zhu and Aryadoust, 2022).

> This is due to the fact that the nature of the interpreting task, which demands the ability to quickly shift attention across many cognitive activities, needs a meta-level skill to perform quality control. Through applying proper cognitive processes and metacognitive strategies, interpreters interact with the task and environment factors, a process that influences interpreters' performance. (Zhu and Aryadoust, 2022)

According to Lan (2019), MI requires a great concentration on non-verbal communication, behaviour and information (Burgoon, Guerrero & Floyd, 2016 cited in Lan, 2019). All behaviour that is "consensually recognized", conventionalised, and regularised "among members of a given social community, culture or society", and displayed with an intent must be noticed and considered by the interpreter. The interpreter must know how to recognise non-verbal messages and

whether/how to interpreter these as intentional. "Communicational" non-verbal information according to Poyatos (1983, p. 138 cited in Lan 2019, p. 32) can be classified as follows:

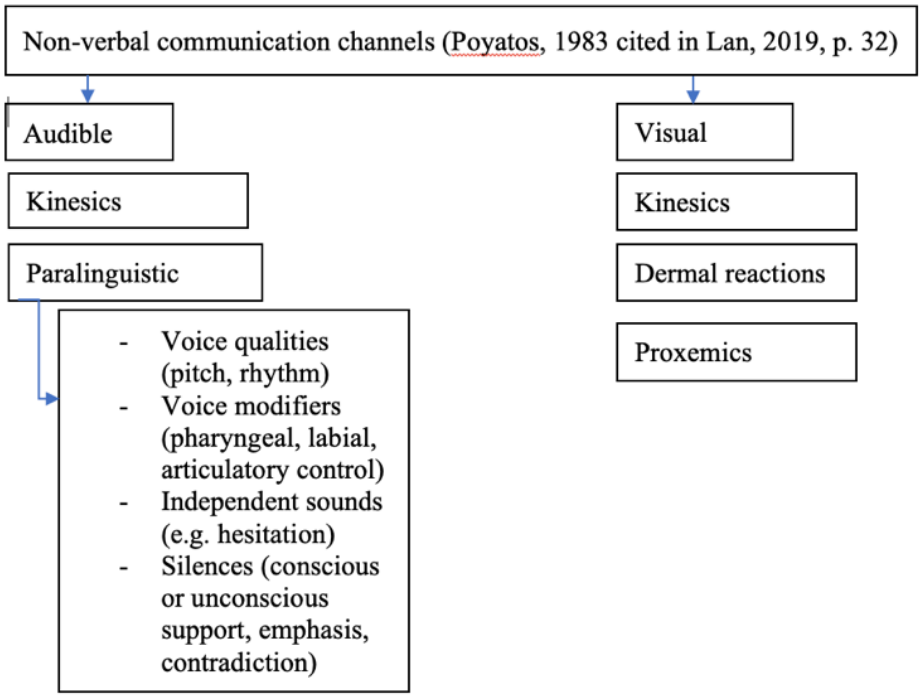


Figure 37. Non-verbal communication channels (Poyatos, 1983)

Burgoon et al. (2016, p. 25 cited in Lan, 2019) distinguishes a series human senses, a combination of which is believed to stimulate and carry certain signals or codes:

- Kinesics (direct/indirect gaze, positive/negative reinforcers such as smiling, nodding, facial expressions, posture such as postural openness, frequent/sporadic gesturing)
- Vocalics (rhythm, pitch variety, silences/latencies, sound pressure loud/quiet)
- Proxemics (close distance, forward leaning, body/facial orientation)
- Haptics (touch)
- Chronemics (monochronistic/polychronistic use of time, use and reaction to time pressures)
- Appearance
- Adornments
- Olfactics
- Artefacts

Figure 38. Interpretative human senses (Burgoon et al., 2016)

It is worth noting that MI must not only identify, recognise and correctly interpret all of the aforementioned non-verbal communicative, behavioural and informative mechanisms in a given interaction context, but also know how to use these non-verbal communication channels correctly. For that, Clifford (2005 cited in Lan, 2019, p. 35) suggests using "psychometric approach to validate the testing of an interpreter's *intelligibility*, *informativeness*" and style of "*delivery*". Carroll (1996, p. 109 cited in Lan, 2019, p. 35) argues that in order for it to be considered a successful

"delivery" MI must display a "pleasing voice quality", "good diction", "appropriate speed", avoiding "hesitations and excessive self-corrections".

Thus, an adept, talented or experienced layperson interpreter might try to control the "cognitive process" otherwise referred to as "the ability to build up a mental representation of the verbal message through comprehension, parsing the information, and integrating it with one's own pre-existing knowledge (Setton, 1999 as cited in Zhu and Aryadoust, 2022)". However, the metacognitive processes, or the "strategies for efficient management of processing resources", which consist of "planning, monitoring, and evaluating (Flavell, 1976)" are only performed by those people who have learnt how to do it (Flavell, 1976).

8. FORMAL KNOWLEDGE, EDUCATION AND QUALITY OF MI IN THE VC

8.1. THE IMPORTANCE OF FORMAL KNOWLEDGE FOR PROFESSIONAL DISCRETION

Flyvbjerg's observation on the fact that "the type of knowledge that produces quality in professional performance is difficult to grasp with traditional scientific methods" (1993, p. 65 Phelan et al., 2019, The interplay between practice, research and education in professionalisation section, § 3) will be the point of departure for this chapter.

However, in view of the Freidson's theory on classification of professional knowledge and in view of the widely held perceptions of knowledge underlying MI presented in the previous chapters, the aim of this chapter will be to calibrate:

- the complexity of knowledge underlying MI
- the need for formal university education to internalise such knowledge and gain the ability to implement it through the exercise of professional discretion
- the importance of successful professional discretion in guaranteeing quality of professional performance
- the salience of premium interpreting quality in guarantee high-end service
- the importance of providing only optimal MI service in the medical context

In order for MI to professionalise, we must learn how to convince relevant social actors of the fact that there is a difference between performing a task to the best of one's ability and performing a task proficiently, competently, and most importantly responsibly, especially when it comes to a task as complex as ensuring doctor-patient communication in a field where a minor error may lead to major implications for all parties involved.

> Professionalism is based on specialized bodies of knowledge and skill that have no coercive power of their own but only what may be delegated to them by the state or capital. They gain their protected status by a project of successful persuasion [...] They must persuade others that the discipline is of special value either to the public at large or to an important interest of the state or an influential elite. (Freidson, 2001, Chapter 9 The Soul of Professionalism, Trust and Ethics section, § 1)

"The length of training, the depth of special knowledge and [...] codes of behavoiur" (Horobin, 2016, The Meaning of Profession section, § 3-3) highlight the professionals' moral involvement with, commitment to, concern about and interest in the patient and instil trust in the profession. The quality of the work being carried out is what truly appeals to the client, the customer or the patient, it is what elicits the feeling of trust and the willingness to trust. These tree parameters play a pivotal role in achieving the immediate functional value, state recognition and social acknowledgement.

Also, medical interpreting has a unique feature to it: not only does it imply "concern" or "involvement with people rather than buildings [...] or accounts" (McCormick 1979, p.13 as cited in Horobin, 2016, The Meaning of Profession section, § 4) as, for instance, medicine, but it

entails dealing with both personal vulnerability experienced by the patients who are distressed and who might feel alone in a foreign country, and professional vulnerability experienced by the doctors, whose reputation is at stake and who are going to be held liable in case of negligence or malpractice, which might hypothetically be a result of deficient interpreting. Professions such as "priests, nurses, teachers, social workers and to some extent [...] lawyers" all share this concern and direct involvement with people, whereas "architects, actuaries, accountants and engineers" do not work directly with people (McCormick 1979, p.13 as cited in Horobin, 2016, The Meaning of Profession section, § 4). Medical interpreters constitute a key figure in doctor-patient interaction, hence the medical centre must ensure his/her/their eligibility to discursively being a part of diagnosis, treatment and convalescence process.

The current workplace reality demonstrates that the majority of "key external players" (García-Beyaert, 2015) practicing in the study relevant area are convinced that medical interpreting is based on mechanical specialisation. Mechanical is not used here in the sense of manual labour, but intellectually effortless, easy to carry out and reduced to mere relaying of words from one language to another. "Prevailing mechanistic view of language transferral [...] does not acknowledge the interactive role of the communicating subjects" (Rudvin, 2005, p. 171).

However, Rudvin (2005, p. 170) pinpoints that: "the act of translating cannot be mechanical because of the fluid nature of its vehicular mode". However, service providers are not "at pains to control and limit [the] source of power" possessed by layperson interpreters (Rudvin, 2005, p. 171), and prefer to rather "trust the interpreter's loyalty blindly". Amateur interpreters are not acquainted with the notion of task discretion and the "degree of permissible participation" (Rudvin, 2005) may sometimes be absolutely disquieting.

It is considered that MI is based on tacit, unverbalizable skills acquired through experience, which are not stipulated by any formal corpus of codified technique, cannot be taught or systematised. Medical interpreting is viewed as an activity grounded in everyday knowledge and performed unselfconsciously. The promotion of multilingualism may serve as a mechanism of exoterisation, oversimplification, demystification, proletarianizing and deskilling of the professional work of this occupation. Moreover, apparently it is not a luxury any more to expect the job applicants to be proficient in at least one foreign language It is "mainstreamed" into the modern labour market as some workaday, commonplace prerequisite, just an (extra) valuable asset, rather than highly sophisticated, conventionalised and fully established profession in the most orthodox sense of this word. The universalisation of the concept of language knowledge and interpreting skills is taken for granted in our modernised society as a side effect or *malignisation* of certain political initiatives on national and international level, globalisation as well as scepticism and indifference of the general public.

Therefore it is not uncommon to call unqualified interpreters who have been working in private clinics for a very long time "professionals" by virtue of experience. However, scientific data showcase that MI entails numerous abstract concepts which are organised, systematised and methodised by means of theories. These abstract theories, concepts and rules have been stipulated in codified texts and became prescriptive and conventionalised in order to be learnable in a classroom. These materials became disciplinarised and came to constitute the body of formal or vocational knowledge. This body of formal knowledge is the core of working knowledge, which

subdivides into diagnostic knowledge and prescriptive knowledge. The former entails extensive groundwork and conceptualisation as well as interiorisation of insights gained during university education and training and allows to troubleshoot successfully. The later implies employment of a repertoire of tested procedures and techniques (mastery of interpreting modes, note taking techniques, etc.).

However, the vast majority of employers and the co-workers of medical interpreters in the private healthcare facilities of the Valencian Community conceive of MI as an activity based exclusively on the practical knowledge, which is learnt situationally or on the job. Therefore, a short-term on the job training (basically shadowing senior members of the team), which the non-professional newcomers receive as part of their onboarding, is believed to be enough. The practitioners' knowledge and skill in the case of learning on the job is severely narrowed down and confined to the *quasi*-automatised performance of very specific tasks under very specific circumstances. The volume of knowledge and skill is boiled down to the most basic notions and zeroed in exclusively on those parts which allow the worker to do just enough to muddle through. These non-professional practitioners may acquire some practical skills such as the ability to work under pressure or the ability to work in team, but they will still lack the extensive body of knowledge accessible only through a thorough and long-lasting education and training, and therefore, they will not be able to exercise discretion properly. It is quite obvious that MI –like any other professional activity– is "fallible and characterised by a certain degree of indeterminacy [i]n fact, the indeterminacy is essential to the mere existence of professions" (Phelan et al., 2020, Professions and the exercise of discretion section, § 2), otherwise we would be talking about mechanical activities based on everyday knowledge which every normal adult can do.

> Without decision-making, in situations with a certain degree of indeterminacy – and the exercise of discretion, in the execution of tasks – there would hardly be any basis for a profession to lay claim to the legitimate control over certain work tasks. In the absence of indeterminacy, the tasks could be carried out more or less mechanically. It would then make no difference really who carried them out. (Grimen & Molander, 2008, p. 179, cited in Phelan et al., 2020, Professions and the exercise of discretion section, § 2)

Phelan et al. also emphasise that "real-life situations are each unique. Even though some situations may resemble each other in type, no two situations are identical" (2020, Professions and exercise of discretion section, § 2). Consequently, it must be taken into account that all of the guidelines, rules, standards of practice and norms of conduct displayed in the code of ethics are "general because if too detailed, they would become dysfunctional, according to Grimen [...] the norms of action cannot cover every detail or coincide fully with all aspects of the situation at hand." (Grimen, 2008, p. 144, cited in Phelan et al., 2020, Professions and exercise of discretion section, § 2). Galligan (1986, p. 8) contends that the vagueness and general character of the codes of ethics allow for "a sphere of autonomy within which one's decisions are in some degree a matter of personal judgment and assessment". Similarly, Dworkin (1978, p. 31 as cited in Phelan et al. 2020 same section and paragraph) describes "an area left open by a surrounding belt of restrictions". This is where the interpreter applies the acquired corpus of formal knowledge within general norms of action or "surrounding belt of restrictions". The structural dimension encompasses:

> The selection of a decision or action which is possible, permitted and thereby available to the decision maker. In an epistemological dimension, however, discretion refers to the reasoning the individual goes through in order to ground a decision or an action in a situation of indeterminacy. In this dimension, discretion was one of the intellectual virtues Hobbes identified in Leviathan, describing it as 'distinguishing and discerning and judging between thing and thing' (Hobbes, 1651/1962, p. 51). The legal philosopher Ronald Dworkin (1978), who used a doughnut hole to symbolize discretionary power as a small space of manoeuvre surrounded by a belt of restrictions, defined structural discretion as context-dependent and occurring 'when someone is in general charged with making decisions subject to standards set by a particular authority' (pp. 31–32). (Tiselius, 2018, p. 751)

Thus, there is clearly a gap between the university curricula and professional action, however, the exercise of professional discretion must always be demarcated in accordance with the codes of ethics and codes of professional conduct and based on a clear delimitation of tasks (Freidson, 2001; Halliday 1987), otherwise referred to as tasks discretion. Consequently, this knowledge and cognisance of what to expect will lead to trust in the profession and the professional, which ultimately may result in recognition of professional profile and eventually in a completion of the process of professionalisation.

Therefore the mistakes made by members of a profession should not be categorised as a wilful neglect or malpractice (Freidson, 2001), but rather unintendedly failed attempts to apply Aristotelian φρόνησῐς (*Phronēsis)* or "applied knowledge that is 'pragmatic, variable, context-dependent, and oriented toward action" (Kinsella & Pitman, 2012a, p. 2, cited in Phelan et al., 2019, The interplay between practice, research and education in professionalisation section, § 1).

However, in our case, the statement that "all professional activity is fallible and characterised by a certain degree of indeterminacy" (Kinsella & Pitman, 2012a, p. 2, cited in Phelan et al., 2019, The interplay between practice, research and education in professionalisation section, § 1) takes on a a new dimension, because if the interpreters who undertake the tasks of communication accommodation, happen to be layperson or non-professional, the degree of fallibility, indeterminacy and lack of control over one's work will escalate to dangerous levels. Moreover, in this case fallibility related to human factor should be reclassified into acquiescent, amenable and pliant professional dereliction of duty, failure to reject inappropriate assignments, and disregard for one's own limitations and lack of proper training. Thus, such fallibility may be qualified as negligence. Given that the tasks cannot be conducted mechanically and unselfconsciously, it is crucial that the interpreter is very well cognisant of the boundaries of the exercise of discretion in the execution of tasks and is in total control of what he/she does. Skaaden argues that in our profession there are two essential principles: that of accuracy in rendition and that of impartiality. The author is convinced that these two principles "in concert outline the specific profile of the interpreters' societal function" and thus, "form the base of the codes of ethics" (Skaaden, 2019, chapter 3.2.2 The interpreter's exercise of discretion).

8.2. THE CONCEPT OF *PHRONĒSIS* IN MI

Phronēsis is integrally related to the exercise of discretion (whereby the interpreter is contemplating, pondering and balancing all sorts of different options *in situ*), as it represents: "the professional's skills in making 'wise' decisions in actual situations" (Grimen 2008a, p. 78; Hibbert 2012,

p. 65; Skaaden, 2017 as cited in Phelan et al., 2019, The interplay between practice, research and education in professionalisation section, § 1).

> The knowing how involved in the mastery of professional skills also has to do with the building of confidence and the experience of making judgements in actual situations (Grimen 2008a: 72). Kinsella and Pitman (2012b: 169) who describe *Phronēsis* as 'wise action in context', state that the knowing how involved in the successful practice of the individual practitioner, moreover, relates to a collective *Phronēsis*. That is, 'the collective good that a professional community commits itself to through its practice as a profession' (ibid.: 9). (Phelan et al., 2020, The interplay between practice, research and education in professionalisation section, § 2)

The expertise grounded in formal knowledge (purely academic episteme) and working knowledge (techne or vocational competencies) are essential for the exercise of discretion, but so is the concept of *Phronēsis*, which denotes the process of application of the aforementioned types of knowledge and skill by means of wisdom, careful pondering and reasoning, circumspection and good judgement, always based on both moral and ethical commitment to achieve collective good through the praxis/practice of profession.

Professional knowledge underlying MI may be subsumed under the Aristotelian concepts of Episteme and Techne, but by no means can professional activity be confined to these intellectual virtues as Aristotle calls them in The Nicomachean Ethics (VI). Aristotle defines *epistêmê* as scientific knowledge distinguished by its eternal nature and existence due to a necessity. *Technê, on the other hand:*

> Is a disposition that produces something by way of true reasoning; it is concerned with the bringing into existence (*peri genesin*) of things that could either exist or not. [...] For instance, carpentry makes this house and medicine produces health in a particular case. (Stanford Encyclopedia of Philosophy, 2020, Episteme and Techne, section 3 on Aristotle)

Thus, MI materialises the previously inexistent possibility of producing health despite a language barrier. In Nicomachean Ethics (Stanford Encyclopedia of Philosophy, 2020) Aristotle believes that both *technê* and *praxis* "aim at some good". This is extremely important, because it is not about possessing the knowledge and the skill or technique, it is about knowing how to correctly employ it, and it is also about the commitment to achieve "some good" such as health as the end goal of medicine, and respectively flawless communication in the case of interpreting. In this case, medical interpreting may be regarded upon as an equalizer, whose benefit consists in facilitating equal access to healthcare for those who do not master Spanish.

> In the case of virtue, by contrast, the value is not in a separate product but in the activity itself. In the light of what Aristotle says about the activity of virtue, we can better understand practical wisdom. For it, doing well (eupraxia) is an end in itself. However, this end is quite expansive; it is doing well as a human being, living life well in general. (Stanfor Encyclopedia of Philosophy, 2020, Episteme and Techne, section 3 on Aristotle)

Thus, the value resides in interpreting itself, but only if this activity results in eupraxia (good performance). Eupraxia cannot exist without arete (=excellence) and arete cannot be achieved and accomplished without education whereby the learner acquires partial practical knowledge and skill, expertise, mastery, etc. grounded in the episteme (*=scientific knowledge).* "Scientific

knowledge concerns itself with the world of necessary truths [purely theoretical approach], which stands apart from the world of everyday contingencies [purely practical approach] [...]" (Stanfor Encyclopedia of Philosophy, 2020, Episteme and Techne, section 3 on Aristotle). So, "Clearly, if medicine is an *epistêmê* which studies health, it is also a *technê* which produces health" (Stanfor Encyclopedia of Philosophy, 2020, Episteme and Techne, section 3 on Aristotle). In order to highlight the importance of *paideia* (=education), Aristotle in his *Metaphysics* foregrounds the importance of distinction between a knowledge grounded in *episteme* and *technê* and knowledge and skill based off of experience (*empeiria*).

> Aristotle contrasts the person of experience (empeiria) with someone who has technê or epistêmê. [...] the person who has a technê goes beyond experience to a universal judgment. [...] As Aristotle says, the master craftsman (technitês) is wiser than the person of experience because he knows the cause, the reasons that things are to be done. [...] Presumably the reason that the one with technê can teach is that he knows the cause and reason for what is done in his technê. So we can conclude that the person with technê is like the person with epistêmê; both can make a universal judgment and both know the cause. [...] He [Aristotle] adds that it is the mark of an educated person to seek the amount of accuracy (takribes) that the nature of the subject matter permits (1094b20–25). (Stanford Encyclopedia of Philosophy, 2020, Episteme and Techne, section 3 on Aristotle)

Both *technê* and *epistêmê* will orientate the action or activity (=*praxis*) towards correct execution (=*arete of technê*.) (Stanford Encyclopedia of Philosophy, 2020, Episteme and Techne, section 3 on Aristotle). In the field of professions, *Phronēsis* cannot be accomplished without *arete of technê* (=excellent performance or execution) (Stanfor Encyclopedia of Philosophy, 2020, Episteme and Techne, section 3 on Aristotle). A layperson interpreter cannot be expected to make shrewd decisions and to exercise discretion correctly if they lack formal knowledge and skills. Skaaden in Phelan, Rudvin and Kermit (2019) have curated a very insightful depiction of the compartmentalisation of different determinants, which would allow us to understand how important the multiple-level exercise of discretion really is. The complex interplay of the following factors is believed to have a major impact on the quality of an interpreting event (Skaaden, 2019 in Phelan et al., 2019, Professional trust and virtue or quality in performance section, § 5-6).

Table 4. Professional knowledge and skill

Cognition	Convention	Context
The interpreter's skills and virtues along parameters such as:	The degree of coincidence or divergence in and between the two working languages' conventions, along parameters such as:	The complexity and grammar of the situational context in terms of:
Bilingual skills Interpreting skills, including mastery of interpreting mode Interactional skills Understanding of own function or role in the communication Understanding of context and situation Processing capacity Memory capacity Stamina and stress tolerance Fatigue Self-confidence	Grammatical and pragmatic device, e.g. deictic device, etc. Markedness Homonymy, including false friends (see Example 3.8) Loan words Register variants Stylistic variants including politeness expressions Metaphors, proverbs, etc.	Degree of formality, number of participants The participants' interactional skills – including awareness of the specific nature of interpreted interaction Expected mode(s) of interpreting; and accommodation thereof Participants' mode of speech; dialogue or lecture style; planned or spontaneous speech Speech quality, e.g. diction, speed, clarity Accommodation of the situation for interpreting External interference or noise

NOTE: Table extracted from Skaaden, 2019 as cited in Phelan et al., 2019 Professional trust and virtue or quality in performance section, § 5-6

Every single element mentioned in this diagram (extracted from Phelan et al., 2020) demonstrates that pure experience gained as an *in situ* medical interpreter would make it impossible for layperson interpreters to correctly exercise discretion.

I would like to contribute by scrutinising the aforementioned quality determinants from the perspective of Freidson's theory of professional knowledge and Aristotelian concepts related to professional knowledge, practice and ethics. The following list of elements comprising MI was designed to showcase all the study-relevant elements of professional knowledge needed for optimal service delivery as well as for guaranteeing the main medical dogma of *primum non nocere.*

1. Genetic and neurophysiological factors

Innate genetically driven factors (inborn brain architecture, brain cell structure, brain plasticity, contribution of genes, etc.) are responsible for

- Foreign language acquisition
  - Processing capacity
  - Memory capacity
    - Working memory
    - Declarative memory
    - Procedural memory
- Stamina and stress tolerance
- Fatigue resistance
- Self-confidence

2. Neurophysiological and genetic predisposition, scientific knowledge and education

In order for the learner to be able to learn and retain information about the conventions of their respective working languages, the following indicators signalling neurocognitive flexibility are required:

- Processing capacity
- Working memory in order to retain and easily and immediately retrieve verbal and lexical information, learn and memorise new lexical units and syntax
- Phonological short-term memory for non-native sound learning and correct articulation of utterances
- Rote memorisation ability
- Declarative and procedural memory
- Noticing ability
- Ability to cope with novelty and ambiguity when learning a foreign language
- Phonetic coding ability
- Grammatical sensitivity
- Bilingual functioning and executive control over linguistic fluency

Only the aforementioned determiners may guarantee quick learning, correct understanding and highly proficient application of:

- Grammatical and pragmatic device, e.g. deictic device, etc.
- Markedness
- Homonymy, including false friends
- Loan words
- Register variants
- Stylistic variants including politeness expressions
- Literal and figurative speech, figures of speech, thought and sound (Metaphors, metonymy, proverbs, personification, apostrophe, idioms, expressions, hyperboles, understatement, litotes, similes, parrhesia, irony, sarcasm, onomatopoeia, homoioteleuton, alliteration, assonance, anaphora, cataphora, epistrophe, asyndeton, polysyndeton, paradox, oxymoron, chiasmus, antithesis, euphemism, dysphemism, diacope, epizeuxis, epiplexis, rhetorical questions, etc.

3. Professional praxis based on education accomplished through the exercise of discretion

- Interpreting skills including mastery of interpreting modes is essential
- Understanding of own function or role in the communication (MI vs. intercultural mediation) is a sine qua non condition for professionalisation, trust in the profession and professional(s) and faithful adherence to the correspondent codes of ethics.

4. Scientific Knowledge and Excellent Practical Skills applied to practice through phronesis

The following are the situational determinant factors which underlie each interpreting instantiation and which require exercise of discretion based on praxis enacted through ethical righteousness and integrity of professional practice (in other words through the exercise of *Phronēsis*):

- Degree of formality, number of participants
- The participants' interactional skills – including awareness of the specific nature of interpreted interaction
- Expected mode(s) of interpreting; and accommodation thereof
- Participants' mode of speech; dialogue or lecture style; planned or spontaneous speech
- Speech quality, e.g. diction, speed, clarity
- Accommodation of the situation for interpreting
- External interference or noise
- Stress management

5. Professional Specialisation

Given that medical interpreting is carried out in a secondary (for the interpreter) institutional sphere (see Freidson, 2001), which is a medical facility (be it public or private), the interpreter must acquire theoretic competencies and expertise in order to successfully undertake his/her/their tasks. This specialisation implies specialised and highly formalised theoretic knowledge.

The interpreter must under no condition be expected to employ theoretic knowledge in order to carry out practical tasks, because these practical assignments correspond strictly to medical staff. Nevertheless, the interpreter must be fully acquainted and familiarised with medical concepts and medical terminology across a wide range of medical specialties: cardiology, hemodynamics and interventional cardiology, haematology and hemotherapy, internal medicine, general surgery, bariatric surgery, gastroenterology, medical oncology (radiotherapy and chemotherapy), oncological surgery, thoracic surgery, plastic surgery, aesthetic medicine, oral and maxillofacial, vascular and endovascular surgery, neurology, neurosurgery, traumatology, orthopaedic surgery, paediatrics, gynaecology and obstetrics, urology, dialysis, neurophysiology, (in)fertility, allergology, pathological anatomy, anaesthesiology, dermatology, electrophysiology, endocrinology, microbiology, laboratory, otolaryngology, nuclear medicine, nephrology, pneumology, preventive medicine, ophthalmology, nutrition and dietetics, phycology, psychiatry, interventional radiology, podiatry, radiology and diagnostic radiology, rehabilitation and physiotherapy, rheumatology, Emergency Room (ER), Intensive Care Unit (ICU), and palliative care *inter alia*.

This can also be construed as vocational knowledge, esoteric in character. Thus, not only does medical specialisation in interpreting imply utmost linguistic proficiency in working languages and extensive expertise in translation and interpreting, but also mastery of and confident navigation through:

- Medical concepts and their etymology
- Notions of Latin and ancient Greek
- Medical terminology used across medical fields
- Medical settings are also characterised by the *urgency of critical need of the patient*, so *stress* inherent to the nature of medical work, must not handicap the interpreters' operability, but enhance other social actors' perception of the interpreters' professionality. In other words, interpreters must learn to successfully manage stressful situations as an intrinsic part of work.

As maintained by Ruiz-Mezcua: "If the translator or interpreter want to performe [sic] a good job, he or she must [...] "become", in a certain way and in most occasions, the Science professional of these specific fields [...]" given that translation and interpreting "is a profession that constantly comes into contact with other disciplines that use it to [...] transmit all kinds of wisdom" or *sapientia* (2014, pp. 265, 267).

If I were to represent all the aforementioned segments or constituents of the specialised professional knowledge of medical interpreters in *grosso modo* I would opt for distilling this section into a diagram where I would adopt a more reader minded approach by including only the most relevant concepts heavily driving on Aristotle's ethics. The schema presented below[51] thus aims to accentuate some key concepts and notions which, once internalised, will allow for a much better understanding of the framework of knowledge underlying medical interpreting. If I were to resume the very essence of profession, I would say that it consists of pursuing excellence in work with diligence and expertise. In the following chapters of this thesis I shall try to elaborate more on each of these components of knowledge.

[51] The structure of this diagram was greatly inspired by the information conflated in the schema designed by Stig Ottosson in his work *Blended/Flipped Learning and Phronēsis Coaching in Higher Education* issued in 2013.

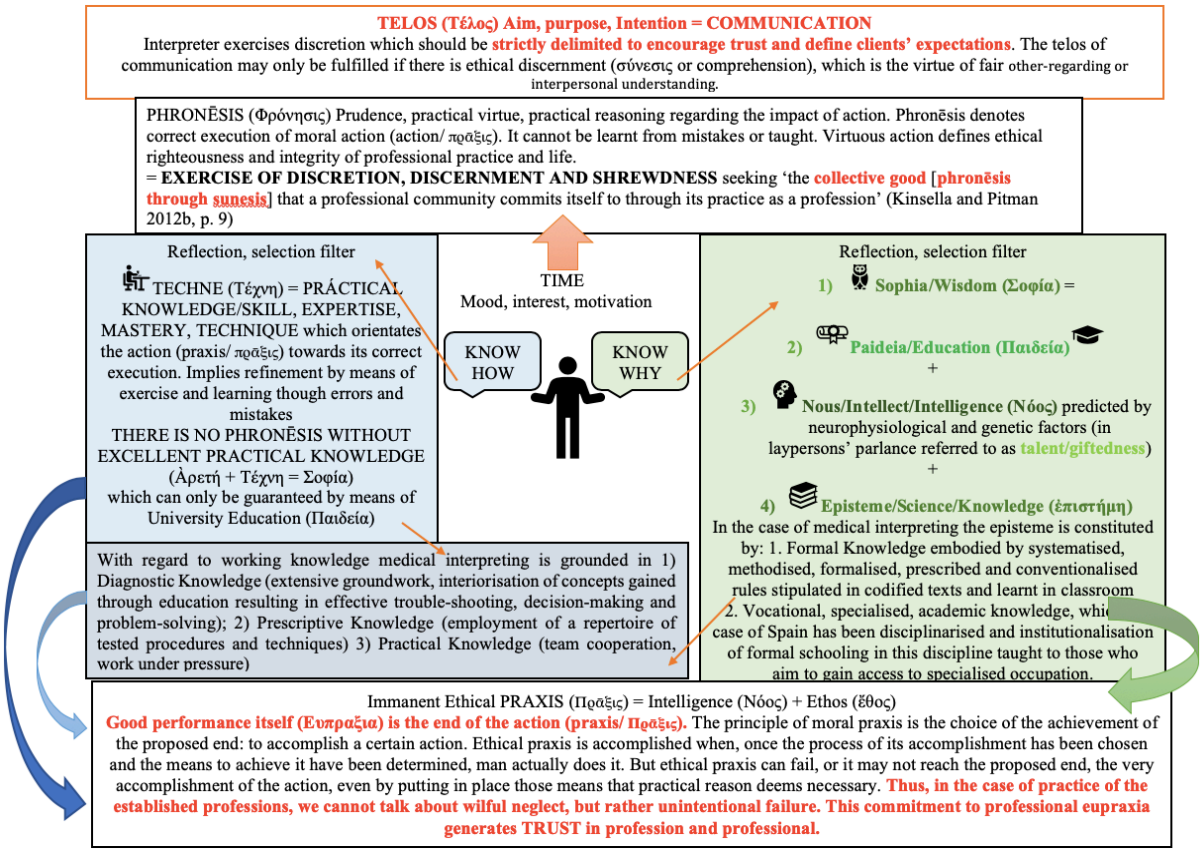


Figure 39. Schematic summary of the knowledge and skill underpinning medical interpreting

8.3. UNDERRECOGNITION OF THE COMPLEXITY OF KNOWLEDGE AND THE NEED FOR FORMAL EDUCATION OF MI

Having defined the typology of knowledge and measured its complexity, this section will seek to demonstrate that the sophistication of this knowledge is severely underrecognised. Skaaden states that: "as yet, few countries have acknowledged the need for interpreter education", but it is only through education that "interpreters, like practitioners of other professions, need to *acquire skills and understanding of the effects of their professional actions*" (2019, chapter 3.5, § 3; chapter 3.5.1, § 7 respectively).

> A first step towards comprehensiveness hinges on society's political will and its readiness to see that 'poor communication not only threatens minority speakers' legal safeguard, but also poses a threat to the professional integrity of the healthcare workers, police officers, or judges in charge of the institutional dialogue'. (Skaaden & Felberg, 2012, p. 8, cited in Skaaden, 2019, chapter 3.5.1, § 7)

According to Phelan et al. (2020, Organised Education for interpreters: an international spectrum of response section, § 1): "Entering the twenty-first century, few countries had reached 'a state of comprehensiveness'[52], that is, measures that include policy planning, organised education, accreditation tests and professionally organised interpreting services".

[52] It is worthwhile noting that Phelan et al. cross-reference Ozolins (2000) who issued an overview on how the quality of interpreting services is catered for across the globe, in which he differentiates four stages of international spectrum of response: 1. Neglect; 2. Ad hoc solutions; 3. Generic services; 4. State of comprehensiveness (Ozolins,

The authors ascribe a lack of stable educational options for some language combinations to a number of subjacent factors that influence such underrecognition. In their opinion the first factor is the failure of the educational institutions to encompass the myriad of languages spoken in some countries.

> In sum, the institutionalization of training in schools associated with universities creates the conditions for the relatively secure establishment, refinement, and expansion (in current jargon, the "manufacture" or "construction") of the specialized knowledge and skill of professions. Furthermore, it provides such training with the prestige of higher, rather than merely technical, education. (Freidson, 2001, Encouraging Occupational Solidarity section, § 1)

Another encumbrance is constituted by the "constant flux" of the languages required by the market. "establishing accreditation measures for the multitude of language pairs needed" (Phelan et al., 2020, Organised education for interpreters: an international spectrum of response section, § 4).

According to Freidson (2001, section 4 Training Programs, § 1-2), the official recognition of the complex body of formal knowledge and skill as the backbone underlying the work carried out by an occupation is an absolutely imperative for professional establishment. The salience of the abstract concepts, the theories and the solid expertise of discretionary judgement being the linchpin of the body of that formal knowledge and skill is indispensable.

The respect and dignification of an occupation, the perception of its outstandingness and worthiness either by "some influential elite" or by the populace may of course propel the members of this occupation towards appreciation and *informal* or *unofficial* recognition, which will undeniably spur the occupation to formalisation and statutory regulation, but the state still needs to be the main proponent of the sanctioned legitimacy of an occupation. The state must officially recognise the occupation as a profession as well as its jurisdictional boundaries and its functional value not only *de jure*, but also *de facto* by supporting and safeguarding this profession.

This means that the role, the responsibilities and the overall functioning and operationalisation (in the sense of being ready and in condition to undertake a destined function) of a profession must be stipulated by law, formalised, and most importantly controlled by appropriate law enforcement strategies of monitoring the compliance.

Legal and medical professionals' fail "to link interpreting quality to their own work" (Skaaden, 2019, chapter 3.2.4 The interpreter's double allegiance and status in the public service setting, § 1-2), which mirrors their unawareness of the social value of the interpreters' professional knowledge. Paradoxically, often physicians seem to disregard the fact that they "rely on interpreting to fulfil their own professional integrity" (Skaaden, 2019, chapter 3.5.1, § 6).

> Legal and medical professionals do not seem to associate interpreting with the quality of their own work or professional integrity, despite their need to communicate with clients and patients. Rather, in cases of language barriers, they ascribe the ownership of the problem of communication to the party speaking the minority language [...] Moreover, observations that medical professionals accept

2000, p. 22, cited in Phelan, 2020, Organised education for interpreters: an international spectrum of response section, § 1).

> working with untrained interpreters or even people who lack the most basic interpreting skills[53] indicate that professionals fail to see the impact of interpreting on the quality of their own work. (Skaaden, 2019, chapter 3.2.4 The interpreter's double allegiance and status in the public service setting, § 1, 3)

What is even worse is that apparently some "doctors are 'happy to make do' with this kind of communication" according to Meyer *et al.* (2003, p. 75 as cited in Skaaden, 2019). The famous case of the hospital cleaner acting *qua* interpreter described by Pöchhacker and Kadrić in 1999 is one of the examples thereof. The doctors involved in this famous case might not have been precisely "happy" about having to muddle through using a cleaner as an interpreter, but they did not seem to mind. Skaaden (2019) mentions another episode denoting reluctant attitude towards legal interpreting which took place at the Norwegian court during a hearing of a high-profile triple murder case – Orderud case. The only person who did not speak Norwegian was the expert witness – British forensic psychologist. In the absence of English interpreter, "the lawyers first tried to take care of the interpreting themselves", but once the prosecution and defence have failed to reach an agreement on proper translations, "the court then installed Natalia, a woman working in the court's cafeteria, in the interpreter function" (Skaaden, 2019, chapter 3.2.4, § 3-5).

> The ad hoc interpreter reveals to the journalist that she is not a native speaker of either Norwegian or English and has never worked as an interpreter before. Her immigrant background appears to be the qualification for her assignment to the interpreter function. (Skaaden, 2019, chapter 3.2.4, § 3-5)

By way of comparison, I shall insert an excerpt from an article published on the website of the National Academy of Medicine of the United States, whereby the reader can confirm that there is a higher level of cognisance of the complexity of interpreting as compared to Spain, for example. Thus, as maintained by Allen et al., 2020[54] in their article "Language, Interpretation, and Translation: A Clarification and Reference Checklist in Service of Health Literacy and Cultural Respect", bilingualism does not imply the ability to interpret:

> It is important to point out that—while all interpreters, by definition, are bilingual—not every bilingual person can interpret. Professional interpreters undertake substantial training in both languages and in moving between them. These days, many interpreters have master's degrees, reflecting the years of practice necessary to become proficient at rendering the product of one language into another in an efficient, accurate, and meaningful way. [...] Bilingual ability differs from person to person. Most bilingual individuals have differential levels of competence in their two languages, often more so if they have not formally studied both languages and learned how to translate and interpret in each of the two languages. This requires more skill than being conversationally fluent in two languages. (Allen et al., 2020)

However, only "when so recognised, an occupation is in a position to control its own work, [task organisation and distribution among workers, which is the division of labour] rather than

[53] For more information check Pöchhacker and Kadrić (1999) famous study *The Hospital Cleaner as Healthcare Interpreter*.

[54] Fort he full article, please visit https://nam.edu/language-interpretation-and-translation-a-clarification-and-reference-checklist-in-service-of-health-literacy-and-cultural-respect/

be controlled by consumers or managers" or employers (Freidson, 2001, section 4 Training Programs, § 1-2). Freidson cites Wilensky (1961) and Spilerman (1977) who call these types of careers "disorderly", "with the work classified as unskilled or semi-skilled" according to the society in general, for "Without jurisdictional protection or other sources of stability and definiteness, the content of jobs will vary to satisfy the differing demands of each employer or customer. Standardization is discouraged" (Freidson, 2001, Division of Labor Based on Free Competition section, § 2). Therefore, "Without any restriction on [...] protective laws or customs to prevent workers from offering to do any kind of work, work-roles, jobs, or occupation cannot have clear boundaries or jurisdictions", which implies that medical interpreting may be bound to de-professionalise:

> Much work is likely to be performed in jobs whose very existence may be fleeting, and whose tasks may change. Such jobs can develop no coherent identity, and those performing them are unlikely to be inclined or able to develop common occupational identity and consciousness. (Freidson, 2001, Division of Labor Based on Free Competition section, § 2)

8.4. THE FALLACY OF *AQUÍ TODO EL MUNDO HABLA INGLÉS* [EVERYBODY SPEAKS ENGLISH IN HERE]

The knowledge underlying MI is believed to be identical to the foreign language knowledge claimed by many Spanish citizens and residents. Regardless of whether it is public or private health care, it is very common to meet doctors or other health professionals who claim to speak English perfectly. This is a very common phenomenon in Spanish medical centres. This was also reported by Angelelli (2015, pp. 60-63). However, according to the Cambridge Monitor barometer published in 2017 by Cambridge University Press, 44% of Spanish population *admit* that their level of English is "low" or "very low" (Soler, 2017). Those who *think* their level of English is "high" or "very high" are only 22% of the citizens (Soler, 2017).

These figures mirror Spain as the country with the poorest grasp of English among the EU member-states which participated in the survey (Soler, 2017). Madrid and Catalonia are the communities whose grasp of the English language is less limited compared to the rest of Spain, as about three out of 10 inhabitants *claim* to have a "high" or "very high" levels (Soler, 2017). Spain, Italy and France have been reported to lag behind the rest of the Member States (Soler, 2017).

Julio Redondas, director of communication at Cambridge University Press, explains to the newspaper El Mundo that Spaniards feel embarrassed about speaking English [...] and it apparently constitutes a major problem for them, although it is not interrelated with the self-esteem of the citizens (Soler, 2017). According to Redondas, the problem is that "we know more English than we think but we don't trust our ability to speak or write it" (Soler, 2017). The weak points in our learning are in the ability to "express ourselves correctly and pronunciation" (Soler, 2017).

According to the Survey on Adult Population Participation in Learning Activities conducted by the National Statistics Institute every five years (INE, s. f.), English is the foreign language used by 40.3% of Spanish population, followed by French (14.0%), German (2.8%), Italian (2.6%) and Portuguese (1.7%) (INE, s. f.).

But given that this thesis inspects language proficiency in a very specific context, the general figure of allegedly 40,3% of general population within 18 to 64 years age frame being able to communicate in English or use it as a foreign language of preference does not say much (INE, s. f.).

As I have already clarified, medical interpreting does not constitute the main concern of the native populace, but medical staff in private clinics should be interested in being able to communicate with their cross-border patients who have travelled thousands of kilometres seeking medical treatment abroad. Therefore I decided to investigate how many citizens who received higher education use English to liaise. My aim is to get an approximation in figures regarding the number of doctors and nurses who claim to speak English.

So, the grid results published by INE (2016) clearly showcase that English is being used as a foreign language of preference by 64,3% of those persons who have successfully completed a university undergraduate degree constituted by 240 ECTS credits (2.967,807 graduates in total) and by 73,5% of those who have successfully completed university undergraduate degree whose ECTS credits amount to over 240, postgraduate degrees such as a Master's degree or a PhD degree (4.462,915 graduates in total).

According to the latest National Health System report published by the Ministry of Health, Consumer Affairs and Social Welfare in 2017, a total of 178,600 doctors practice in Spain in both the public and private sectors (Nova, 2019a). These figures are similar to the report issued in 2015 (Nova, 2019a). With regard to nursing, 245,533 nurses were reported to work in Spain in 2017 (Nova, 2019b). So, these figures basically indicate that 144,839 out of 178,600 doctors and 157,877 out of 245,533 nurses practicing in public and private sectors might potentially fall within the 64,3% of those categorised in the grid as university graduates, and therefore speak English.

Ortega-Herráez and Blasco-Mayor (2018) X-rayed the current situation of language provision in the public services within the geographical area of the Valencian Community. The authors pinpoint that the rights laid down in the national laws (Ley Orgánica 3/1986 and Ley 41/2002) which are meant to safeguard the interests of the citizens in terms of medical care cannot be materialised in the case of foreigners in spite of their entitlement to exercise these rights. Thus, according to Ortega-Herráez and Blasco-Mayor (2018, p. 186) it can be considered as incompliance with the law because even though the rights are recognized *de iure* they are not acknowledged *de facto*.

They reveal that "the quality manager of a reference hospital in the city of Valencia ensures that "*aquí todos hablan inglés*" [everybody speaks English in here]. This sweeping "generalisation whose veracity is at the very least doubtful" (Ortega-Herráez & Blasco-Mayor, 2018) implies double jeopardy.

Firstly, it establishes English as *lingua franca* or, in other words a one-size-fits-all universal solution for all types of communication problems. This implies that all of the patients that they see in that hospital master English language to an extent that would allow them to express themselves in this language utilizing medical terminology.

Secondly, the official narrative of the healthcare officials purports to persuade those concerned that all the hospital staff has advanced linguistic competence in English, which enables them to

communicate safely with English-speaking patients without imperilling the accuracy of the diagnosis and the evolution of the state of the patient. In ensuring that all practitioners speak English the hospital administration renders communicative problems involving foreign patients inexistent (Ortega-Herráez & Blasco-Mayor, 2018, p. 188).

Nevertheless, although this statement is extremely widespread in healthcare settings, it poses a threat because no evidence was found to substantiate its veracity (Ortega-Herráez & Blasco-Mayor, 2018, p. 188). In addition, according to the interventionist radiologist from the Reina Sofía Hospital in Córdoba, Ramón Ribes, 90% of the medical professionals in Spain do not even know how to correctly spell their 'e-mail' address in English, and only 5% thereof dare to give conferences abroad ("El 90% de los médicos españoles no sabe ni dar su 'e-mail' en inglés, según un experto", 2009).

Thus, the statement of "everybody speaks English here" rests on uncertain and speculative foundation in the absence of effective mechanisms of supervision and control. The official documents do not specify what verification criteria, if any, were used to undergird the claims of the participants. Apparently, nobody puts in question the veracity of such claim. Claiming to know a language does not imply Being proficient in the language, but rather having acquired certain notions of that language. The entrenched idea of bilingualism as a synonym of linguistic proficiency is going to be very difficult to root out.

This is the very case where there is dearth of support on behalf of the general population. The perception is fragmented into different opinions and shaped by "scepticism or indifference" (Freidson, 2001, section 7, subsection The Contingencies of Knowledge, § 1-3). The "official position of disciplines purporting to serve those concerns [language provision] may become an empty shell and crumble over time, their position ultimately usurped by another more popular discipline or by schismatic movements which fragment if not dissolve the original" (Freidson, 2001, section 7, subsection The Contingencies of Knowledge, § 1-3).

8.5. ADMINISTRATIVE AUTHORITY AND COGNITIVE AUTHORITY IN MI IN THE CV

A monopoly over certain types of highly specialised undertakings implies the entitlement and eligibility of the occupational group to assess and supervise its own work. Thus, occupational control is inevitable corollary of the inception of a labour market shelter endorsed and promoted by the state. Occupational control implies internal (inner) stratification, whereby selected members become "administrative authority" (Freidson, 2001, The Bureaucratic Division of Labour section, § 4; Distinguisching Labour Markets section, § 3; Chapter 4 Training Programes, § 3) superintending the process and the product. Thus the role of "supervisors" and "managers" occupies a higher position and status in the occupational hierarchy (Freidson, 2001, Chapter 4 Training Programes, § 3)

Given that medical interpreting certainly was not granted and/or guaranteed a monopoly in its sector, medical interpreters are not usually those who assume occupational control of their own work. MIs are not entitled to exercise occupational control over the competences of the newcomers or over the quality of the product that is being delivered.

The supervisors in many private medical centres do not belong to the translation and interpreting niche, have neither specialised body of formal knowledge an interpreter/translator should have, nor skill, nor willingness to understand how the process of interpreting actually works. It is normally the head of department of public relations and marketing or a doctor who selects and supervises MIs.

This implies that the administrative authorities do not understand what criteria to use in order to select the most suitable candidates. They confuse the alleged ability to speak a language with the ability to interpret. They are not qualified to control the quality of the work being delivered. The underqualified amateurs with unreliable discretionary judgement do not exercise task discretion, which is convenient in that the task discretion exercised by professional graduates may not be viewed as beneficial for the businesses. Professional MIs who decide to exercise task discretion are accused of bad attitude, inflexibility and unwillingness to adapt their service to the current market needs. As a result, professional MIs are marginalised and might even find themselves in risk of losing their job.

Thus, the internal three-tiered stratification in the case of translation and interpreting, which encompasses internal division among practitioners, administrative authority constituted by managers supervising and profession, and cognitive authority constituted by educational institutions which maintain control over training (Freidson, 2001, Training Programs introduction section, § 3-5), is malformed in the case of medical interpreting in private healthcare centres in the Valencian Community. The (state-approved) de-regularisation of private sphere as far as medical interpreting services are concerned aggravates the situation because the "cognitive authority", which is essential for regulating the training (Freidson, 2001), plays practically no decisive role in maintaining control over training by justifying jurisdictional boundaries over the claimed occupation expertise, or in delimiting interoperability and interrelatedness with other occupations. The specialised faculties are "authoritative sources" which are meant to establish (and in the cases of traditional professions they actually do establish) "legitimacy of the practical work" (Freidson, 2001). University education spawns a climate of "community" and "solidarity" (Freidson, 2001, Encouraging Occupational Solidarity section, § 2), thus constructing the identity shared by the members of an profession. Common intellectual, social and economic interests constitute an underpinning of this identity, which Collins calls "consciousness community [...] formed on the basis of common and distinctive experiences, interests, and resources" (1979, pp. 58, 134 in Freidson, 2001, Monopoly, Social Closure and Disciplinary Community section, § 1-2). Moreover:

> This seems to be especially true of those who go through a longer than average period of vocational training or schooling, who do relatively complex discretionary work in which they take great interest, and who see their work as a long-term career. If only because of their sunk costs in that extensive training, they become committed to their body of knowledge and skill, and wish to advance it and protect its integrity. They do so by forming social closures without which their knowledge and skill cannot become formalized. Their work is institutionalized by the drawing of jurisdictional boundaries so that it can be maintained and cultivated as a coherent, or at least recognizable, discipline. (Freidson, 2001, Monopoly, Social Closure and Disciplinary Community section, § 1)

Even though the cognitive authority regulating interpreting in Spain has succeeded in formalising the body of professional knowledge underpinning interpreting, it has failed to establish the training/education credentials as a prerequisite to perform a (thereby) delimited and defined set of tasks by providing a scientific rationale and justification for task ownership. Thus, the members of the MI occupation have the expertise, but they cannot claim ownership over it. The cognitive authority has delimited the practitioners' competences to carry out certain types of work, but it has failed to justify the interoccupational jurisdictional boundaries of this occupation.

8.6. UNIVERSITY TRAINING VS CRAFT-LIKE TRAINING

Currently there is a bifurcation between the concepts of 1) academic training which is being duly provided by the higher education institutions, and 2) the craft type of training, which in the case of some private healthcare centres in the Valencian Community consists in shadowing the senior staff members *acompañamiento de las [traductoras/interpreters] seniors*.

In distinguishing between profession and amateurship, Horobin (2016, The Meaning of Profession section, § 14) pinpoints that one of the main differences rests on the type of training (or lack thereof) undergone by the applicant, thus, amateurship relies on "naturally endowed [training] of lowly client-dependent status", whereas the professional training or "acquired skills" allows for "honorific independence" bestowed upon professionals:

> My contention is, then, that 'profession' in the bourgeois sense of a special kind of occupation also carries ambiguous connotations of 'professional' as non-amateur, as describing services performed for gain rather than satisfaction or obligation, of skills acquired rather than naturally endowed and of lowly, client-dependent status as against the honorific independence of the gentleman. (Horobin, 2016, The Meaning of Profession section, § 14)

I think that the following excerpt is worth reproducing as it depicts and expounds the struggle that medical interpreting is locked in:

> How does the ideology of professionalism, which is generically rooted in specialization, contend with the challenge of populist generalism advanced by consumerism, and elite generalism advanced by managerialism? The components of the ideology of professionalism that can successfully do so stem from the kind of education at the foundation of expertise. Against populist generalism it counterposes knowledge and skill based on cultural or scientific concepts that it claims are, at best, only touched on in general public education, and that are too esoteric and complex to be understood spontaneously or to be learned quickly by the average person. Against elite generalism it asserts that its knowledge and skill are too complex and esoteric to be managed by those who have only general knowledge and skills, however advanced. But equal in importance to the complexity of its specialized knowledge is its claim *to general knowledge*. The ideology of professionalism claims that its qualifications go beyond specialization. Unlike a purely technical education, ideal-typical professional training provides or requires prior exposure to high culture in the form of advanced general education. The ideology of professionalism asserts knowledge that is not merely the narrow depth of a technician, or the shallow breadth of a generalist, but rather a wedding of the two in a unique marriage. This wedding of liberal education to specialized training qualifies professionals to be more than mere technicians. (Freidson, 2001, Beyond Specialization and Service section, § 1-2)

Thus, interpreting is mistakenly associated with language learning and ability to speak in tongues. And language learning is viewed as an activity that lacks scientific concepts and therefore

can be and in fact is taught in general public education establishments, such as schools for example. It is believed to be exoteric, effortless, spontaneously understood and instantly learned by any average person. In conclusion, it has been popularised and proletarianized to an extent where it became generally accessible. Moreover, as my research and experience manifest, the administrative authority in charge of supervising medical interpreters was never constituted by medical interpreters, but by people belonging to other professions (doctors, public relations managers, etc.), which is an indicator of elite generalism. Interpreting is not viewed as overly complex and inaccessible and therefore any manager with only general knowledge is considered to be capable of, competent, eligible to supervise the quality delivered by the in-house interpreters. On the other hand, medical interpreting must not be regarded upon as narrowed-down craft-type technical specialisation, because in order to exercise discretion optimally[55] by application of epistemic, praxeological and deontological constituents of a shared professional identity to situationally and contextually unique interdisciplinary professional activities "high culture" and "advanced general education" are required.

To conclude, I would like to counter the ambiguity I have encountered within the set of criteria regarding interpreter qualifications displayed in the ISO 13611 (2014) and ISO 21998 (2020). Both of these international standards delimit the competences and qualifications required to provide community and healthcare interpreting services. Paragraph "e" of the section Evidence of qualifications in ISO 13611 calls into question the necessity of obtaining specialized undergraduate (BA) degree or postgraduate (MA, Ph.D.) degree. The authors of this international standard highlight the futility of formal university education by stating that 5 years of uninterrupted experience would suffice for a person to be considered a qualified interpreter (ISO 13611, 2014, pp. 8-9). In the section on *Healthcare interpreting qualifications* (ISO 21998, 2020, p. 8), four options are being presented as valid: a) an "official certification in healthcare interpreting"; b) "a recognized degree in healthcare interpreting from an institution of post-secondary education"; c) "a recognized degree in interpreting, linguistics, or language studies, which includes at least one year of healthcare interpreting training from an institution of post-secondary education"; d) "a recognized degree in any other field from an institution of post-secondary education, obtained at any time, and two years of continuous experience in healthcare interpreting, in the last ten years, in cases where a) to c) cannot be met (e.g. in a country where healthcare interpreting is just emerging). In the case where only a diploma from an institution of post-secondary education and experience are provided, interpreting service providers and healthcare organisations are recommended to document third-party testing to ensure healthcare interpreting competences, in order to decrease liability and to protect patients from risk" (ISO 21998, 2020, p. 8). In the section on *Linguistic assistance* the authors of the International Standard 21998 go on to say that "the assistance of a bilingual individual may be considered as a last resort" (2020, p. 8).

In my personal opinion the statements that diminish the gravitas of formal education lead towards de-professionalisation. An aspirant cannot become a doctor unless they successfully complete their formal education. An aspirant cannot become a lawyer by the virtue of 2 years of continuous experience.

[55] Please check the concept of phronēsis depicted in previous chapters.

"The characteristic method of selection for professionalism is the training credential. Its possession earns both inclusion in the ranks of the elect and exclusive right to practices or jobs requiring a defined set of skills" (ISO 21998, 2020). For the time being, credentialism based on "educational testing" (ISO 21998, 2020). plays no discriminatory role in employment. Thus, "educational testing", in other words the credential confirming the completion of appropriate training or acquisition of university education has no value in the case of medical interpreting in the study-relevant area.

An alternative is the heuristic approach, also known as "trial and error approach" or "employment of anyone who offers to perform a particular set of tasks" (ISO 21998, 2020, § 2). Even though in theory it might be risky (especially in the field of medicine) and expensive in the case of lawsuits nobody seems to care. The common criteria for employment which replace credentialism based on training and education are kinship, ethnicity (when self-proclaimed bilinguals are preferred over T&I graduates), personal recommendations, highly doctored and undocumented résumés or attractive advertising, etc. (ISO 21998, 2020, § 2). These alternative criteria constitute an "unfair basis for exclusion from" the job and lead to exploitation (ISO 21998, 2020, § 2). Thus, I shall repeat it again: the employment via university-education-based credentialism has not been put in place, because no licencing mechanisms have been established to regulate it. The lack of licensing mechanisms is due to absence of legal basis in terms of laws regulating medical interpreting. I contend that medical interpreting is not being referred to in the current Spanish legislation because apparently it does not fulfil societal function important enough to be mentioned in legislative instruments. Thus, the problem of language barrier in Spanish medical sphere is being either overlooked or denied.

9. HYBRID PROFILES IN PUBLIC SECTOR

For the purpose of this and the following chapters, the concept of a "hybrid profile" must be clearly defined and differentiated from other similar notions. Thus, we must distinguish *interprofessional role hybridisation* from *intraprofessional role distortion/extension*. The former is far more likely to occur in the case of occupations at embryonic stage of development, whereas the latter can be observed in the case of occupations at more advanced stages of professionalisation, but whose members' professional autonomy still failed to be acknowledged.

Subsequently, MIs practicing in Australia and New Zealand –countries, where MI has reached advanced levels of professionalisation–, have been reported to experience difficulties in terms of adhering to the correspondent codes of conduct and ethics (Crezee & Julich, 2020). Reportedly, the healthcare professionals, –who abide by the existing "institutional ethics" (Freidson, 2001)–, will not let MIs exercise their professional authority and autonomy by explaining their contracted role during the "introduction" (Tebble, 2014, p. 422 cited in Crezee & Julich, 2020). "Moreover, some interpreting services also ask interpreters to telephone patients to double-check that they have transport to health appointments, or that they have collected their prescribed medication and know how many tablets to take and when [...] clarify technical language [...] summarise information and show empathy towards the [...] client [...] provide the consumer with emotional support" (Crezee & Julich, 2020, pp. 217, 224, 230, 232). However, all of these tasks can be classified as an minor extension or a slight distortion of the MI's role, not leading to a serious misconstrual of MIs' role boundaries:

> [A]n overwhelming majority of health professionals disagreed that interpreters should explain healthcare procedures on behalf of health professionals while they attended to other tasks, since this is indeed their own responsibility and not that of the interpreter (Crezee & Julich, 2020, p. 229).

The situation in Spain, however, differs drastically. Given that MI is not a recognised profession no "guidelines for practice" (Crezee & Julich, 2020), tasks or responsibilities are normally included in the Mi's contract. In fact, in Spain the official designation of MIs in the labour contract is "administrative assistant", "translator" or "public relations". And the fact that MIs are on-staff employees of private companies (each having its own institutional ethics), exacerbates their helplessness caused by the lack of professional autonomy. Therefore, an intraoccupational role extension becomes an intraprofessional role hybridization.

Generally speaking I have identified four hybrid profiles that are currently burgeoning in this particular socio-historical context. Two operate in the public medical settings and two in the private medical settings. These profiles include: 1) IMs in the public healthcare sector; 2) medical professionals doubling up as interpreters in the public healthcare sector; 3) medical professionals doubling up as interpreters in the private healthcare sector; 4) international patient assistants operating in the private healthcare sector. The public medical settings in the study-relevant area are more likely to provide services to:

1. EU citizens who undergo non urgent medical procedures for free in public facilities (fraudulent health tourism)

2. Those who develop a condition or suffer an accident when already abroad (requiring unscheduled emergency medical assistance)
    a) Undocumented, non-regularised immigrants (not subject to tax liability)
    b) Foreigners with a valid residence permit granted under the general foreigners' regime and Ley 14/2013 on support for entrepreneurs and their internationalization
        - Migrant workers (also referred to as economic migrants)
        - International residents on a regular basis (also referred to as social migrants)
    c) Tourists (both EU and non EU)

The language profile would range from the languages of Europe (mainly Romance, Germanic, Slavic) to more exotic languages and cultures (Asian, African and Arabic). It is difficult to find graduate interpreters offering the required exotic language combinations. Due to poor educational level, hardly any patients of this population segment master English. Very few medical professionals can understand and communicate properly in non-European languages. Unlike in the case of the EU Directive on the mutual recognition of Professional Qualifications issued in 2005 (The European Parliament and the Council of the European Union, 2005), which deems that all EU medical professionals "meet the same professional standards" (Footman et al. 2014, p. 29), in the case of non-Member States no mutual recognition of qualifications for medical professionals has been achieved yet, which rules out the possibility of cross-border professional mobility or migration of professionals, and thereby, precludes the recruitment of bilingual or multilingual medical professionals from overseas.

9.1. INTERCULTURAL MEDIATION: DEFINITION OF THE CONCEPT

This section will be dedicated to the complex situation of intercultural mediation. Even though no language provision services are being currently provided in Spanish public healthcare, one may venture the opinion that intercultural mediation (henceforce IM) is starting to very slowly colonise Spanish public healthcare. IM is an orchestrated and strategized attempt to conveniently mainstream a new hybrid profile even though it causes distortion in the rational/natural division of labour. A series of professionalisation mechanisms are being deployed to promote and popularise IM to the detriment of unsuspecting service receivers.

So, as soon as the scholarly locus was shifted to the community interpreting or public service interpreting in 1990s, the figure of "interpreter as mediator" introduced in 1980s by Knapp-Potthoff & Knapp (Baraldi & Gavioli, 2015, p. 247) re-emerged occupying the foreground of dialogue interpreting arena and stealing its limelight. As maintained by Pöchhacker, T&I assignments in public services have been taken over "by mediators employed by various migrant-oriented NGOs because the established translator and interpreter training institutions have not met the increased need for IMs in recent years" (Pöchhacker, 2008, pp. 20-21 as cited in Pokorn and Mikolič Južnič, 2020, p. 89). According to Pokorn and Mikolič Južnič (2020, p. 100) one of the reasons that has triggered the employment of outsiders is the failure of the established European institutions that train interpreters to "respond to the pressing need for interpreters in languages

that were not traditionally taught" (Pokorn & Južnič, 2020). The potential candidates did not qualify for enrolment for national higher education institutions because they lacked the required level of education, which constituted the main prerequisite matriculation (Balogh et al. 2016, cited in Pokorn & Južnič, 2020). In the absence of professional MIs who could meet the ever increasing demand, employers ended up resorting to practically "anyone who could potentially help bridge the language barriers" (Pokorn & Južnič, 2020). Some authors view IMs as a response or "reaction" to the increasing number of refugees whose languages were not taught at the majority of European T&I faculties or training programmes (Pokorn & Južnič, 2020). The situation has not changed since and in 2019 the problem of untrained IMs still pervades. In 2019, the World Health Organization verbalised concern regarding the lack of proper education for IMs:

> Intercultural mediators are often required to undertake these tasks after limited training and in the absence of professional standards and ethical codes. IMs working in the WHO European Region were often found to lack sufficient training and formal certification because most Member States lack an accreditation process. The review did not identify evidence on the effect of IM on the health status of refugee and migrant patients. IMs' insufficient training, dominance in a three-way dialogue, and overemphasis on cultural differences of patients to reinforce their role as experts on the patients' culture were identified as critical issues, which can result in disempowering patients and reinforcing the power imbalance and cultural stereotypes in the therapeutic relationship. (World Health Organization Regional Office for Europe & Health Evidence Network, 2019, pp. iv-v)

Therefore, Pokorn and Mikolič Južnič "insist on the use of trained interpreting professionals" in every triadic communicative event requiring interpreting and on the need to educate the stakeholders and the general public about the nature of professional MI and about the indispensability of "professional interpreting service provision, particularly in high-risk, multilingual communicative events, such as in asylum procedures, hospitals, courts, or when dealing with the police or social services, i.e., in situations where unskilled help might result in negative life-changing or life-threatening events" (Pokorn and Mikolič Južnič, 2020, p. 102).

Nevertheless, it is worth noting that the two profiles, that of a MI and that of IM, overlap to an important extent. This partial overlap can be explained by appropriation of linguistic, cultural and cognitive dimensions of mediation in interpreting (subsumed under interpreting) by converting them into interpretation aspects subsumed under mediation. Pokorn and Mikolič Južnič argue that such overlap between the two profiles which leads to "distorted definitions of the interpreter's competences and performance, conceptual confusion in the research literature, and mismatched expectations of language services consumers" (2020, p. 80). Baraldi and Gavioli (in Pöchhacker, 2015, p. 248) Pöchhacker (2008a) pinpoint the three-dimensional nature of the notion of "mediation in interpreting".

1. The linguistic and cultural dimension accentuates the integrity and inextricability of the linguistic and the cultural building blocks of interpreting.
    - Due to its bidirectionality in rendering the message during triadic bilingual (or multilingual) interaction healthcare interpreting is construed as "a form of mediation" (Baraldi and Gavioli in Pöchhacker, 2015, p. 248). "Expansions" or "linguistic adaptations" may be needed to "reformulate primary participants' [utterances]" (Baraldi, 2012; Van De Mieroop et al. 2012 in Baraldi and Gavioli in Pöchhacker, 2015, p.

248). Interestingly enough, interpreting cannot be subsumed under IM in that mediation involves intervention. Interpreting was never construed as mediation until someone willingly or not introduced it into the equation. It was a very fashionable term used both in Translation and Interpreting Studies in the nineties. Researchers and academics used it without any limits when referring to T&I activity. Suddenly everything was mediation and interpreters were all mediators. It's a misnomer and it has contributed to a lot of fuzziness and confusion in our field. It has, in fact, not succeeded as a paradigm in Translation or Interpreting Studies, and is now hardly ever seen in academic papers.

- The interpreter needs to "establish reciprocity" according to Davidson (2002, as cited in Baraldi & Gavioli, in Pöchhacker, 2015, p. 248). "Interpreter needs to act on the communication process as such, re-establishing relevance" or, in other words, "accomplish reflexive coordination" (Baraldi & Gavioli, 2012b, in Pöchhacker, 2015).
- "By displaying sensitivity to participants' narratives, interpreters contribute to the social construction of narrative events and the reconstruction of participants' perspectives" (Baraldi and Gavioli in Pöchhacker, 2015, p. 248). This third and last point is about conveying the participants' lifeworld in a way in which they construct their reality, taking into account the stances they take, events they portray, etc. In other words the rendition into target language must mirror the participants' perspectives.

2. The cognitive dimension implies working through utterances that "are not translatable without considering the contextual assumption they entail" (Baraldi and Gavioli in Pöchhacker, 2015, p. 248). The cultural aspect of mediation has been construed as a mechanism of bringing forward the importance of "intercultural bridging of values and beliefs, enhancing positive transformation of differences between cultural and speech communities" (Cronin, 2006 in Baraldi and Gavioli in Pöchhacker, 2015, p. 248). IM is believed to be achieved through language adaptation to participant's knowledge and cultural values. In doctor-patient communication, for instance, interpreters may adapt Western medical language to the cultural conditions of participation of Latin American patients (Angelelli 2004a, 2012 in Baraldi and Gavioli in Pöchhacker, 2015, p. 248) or Zulu patients (Penn & Watermeyer, 2012 in Baraldi and Gavioli in Pöchhacker, 2015, p. 248). Interestingly enough, the authors do not provide any examples or explanations of how this can be done in practice and how to standardise and formalise the knowledge that would allow somebody to do it.
3. According to Baraldi and Gavioli, the contractual dimension "involves facilitation of communication as management of conflict and power imbalance" (Baraldi and Gavioli in Pöchhacker, 2015, p. 248). However, it is not clear how IMs would do it and how one can rest assured that this power will not be used to their detriment and at their expense.

Summarising, I believe that Franz Pöchhacker ideally envisions (inter)cultural mediation in interpreting as a complex cross-cultural and cross-linguistic management of bidirectional and bilingual interaction, where the mediator convenes dialogue-like, context-sensitive, recipient-

oriented and culture-centred communicative acts, thus, enhancing reciprocity and active participation of parties. Nevertheless, as Baraldi has pointed out, a number of renowned scholars, including Pöchhacker (2008, cited in Baraldi, 2019), call into question the nature of "competence" of IMs and its "effectiveness" (Hale, 2007, cited in Baraldi, 2019). In his article "Interpreting as mediation", Pöchhacker (2008) maintains that "terminological indeterminacy" obstructs the professionalisation processes of community interpreters: "Every interpreter is a mediator (between languages and cultures), but not every mediator is an interpreter" (Pöchhacker, 2008, p. 14 as cited in Pokorn and Mikolič Južnič 2020, p. 89). The main discrepancy lies in the ways both figures exercise their agency. According to Angelelli (2012, cited in Baraldi, 2019) interpreters' agency may have positive and negative implication:

> [Interpreters] may (1) become co-participants and co-constructors of meanings; (2) set communication rules and control the information flow; (3) paraphrase or explain terms or concepts; (4) slide the message up and down the register scale; (5) filter information; (6) align with one of the parties; (7) replace one of the parties. (Angelelli, 2012, cited in Baraldi, 2019)

Other studies rather showcase a strong gravitation towards a more culture-centred approach of interpreting, whereby those who assumed the role of interpreter display behaviours such as a) advocating for the migrant patients (Greenhalgh et al., 2006 in Baraldi, 2019); b) accelerating integration (Leanza et al., 2014m cited in Baraldi, 2019); c) cultural brokering, "for instance, by adapting the language of Western medicine to Zulu patients' ways of expressing, by encouraging side conversations, adding details, simplifying jargon, and paying attention to the patient's life-world" as maintained by Peen & Watermeyer in 2012 (cited in Baraldi, 2019).

9.1.1. The figure and the training of IM in the public healthcare in Spain

According to Tomassini (2012, p. 44), Italy, France and Spain "share a similar attitude concerning cultural and linguistic mediators, while this separation is not common in other European and non- European countries". Certain institutions "tend to prefer cultural mediators to 'pure interpreters', as they can play an active role in the organisation of services [and] act as a bridge between institutions and migrants" (Tomassini, 2012, pp. 43-44), which means that they are viewed as bilingual social workers.

In Spain the term "intercultural mediator" is used as a synonym for layperson migrant interpreter, who allegedly masters exotic languages, and who performs predominantly in public healthcare settings. However, unlike in other English-speaking countries, the same name is also used to define the figure of intermediary or broker, involved in cultural conflict prevention and resolution. Consequently, both occupational profiles share the same name, but correspond to different professional strata.

The first profile corresponds to immigrants, who claim to master exotic languages, who self-identify as IM, whose duties include but are not limited to interpreting. In spite of being an emergent profile, it has not failed to contribute greatly to the degradation of the profile of MI. It has also contributed to the entrenchment of the fallacy that literally anyone from anywhere can be an interpreter. It has caused MI fees to plunge. This profile has spawned on the pretext of unavailability of interpreters with exotic language combinations.

The profile requirements for social workers allegedly competent in IM clash with the profile requirements presented in Antonin Martín (2013), who provides the following definition of IM:

> The profile of the mediator who best fits the current needs in European countries is that of a person -man or woman-, above 25 years of age [...] sharing the cultural origin with the group of immigrants whom he/she interacts with (or at least is connected to that group), with migration experience, and with a long period of residence in the host/recipient society. [We are talking about people who] are competent in the languages they mediate from and into (native, vehicular and [societal languages] of the receiving country), linked to the organizational structures and networks of their community and who, preferably, have experience in natural mediation. They usually have a medium to high level of academic training in their [respective] country of origin, and they usually participate in different training courses in the recipient society. (2013, p. 61)

Such categorical restriction might even preclude second generation migrants from applying for position, although it would have been more rational and reasonable to set criteria based on university education and qualification, occupational competence, experience and, of course knowledge and skills, in order to disqualify candidates when screening resumes Antonin Martín (2013, p. 61).

This been said, Niño Moral (2008, p. 1068) mentions that the Ministry of Health announced allocation of grants for IM placements for graduates who have specialised in IM, as well as grants for cultural mediation in health centres of the Valencian Community allocated to students in their final years of the Official School of Languages (Escuela Oficial de Idiomas) or to students whose studies are related to the learning of foreign languages. This part is very interesting because it touches upon one of the most important topics of this thesis: training in general and training in the case of IM. Thus, in this excerpt we can clearly distinguish three different training paths that the Ministry of Health deems suitable for the "occupation": a) university degree; b) the Official School of Languages; 3) studies related to foreign language acquisition. For the record, the Ministry of Education and Vocational Training and the educational administrations offer the adult population a possibility of learning a great variety of foreign languages through the Official Schools of Languages (EE.OO.II.). European modern languages, languages that are co-official in the Spanish State and other languages of special interest for cultural, social and economic reasons such as Arabic, Chinese or Japanese are being taught at the EE.OO.II. The teaching is offered at different levels of competence, starting from the most basic (from level A2 to level C2 of the Council of Europe) and for different purposes (both general and specific). The teaching of the EE.OO.II. is aimed at people who need to acquire or perfect their skills in one or more foreign languages, or to obtain a certificate attesting to the level of competence they already possess. The Official Schools of Languages constitute a network of official non-university level centres. The EE.OO.II. are institutions of public ownership, that is, dependent on the Ministry of Education and Vocational Training or on the Autonomous Communities. Thus, as the reader can see, no consensus has been reached yet on the training for IMs:

> Despite the time elapsed since the first mediation programmes, IMfI [IM for Immigrants] continues in a precarious situation of great diversity in organisations or institutions engaged in this field and as to the ways of understanding the professional practice on behalf of all those involved. This results in the absence of a consensual and recognised professional qualification, to which inadequate training of mediators can be added. Moreover, due to the general economic crisis, are shortened and, even,

> closed programmes and grants devoted to mediation and to the participation of mediators in European transnational projects. (Rozi, 2015, p. 10)

The second profile corresponds to social workers [*trabajadores sociales*], who were specialised in IM. This profile has absolutely nothing to do with interpreting. The Ley Orgánica 5/2012 on mediation in civil and commercial matters (*Ley 5/2012, de 6 de julio, de mediación en asuntos civiles y mercantiles*) draws up in Art. 11 the conditions under which the aspirant may exercise the position of mediator:

> The mediator must hold an official university degree or advanced vocational training and must have also successfully completed a specific training to exercise mediation, which is acquired by taking one or more specific courses given by duly accredited institutions, which will be valid for the exercise of the mediation activity in any part of the national territory. (Ley 5/2012, Art. 11, my translation)

In addition, the Art. 13 stipulates that:

> 1. [The mediator shall facilitate communication between the parties and ensure that they have sufficient information and advice] (my translation)
>
> 2. Ley [The mediator shall develop an active conduct aimed at bringing the parties together, with respect for the principles set out in this Law]. (Ley 5/2012, Art. 13, p. 10, my translation)

Social workers in Spain enjoy social prestige. It is a pre-existing profile, that has already been regularised and is fully regulated by law. Social workers in Spain have their own official university Degree and specialisation in immigration and interculturality or intercultural mediation[56]. Valverde Jiménez (2013) argues that IM in Spain is also taught at the universities as postgraduate degree such as Master's degree or expert courses. Thus, social workers have managed to establish a career, a specialism, and officially regulated subjects within the official degree programmes IM against the backdrop of social work has nothing to do with interpreting, however there is a major conflict of interests between T&I and social work. The problem is that the specialty of IM is absolutely useless in social work, because one cannot claim to be an expert in all the existing cultures in the world, one must apply knowledge of certain cultures to very specific contexts, but one cannot be an expert of a culture without the knowledge of its language.

One cannot purport to successfully and safely communicate with certain minorities only on the basis of the alleged knowledge of their culture, in that one must master the language of these minorities to be able to talk to them. Social workers have used their prestige and prerogatives to take over as many social areas as possible, including the area of linguistically disadvantaged and vulnerable minorities in order to anchor themselves to the social position of prestige. Social workers constitute a discipline "familiar to the general population because they provide services directly to many of its members", and therefore, "a special position for them in the labor force is not as dependent on widespread popular approval as are the core disciplines, but both activist and reactive states are likely to be concerned with establishing a special status for them" (Freidson, 2001, The Contingencies of Knowledge section, § 3-4).

[56] All information on the official Degree in the University of Valencia, its curriculum and interculturality course is available here: https://bit.ly/3AyAKZJ

However, social workers specialised in IM have usurped a professional stratum that should have been originally and naturally assigned to interpreters. In other words, social workers have usurped a niche that naturally belongs to interpreters by convincing the "key external players" (García-Beyaert, 2015) that the work with immigrants must come under their purview, when in reality social workers are in desperate need of interpreters because they do not understand their end users. It is absolutely irrational and paradoxical, because the needs of the end users cannot be fully met as they cannot be properly vocalised, transmitted and conveyed. And social workers cannot do anything about it because their university degrees do not require languages as the prerequisite for enrolment.

The employers perceive the existing problem, they see that social workers fail to assist their end users due to language gap and therefore social workers view interpreters as a competing figure and as a threat to their profession. Social workers are not interested in assisting the disadvantaged minorities, as they only seek to safeguard their own economic interests. Therefore, due to its uselessness in this specific context and due to the lack of altruistic motivation social workers specialised in IM should have lost their social value.

Apart from university education there is actually a 300-hour course called a distance learning course provided by National Employment Institute in 2020 in Valencia "Curso INEM 2020 Técnico Superior en Mediación Intercultural en el Ámbito Social a distancia en Valencia provincia". This course is delivered for free, it falls within the category of social and health subject area. This training is geared towards any person who is willing to broaden the scope of their education. The only prerequisite to access the course is to be a worker with a permanent employment contract registered with the social security system.

Some universities also offer this type of IM courses[57]. For example, a three-month course of periodic training was offered by the James I University. It was geared towards staff working in organisations of the Third Sector[58], social agents, professionals working or wishing to work in the field of mediation, and university students. This course in particular teaches that the main competence of IMs is conflict management in different areas of intervention (such as reception, education, legal, employment, etc.), intercultural communication, mediation and knowledge of religions. The course organisers distinguish three types of mediation: preventive, rehabilitative (conflict resolution) and transformative.

However, the most important and shocking part is that these mediators are supposed to work with 2nd and 3rd generation immigrants. This would explain the fact that no foreign languages are required for enrolment and practice, but then it is unclear why would a "person who was born and resides in a country that at least one of their parents previously entered as migrant" (European Commision, s. f.[59]) need a cultural mediator if they already belong to this culture because they were born and grew up in this culture. It is unclear what sense it makes to provide culture mediation for people who have been immersed in this culture their whole life. Thus,

[57] For instance, Universitat Jaume I: https://bit.ly/3giKssk

[58] The Third Sector in Spain is constituted by privately owned
non-profit organisations with their own legal personality, registered in a public register, which reinvest their profits in their own activity.

[59] https://home-affairs.ec.europa.eu/pages/glossary/second-generation-migrant_en

given that the languages do not constitute a criterion of admission, these courses are non-language specific. So, interestingly enough, there is apparently no consensus on what education, previous training or requirements in general, language combinations and proficiency, etc. would qualify a person for IM.

Thus, what happens is that both IM profiles, –that of immigrant IM and that of social worker– have usurped our professional expertise and practice, and both figures have knocked us out of the game. The state, who has the power to regulate the access to work activities, serves the interests of certain groups to the detriment of others who should naturally enjoy the privilege of professional practice:

> But when general support from the population is fragmented by sectarianism or weakened by general skepticism or indifference, the official position of disciplines purporting to serve those concerns may become an empty shell and crumble over time, their position ultimately usurped by another more popular discipline or by schismatic movements which fragment if not dissolve the original. (Freidson, 2001, The Contingencies of Knowledge section, § 3-4)

This is exactly what is happening with interpreting in Spain, therefore, our position has been ultimately usurped by another more popular, more established and regularised discipline. Now we cannot lodge a complaint of labour encroachment by social workers because it would be difficult to classify it as a crime since our occupation is not legally recognised, but the fact that there is a subject called "intercultural medication" in the curriculum of the Degree in T&I can definitely lead to accusations of professional encroachment by social workers. In my opinion, only a forensic examination of knowledge and expertise underlying these profiles and a court decision can put an end to the existing confusion.

9.1.2. IM services in Spanish medical sphere (case studies from Madrid Barcelona and theVC)

Baraldi and Gavioli (in Pöchhacker 2015), Pöchhacker (2008 in Baraldi, 2019), Pokorn and Mikolič Južnič (2020), Angelelli (2012 in Baraldi, 2019) and Hale (2007 in Baraldi, 2019) have conducted major investigations of paramount importance, which are being ignored by all relevant social actors. IM has become a vogue and the non- cognoscenti are inclined to promote it as if there was no research conducted warning against it. IM is being hyped as a much more sophisticated solution than interpreting. Dr. Belén Padilla Ortega, vice-president of the Madrid College of Doctors ("Disponer de servicios de interpretación en asistencia a inmigrantes reduciría el uso de Urgencias, según un estudio", 2018) stated:

> It is therefore necessary to have professionals who build communication bridges between doctors and patients, who not only speak their language but also know the cultural reality of these countries, the host country and the country of origin, and who have undergone training both in health matters and in IM in order to know how to act. [...] The mediator must have ethical, cultural and medical training, working in a framework of interdisciplinary collaboration]. (Dr. Belén Padilla Ortega, vice-president of the Madrid College of Doctors, my translation)

According to Javier Alonso, coordinator of Semergen's Immigrant Care Working Group, sometimes medical staff fails to get the message across, because "translation does not always stand

for full understanding" ("*traducir no siempre es entenderse del todo*") (Ortega, 2018). Before the economic recession, there was the figure of social and healthcare mediators:

> But since the onset of the financial crisis this figure was got rid of. This figure, which was very valuable, has not been recovered [...] they helped not only with translation, but also to overcome cultural barriers when explaining the processes [...] they know the peculiarities of each culture and know how to explain things well so that decisions are informed as much as possible and the patient becomes aware of the situation [...] mediation was very helpful because, for example, in pregnancy programmes, certain things need to be explained, not just translated. (Ortega, 2018, my translation)

IMs at the Hospital del Mar in Barcelona (Iniesta et al., 2007, pp. 472-473) were reported to have been carrying out a series of vaguely defined tasks such as avoiding possible conflicts between professionals and users, accompanying the user in the care process, helping during the clinical interview, medical report, etc., translation and explanation of therapeutic guidelines, exercises, treatments or cures, information on health resources appropriate to each case and other non-study-relevant tasks.

One of the main goals of IMs that has caught my attention is to "promote the autonomy of patients after the completion of treatment, by means of understandable information" (Iniesta et al., 2007). The authors did not report on the education or training that the cultural mediators have received. The mediators were only reported to have undergone a:

> In addition to having received the specific training designed for the position, our mediators share the same cultural background as the users of our catchment area, which elevates them from being simple translators to understanding the cultural universe and the concepts of health and the health system in which each individual is situated. (Iniesta et al., 2008, pp. 472-473)

However, it is not clear why somebody would assume that two people would have similar thoughts, ideas or perceptions on a topic only based off of their belonging to the same geographical region. Also, why would somebody assume that two people would have the same culture only because they both were born, grew up, or lived in a given country or region.

There is a tendency to believe that by employing an interpreter instead of an IM one is settling for less. It has become commonplace to praise the fact that IMs do not confine their functions to mere linguistic translation [no tan sols la de traductor lingüístic], but rather can offer advice on the basis of a shared culture as can be read in the website of El parque de Salud Mar[60].

Puyol and Martín (2010) report that the Translation and Interpreting graduates who work as IMs in Ramón y Cajal Hospital in Madrid provide a 250-hour-long training course, which encompasses theory and practice, in IM in healthcare settings (Elidrissi, 2018).

Back in 2010 a course of the above mentioned characteristics was geared towards 18 migrants of sub-Saharan, Latin American, Maghreb and Eastern European origin. Six of the course attendants were volunteers who worked as MIs in consultation. Their functions were not confined to interpreting "inside the consultation with a physician" (Elidrissi, 2018). The IMs were expected to go to the headquarters of the corresponding associations and from there inform the users about the disease, adapting the information to their needs.

[60] https://www.parcdesalutmar.cat/es/hospitals/hospital-del-mar/seveimediaciocultural

According to El Mundo (Elidrissi, 2018) newspaper article the linguistic interpreting and IM service (SIMI) has two professional figures who assist doctors during consultations: the interpreter and the intercultural mediator. The coordinator of the project "*Salud entre culturas*" explains that "interpreters are usually Translation and Interpreting or Philology graduates and we use them for consultations conducted in vehicular languages such as English, French, Arabic, Chinese or Russian". As far as IMs are concerned, the *Salud entre Culturas* team members began training people, mainly of sub-Saharan origin, who speak Spanish, at least one vehicular language and other minority languages to detect and resolve any intercultural conflicts that might arise (Elidrissi, 2018).

It is worthwhile underlining that both the director and the coordinator of the aforementioned project "Salud entre culturas" are neither academically nor professionally linked to translation or interpreting. The director of the project is a doctor, specialist in tropical medicine, and the coordinator is an expert in development cooperation and humanitarian aid.

It is essential to understand that according to Freidson (2001, section 4, § 3) "occupational control requires that some members of the occupation become supervisors or managers" of this occupation, because "under such circumstances, the occupation becomes stratified by administrative authority". However, this is not the case, as both MI and IM are professional from other professional strata, who have no knowledge whatsoever of the discipline and yet they have been assigned by yhe institutional authority to supervise the work of MI and IM (Corsellis, 2011).

Occupational control of work is contingent upon exclusionary labour market shelters securing occupational monopoly "over particular kinds of specialised work and over the right to supervise and evaluate such work" (Freidson, 2001, section 4, § 3). This is clearly not the case of IM in Ramón y Cajal Hospital in Madrid. The translation and interpreting graduates have not been commissioned or appointed to assess and superintend the execution of the assignment in the department of IM.

The El Mundo article narrates the story of a 30-year-old Cameroonian asylum seeker, who arrived in Spain several years ago due to the political persecution he suffered in his country. When in dire need to see a doctor he came across Ramon y Cajal hospital, where back at that time there was only one interpreter. Later, through another NGO, he met Peña and began training as a mediator. He explains: "I was very interested because for me it was an opportunity to work and in a field that I like because I have seen myself like that". Out of 300 dialects spoken in Cameroon, Serge Adjaba claims to speak Eton, Ewondo, Bulu, Bangangté, Duala, Basa and Fang, in addition to English, French and Spanish.

Finally, Dr. José Antonio Pérez Molina explains that immigrant population is more acquainted, familiarised with and used to palliative approach to healthcare, whereas in Spain doctors rather envision a preventive approach. This constitutes a major cultural barrier, according to Dr. Pérez Molina, because these patients are more accustomed to visiting doctor's consultation when they have already fallen ill. According to the same doctor, "mediators are trained to understand the language, have health training and also modulate the information from the cultural point of view [and] thanks to that we can provide quality care [...]" (Elidrissi, 2018).

In a very interesting interview aired on TeleMadrid in 2018[61], the coordinator of *Salud entre culturas* and one of the IMs are being asked about the functions that IMs normally carry out. I shall insert two of the transcribed excerpts for a quick thematic analysis italicizing and highlighting the most relevant content thereof:

Interviewer: And also [...] I imagine because there are many times [when] this is not just a matter of translation, [because] if it was just about translation then we would do it with Google Translate, right? [...] what you do goes beyond simply explaining to the doctor what the patient is saying [...] Mediator: Indeed, at the consultation it is not just about the interpreting, it is not just mere interpreting that is done, but also mediation. Mediation refers to cultural and social keys because, as you said, for example, how a doctor can explain to a patient that she has latent tuberculosis, it is not just necessary to just explain to her, a mere interpretation is unnecessary, it is necessary to explain to her what latent tuberculosis really is [explain] that a person can be infected with the tuberculosis bacteria without being sick and without being able to infect people, this must be understood because they cannot understand [when] a person says that you have the bacteria in your body and that you are not sick, for example, the organisationation of the health system here in Spain [is] very different from what exists in our countries, there is no clinical history there, there is nothing, everyone fends for him/herself as he/she can [...] there we do not have a concept of preventive medicine [...] many cultural, social, linguistic keys must be understood, to be able to explain to professionals [...] it is not just a matter of interpreting words, it is not just a matter of linguistics [...] gestures are interpreted, looks are interpreted, languages are interpreted not words [...]	Entrevistador: Y también [...] me imagino porque hay muchas veces que no solamente es traducir si fuera traducir estaría el Google Translator este, no? [...] vosotros vais más allá de simplemente explicarle al médico qué es lo que está diciendo el paciente [...] Mediador: efectivamente en la consulta no es solamente interpretación no se hace solamente la interpretación además de la interpretación se hace también mediación mediación se hace referencias a claves culturales, a claves sociales porque como tú lo decías por ejemplo como un médico puede explicar a una paciente que tiene la tuberculosis latente, solamente no hace falta solamente explicárselo una interpretación solamente no hace falta hace falta explicarle realmente lo que es la tuberculosis latente que una persona puede ser infectado de la bacteria de la tuberculosis sin ser enfermo sin poder contagiar a gente eso hay que comprenderlo porque ellos no pueden comprender una persona dicen que tú tienes la bacteria en tu cuerpo y que no estás enfermo por ejemplo la organización del Sistema sanitario aquí en España muy distinto de lo que existe en nuestros países allí no hay historia clínica no hay nada cada uno se busca la vida como puede [...] allí no tenemos concepto de la medicina preventiva [...] hay que entender muchas claves culturales, sociales, lingüísticas para poder explicarles a los profesionales [...] no es interprete solamente las palabras no es solamente algo lingüística [...] se interpreta gestos, se interpretan miradas, se interpretan lenguas no palabras]

The excerpt inserted above corroborates that, in spite of well-meant efforts of this NGO and despite the fact that the IMs are allegedly acting in good faith, there is a series of misconceptions that are being instilled into the general public's perception of "interpreter" creating polarised views.

This is done throughout the whole discourse with one patent overarching theme: mediators are not like interpreters; not only do mediators render the utterances, they go beyond mere discourse by conveying the cultural wholeness. The constant repetition at the beginning and at the end of this discourse is noteworthy: "at the consultation it is not just about the interpreting, it is not just mere interpreting that is done"; "it is not just necessary to just explain to her, a mere interpretation is unnecessary, it is necessary to explain to her what latent tuberculosis really is";

[61] Available on: http://www.telemadrid.es/programas/buenos-dias-madrid-om/Conocemos-Salud-Hospital-Ramon-Cajal-9-2023987587~20180622024632.html

"it is not just a matter of interpreting words, it is not just a matter of linguistics [...] gestures are interpreted, looks are interpreted, languages are interpreted not words [...]".

As regards the Valencian Community, the "translation" service of the Marina Baixa hospital, located in the Valencian Community, yet again epitomises the dismantling of the symbiosis between language and culture, by stating that they have employees with two different profiles: interpreter and intercultural mediator. The Hospital de La Vila reports to have recorded 3,750 interventions accomplished by the "translation" service in the first half year of 2010 ("El servicio de traducción del Hospital Marina Baixa realiza más de 3.750 intervenciones", 2010).

This language provision service covers language assistance in English, French, German, Dutch, Norwegian, Swedish, Finnish and Danish. This service is constituted by an interpreter and an intercultural mediator, whose main duty is to intervene during the encounter on request of the patients. Some of these interventions are carried out in the Emergency Department and the Intensive Care Unit, mainly to inform the family about the state of the incoming or admitted patients. The hospital also provides translation service of documents that might be of interest to the patients, such as medical insurance related paperwork, repatriation documents, billing related forms, or the processing of the European Health Insurance Card.

In conclusion, IM has been used as an alternative to professional MI in a number of public medical facilities across Spain, which is an indicator of social value and recognition.

9.1.3. Critical review of the tasks of IM in interpreting studies

As we have just determined, IM tends to showcase a disquieting overinvolvement with the diagnostic and therapeutic processes of patients they purportedly assist. This section will serve as a very brief reflection on the extent of such overinvolvement.

Thus, as regards the repertoire of duties and tasks ascribed to IMs, I would suggest that these can range from less intrusive to more invasive. Some tasks including rephrasing discourse in order to elicit a concise answer, intervening inorder to ask the doctor to explain, clarifying that the prescription has an expiry date, informing the doctor of the low educational level of the patient, which may perhaps hinder the proper understanding of the situation (De Souza, 2016, Table 17) should definitely fall within the interpreters' remit. These tasks entail a rather low level of interference, however it is true that the boundary between sensitisation and overinvolvement is sometimes blurry.

The differences of drug dispensing among different countries are a perfect example of a sociocultural construct that interpreters and IMs must be aware of. However, we must pay heed to some other tasks, which reportedly include the explanation of the diet including food properties, calories, etc., customs, traditions, rituals, differences in healthcare systems" (De Souza, 2016, Table 17 section). These tasks depict the mediator's active position in terms of the participation in the communicative process.

There are also other tasks that exceed the expertise of a language service provider and that are simply beyond any logic. For example, one of such tasks may be suggesting that the clinic/the provider should adapt themselves to and accommodate the needs of the patient by agreeing to regularly draw blood from the patient because this is what the patient expects. Otherwise the

patient will be intent on getting themselves admitted to the hospital on a regular basis (De Souza, 2016, Table 17 section case study N° 11).

Patients should not be given a carte blanche to dictate their own rules and to impose their culture forcing it upon the practitioner. Tolerance and respect should not come to signify absolute all-embracing permissiveness, forbearance and leniency in the treatment of certain ethnical groups, whereby medical workers may feel obliged to give in to the whims of foreign patients when responding to the demands imposed by these patients who are totally unacquainted with Western standards of medical practice.

I also deem worthy of attention and discussion both the patronization and the infantilisation of foreign patients, whereby the intercultural mediator takes over as supervisor and advocate of the patient. The patient should by no means be infantilised and treated as if they did not know that another country implies another language, another culture, and thus another treatment strategies. Patient's ethnomedical approach must under no circumstances be extrapolated to the medicine practiced in the host country, because:

> Due to the double allegiance inherent in their professional function, interpreters serving as 'advocate' for one party may soon harm the interests of the other [...] Such examples bring to the fore the importance of keeping the interpreter's 'agency ' separate from that of 'advocacy'. (Skaaden, 2019, chapter 3.3.2, § 11)

Reportedly, some IMs went as far as to counsel the provider on how to recommend the patients to get a priest to bless their home because the ghostly presences they were supposedly sensing were some sort of demonic manifestation rather something they might have been experiencing due to hallucinations or mental disorders (De Souza, 2016, Table 17 section, case study N° 6). This is obviously a clear example of a gross interference into the patient's integrity.

The fact that some IMs "nee[d] to interpret in a different way to match the messages they expect or they will not trust the provider" (De Souza, 2016, Table 17 section, case study N° 7) is absolutely incompatible with the essence of interpreting and the professional knowledge underpinning this activity. The fact that the author herself acknowledges that "culturally competent delivery of interpretation may require distortion of original message from a linguistic point of view to elicit same response as if stated in target language" (De Souza, 2016) clashes with the main idea behind MI. It is unclear on what basis the author has made these assertions. Where is scientific data underpinning and substantiating these assertions? If the patient, the family member or the doctor were to audio record the intercultural mediator's performance and to discover such adulterations it could lead to serious consequences and even lawsuit. Ozolins (2016, p. 282 cited in Crezee et al., 2020) states that "[f]iltering, aligning or replacing can in no way be reconciled with impartiality, and destroy this basis for interpreting". Such initiatives undermine the trustworthiness of the collective identity of language service providers.

Some tasks that are being assigned to IMs are not only difficult to define and delimit, but also, due to their vagueness, it is difficult to fathom out how IMs are supposed to tackle these fuzzy assignments. The following tasks described by Gimenez (1997, cited in Rozi, 2015, p. 9) are not concrete standardisable tasks with clear jurisdictional boundaries:

> To promote the recognition of the other as interlocutor, to promote better understanding of the other and effective communication with the other, to overcome barriers to relations (such as overcoming prejudices and stereotypes, overcoming fears and misgivings), to promote coexistence, to realise the potential for mutual enrichment underlying non-hierarchical multicultural situations, to avoid, prevent or regulate situations of conflict, to adapt the organisation and functioning of institutions (such as schools or hospitals) to beneficiaries and gain efficient access of users to the institution and the management of it and finally, to facilitate cooperation, often required, among ethnically differentiated subjects. (Rozi, 2015, p. 9)

These tasks are not tasks, but rather global goals touching upon some important agendas such as antiracism, antixenophobia, social inclusion agendas. It is pretty unfathomable how an intercultural mediator can tackle these global issues.

9.1.4. Critical review of the figure of IM in interpreting studies

In this section we will analyse a number of national and international interpreting studies with the aim of fathoming the rationale behind the polarisation between the advocates and the opponents of IM. The tendencies described above unveil an ideology of downgrading the interpreting process and reducing it to "mere words". This ideology is promoted not only by some scholars, but also by official international organisms. The EU project TIME "mischaracterizes" the concept of interpreting by outlining that "the aim of *interpretation* is to convey the meanings of what is said during an interpersonal encounter as accurately as possible", whereas:

> *IM* is a much wider and a more enriched means of communicating messages from sender to receiver and vice versa. Thus, IM is a bridging of cultures, meanings, silent languages, terms, collocations. [...] Interpretation differs from intercultural mediation mainly in so far as it focuses mostly on the language structure and not on the inner meanings of a message. (Theodosiou & Aspioti, 2015, pp. 16–17, cited in Pokor & Južnič, 2020, p. 86)

A number of scholars argue that IM outweighs more orthodox forms of interpreting, in that IMs "bring much more to the table than the accurate interpretation of messages into another language in healthcare" (De Souza, 2016, 8.9 section MIs' Essential Role in Culturally Competent Healthcare). However, it remains unknown how IMs can "bring more to the table", because it remains unknown whether and how the knowledge underpinning IM can be codified, systematised, regularised and standardised is order to become verbalizable, attainable through formal university education and accomplishable in practice. Up to now we have only seen vague conjectures. It is worth noting that Martín and Phelan (2010) also found "no recognized, unified code of practice" for IMs (cited in Pokorn & Južnič, 2020, p. 91).

IMs "are preferred to professional interpreters, in that they are presumed to be more competent in dealing with the possibly different 'cultural' perspectives of healthcare providers and migrant patients" (Baraldi & Gavioli, 2017, p. 84; Angelelli, 2015, p. 47). The knowledge of IMs allegedly stems from "their experience in intercultural communication" (Baraldi & Gavioli, 2017, p. 84; Angelelli, 2015, p. 47). IM in public healthcare is meant to bridge the gap or reduce cultural contentions and differences between the expectations of the host country's caregivers and the migrant patients. This cultural conflict derives from health-related notions (such as pain, pain threshold, illness, convalescence, treatment, etc.) which have been interiorised and

conceptualised in a different manner (the famous pain scale described by Angelelli, 2012). The interlocutors' lifeworlds, mindsets and the cultural prism through which they view the shared reality are different.

The justification for IM implies constant regurgitation of literalism (De Souza, 2016)[62] being the most important characteristic of MI, which oversimplifies and deskills the process of interpreting reducing it to the mere usage of calques. De Souza bases her research on the American model. There, interpreters have no training whatsoever, no higher education, no native language competence, no interpreting competence, and therefore the rendition that they produce is calque-ridden. They know the language they speak at home, the language spoken by their families, but their language knowledge has not been acquired at an official level and at the official education institutions. Obviously, they lack training in terminology, which results in them using numerous calques and words they make up. Thus, the "literalness" is so brutal that nothing can be understood.

De Souza views MIs as "*verbatim* inter-linguistic reproducer[s]" and "neutral and invisible conduit[s]" as opposed to "impartial yet visible active participant, as advocate, intercultural communication mediator, or communication facilitator or coordinator with self-agency" (De Souza, 2016, Trends in interpreting research section, § 3).

Theodosiou and Aspioti (2015) also "attempt to redefine the profession of community interpreters by reducing the interpreters to mindless machines in order to replace them with IMs who are supposed to subsume the competences traditionally ascribed to community interpreters" (Pokorn & Južnič, 2020, p. 90).

Rodríguez et al. (2009, p. 142) also pinpoint the persistent tendency to dissociate "words" from "ideas" behind them:

> In order to be able to transfer the meaning of a discourse from one language to another, it is necessary to have linguistic, but also paralinguistic and cultural knowledge. In our opinion, it is clear that the interpreter needs to have these skills in order to do his or her job effectively. However, the belief sometimes persists that translation/interpreting is only linked to the words, and not to the ideas behind them. (Rodríguez et al., 2009, p. 142)

Pena-Diaz (2016, p. 633) also makes a clear distinction between interpreters and mediators and promotes IM as a non-mutually exclusive solution to ethnic and cultural disparities:

> Not only interpreters or translators, but mediators are needed. As we have seen, the mediator is a new figure which is slowly beginning to appear. Not only does s/he deal with the linguistic transfer of ideas and concepts but also with the cultural aspects which seem to occur very frequently. (Pena-Díaz, 2016, p. 633)

[62] "Therefore, the function of interpreting is not to provide literal word for words renditions" (De Souza, 2016, 1.1 Language and Culture section); "Literal renditions never make sense in the other language" (De Souza, 2016); "Solomon (1997) mentioned that ethical codes based on the invisibility paradigm to 'intervene only when necessary', or 'keep a low profile', promote neutral literalism, in place of the more desirable 'nuanced interpretation'" (De Souza, 2016, 2.4.3 Interpreter role typologies section); "High context communicators emphasize multi-layered contexts, and literal interpretation will not work when interpreting high context communication" (De Souza, 2016; "It is unrealistic to expect interpreters to convey the interpreted message in a literal manner without any alteration" (2.4.5 Interpreters as active participants section); "Literal interpretations become inadequate, even dangerous" (4.2.6 Strategies of addressing cultural issues section).

Interestingly enough, the author does not specify what are these cultural aspects. In the absence of concrete examples of these "cultural aspects", one may tend to perceive the vagueness of these statements.

According to Montalt-Resurrecció and Shuttleworth (2012, p.14):

> Like translators, mediators are no longer understood as neutral vehicles or passive conduits for the transmission of pre-existing entities. They are viewed as co-constructors of knowledge and meaning-making symbols, be it within the same language or in a different target language. In fact, in the field of interpreting, contributions (e.g., Angelelli, 2004; Bolden, 2000; Metzger, 1999; Roy, 2000; Wadensjö, 1992, 1998) have evolved over the past two decades towards an understanding of the role of the interpreter as an interactive participant in cross-cultural communication rather than as simply someone who relays linguistic messages from one language to another. (Angelelli, 2004)

According to T-SHaRE project (2012, pp. 29-31) IMs "are not mere translators" as their role involves "more than linguistic translation [...] a mere technicality [which] doesn't [sic] consider all relational dimensions, nonverbal communication [...] feeling of ashamedness, confusion, suspiciousness, trust and mistrust". They view IM as a "*bridge* between two worlds", whereby IMs "explain [...] the values" in order to facilitate integration instead of assimilation (T-SHaRE, 2012, pp. 29-31). IMs are expected to showcase "active and critical presence" by "reformulat[ing] the meaning of stories, experiences and symptoms in a new productive form", thus "moving from one symbolic and semantic system to another"(T-SHaRE, 2012, p. 30).

Other authors, such as Verrept (2019 in Pokorn and Mikolič Južnič, 2020, p. 86), have also suggested that: "While interpreters overcome language barriers without necessarily achieving mutual comprehension, the IMs ultimately ensure mutual understanding".

This is yet another unsubstantiated assertion. Who said that the two parties are willing to understand each other? Sometimes they don't want to understand each other, or one of them lies or withholds information, or remains silent even if they have understood the question. Authors such as Grandgeorge (2020) expressed the need and importance of coming to the realisation of the sheer complexity of human communication.

One may have more affinity with this or that way of expressing oneself, or gestures, but that would in any case apply to cultures far away from each other. Where do they learn communication techniques? Are they innate? From what IM advocates say, interpreters are parrots, and know nothing about human communication, a statement that can only be qualified as an absolute fallacy, in that interpreters do learn about the complexities of human communication in the official prestigious higher education institutions, which cannot be said about intercultural mediators. So, I wonder where do mediators learn all these self-assigned sophisticated communicative techniques? And also, how and where has all this mystic knowledge been codified, standardised, regularised and applied. De Souza insists that:

> Communication does not occur unless the receiving party understands the message, so merely interpreting messages without checking for understanding is akin to providing someone with information that they may not have understood. (De Souza, 2016, Two theoretical models: Conduit or advocate?, § 1)

These excerpts may have a *gaslighting effect* on some non- cognoscenti readers, because this assumption depicts MI as a nonsensical activity devoid of discernment. Culture is an inextricable

part of the language, so it is impossible to interpret without taking it into account, the question is how faithful to the original the interpreter decides to be and how far could the process of domestication/ adaptation/ recontextualization in interpreting go. De Souza is generalising very concrete occurrences form a very specific context, which goes against the scientific method, is unscientific and dangerous, and should trigger a response form the scientific community.

De Souza specifies that "one of the goals in MI is accurate communication (the absence of miscommunication), and not necessarily just accurate interpretation (the absence of interpreting errors, omissions, additions or distortions)" (De Souza, 2016, 1.1 Language and Culture section, § 10). However, it is impossible to obtain accurate communication without an accurate interpretation, even though an accurate interpretation does not always guarantee an accurate communication.

This implies that the occupational/jurisdictional domain of the exercise of discretion traditionally ascribed to language service providers will dilate until trespassing the demarcation of other occupations and professions. This will imply violation of the division of labour, because the sufficiently distinct tasks and the clear limits of the compartmentalisation of distinctive tasks which allows for clear jurisdictional boundaries are two key features of the conservative, traditional and conventional profession. So ultimately, I have reached the conclusion that the only thing the platitude about the importance of becoming intermediaries "influencing the flow and content of information" does is to distort the image and the role of professional interpreter (Kaufert et al., 1986, cited in De Souza, 2016, 1.4.2 Traditional public view of interpreters as conduits section, § 2).

It was reported by Pokorn and Mikolič Južnič (2020) that some official documents such as California Standards for Healthcare Interpreters "are often used in support of the reduction of interpreting to a mechanical replacement of source-language words by target- language words instead of providing the nuanced discussion that appears in the literature" (Pokorn and Mikolič, 2020, p. 86). According to the same authors, Verrept (2019, p. 9 as cited in Pokorn and Mikolič Južič, 2020, p. 86) has also been found to "mischaracterize" or directly misappropriate the definition of the concept of "interpreters":

> "The intercultural mediator has been described as an intermediary who helps to construct shared meanings in the search for conflict resolution [51]" Reference 51 refers to an article by Boss-Prieto et al. (2010:14, emphasis added) that reads: "The interpreter is not a translator of words, but an intermediary that helps the construction of meanings between two linguistic worlds in the search for conflict resolution." Verrept (2019) thus uses an article in which interpreters are defined as the constructors of meaning to support his claim that, contrary to interpreters, the IMs are those who help construct shared meanings. This is not the only instance in which previous research has been mischaracterized in the report. (Pokorn & Mikolič, 2020, p. 86)

It should be noted that all these statements have not been proven scientifically. All is based on assertions rather than on robust empirical evidence. These assertions are all based on the artificial mystification of the cultural elements present in practically all human utterances. The only thing that these scientifically unsubstantiated ventured opinions do is favour cheap labour and employment of unqualified people.

Pöchhacker (2008) and Martín and Phelan (2010) reject such "simplification of the role and competences of the community interpreter and insist on drawing a difference between these profiles [...]" (Pokorn and Tamara Mikolič, 2020, p. 90)

> Falbo (2013:34–37) argues that since language and culture are inseparable, linguistic and cultural mediation are in fact intrinsic to the job of the interpreter, [...] the main difference between the profession of community interpreters and the emerging profession of intercultural mediators with respect to ethical positioning and role lies in their ethical imperatives, with the codes and standards for intercultural mediators stressing advocacy as a key task of this emerging profession. (Pokorn & Mikolič, 2020, p. 87, 100)

In the same vein, Skaaden thinks that "the deconstruction of 'cultural mediation' shows that the approach has repercussions not only for the professional integrity of interpreters but also for the high-status professionals they serve" (Felberg and Skaaden 2012; Skaaden 2013, p. 180 as cited in Skaaden, 2019, chapter 3.3.2, § 1).

This repetition clearly has a gaslighting effect on the reader. Please note how the so-called mediators insist on the importance of going beyond interpreting and on the special mystical skills that only the mediators possess in order to convey meta-linguistic elements of interaction. The mediator cited above (TeleMadrid, 2018) made a rather startling statement: "it is necessary to explain to her what latent tuberculosis really is". This should fall under doctors' remit, and in taking over these duties the mediator usurps doctors' responsibilities. This might be dangerous because people with 150 hours or 250 hours of training take the liberty of taking on the role of bilingual professional ("professional" here obviously refers to doctors or nurses).

But what is the rationale behind this tendency to promote IM? Baraldi & Gavioli (2017, p. 101) clearly distinguish between "intercultural adaptation" and "cultural essentialism" perspectives. Intercultural adaptation involves recontextualisation of different cultural assumptions, whereby culturally sensitive topics are redesigned, re-engineered, restructured and discursively reformulated in order to accomplish mutual understanding. Cultural differences work as "enriched choice, which doctors and patients can take into account when making decisions" (Baraldi & Gavioli, 2017).

Cultural essentialism does also entail explicitation or unpacking of the culturally entrenched idiosyncrasies exhibited as unfamiliar behaviour by the patients and by the caregivers, but it inhibits the natural evolvement or the conversation and the natural unfolding of the interaction (Baraldi & Gavioli, 2017, p. 101). The interlocutors are not provided with the possibility of "dealing" and discussing certain culturally embedded behaviours "directly". Instead, "the mediator's intervention impedes, rather than promotes, interlocutors' participation and leads to the interactional construction of stereotypes and prejudice" (Baraldi & Gavioli, 2017).

Such "autonomous initiatives taken by mediators" may lead to ascribing or attributing interlocutors to a particular group of people by generalising and stereotyping their behaviour, and the risk thereof is that the patient might be perceived and treated primarily as a member of a group rather than independent individual. This is "a burden which encumbers interlocutors' active participation, thus causing possible failure of an effective doctor-patient interaction" (Baraldi & Gavioli, 2017, p. 102).

In short, "healthcare providers authorise the mediators to explain medical issues", in other words, "deal with the contents in their own terms" supposedly in ways that are understandable and acceptable for the patients". This entails leeway to "make relevant a series of assumptions" (Baraldi & Gavioli, 2017, pp. 101-102), in other words, to filter information and foreground those parts which the mediator gauges as relevant, meaningful and contributing to the encounter or to the resolution of possible cultural conflict during that encounter.

Often mediators would distil or boil down the rest of the information that has been elicited during the encounter, eschewing the parts which they render irrelevant. But, the question is, are they thus contributing to the empowerment of the patients? Mediators work is characterised by a significant and unbridled extent of autonomy, but is this autonomy going to be used in way that will enable both doctors and patients to make "informed" decisions?

The existing codes of ethics (for example, IMIA, 2006) prescribe that interpreters must not interfere in the communication and stipulates that interpreters:

> [a)] must not interject personal opinions; b) [...] will engage in patient advocacy and in the IM role of explaining cultural differences/practices to healthcare providers and patients only when appropriate and necessary for communication purposes, using professional judgment, c) [...] will use skilful unobtrusive interventions so as not to interfere with the flow of communication in a triadic medical setting. (IMIA, 2006)

This means that the codes of ethics are not categorically forbidding IM, it means that they restrict its usage to those situations where it is necessary and where the educated/trained interpreter is competent enough to use their professional judgement, which is what sociologists calls discretionary judgement as we have seen in the first part of this section. But I insist, the precondition is therefore that the interpreter be *professional*, which in our case means having accomplished appropriate university education or training. The fact that the interpreter is a graduate in Translation and Interpreting will help instil trust and the notion of professionalism that will definitely help the patients and the doctors rest assured that their discourse has been rendered accurately.

Thus, the transcultural adaptation must occur "within mediators' work of rendition" in accordance with professional interpreters' conduct in order to eschew "advocacy with the consequent risk of an essentialist defence strategy". "Rendition is an extremely important intercultural operation that requires high professional achievement", whereas mediation "seems to have to do more with expertise in coordinating interlocutors' participation and room for speaking, rather than with knowing and treating cultural presuppositions" (Baraldi and Gavioli, 2017, p. 103).

In the countries where MI has made great strides in professionalisation (e.g. USA, Australia, New Zealand) the risk of it being denigrated is less considerable, as it is no longer an emergent occupation, but a practically established profession. However, highly restrictive "codes of practice/ethics [preventing the interpreter] from intervening in th[e] situation" spurred the advent of non-interpreter-profile-endangering foreign-language-related occupational figures, such as "patient navigators" or "case managers" (Crezee & Roat, 2019, The role of the interpreter and the patient navigator section, §1). Nonetheless, apparently, it is no longer the interpreter's "literalism" (De Souza, 2016) that is causing the problem, but rather certain types of patients, who need additional assistance with "health education/health literacy", "numeracy", "psycho-social

support", "cultural divergencies", "transportation" and "financial issues" (Wells et al., 2008 cited in Crezee & Roat, 2019, Patient navigators section, § 5). The authors argue that patient navigators would have a "teaching role: e.g. suggesting alternative ways of explaining complex medical matters [...] interpreting into plain language [changing the] register/level of formality [...]" (Crezee & Roat, 2019, Role comparison of navigators and healthcare interpreters section, § 4), services that I dare speculate only the users of public health care with little or no educational background/medical knowledge and low socio-economic status would be in need of. Thus, in this case, we are not talking about hybridising, usurping and replacing MIs, but rather about providing yet another complementary hybrid figure, –a type of foreign-language-proficient social-worker–, for those patients, who due to life circumstances beyond their will or control would not take the "stew" (Crezee & Roat, 2019, The importance of a patient navigator section, § 1) metaphor as an insult to their capacity to understand, but rather as a life-changing explanation.

Although it would be a sweeping generalisation to state that all IMs blur interoccupational boundaries and interfere in a way that may prove to be disrespectful or even dangerous with regard to the patients, all analysed data indicate that all the aforementioned factors may lead to the exclusion of patients instead of their empowerment. Nevertheless, this new cross-fertilised breed of occupation engendered a hybrid between social worker and interpreter and this new role is gaining ground with startling facility. Even though the state endorsement is still lukewarm in a sense (there are very few IMs in public healthcare setting in Spain), it still gets more promoted than professional MI provided by qualified graduates. Apparently the denigration of conventional, classic or traditional interpreting which has always taken cultural background into account, is a good PR strategy. This is a perfect example of Freidson's *folk concept* and social constructionism (Burr, 2015), whereby we can see how important the role of society actually is in constructing the commonly shared realities.

9.1.5. IM through the lens of the sociology of professions and the Freidson's concept of professional knowledge

The main goal of this section will be to fathom out how and why IM usurps the niche of MI, and the nature of the professional knowledge behind this phenomenon and how it differs from the professional knowledge underpinning MI. First we will try to fathom how IM gains visibility through the deprecation and de-mystification of interpreting. Then, we will examine the assignments that IMs claim expertise and ownership over. Subsequently, we will discuss the typology of professional knowledge following Freidson's classification in order to discover whether the knowledge related to cultural sensitivity is unique and exclusive to IM.

Neal and Morgan (1998, p. 10) have described a phenomenon where "professional groups routinely disparage members of related or competing groups". Sinclair (1997 in Neal and Morgan, 1998, p. 11) reports on the "definitional and social-closure issues when, as part of [doctors'] everyday discourse, they discuss frauds, quacks, and those involved in alternative medicine". And this is exactly what is currently happening with MI: a group of *soi-disant* IMs and their advocates, many of whom are not even university graduates, let alone specialists in MI, disparage MIs. Apparently, all the aforementioned scholars follow the second tenet of a five-stage-temporal-sequence in the evolution of professionalisation processes presented in Caplow's (1954, pp. 139-

140 as cited in Neal and Morgan, 1998, p. 11) socio-historical approach to professionalisation: "a change in the name of the occupation".

> These unsubstantiated claims reduce interpreters to mere conduits of a linguistic code without taking into account meaning or culture and liken them to machines mechanically replacing source-language linguistic items with some near-equivalents from the target language. (Verrept 2019, p. 48 in Pokorn & Mikolič, 2020, p. 86)

Thus, the expansion of competence and the mystification of cultural components in language are highlighted to promote IM and disparage interpreting. Please note how the WHO Health Evidence Network Synthesis Report 64 (World Health Organization Regional Office for Europe & Health Evidence Network, 2019, pp. iii- iv) and TIME project[63] (2015, pp. 4–5) both reviewed by Pokorn and Mikolič (2020, p. 101), associate IM with socio-cultural brokerage, provision of psychosocial support (including acting as liaison inside and outside medical settings), co-therapy (in mental health-care settings), assistance in navigating the services, building trust and therapeutic rapport, conflict prevention and resolution, facilitating integration into health systems, enabling empowerment by providing information on the available health and social services and on health-care entitlements, and performing advocacy against institutional racism or discrimination. According to T-SHaRE project (2012, p. 33) IMs must possess knowledge of "general anthropological concepts [...] medical anthropology [...] aetiology [...] diagnostic categories [...] ability to 'break down the jargon'". Thus, the professional knowledge and expertise underpinning interpreting is considered to be insufficient to meet these "sophisticated" demands. However, I still fail to comprehend where is the scientific and empirical evidence on which these claims are based?

Thus, the typology of professional knowledge and the expertise that is being assigned to IMs is extremely vague and artificially mystified because the distinction between community interpreters and IMs "was only possible if promoters of IM limited the notion of interpreting to linguistic transfer only" (Pöchhacker, 2008, p. 21, cited in Pokorn & Mikolič, 2020, p. 89).

The advocates of IM view the professional knowledge and skill underlying MI as mechanical, automatised, technical and noncognitive activity. In their own words, interpreter is like an "invisible machine, voice box, conduit role, language technician", who merely "helps to understand the language", who is "only" there "to address my inability to speak the language" (De Souza, 2016, section on Recommendations for medical interpreters, table 46, The Invisibility-visibility continuum). IM, on the contrary, is promoted as "co-diagnostician, patient representative, cultural informant", who helps "to communicate, navigate the system and advocate for [the patients'] rights". Please note that interpreters are viewed as "language professionals", who were trained within "linguistic paradigm", whereas IMs "multifaceted professionals" trained within "social and medical paradigm", which makes them professionals in "languages, culture and healthcare" (De Souza, 2016).

The major problem of intercultural mediation is that the body of knowledge that they allegedly possess cannot be called "professional knowledge", as it is extremely vague, unverbalisable, unformalizable and unstrandardisable. Also, cultural knowledge in this context cannot be viewed as sophisticated, unique and requiring extensive university education, as any migrant already has it.

[63] Erasmus+ project *Train IMs for a Multicultural Europe* (TIME)

Thus, it is not the interpreting that is mechanical, it is the cultural knowledge employed by the immigrants that is mechanical, in that it is based on the knowledge, skills and notions every normal adults learn during the course of their everyday life (Freidson, 2001, Types of Specialisation section, § 4). Which is why the mediators from the Ramon y Cajal hospital in Madrid[64] can "mediate" on the basis of their naturally acquired everyday cultural knowledge. Unlike professional interpreters, these mediators use no task discretion. Nor do they use any discretionary specialisation, which rests on employment of "a body of formal knowledge that is gained by special training, which is why practitioners are called experts or specialists [...]" (Freidson, 2001, Types of Specialisation section, § 4).

"Incidentally, 'indeterminate' personal knowledge cannot be seen as the habitus of professional education. It is [...] often a contested definition. As Jamous and Peloille suggest (1970, cited in Atkinson 2016, The Reproduction of the Professional Community chapter, § 46), there is a tension between the 'tacit' and the 'technical' (often expressed as 'scientific')". The unself-conscious, tacit, unverbalisable natural knowledge of certain cultural practices does not imply the ability to identify culture-related needs, successfully troubleshoot them and successfully resolve them. These skills are not stipulated by any corpus of technique, and therefore cannot be granted the status of a profession. Culture, in all senses, is constantly evolving. No one is culturally competent in everything all the time. Cultural knowledge alone "cannot be codified or described systematically; [it] must be learned by practice, become part of the eye, ear, and hand" (Freidson, 2001, Skill and the Tacit section, § 3). The concept of culture *per se* cannot be learnt through conventionalised technique following prescriptive rules, which have been stipulated in codified texts taught in classrooms. In an attempt to rationalise culture sensitivity I can only view it as a corollary part of the interpreting process, not as a separate profession or occupation. It cannot be considered as a separate profession and be given more importance that interpreting itself because it lacks scientific grounding and stipulation of application and safe implementation in daily praxis. Therefore, it will always remain "separate from but not independent of substance" (Freidson, 2001), which in this case is interpreting.

However cultural sensitivity and the skill to properly reason out a perfect solution without adulterating the original discourse "can be developed fully only with extended practice and experience" (Freidson, 2001, § 3-4). The concept of culture is constituted by a self-evident lifeworld, crystallised and internalised patterns of behaviour and world perception. The interpreter sees and hears culture-related signals and symbols, interprets them and integrates them into the conversation between the patient and practitioner. Thus the knowledge underpinning culture sensitivity can be classified as a theoretically substantiated skilful intellectual technique intimately related to a formalised language expertise.

Cultural knowledge per se lacks its own grounding because in order to be considered discretionary specialisation it must rest upon a solid basis of standardised and systematised knowledge unique and exclusive to an occupation, which can be controlled, standardised up to an extent (leaving room for discretionary specialisation), and systematised. We cannot try to professionalise an emergent occupation without any distinctive formally systematised body of knowledge, with

[64] Program available on: https://bit.ly/3i3vzuE

blurry interoccupational boundaries, and no task discretion framework by means of de-mystification and scientifically unsubstantiated disparagement of other occupations.

My question for IM advocates is how can it be scientifically determined that the vaguely delimited cultural knowledge of an immigrant is more unique, sophisticated and exclusive than cultural sensitivity of a professional communicator? How can it be scientifically determined that the mediator knows how to implement the cultural knowledge they possess successfully? There are no prescriptive professional norms to align mediators' performance with. But apart from this, the very fact that an intercultural mediator belongs to the same culture as the patient does not guarantee anything *per se*. IMs must be very careful when oversimplifying, adulterating, distorting the original discourse and deleting jargon or specialised verbiage, which they may not even (fully) understand themselves. All these excessive mechanisms of patronisation manifested through "inclusive" rhetoric, "plain language", register re-adjustement, etc. may translate into partial or complete bastardisation of medical discourse. As Fuller (1998, p. 36) maintains: "In the transformative act of making science accessible a process of recontextualization occurs where science is repackaged to fit the discursive configurations [...]", which in a medical context, where people's lives, safety and wellbeing is being dealt with, may result in unmonitored carte blanche leading to detrimental consequences.

How can professional boundaries be established and how can somebody control the performance of IMs? How can a hospital, for example, guarantee that IMs exert their discretionary specialisation duly and appropriately? Without trust there cannot be social closure, licensing and credentialism. The trajectory of the transition of the occupation from medical interpreter to intercultural mediator rests upon uncertain speculative foundation in the absence of substantiated theoretical grounding.

> T. H. Marshall stated in 1939 that 'Professionalism is not concerned with self-interest, but with the welfare of the client'. Common good was paramount while individualism and self-interest were of lesser importance. (Mungham & Thomas, 2016, Descriptions of the legal profession section, § 8)

Mungham and Thomas (2016) also maintain that a "position of service is also offered as the primary justification for the special privileges enjoyed by the profession" (Descriptions of the legal profession section, § 6). The authors also cite Hailsham who unpacks the importance of always seeking the welfare of the client (the patient and the doctor in this case are both our clients):

> In order to protect the public from the charlatan or the quack, entry into the profession must be guarded, its standards policed, and its rules of practice defined in the first instance by the profession itself... The ground rules of completion are designed for the interests of the public and not for the interests of the profession alone. (Hailsham, 1971, cited in Mungham & Thomas, 2016, Descriptions of the legal profession section, § 6)

In fact, this altruistic model which encourages professionals to act in the clients' best interests constitutes a source of the profession's charismatic authority and the justification for the claims of power "to determine the conditions of practice independently of the state" and privilege "in state protection for the monopolistic economic basis of that practice" (Mungham & Thomas, 2016, Descriptions of the legal profession section, § 13). Let's be honest, who in their right mind would like to be co-diagnosed by somebody who has no medical training whatsoever and alters

your/doctor's discourse without you/him/her even knowing to allegedly "help" you communicate? Normally, when people go to the hospital they go to see the doctor, the expert, the specialist in the ailment they suffer from. All intervention into the process of treatment must be rigorously controlled and thoroughly regulated by the state, because we must not forget that we are dealing with the patients' lives and health. The role of intermediaries must be very carefully pondered and vetted.

The adulteration of discourse can potentially hinder the integration process of the foreign speaking patients, which is purportedly one of the final goals pursued by IM. On the contrary, in order to encourage patients' participation and empowerment the interpreter should not become a surrogate and replace what is supposed to be the patient's/doctor's discourse with their own:

> Martín and Phelan argue that community interpreters should allow the primary speakers in the interpreter-mediated conversation to sort out cultural problems themselves by allowing them to ask more questions and that they should provide a cultural explanation only as a last resort. (Pokorn & Mikolič, 2020, p. 90)

Apparently, IM advocates do not seem to realise that a further dilation of the IMs' task repertoires by means of adoption of conflicting roles (advocate, mediator, co-diagnostician) may seriously narrow and impair the domain of the practitioner in charge of the institutional encounter, which would imply serious infringement upon clients' or patients' rights.

9.1.6. Professionalisation prospects of IMs in Spain

This section will be dedicated to analysing professionalisation prospects of IMs in Spain. At this point it is clear that general support of the population towards interpreting is "weakened by general scepticism or indifference", and this is why I believe there is a risk of it becoming "an empty shell", and its position in the strata being taken over or "usurped by another more popular discipline", which in this case may very well be IM (Freidson, 2001, section 7, subsection The Contingencies of Knowledge, § 1-3). The inclination towards trivialisation and stereotyping of interpreting as mere translation of words and the tendency to extol mediation as a highly mystical process inaccessible for those who do not share the cultural origin of the patient may lead to deprofessionalisation of interpreting and usurpation of this role by mediators. According to Pokorn and Mikolič Južnič (2020) the attention is never drawn to the fact that the fundamental difference between MI and IM lies in the degree of the specialisation of training, because the highly sophisticated university education of MIs would render IM so generic, non-specific, primitive, unrefined and vague that it would instantaneously render all attempts to professionalise unsubstantiated. As stated by Pokorn and Mikolič:

> Despite this avowed lack of interpreter training of [IMs], proponents of [IM] in this configuration do not identify the fundamental difference between [IM] and community interpreting in terms of interpreter training, and instead ascribe this difference to their abilities and tasks. (Pokorn & Mikolič, 2020, p. 87)

Vague task demarcation, the dilation of the IMs' abilities, and the claim to be able to better relate to the patient due to the same cultural and ethnical background, constitute the only way for the advocates of IM to debase MI and disassociate themselves from it:

> Generally, IMs are argued to possess a more extensive list of skills and competences than community interpreters. Becker, Grebe, and Leopold (2010:10–11), for instance, claim that language and integration mediators "can contribute skills – especially necessary, basic technical knowledge and terminology in social services, education and health – that are not necessarily included in pure interpreting training," and that they do so "at reasonable costs." This statement suggests a devaluing of interpreting education by ignoring the communicative function of interpreting and by failing to attribute the acquisition of extralinguistic knowledge and specialized terminology to this academic preparation (Pokorn & Mikolič, 2020, p. 87)

This excerpt from the Research Report on IM for Immigrants in Spain (Rozi, 2015) fully undergirds the point expressed above:

> Spain is the country that has the most universities in EU (more than 40 institutions) offering bachelor's degrees in Interpreting and Translation, while, according to the Index Translationum of UNESCO, Spain is the second country in the world after Germany that produces the most translations by professionals and freelancers (Valero, 2014). This long tradition, recognition and practice of translation and interpretation in the country, is the main reason why there is a distinct separation between the institutions of translation and IM. IMfI [IM for Immigrants] comes to fill a void that translation and interpretation leave – namely to reconcile the parties and restore or construct communication, mutual understanding and tolerance in society – and not to substitute them. (Rozi, 2015, p. 9)

This statement lacks scientific evidence. It was an invasion of our field without our permission. We have been training interpreters in the public services for years, long before mediators emerged. Mediators usurped our niche because our field lacks social closure, not because we let them, or because we don't train our interpreters properly. It happened because an aura of mystique has been promoted by idealising the role of mediator as the ultimate solution to major social problems, and by overemphasising the notion of culture as an autonomous realm existing beyond mere words. The concept of the occupational prevalence of IM over interpreting has plagued the field of public medical settings due to specific characteristics of patients' profiles.

9.2. POLYGLOT NURSE DOUBLING UP AS PROFESSIONAL TRANSLATOR AND INTERPRETER

In this section I shall seek to illustrate the role that bilingual/multilingual medical staff plays in the public healthcare in the Valencian Community. After a brief contextual introduction I shall proceed to thoroughly analyse the case of a polyglot nurse who is also a professional translator and interpreter, who works at the transplantology department in a public hospital located in Alicante. But by way of introduction I would like to start off by providing a brief explanation of the differences between the job requirements for medical staff in public and private healthcare sectors.

So, according to Niño Moral (2008, pp. 1065-1068), one of the measures adopted by the privately managed state hospitals is the tendency to hire staff with language skills, whereby the employers discriminatorily single out hospital staff on the grounds of their knowledge of foreign languages. This recruitment policy is apparently the norm at the Torrevieja hospital (province of Alicante) where, the knowledge of English in all job categories and the knowledge of German language in almost all job categories constitutes one of the minimum requirements and a basic

precondition for an application to be processed by the human resources team. Several news reports issued by the press also point towards recruitment of healthcare staff from Eastern European countries in this same hospital. Nevertheless, this medical centre has an interesting particularity: it is a privately managed public hospital, which allows it to include the command of foreign languages among its staff selection criteria. It seems that this selection criterion cannot be applied in the case of hospitals managed by the Conselleria de Sanitat (local health authorities), as it would be considered discriminatory (Niño Moral, 2008, p. 1066). The same author goes on to say that the figure of interpreter does not constitute a job category *per se* yet, which is why public employment cannot issue a notice of vacancy for the position of medical interpreter (Niño Moral, 2008). However, the hospital administration may employ interpreters on a contract basis, which is the case of Marina Baixa Hospital, where there is an interpreter available, although only in the mornings (Niño Moral, 2008).

Libro Blanco de la traducción y la interpretación institucional (2011, pp. 58-59) also corroborates the aforementioned information. According to the author, in the absence of official recognition of the figure of interpreter in the health services, no professional category was established either. The lack of recognition of this profession gives rise to recruitment of applicants who have completed "bachiller" (Spanish Baccalaureate equivalent to British A levels) or vocational training studies. Normally even a language proficiency certificate issued by the Escuela Oficial de Idiomas (Official School of Languages) is sufficient, which is a public network of non-university level centres which allows the adult population residing in Spain to learn foreign languages and to obtain a certificate attesting to the level of linguistic competence they possess. The EOI are regulated by the Ministry of Education and Vocational Training as well as by educational administrations. In some cases, the recruitment of non-professional interpreters is justified by the lack of qualified candidates as well as by the absence of regulated studies (for example, in the case of "exotic languages" or dialects). Thus, no specific qualification is required to access the position of interpreter/mediator in the health services (*Libro Blanco de la traducción y la interpretación institucional*, 2011, pp. 58-59).

Thus, "medical interpreter" is not considered a proper job category in the Valencian Community. No budget is allocated in public hospitals to employ interpreters on a contract basis. Public medical centres cannot include the command of foreign languages among its staff selection criteria either. Their only solution to deal with the foreign patients and their families, especially in situations as delicate as death of a patient or request for organ donation is to look for somebody who already works in the hospital and claims to speak languages. The topic of organ donation rises to prominence due to the fact that Spain has been acknowledged as the world leader in organ donation and transplantation for twenty-seven consecutive years. The family interview for requesting organ donation is extremely delicate and highly sensitive and may be severely hindered by the language barrier especially in regions such as Valencian Community, where a historical maximum in international tourism was registered in 2019. According to the National Institute of Statistics (INE) more than 355.000[65] foreign residents have been reported to have resided in

[65] Data available on: https://www.ine.es/jaxi/Datos.htm?path=/t20/e245/p08/&file=03002.px#!tabs-tabla

Alicante throughout 2019. These socio-demographic conditions make the presence of a medical interpreter in the one of the biggest public hospitals in the city of Alicante absolutely imperative.

Dr. Carlos Santiago Guervós, Head of the Transplant Coordination Service of the General Hospital of Alicante maintains that:

> Alicante is a province with very special characteristics, given that its foreign population amounts to around 350,000 people out of a population of 1,800,000. This is also reflected in the donation, because between 30 and 40 percent of the donors are not Spanish [...] [t]his poses a series of linguistic and also cultural difficulties, because up until now we have had donors of 30 nationalities. Thus, a new model was developed at the Transplant Coordination department of the General Hospital of Alicante, which consists of dealing with the families who have to contend with the death of their family member. The moment when the death of a family member is being communicated implies distress and great emotional impact. In the case of non-Spanish patients, the added pain is that they are in a country that is not their own, which intensifies their distress and pain. (Ortega, 2018, my translation)

Last year, donors from the UK, Ecuador and Germany topped the list at the hospital (Ortega, 2018). Dr. Carlos Santiago Guervós goes on to say: "Creamos una figura, la del cooperador cultural, que no es un traductor porque en estas situaciones se viene abajo [We created a figure called the cultural cooperator, who is not a translator because a translator in these situations would [simply] fall apart]" (Ortega, 2018). In order to give the best possible coverage to these families, the department started considering a new method within the Alicante Model. The doctor has explained that:

> You can get by in some languages but not in so many, and [therefore] we considered creating a figure, that of cultural cooperator, who is not a translator because in these situations a [regular] translator would be emotionally affected [in the sense of being traumatised by the severity of the situation], they [translators] are not prepared for these scenarios. Therefore, we looked for people within the medical staff who could speak quite a few languages. (Ortega, 2018, my translation)

And the Alicante University Hospital just happened to have a unique solution. The doctor proudly talks about one of the members of his team:

> A Spanish nurse who has lived in Switzerland and is fluent in four languages: French, English, Italian and German. We prepared her for the family interviews, with a group of psychologists. The handicap that health professionals sometimes have is that they have not received adequate training to communicate bad news, and we thought it was vitally important that these people who were going to collaborate with our cooperators had that preparation. (Ortega, 2018, my translation)

Silvia Mira Audinis, the protagonist of this case study, whose daily tasks constitute a combination of two professions: nursing care and professional translation and interpreting, explains how it all started:

> [00:03:50] I've been lucky enough to work in two things I've enjoyed: languages and nursing care. [One day I was working as a nurse at the hospital in Alicante and they were looking for someone who spoke English and someone knew that I was there, that I spoke English and they came looking for me. They needed help because there was a patient in the ICU with a brain death whose family members only spoke English and whom [the hospital employees] wanted [wanted to conduct a family interview with in order to] request [consent for] organ donation for a transplant]. (Pérez Molero, 2015, 00:03:50, my translation)

Silvia Mira Audinis is a registered nurse and she also holds a degree in Translation and Interpreting conferred by the university of Alicante[66]. She is also a sworn translator of Spanish and German. The polyglot nurse was reported to speak German, Catalan, Spanish, French, English and Italian. She has stated in the documentary that she learnt the languages during her residence in Switzerland (Pérez Molero, 2015, 00:04:50).

This case has proven to be a *sui generis*, therefore the story of Silvia Mira Audinis was featured in a feature-length documentary directed by Antonio Pérez Molero in 2015 and broadcast on a national TV channel called "The Interpreter".

To the best of my knowledge, this is the only case where one worker combines two occupations, one thereof a full-fledged, traditional, ritualised profession, the other one an occupation in embryonic stage of development, and both on professional level. It is much easier to find a medical worker, be it a nurse or a doctor, who is (or at least claims to be) bilingual or multilingual, or who has a good command of a given language rather than somebody who has successfully completed two university degrees and apart from that is a hyperpolyglot. Naturally, a person with such an overqualification would be the optimal solution for the patients in any hospital or medical centre, but it is extremely difficult to find professionals with this profile. Nevertheless, there are many medical professionals who are bilinguals or even polyglots, who are preferred over professional MIs even though they do not possess any type of specific qualification apart from their alleged linguistic knowledge. I shall dedicate the following chapter to unpacking the phenomenon of medical staff who doubles up as interpreters in private healthcare sector.

[66] LinkedIN profile of Silvia Mira Audinis: https://www.linkedin.com/in/silvia-mira-audinis-15aa4551

10. HYBRID PROFILES IN PRIVATE SECTOR

In this section I shall submit to scrutiny the current situation with hybrid profiles in the private healthcare settings. I would like to start this section by briefly defining the profile of the patients who usually undergo treatment at private medical facilities:

- affluent elderly population (expatriates), who seek foreign retirement as long-term residents in Spain
- international travellers, who visit Spain
    - out of the peak tourist season, such as business tourists and regular tourists,
    - the traditional high season travellers
- the genuine medical tourists, who intentionally seek to undergo a planned elective treatment which is the main purpose of their journey abroad

These patients have consciously selected Spain as their destination for travel, retirement or medical treatment. Therefore, unlike the immigrant patients, these potential patients, especially medical tourists, know beforehand what to expect and what they embark upon when they seek cross-border medical assistance.

The high number of foreign-speaking patients and the willingness to offer a personalised service and improve competitiveness led many hospital chief executives and procurement managers to recruit diglot or polyglot medical professionals under the EU Directive 2005/36/EC (2005) (Footman et al. 2014, p. 29). Professional mobility of medical workers enabled by the EU "mutual recognition of a series of qualifications for medical professionals" (Footman et al., 2014, p. 9) spawned the development of two major hybrid profiles:

- medical professionals doubling up as interpreters
- plurilingual medical/patient assistants with extensive task repertoire.

This chapter will be dedicated to breaking these profiles down and searching for the rationale behind their development.

10.1. MEDICAL STAFF DOUBLING UP AS INTERPRETERS. GENERAL OVERVIEW

The medical tourism phenomenon has spawned the emergence of new breeds of medical workers and also new breeds of interpreters. Professional usurpation for the sake of status and employability has brought the notion of the division of labour and the compartmentalisation of tasks to a new level of duty redistribution and reallocation, whereby interpreters have been literally ousted form their own jurisdictional boundaries and replaced by bi- and multilingual doctors and nurses. The latter can either be genuinely bilingual or self-identify as proficient users, but both seek to claim ownership over the MI's professional expertise.

Drawing on the resources that a hospital or a clinic already has for time- and cost-saving purposes may be one of the major rationales behind the recruitment and deployment of bilingual staff. Tapping the resources that are already on the payroll is also a strategy of competitivity

enhancement, in that foreign speaking patients greatly appreciate it when medical staff interact with them in their own language (Regenstein et al., 2013, p. 8). Private healthcare seeks to employ tactics in order to stand out by offering a more foreign-patient-centred service (Martínez-Gómez, 2007, pp. 1048-1049). Such direct interaction without further need for liaison denotes "tangible demonstration of respect for the patient and can help to forge a stronger patient-doctor bond" (Regenstein et al., 2013, p. 8). The expectations that the private healthcare users have regarding the service providers are extremely high and they imply personalised and customised care.

But, even though using bilingual medical professionals for a better rapport development may be a clever strategy *per se*, the problem however lies in the lack of formal and proper competency testing.

> In practice, "bilingual" clinicians' non- English language skills are heterogeneous, ranging from those with very limited competency, who might speak just a few words of another language, to those who are native speakers and even received their medical training in a non-English language. (Regenstein et al., 2013, p. 1)

There are no requirements as to "the necessary training nor precise measures of competence for bilingual clinical staff" Regenstein et al. (2013). "Bilingual staff are often used to interpret, without any assessment of their skills" Moreno et al. (2007, pp. 331-335).

Hence, it is not only the government authorities who base their funding priorities on "expedient parsimonious frugality" (Orlov, 2019), but also the procurement managers of private medical centres, who in spite of budget availability still prefer to expand their offer portfolio to cover language provision by means of bilingual or plurilingual clinical staff. Medical professionals may not all be intentionally "competing for access" to the profession of MI, but they are willing to "improve their status by new acquisitions or the relinquishment of less attractive properties" (Hughes in Dingwall, 2016, introduction section, § 10-12). In this case, their alleged ability to communicate directly with the patient without being dependent on a third party constitutes a great asset.

Consequently, linguistic knowledge as professional competency in this particular case can be classified as a secondary and ancillary in nature. It is viewed as a co-adjuvant factor in terms of enhancing the applicant's employability. This appropriation leads to devaluation of medical interpreters as their presence in the consultation is no longer required. This phenomenon has a direct bearing on de-mystification of our profession by means of its de-specialisation. The *laissez-faire* ideology popularises and secularises the knowledge underpinning medical interpreting, it basically vulgarises it to an extent where everyone can have an open indiscriminate access to that knowledge, where anybody can claim eligibility and entitlement to use their linguistic skills, be it because they are bilingual, or be it because they overestimate their abilities and underestimate what it actually means to communicate in a language. Cox and Lázaro also decry the caregivers' failure to:

> Realise the importance and added value of professional interpreters (Elderkin-Tompson *et al.*, 2001). Medical staff may overestimate the patient's own language skills, and/or judge that ad-hoc interpreters suffice for language mediation. However, even if a patient seems fluent in daily small talk, (s)he may not yet have the proper repertoire for communicating effectively with a doctor. (2016, p. 37)

The popularisation of knowledge has led to the lack of necessity to preclude entry to the occupation. As maintained by Hale (2007, p. 35): "professionals working with interpreters rarely understand the complexity of the task". This same statement can be easily applied to those who claim to be able to "speak a language" or those who claim to "know a language" [*saber un idioma*], despite their assertiveness, they are not cognisant of the complexity of the tasks. Some physicians who did facilitate linguistic exchange or those who did provide medical advice in a foreign language do recognise that this activity entails complex body of formal knowledge and skill as well as the exercise of considerable amount of discretion:

> Non-professional interpreters can be a liability in any field if they don't have the linguistic skills for the subject they have to address. [...] When I worked as a doctor in Lyon, I initially found there were legions of new medical terms, acronyms, names of anatomical parts and idioms which my otherwise fluent French did not cover. It took me several months before I began to feel confident that I could avoid misunderstandings in this new clinical setting. (Laurence Gruer, Honorary Professor, University of Edinburgh, BJM, 2020)

> In a senior house officer[67] job in the Midlands, serving a very large Indian and Pakistani population, as well as managing my own patients I was called by colleagues in other wards to come and help them, adding to my workload. At the time I thought little about it. Retrospectively, this was dangerous medicine for the patient, me and the health service alike. I did my best but it was wrong to do so and it was also wrong for colleagues and the health service to have such an expectation. The value of a professional interpreter is to allow health professionals to practise as safely as possible. Excepting in emergencies, the use of family interpreters whether children or adults should be called out and banned as malpractice. [...] Most family members do not have the vocabulary or concepts to interpret complex medical matters. Even as a person whose first language was Punjabi and who is trained in medicine, I was lacking in many anatomical and physiological terms (some of which do not exist in Punjabi, Hindi or Urdu) to permit accurate translation or to improvise by using appropriate analogies. Excellence in communication is fundamental to safe and effective healthcare (Bhopal RS. Migration, Ethnicity, Race and Health in Multicultural Societies. 2nd ed. Oxford: Oxford University Press; 2014. (Raj Bhopal, Emeritus Professor of Public Health, Usher Institute, The University of Edinburgh, BMJ, 2020)

It is clear that both physicians definitely value the sophistication of the body of knowledge and skill required to provide a proper verbal interpretation of the participants' utterances. They also recognise that a substantial amount of discretion needs to be exercised by the person who interprets in order to convey the message accurately. Professor Bhopal challenges the whole idea of hiring bilingual doctors or doctors who claim proficiency in one or several languages. Drawing on his own professional experience he decries the suboptimal and therefore unacceptable attempts that some physicians might make to muddle through fumbling for the right words. Professor Bhopal believes that neither the medical facility, nor members of medical staff should rely on and expect their bilingual colleagues to double up as interpreters. However, these opinions are rather exceptions than the norm.

[67] Definition available at https://medical-dictionary.thefreedictionary.com/senior+house+officer: An obsolete junior doctor post in the UK, which followed the pre-registration house officer year and precedes GP or specialty training. The tenure of each post was usually 6 months and some posts are linked in clinical rotations to give a broader clinical experience; doctors intending to remain in hospital practice must obtain a higher diploma from a Medical Royal College before progressing to registrar level.

10.1.1. Clinical staff doubling up as interpreters in the VC

Many private hospitals in the Valencian Community have already started to expand their offer portfolio by putting allegedly polyglot doctors, medical staff and administration staff on the payroll in order to attract clientele from abroad and boost competitiveness. This idea has reified into a normalised practice as a result of professional migration. The labour market demands (at least in the private healthcare system) might have changed and the domestic workforce is no longer as appealing as foreign-trained specialists. The command of a second language that could be used to conduct the consultation in became a major asset. As a general rule many of these migrating professionals from abroad would also claim to speak English. So, the continuous outflow of professionals has normalised their incorporation into the destination healthcare settings, so that now "many countries are reliant on foreign healthcare professionals to replenish their workforce" (Footman et al., 2014, p. 4). Cerdán (2014, pp. 16-17) has conducted an interview with the financial director of the International Medimar Hospital (Hospital Internacional Medimar) and this is an excerpts thereof:

> [During the face-to-face interview with Ms. Esther González, who we turned to due to her position in the hospital as financial director, a reality that exists across the whole Spain became evident. The opinion of the financial director of this private clinic is that the interpreter is becoming less and less necessary because [one of the] requirements of the hospital is that its staff (nursing assistants, nurses, doctors, administration staff...) speaks English. She added that it would be idyllic if they spoke French, given the high number of patients from Algeria who use it as *lingua franca*]. (Cerdán, 2014, pp. 16-17, my translation)

In view of the development of medical tourism the demand for health professionals who speak several languages especially for certain sectors (e. g. plastic surgery and assisted reproduction) is expected to rise by 40% in 2017 alone, according to Adecco's forecasts (Pascual & García, 2017). From a social point of view, health tourism values immigrants with a professional healthcare profile, as well as second generation immigrants, who have knowledge of the languages and culture of the different countries of origin of international patients. Furthermore, medical tourism constitutes an entry point for expatriates with healthcare profiles who wish to return to Spain and who may be able to furnish different perspectives on a number of issues such as the standards of practice or action protocols used across different countries. The expatriates' added value is the languages they claim to be proficient in. All this knowledge enriches their expertise and helps optimise the care of the cross-border patients making their experience at an overseas hospital more homelike (Pascual & García, 2017).

The candidates with medical education, such as a Degree in Nursing for example, are deemed to be the most suitable for the job and therefore happen to be the most sought after (Pascual & García, 2017). Healthcare job offers associated with languages and linked to this type of tourism have increased by 20% in the last five years. Fluency in English came to constitute a basic requirement for employment (Pascual & García, 2017). However, there is an increase in job offers that require a third language ("Las ofertas de empleo en el sector sanitario se incrementarán un 40% con respecto a 2016", 2017). Russian, Arabic, Chinese, German and French are the most demanded ("Las ofertas de empleo en el sector sanitario se incrementarán un 40% con respecto a 2016",

2017). This may lead to the return of expatriates Adecco (2017, pp. 1-5). Dr. Esther Charro, Adecco Healthcare Service Director, posits that:

> This type of tourism increases the need for qualified jobs in the healthcare sector, such as doctors, nurses and technicians; it helps to create new profiles in the sector, such as health assistants; and it reinvents the existing ones by putting into value new skills and competences. (Dr. Esther Charro, 2017, p. 2)

As reported by Adecco (2017, pp. 1-5), profiles mastering 3 or more languages are being sought after in the area of nursing. The demand for technical profiles with language and commercial skills will also increase. English is essential in addition to at least one other language.

Numerous websites belonging to private clinics and hospitals located in the Valencian Community advertise the availability of doctors from different countries: "The HCB model offers to our patients services by nationalities [...] [provided by] specialised doctors and nursing staff from Spain, Holland, Germany, Russia, Scandinavian countries, England and Arab countries as well as multilingual and international administration and reception staff " (HCB, 2020)[68]. Valencian Institute of Infertility offers "Dedicated international department: Airport Pick-up service, 24-hour telephone service for emergencies, Skype consultations, counselling service, one personal medical assistant for each patient and English-speaking doctors of international prestige" (IVI, 2020)[69]. This is how IVI in Spain[70] explain their policy:

> We have worked [...] to gear up our clinics in Spain to an international patient base. We can offer multilingual staff and English-speaking doctors of international standing as well as practical conveniences such as an airport pickup service, video consultations and counselling, with a personal medical assistant who will accompany you through the whole process.

Medicality International Medical Centre also offers "medical assistance in Spanish, English, German, French, Italian or Dutch" (Doctoralia, 2020)[71]. All the staff speaks fluently both Spanish and English, and depending on the specialist, also German, French, Russian, Italian, Dutch and Chinese, as reported in a press release (ABC Comunidad Valenciana, 2017). The concept of the centre is based on the treatment adapted to each client according to their origin. According to Ilona Kunze, Medicality's Medical Director, "we understand that communicating in their language and having international staff sensitive to cultural differences, makes foreign patients feel much more comfortable" (ABC Comunidad Valenciana, 2017).

The flood of foreign patients has forced clinics such as ProcreaTec to create an international patient care department, where groups of polyglots are in charge of answering incoming phone calls or e-mails, and even offer lists of hotels, locate nearby as well as information on how to get around the city (Comando Actualidad, 2016).

[68] For more information, please check the official website https://www.clinicabenidorm.com/paciente-extranjero/hcb-paciente-internacional/
[69] For more information, please check the official website https://ivi-fertility.com/patient-journey-overseas/
[70] Excerpt extracted from: https://ivi-fertility.com/blog/ivi-baby-plan-fertility-clinics/
[71] For more information, please check the official website https://www.doctoralia.es/clinicas/medicality-international-medical-center#

Hospital Quirón in Valencia also advertises their readiness and willingness to deliver medical assistance in English (Hospital Quirón, 2020)[72]. In an article released in 2018 (Europa Press, 2018) it is revealed that Quirónsalud offers translators and bilingual medical staff, which places this private hospital chain at the forefront of international medical assistance. Quirónsalud has an international department that is available 24 hours a day and can attend to patients in any language at any time of the day. In addition, these hospitals have entire wards specifically designed to host international patients and a translation service, that at Quirónsalud Torrevieja offers eight interpreters and at Quirónsalud Valencia - five (20minutos, 2018).

IMED Valencia estimates that around 20% of their patients will be foreigners, therefore it is strictly required that all of the hospital staff possess knowledge of English: "[knowledge of English has been required for all employees [...] We have receptionists and people who, of course, speak English, French, but also Norwegian, Russian... and we have one person who speaks Chinese]" (Salinas, 2017). Hospital Internacional Medimar is yet another example of medical facility geared towards medical tourism:

> The international patients [sic] department is well equipped to dealing with [sic] foreign patients, and provides all necessary services (see the full list below). It can also assist you in 8 languages, including English, French, Russian, Arabic and Chinese.[73]

These are just a few examples which might not be totally generalisable, but which still showcase a marked tendency to either hire physicians from other countries or to hire Spanish doctors and/or medical staff who speak English or are multilingual. To delve even deeper, I analysed an article which releases the figures of the foreign-born doctors working in Spain. This article from the Redacción Médica Journal (Nova, 2019) draws up the dynamics of migrating medical professionals. Thus, an OECD (The Organisation for Economic Co-operation and Development, OECD) study reveals that there are 16,000 foreign-born doctors in Spain. The percentage of foreign-born doctors working in Spain has increased has risen from 7.5 percent of the total number of doctors to 13.7 percent in just 15 years. According to the latest available figures, this increase is also reflected in the nursing profession, although with a lower incidence. In the case of nurses, the percentage of professionals is 4 percent of the total number of professionals, which in 2000 was 3.4 percent (Nova, 2019).

By checking the professional profiles and perusing the CV's of all doctors who work in four major private healthcare facilities in the Valencian Community, I found out that out of 432 doctors from four different private healthcare facilities[74] only 32 doctors were actual bilinguals coming from overseas. Out of 153 doctors working at the first facility, which claims that more 80%[75] of their patients are foreigners, 20 doctors came from abroad. Four of them were native

[72] For more information, please check the official website https://www.quironsalud.es/valencia/es/pacientes-visitantes/atencion-paciente-internacional

[73] For more information, please check https://www.health-tourism.com/medical-centers/hospital-internacional-medimar/

[74] For more information, IVI RMA (2021) and the following links: https://www.clinicabenidorm.com/especialidades-medicas; https://vithas.es/cuadro-medico; http://www.imedlevante.com/es/pagina/especialidades-levante-benidorm

[75] For more information, please visit the following link: https://www.clinicabenidorm.com/quienes-somos/hcb/

German speakers, 1 native English speaker, 1 native French speaker, 4 of them spoke Arabic, 6 spoke Dutch, 1 person was from Italy and 5 from Russia.

Out of 20 doctors from the second facility – 1 was native Portuguese speaker, 1 was native French speaker, 1 was native German speaker, and 1 had Italian as their mother tongue. This second facility reportedly treats around 4000 patients per year, 30% whereof are from overseas (IVI RMA, 2021). Out of 121 doctors, who work at the third medical centre only 4 were foreigners (2 thereof spoke Arabic and 2 – Russian). Out of 140 doctors from the fourth private clinic only 4 were bilinguals: 1 person speaks Dutch, 2 people speak Russian and 1 person speaks Arabic.

In my opinion this research is extensive enough to showcase that, apart from the first private hospital, relatively very few foreign doctors have been hired so far[76]. It is worth clarifying though that it is practically impossible to know how many of these 432 doctors self-identify as proficient users of English or any other foreign language, or how many thereof assess their foreign language skills as adequate and use them to conduct consultations.

10.1.2. Genuine bilinguals *versus* self-proclaimed proficient users

We may want to be very careful when we talk about Spanish doctors being allegedly able to communicate in foreign languages. On the one hand there may be medical professionals who indeed hold sufficient linguistic capital to be able to communicate with their patients, on the other hand there may be many medical workers who are convinced of their linguistic proficiency and self-sufficiency, but whose eligibility has never been subject to scrutiny and the truthfulness of their claims has never been verified. In many cases medical professionals are just overestimating their foreign language abilities. While it may be true that "more and more doctors speak English and communicate relatively well with their patients" Aguilar (2012, pp. 131-132), not all who claim fluency are actually proficient:

> Let's face it, the problem is that they think they speak English but they don't really [...] And often what happens is that the patient says I don't understand a word and so you've got to be very diplomatic with the doctors obviously, you know? [...] the patient could be asking for an interpreter and the doctor would be saying, NO, NO, NO, NO!!! They don't bother [...] [Or we speak enough English] or whatever and the problem is that they don't speak that well. (Aguilar, 2012, pp. 131-132)

Reportedly, some medical professionals even perceive interpreters as intruders (Aguilar, 2012, p. 125). The author postulated that some doctors and nurses 1) fail to accept the volunteer interpreters' position as part of naturalised, routinised and normalised order of things; 2) fail to acknowledge interpreters' linguistic capital as a valuable asset; 3) claim to possess same linguistic capital, which leads up to non-recognition of the interpreters'[77] position in the field (Aguilar, 2012, p. 126).

This may be happening due to anglomonolingualism in medicine through the internationalisation (or americanisation) of medical journals (IntraMed, 2010). Such "uniformisation of thought as a consequence of the hegemony of English is reinforced by the fact that researchers

[76] I am saying this in 2022

[77] Be it professional interpreters, layperson interpreters, volunteer interpreters, etc.

only read US journals and books [adapting themselves] to American reasoning, concepts and ideas" (Navarro, 2001, p. 44).

In many countries, university students use English textbooks - which they barely understand - or translations of manuals initially written in English; in either case, with data often limited to the territory of the United States (Navarro, 2001). Navarro maintains that the current preponderance of English is a direct consequence of the political, military and economic supremacy of the United States since the end of World War II (2001, p. 37). Thus, the English language has been imposed on the rest of the world through commerce, culture, politics or force (Navarro, 2001). Navarro contends that:

> Since 1970, when the world supremacy of American science was generally accepted in the Western world and English was already accepted as the international language of medicine, the number of non-English-speaking authors who published their works in English began to increase, not only in major international journals but also in national ones, many whereof started to be published in English. (Navarro, 2001, p. 37, my translation)

According to Navarro (2001, p. 40) nowadays virtually no one would bother to read or have an article written in a language other than English. Apparently, "there is an unconscious association between the quality of a text and the language in which it has been written" (Navarro, 2001). Allegedly, the rationale behind it has been embedded in the idea that everything that is being published in a language other than English will end up being perceived as either "unimportant or of inferior quality" Navarro, 2001). Thus, as it has been objectively proven by a group of Scandinavian researchers (Nylenna et al., 1994, pp. 149-151, cited in Navarro, 2001, p. 46) that "there is a widespread belief that an article written in English is, by the virtue of mere fact of being written in English, of higher quality than one in Spanish or any other language" (2001, p. 45).

Navarro states that the regularisation and routinisation of the reading of medical articles in English and the access to major scientific developments through specialised journals and textbooks of medicine written in English have changed the way doctors in the rest of the world express themselves in their mother tongue (2001, p. 38). This phenomenon became patent due to an increasing use of:

- anglicisms (e.g. by-pass, flutter, screening, spray, relax, test, stress *inter alia*)
- anglicized spelling in medical texts written in Spanish (e.g. halucinación, aprovar, massage *inter alia*)
- lexical anglicisms aka false friends (e.g. urgencia (emergency) vs. urgency (vesical tenesmus))
- excessive use of medical anglicisms substituting Spanish terms (e.g. gripe displaced by influenza, traumatismo replaced by trauma, vírico" displaced by viral)
- syntactic anglicisms denoting the abuse of passive voice uncommon in Spanish
- adjectivisation by juxtaposition of two nouns to give the first one the character of an adjective (depresión posparto)

- adoption of substantivized adjectives formed by juxtaposing an adjective before a noun totally disregarding the interposition of a preposition (vacuna anti-hepatitis, nefropatía analgésica) (Navarro, 2001, pp. 38-40).

The fact that healthcare professionals are able to read scientific articles in English is exactly what leads them to think that they are fluent in English, even though their actual level of linguistic proficiency might be extremely subpar in reality. Navarro argues that while reading and understanding a written discourse may be achieved without great difficulty, writing and oral expression has proven to be much more difficult" (2001, p. 46). Navarro (2001, p. 46) urges everyone to be realistic and concede that:

> The active knowledge of even a single foreign language constitutes for ordinary mortals [...] a task that demands immense time investment and dedication, however much the advertising of distance learning courses such as 'speak English in 15 days' attempted to convince us otherwise. (Navarro, 2001, p. 46)

The author also cross-references Salvador Reguant (1994, as cited in Navarro 2001), who is deeply convinced that: "llegar a un fluent English por parte de los científicos no angloparlantes es difícil, y, en la práctica, sólo un porcentaje muy bajo de españoles es capaz de intervenir eficazmente en reuniones científicas [reaching fluent English by non-English speaking scientists is difficult, and in practice only a very low percentage of Spaniards is actually able to intervene effectively in scientific meetings] (Reguant, 1994, pp. 435-438, as cited in Navarro 2001, p. 46). Navarro (2001, p. 47) also draws upon Meyer's (1975) persuasion that this problem mainly affects verbal expression in order to emphasise the difficulty to produce flawless oral discourse. "Moreover, a language barrier is created between upper class medical science and lower class medical practice" (Vandenbroucke, 1989, pp. 1461-1462, cited in Navarro, 2001, p. 49). Therefore, it is imperative to design and pursue a safety-oriented strategy in order to meticulously and formally screen, test and monitor the quality of clinicians' alleged language skills.

10.1.3. Foreign language proficient patients

Another extremely important aspect to bear in mind is the fact that the physicians practicing in the private healthcare facilities in the VC are not the only ones who remain adamant about using medical interpreters (provided that this service is actually offered by the medical centre). Many patients also prefer to employ their foreign language skills during the encounter. The profile and expectations of the cross-border patients who are users of private medical assistance differ substantially from those of foreign patients who seek medical treatment in public health.

It was reported that the percentage of foreign patients in some medical institutions of Costa Blanca exceeds 80% (HCB, 2016)[78]. The majority of these patients come from Holland and Belgium (45%), the UK (22%), 20% come from Scandinavian counties, 7% corresponds to Russian patients, and 6% represent Germans (HCB, 2016). The figures that were released in 2016 on the official website of the Valencian Institute of Infertility indicate that although the percentage of

[78] Hospital Clinica Benidorm (2016) "Quienes somos" section https://www.clinicabenidorm.com/quienes-somos/hcb/

foreign patients is not as high as in some hospitals located in Costa Blanca (only 20% as opposed to over 80%), the richness of the variety of their countries of origin is something really astonishing: more than 90 different countries. Despite such geographical diversity the vast majority of patients come from Italy, France, United Kingdom, Germany and Switzerland (Valencian Institute of Infertility, 2016)[79].

The EF English Proficiency Index (EF Education First, 2019) reveals a major disparity in the level of English language proficiency among different countries. Thus Netherlands has the highest English language proficiency level in the world (1st position out of 100 countries) reaching the score of 70.27 and thus towering over the rest of the countries. Belgium occupies the 13th position and still enters the classification of "very high". Sweden was assigned the second position, Norway occupies the 03rd position, Denmark ranks 4th closing the top four countries with highest English language proficiency in Europe and in the world.

Germany ranks tenth, which is still attributed to the "very high" classification. Switzerland descends to a lower level, which is still labelled as "high" ranking 19th . France, whose proficiency level has descended to "moderate" occupies the 31st position out of 100. Italy ranks 36 which still falls within the category of "moderate" and, last but not least, Russia has descended to the 48th position falling within the "low" category.

Thus, it is blindingly obvious that the majority of the countries where the medical tourists arrive from have achieved a considerable degree of linguistic proficiency raging from "moderate" to "very high", which allows for direct communication during the encounter, provided that Spanish physicians are also prepared and willing to conduct the consultation in English. However, it is worthwhile noting that the data presented above cannot be completely generalisable, thus the linguistic proficiency is not something that can remain plateaued and be applicable to all citizens without exception.

On the other hand, there are patients from France, Italy or Russia who might have either excellent linguistic competence in English and therefore rather opt for dyadic communication, or poor linguistic competence in English, but who regardless thereof might still choose to liaise in English. Undoubtedly, this bilateral anglomonoliangualism renders interpreting services unnecessary and redundant and constitutes a problem which backpedals the process of professionalisation.

10.2. INTERPRETERS DOUBLING UP AS MEDICAL ASSISTANTS

This section will seek to analyse the rationale behind the emergence of a very distinct occupational profile: personal healthcare assistant Assistant (APS *asistentes personales sanitarios*). Spurred by the burgeoning of travel tourism this newly emergent job profile is based on healthcare knowledge (such as nursing), communication and commercial skills, and the alleged mastery of 3 or more foreign languages (Pascual & García, 2017; Adecco, 2017, pp. 1-5).

Often the recruitment of interpreters rests on the selection of candidates on the basis of several CVs, as well as through word-of-mouth "publicity" and acquaintances recommendation (Cerdán,

[79] For more information, please check the original article published on the official website https://ivi.es/notas/ivi-recibe-el-premio-a-la-mejor-estrategia-internacional

2014, p. 16). After a personal interview has been conducted, a probationary period ensues (Cerdán, 2014). The employers do not look for a profile of an interpreter, and it doesn't even matter that the candidate might hold a Master's degree in medical translation, since the potential employers simply do not consider that these studies are even necessary to carry out the tasks that the interpreter performs in their hospital (Cerdán, 2014). The fact that many of these interpreters are non-professionals plays a key role in profile hybridization, in that their unfamiliarity with the correspondent codes of ethics of professional MIs facilitates their acquiescence to the performance of any tasks they are required to undertake by the institutional elites. The employers opt to put on their payroll undemanding non-professional interpreters because they will not exert tasks discretion, nor will they try to demarcate their professional boundaries, thus ensuring absolute compliance with the position requirements.

The previous section sought to demonstrate the burgeoning of the tendency to hire bilingual, plurilingual or allegedly foreign language proficient medical professionals. However, it was revealed that foreign language proficient doctors currently practicing in the study-relevant area were relatively small in number. Therefore, private centres geared towards medical tourism still need interpreters, however their tasks are being reprioritised and reallocated so as to match the employers' expectations.

Many physicians prefer to conduct the encounter themselves, even though many of them visibly struggle to communicate with their patients. This results in them relinquishing other tasks, which they deem less attractive, more time consuming, less rewarding and less lucrative or profitable to the medical interpreter. Consequently, this fourth type of profile hybridisation consists in delegating certain duties, tasks and responsibilities to the interpreter, who ends up acting as a multilingual medical assistant, while the physicians hijack the tasks of interpreters.

The tendency to "help" clinicians is not new though. Hsieh had already reported that interpreters had a predisposition to blur the lines between the roles and take over the provision of "services typically associated with providers" (Hsieh, 2006, p. 925). The co-diagnostician role implies "deviating from the conduit role and [...] assuming responsibilities typically associated with providers (e.g. diagnosing the illness, educating patients, or providing support)" (Hsieh, 2006). Some of the tasks that interpreters had been found to perform included history taking, giving medical instructions and providing medical advice without the doctor giving any recommendations at all (Angelelli 2004, cited in Hsieh, 2006, p. 925).

The rationale and justification that apparently motivated such behaviour is the interpreters' perception of themselves as part of a team and their willingness to contribute to the joint effort by "aiding" the team they belong to (Hsieh, 2006, pp. 924, 935). Obviously, the patients run the risk of being misdiagnosed or receiving erroneous treatment, but they are "not in a position to evaluate the quality of the information and may still believe that the advice is given by the provider, rather than the interpreter" (Hsieh, 2006, p. 936). Such practices must clearly be outlawed since the interpreters do not receive any "training in soliciting, screening, and evaluating medical information" (Hsieh, 2006, p. 925). Nonetheless, such behaviour remains obscured by the fact that patients are not aware of the interpreter's taking over provider's responsibilities, and they think that the instruction or advice comes from their doctor rather than interpreter. "There is

no system in place to ensure the quality of information that is independently provided by the interpreters, which may increase the risk of malpractice lawsuits" (Hsieh, 2006, p. 936).

The situation described in Hsieh addressed the interaction within the consultation, which only highlights "the prevalent ideology of conceptualizing interpreters as a role that only is meaningful in provider–patient interaction" (Hsieh, 2006, p. 936). My research is therefore aimed at bridging the academic gap by analysing the interpreters' role not only inside but also outside the consultation, which is when they are alone with the patients. Inter-occupational usurpation in one domain triggers responses in other domains. This domino effect is manifested through a many-sided hybridisation of profiles. The institutional authorities encourage such profile combination, because it is both time-saving and cost-saving.

10.2.1. Profile hybridisation as viewed by professional MI

The realm of medical expertise works through a fairly established hierarchy grounded in the division of labour and the compartmentalisation of tasks of each category of medical workers who carved out their niche and reputation a long time ago. Therefore, it will be very difficult for the medical interpreters to gain a secure foothold in the medical realm as MIs do not constitute a "medical element" (Torroba, 2015, pp. 49-50). The healthcare domain constitutes a "secondary institutional sphere" (Freidson, 2001) for MIs, where the main authority is exercised by medical workers. This denotes major power imbalance.

It is worth noting that hospital administration and medical professionals of some private medical facilities are adamant that they do not need to know what an interpreter is and how to work with them.

> Several attempts have been made to deliver workshops, talks, etc., to healthcare personnel on how to work with interpreters in consultation to avoid all these misunderstandings, dispel doubts, offer guidelines, etc., but the proposal did not bear fruit, because healthcare personnel (the majority thereof) have considered it absolutely inappropriate for an interpreter to teach them how to conduct a consultation, when the workshops were intended merely to showcase that the interpreter constitutes a part of the consultation which medical staff should learn how to cooperate and to work in team with. (Torroba, 2015, p. 51)

Thus, the rationale behind such a reasoning is the "mistaken impression" as to the role of medical interpreters. Torroba (2015, p. 60) has also addressed the issue of the role conflict and workload, deploring the lack of understanding. The professional MIs, cannot help but yield to the requirement and expectations of those in position of power in order to avoid marginalisation. And this is how the new profile of "patients' personal companion" in Ginefiv clinic in Madrid was established (Torroba, 2015, p. 62). This figure combines functions related to patient information with the interpreting tasks. However, this "dual role" [doble labor] is bound to result in misunderstandings:

> The existing confusion regarding the tasks of the interpreter is hardly surprising if we take into account that many of the assisting reproduction clinics in Spain do not present the interpreters for who they are, but rather as bilingual patient care workers [who are there to help with] any arrangement that the patient may need. The only added bonus is that they carry out these tasks in the patient's language, but their duties go far beyond interpreting.

> [Esta confusión con respecto a las tareas de la intérprete no puede extrañar si se tiene en cuenta que muchas de las clínicas de RA en España no presentan a las intérpretes como tal sino como trabajadoras bilingües de atención al paciente para cualquier gestión que este necesite. El único añadido es que lo hacen en la lengua del paciente, pero sus funciones van mucho más allá de interpretar. La intérprete tiene más funciones porque no es práctico para la empresa que puede pagar a una intérprete para ejercer multitud de tareas]. (Torroba, 2015, p. 63)

Thus, more extra functions are being allocated to the interpreter because it is not practical for the company to settle for less when they know that they can pay an interpreter to perform a myriad of tasks (Torroba, 2015). Interpreters are expected to go beyond their competences of a mere interpreter and they have to comply with the requirements imposed by the employers if they want to preserve their position (Lleó & Torroba, 2014, p. 260).

The fact that international patients with fertility problems have to cross boundaries to arrive in Madrid for an on-site treatment only on one or two occasions presents a further difficulty for the role delineation of medical interpreters, because for the rest of the time the only person who they will contact will be the interpreter, because "we are the link between them and the clinic" (Lleó & Torroba, 2014, p. 261). Therefore:

> On some companies' websites [the interpreters] are presented as the patient's hostesses, accompanying the patient during treatment for logistical, medical and emotional support and any other type of support the patient demands [...] The objective of these clinics is to sell the attractiveness of personalized treatments through this type of bilingual workers, mostly women. (Torroba, 2015, p. 63)

Torroba goes on to say that members of the healthcare staff may sometimes be inclined to think that "the involvement with the foreign-speaking patients is divided between them and the interpreters, without conceiving of the interpreter as a [language] support personnel, but rather as an option, chance or opportunity to shirk from their involvement" (2015, p. 63), duties and responsibilities.

Languages came to constitute a bonus or a secondary tool to carry out primary tasks of "logistical, medical and emotional support" (Torroba, 2015, p. 63). Part of the doctors' theoretical knowledge is being de-mystified and learnt by the interpreters, but the latter cannot benefit from it in contexts other than this specific clinic. The interpreters are overburdened and overloaded with tasks that should not fall within their remit. Such hybridisation leads to destabilisation of those occupations which are professionalising.

10.2.2. Ostracism and marginalisation of professional interpreters in job advertisements

This section will be dedicated to the analysis of a series of job advertisements placing a specific emphasis on the candidate description and job description. Before we proceed with the analysis, we must understand that the bureaucratic organisation (a private medical centre in this case) does not base its "requirements for the position it wishes to fill on what it can expect from the external educational programs" (Freidson, 2001, Ideal-Typical Models of Training section, § 2).

Apparently, the private hospitals and clinics in the VC do not rely on the "external system of education" (Freidson, 2001), in other they do not pursue the goal to hire professional interpreters. These hospitals and clinics do not "mount [their] own training programs" incurring extra

expenses (Freidson, 2001) either, as the newcomers are only instructed to shadow senior employees in order to learn protocols they will need to follow in order to carry out the corresponding tasks, which sometimes may include interpreting and translation, but are not confined thereto. "The form of training" (Freidson, 2001) is standardised, it is an official university degree and a Master's degree in Translation and Interpreting, but the employers do not deem the existing training necessary to work as patient or medical assistant.

Technically, there is a huge discrepancy between the officially assigned status which appears in the job contract, the actual qualifications, competences and professional skills (or lack thereof), and the tasks that they are required to undertake. No standards have been established yet to regulate the "mix of skills" and the level of education whereby these are acquired or attained. There is no "standardisation in job slots or job descriptions across organizations" (Marsden, 1986, p. 234, in Freidson, 2001, Ideal-Typical Models of Training section, § 4), since every medical centre has its own protocols of action and tasks which fall within the remit of multilingual personnel.

The analysis of job advertisements will help us learn what competencies are being prioritised, what competence level and subsequently typology of knowledge and skill do these competencies belong to, and last but not least, this analysis will reveal to what extent interpreting has been merged with other occupations.

By using InfoJobs and Jooble search engines, as well as the "Work With Us" tabs of different private hospitals and clinics, I have singled out a number of interesting non-clinical vacancies zeroing in on the geographical area of the VC. The analysis reveals that very few job advertisements (close to zero) were looking for "interpreters" or "translators", which already is a huge self-explanatory indicator by itself. Therefore, I had to expand the scope of research and include job advertisements whose main requirement was either bilingualism of the applicant or alleged knowledge of a (number of) language(s), but whose heading or title did not contain the term "translator" or "interpreter". After a thorough scrutiny of a series of job adverts, I narrowed the total number of those adverts which I deemed suitable for the study down to 15. Afterwards I have translated them into English. I adjusted the layout of some of these adverts in order to facilitate the visual perception thereof and restructured the contents without altering the order of appearance.

The following are the job advertisements for non-clinical vacancies in private healthcare settings in the VC[80]:

1. Patient care [*atención al paciente*] (see Appendix A)

Statement of duties:

The incumbent will be responsible for managing international patients' enquiries, adjusting the schedule for appointments, registering patient information, making sure that the medical history is complete [and no] data required for treatment and subsequent follow-up [is lacking]. [The patient care manager] will also coordinate the follow-up of the patient along with the

[80] It must be clarified that all screen shots of the job advertisements will be displayed in the Appendix section because the link to verify the veracity of the advert may no longer be available as these vacancies may be filled.

doctors, address their doubts, complaints and claims, and register suggestions in order to [either] solve them or channel them to the appropriate [department]. Finally, they will deal with the [telephone calls in the] call centre and issue the invoices corresponding to the payments made by the patients.

Requirements:

- certificate of disability equal or superior to 33%.
- previous experience in similar position of at least two years.
- communicative, empathetic, flexible and patient-oriented person
- time flexibility is required
- languages (French or English) are desirable

2. International patient care [*atención al paciente internacional*] (see Appendix B)

Statement of duties:

The incumbent will be responsible for managing patients' enquiries, adjusting the schedule for appointments, registering patient information, making sure that the medical history is complete [and no] data required for treatment and subsequent follow-up [is lacking]. [The patient care manager] will also coordinate the follow-up of the patient along with the doctors, address their doubts, complaints and claims, and register suggestions in order to [either] solve them or channel them to the appropriate [department]. Finally, they will deal with the [telephone calls in the] call centre and issue the invoices corresponding to the payments made by the patients.

Requirements:

We are looking for a professional with previous experience in a similar position of at least three years, with high-level proficiency in Italian and English. knowledge of French and/or German would be an asset. communicative, empathetic, flexible and patient-oriented availability to rotate shifts.

3. Administrative assistant [*auxiliar administrativo*] (see Appendix C)

The incumbent will be in charge of managing the different areas of the [...] clinic in Valencia, digitising documents (scanning) and archiving files [sorting them] in the different folders and departments

4. Customer care [*atención al cliente*] (see Appendix D)

selects interpreters for its customer care area, at the workplace [located] in South Tenerife

Minimum requirements:

- minimum 1 year of experience in customer service areas
- mastery in [the following] languages:
  - English
  - German
  - Scandinavian
  - French
  - Dutch

5. International medical assistant [*asistente medico internacional*] (see Appendix E)

The incumbent will be responsible for managing patients' enquiries, adjusting the schedule for appointments, registering patient information, making sure that the medical history is complete [and no] data required for treatment and subsequent follow-up [is lacking]. [The patient care manager] will also coordinate the follow-up of the patient along with the doctors, address their doubts, complaints and claims, and register suggestions in order to [either] solve them or channel them to the appropriate [department].

Requirements:

We are looking for a professional with previous experience in similar position of at least two years, with high level of French / English, German [skills] will be appreciated: communicative, empathic, flexible and patient oriented.

6. International patient care assistant [*auxiliar atención al paciente internacional]* (see Appendix F)

Statement of duties:

The incumbent will be responsible for receiving international patients who came for a consultation and adjusting the schedule for appointments. [The patient care manager] will also coordinate the follow-up of the patient along with the doctors, address patients' doubts, complaints and claims, and register suggestions in order to [either] solve them or channel them to the appropriate [department]. The incumbent will deal with the [telephone calls in the] international call centre, carry out an over-the-phone-monitoring and manage payments.

Requirements:

We are looking for a professional with previous experience in similar position of at least two years, communicative, empathic, flexible and patient oriented. Language competence in French, German and English is required.

7. Hospital interpreter [*intérprete para centro hospitalario*] (see Appendix G)

Statement of duties:

The mission of this position will be to collaborate and transmit the appropriate information between users and hospital staff. It must be accurate and reliable, providing the highest quality customer service.

Functions and tasks:

- Attending to the patients' needs and helping the patients and their relatives with matters of personal nature
- Providing a bidirectional translation/interpretation service for users, those who accompany them and hospital staff
- Acting as a link between the centre and the outpatients; contacting the consulates and corresponding services in the event of death; and checking agreements with insurance companies

- Carrying out administrative and management tasks such as: managing payment methods with the patient, assessing the available coverage and confirming a posteriori whether the patient complies with the payment guarantees for admission to the [healthcare] centre;
    - Contact consulates and corresponding services in case of death

Minimum requirements:

- Experience in companies of [the healthcare] sector or customer service
- Academic education related to the position
- Indispensable knowledge of the following languages:
    - Spanish
    - English
    - German
    - Dutch
    - French
    - Scandinavian languages (Swedish, Norwegian, Danish and Finnish)

Qualifications:

- Advanced vocational training
- Experience: 1 year

8. Interpreter-administrative clerk for a clinic [*interprete-administrativo/a clínica*][81]

Requirements:

- Minimum qualifications: intermediate vocational training (administrative clerk)
- Minimum experience: at least 2 years
- Minimum requirements: the incumbent profile with demonstrated experience in similar position, good presence, responsible and committed to the work

Description:

Currently seeking [a combined position of] an interpreter-administrative clerk for national and international patient care service provision. the position requires a high level of both German and English, in addition to the administrative tasks related to this post.

9. International Patient Care [*atención al paciente internacional*] (see Appendix H)]

Profile being sought after:

- an expert in medical translation/interpreting English - Spanish

[81] It must be clarified that this particular job advertisement was not screenshotted as the rest of the job adverts presented herein, and –in an attempt to recover this information– I realised that this employment offer was no longer retrievable due to the antiquity of the vacancy (2017), however, it was still included into the data corpus as it enriches the analysis and widens the repertoire of designations being employed to refer to medical interpreters.

- second and third languages will be considered an asset, in particular Russian, Chinese or Arabic
- user level office management
- customer service experience
- previous experience in a similar position and knowledge of international insurance companies will be an asset
- The incumbent will have the following functions:
- Premium escort of the international patients
- Performance of administrative tasks derived from the medical treatment [that the patient had undergone or is yet to undergo] and management of international insurance coverage
- Teamwork to facilitate the achievement of the department's objectives

10. Administrative Assistant [Aux. administrativo/a (see Appendix I)]

Statement of duties:

a) To attend over the phone to those interested in the package of services being offered by [our] hospital, especially those [prospective patients] who are keen on a specific offer being provided, making sure that the person concerned is duly provided with all relevant information

b) To coordinate the first appointment of the interested party during the external (outpatient) consultation, trying to cater for the preferences and priorities of the interested party; guaranteeing, if necessary, a minimum waiting time between the telephone call and the first visit

c) To receive the interested party on their first visit to the hospital and interview them in order to advise them on the offer they have been enticed by, analysing their real needs and interests

d) To collaborate with the Hospital Management / Communication and Marketing Manager, in proposing commercial actions and/or developing hospital products and services

e) To prepare [and submit] monthly reports and statistics with sufficient information regarding the [dynamics of the] portfolio/package of services: most demanded specialities and treatments, number of people who have contacted by phone [and shown interest], number of people who have contacted by phone and come to the hospital, number of people who have contacted [us], come to the hospital and eventually ended up turning down the service being offered, number of people who have contacted, come to the hospital and taken up the offer, etc.

f) To contribute along with the Medical Management of the Hospital to the diffusion of the range of services [being offered by the hospital] among the group of medical professionals, promoting an optimal professional relationship that would facilitate the agile management of appointments and personalised attention

g) Be proactive in identifying and communicating suggestions, non-conformities, risks, etc. detected in the work area [...]

Requirements:

- Bilingual level in English.
- Other languages will be considered an asset

11. Multilingual sales representative, healthcare sector [*comercial con idiomas, sector sanitario*] (see Appendix J)

Statement of duties:

1. to participate along with the hospital management in putting forward proposals containing specific initiatives as regards commercial actions, and/or development of products and services of the hospital as well as promoting and encouraging their distribution
2. to spearhead and undertake measures / lend greater vigour to the pursuit of clients; to promote and maintain relations with them [to an extent which will enable the incumbent] to pinpoint to the hospital management the needs that the incumbent should be able to identify, as well as proposals to improvements, preferably undergirded by the clients' satisfaction evaluation
3. to provide personalized attention to those interested in the general or specific services offered by the hospital, as well as to the patients who have responded to the service offer in question. [The incumbent must also carry out] other functions associated with this department

Requirements:

- previous experience in the field of commerce from 6 [months?] to 1 year
- advanced level of English and German is an indispensable requirement. A third language will be considered an asset: Dutch, Russian and other languages

Please desist from applying for registration if your profile does not match the [entry] requirement in terms of not having a good command of at least two of the above mentioned languages.

12. Arabic and/or Russian freelance translator [*traductor/a árabe y/o ruso – freelance*] (see Appendix K)

The incumbent will support the clinic and wellness area in all the requirements related to translation and/or interpreting that may arise. You will work hand in hand with international teams within the clinic and wellness areas to offer our guests the best possible service during their medical consultations or treatments.

Requirements:

- Minimum qualification: undergraduate degree (bachelor's degree)
- Experience: 2 to 3 years

13. Multilingual patient care technician/coordinator [*agente de atención al paciente con idiomas*[82]]

Requirements:

- minimum qualifications required: intermediate vocational training
- minimum experience requirement: at least 3 years
- minimum requirements: it is essential for the incumbent to have a conversational level of English and/or French and to display vocation for service [assistance-focused approach]
- [Prior] experience in contact centre and customer service is highly recommended as well as, working capability, communication skills and empathy

Statement of duties:

- administer and manage phone calls from patients and family members
- make phone calls to change, shift or reschedule an appointment, or conduct an information campaign
- manage medical appointments
- manage schedules
- administrative work including organisation and planning

14. Clinic assistant - intermediate level of English [*auxiliar clínico – inglés medio*] (see Appendix L)]

Terms of employment:

The incumbent will be responsible for the coordination of all medical documentation of all patients in the clinic at the administrative level. The incumbent will also assist the clinic management and medical coordination with administrative tasks.

Statement of duties:

- responsible for the organisation, internal filing and record keeping of all the laboratory results of all the guests (genetic tests and extra tests from any laboratory)
- processing all the results coming from the laboratory
- sending the results to the patients

[82] It must be clarified that this particular job advertisement was not screenshotted as the rest of the job adverts presented herein, and –in an attempt to recover this information– I realised that this employment offer was no longer retrievable due to the antiquity of the vacancy (last seen in 2017), however, it was still included into the data corpus as it enriches the analysis and widens the repertoire of designations being employed to refer to medical interpreters.

- keeping all the results up to date
- coordinating with the medical professionals the drawing up and the submission of medical reports in the stipulated time and sending them to the guests within the appropriate timeframes and in the appropriate manner
- personally monitoring the requests of the genetics specialist and submitting to her daily reports
- reviewing dispatch notes and pharmacy bills, as well as laboratory bills
- preparing cubicles for specialists (material, equipment, distribution, white coats, activity list)
- managing medical bills for insurance companies
- ordering, monitoring and managing tests carried out in other collaborative centres
- [using specific software such as] CITRIX platform in order to monitor [the patients' tests carried out at other medical centres]
- managing urgent pharmacy orders
- detecting and resolving incidents that occur with customer payments subsequent to their departure
- ensuring that patient data confidentiality is maintained at all times. Collecting and shredding confidential documentation from nursing department

Specific competencies:

- Degree: university degree (desirable)
- Languages: fluency in English and Spanish
- [...]
- client-focused approach
- proactivity
- teamwork
- responsibility
- continuous improvement

Requirements:

- Minimum qualifications: other qualifications, certifications and licences
- Experience: 2 to 3 years

15. German and Spanish speaking people wanted [for assistance] [*Hacen falta 15 personas que hablen alemán y español*] (see Appendix M)

In view of the (catastrophic) health situation, the Quirón Clinics company is going to transfer health personnel (nurses) to Spain. We are looking for staff who speaks German and can act as interpreters, under the following circumstances:

Working hours: 7 hours a day (08`00 - 15`00 and 15`00 - 22`00) Initially, 21 days (=1 month) [which may] possibly be extended up to 2 months

At the moment I need 15 people willing to carry out this task in Madrid. I may also need people in Germany. [...] If those who are interested in this job offer could also give us a steer regarding their fees, it would make the negotiation with our client easier. [...] the work will be paid for. If those who are interested are self-employed, they will invoice their services to my company, with the [Spanish] Personal Income Tax withholdings [with the corresponding amount withheld for the purposes of the Personal Income Tax (IRPF)] + VAT. If the incumbents are not self-employed, we can make an employment contract for them. Given the situation, at least we will reduce our "regular/ usual" commercial profit margin, as well as that of our usual interpreters. But it is a job, and as such it must be paid for.

By perusing the above presented job advertisements, one realises that the emergence of these hybrid profiles was spurred by three factors: 1) under recognition of the complexity of professional knowledge of MIs; 2) parsimony; 3) lack of proper regulations.

> In the market logic of privatized public services, the absence of specific measures paired with little knowledge, sensitivity or interest by public contract issuers regarding the intricacies of cross-cultural and cross-linguistic communication, takes us to a situation where effective communication is de-emphasized. (García-Beyaert, 2015, p. 54)

As García-Beyaert puts it: "If regulation is loose or evasive in regards to actual quality, what are the incentives for *decision-makers* or for the service *providers* to ensure that every measure is taken to provide actual professional interpretation, guaranteeing effective communication in every case?" (2015, p. 54; original emphasis).

10.2.2.1.Analysis of designations

Please note the tremendous variety of designations used to refer to the same profile and role. The nomenclature of these job adverts denotes vagueness of these profiles, however this profile has already become socially entrenched and conceptualised in spite of its terminological fuzziness:

1) Atención al paciente (Patient Care)
2) Atención al paciente internacional (International Patient Care)
3) Auxiliar administrativo (Administrative Assistant)
4) Atención al cliente (Customer Care)
5) Asistente médico internacional (International Medical Assistant)
6) Auxiliar ATP internacional (International Patient Care Assistant)
7) Intérprete para centro hospitalario (Hospital Interpreter)
8) Intérprete administrativo (combination of Interpreter and Administrative Clerk)
9) Comercial con idiomas (Multilingual sales representative)
10) Traductor (Translator)
11) Auxiliar clínico (Clinic assistant)
12) Agente de ATP con idiomas (Multilingual patient care technician or coordinator)

It is absolutely obvious that virtually all the job advertisements apart from the 7th (Intérprete para centro hospitalario / Hospital Interpreter) and the 12th (Traductor/Translator) represent

mixed profiles and roles. Therefore, a conclusion can be drawn that the employers are willing to combine several profiles into one to save expenses. Rudvin has also noted that the "interpreter competence is traditionally assessed according to the parameters set by the host institution" (2005, p. 160) than by the patients or the academic standards, which "reflects a clear power hierarchy [...] which may affect communication effectiveness" (García-Beyaert, 2015).

10.2.2.2. Usurpation of medical, administrative and linguistic niches

What does the term "patient care assistant" actually mean? What care? Assisting how? We are witnessing the emergence of a unique occupying profile, which usurps multiple occupational strata: medical, administrative and linguistic. The duties of this hybrid profile belong to four different professional niches.

The following duties, for example, should definitely come within the purview of medical workers: making sure that medical history is complete and no data required for treatment and subsequent follow-up is lacking, coordinating the follow up of the patient along with the doctors (Nº 1, 2), carrying out over-the-phone monitoring (Nº 6), providing information about the services being offered by the hospital, coordinating the 1st medical appointment, receiving the patients on their 1st visit to the clinic/hospital and interviewing them in order to advise them on the package/offer they are interested in and analysing their real needs (Nº 10).

The following tasks are normally attributed to the niche of administrative workers: rescheduling appointments, managing schedules and appointments, dealing with the telephone calls in the international call centre, conducting information campaigns, taking patients' details (Nº 1, 2), digitising documents, archiving files (Nº 3), contacting consulates and other corresponding services in the event of death of the patient, checking agreements with insurance companies, assessing the available insurance coverage, confirming whether patients comply with the payment guarantees, managing payments (Nº 7), customer service (Nº 9).

The tasks such as putting forward proposals containing specific initiatives as regards commercial actions, development of products and services of the hospital as well as promoting and encouraging their distribution, pursuing prospective clients, promoting relations with the patients, identifying patients' needs, making proposals for improvement, providing personalised information to the patients (Nº 11).

The authors of job advertisements Nº 7 and 12 look for interpreters and translators, who transmit appropriate, accurate and reliable information by providing bidirectional "translation" and act as a link between the centre and its patients (Nº 7), as well as translate during medical consultation. These are the only 2 advertisement that view interpreting as a distinctive occupation. The rest of the advertisements only look for people with languages, which they see as the means to carry out all the above mentioned tasks. Rudvin has perfectly captured the essence of the problem of market demands invading and metastasising the very nature of MI and lack of regulations stipulating occupation's *modus operandi* and jurisdictional boundaries:

> If and when the interpreter's mandate and role is challenged by an interlocutor who either restricts her ability to perform [...], or to go beyond her role by asking for opinions and advice (especially when the interpreter knows the client), it is both her duty and her privilege to safeguard her professional ethics, role and reputation by resisting the claims of a bullying "superior" because she can fall back

> on national laws prescribing the duties and limitations of her profession. In the private sector, however, this may change somewhat as that prescription no longer holds: a client can draw up any manner of contract with an interpreter, prescribing a very different role. Being paid by a private party, she no longer enjoys that same level of protection. The public vs. private factor will then also affect the interpreter's own stance and group alignment and the relationship with the service provider. (Rudvin, 2005, p. 175)

It is clear that the prospective employers are not interested in professional interpreting, but instead in multilingual personnel who can double up as an assistant, sales, representative, patient care coordinator, nurse, doctor, administrative assistant, etc. As it has been determined in the previous section, the employers may be inclined to think that there is no acute need for interpreters as medical personnel is allegedly foreign language competent. Most of the doctors claim to speak either English or the language of the patient, so the interpreting is not needed within the consultation itself, but rather outside the consultation. Thus, the multitasking in this specific case is based on the usurpation of competencies of other professionals. According to Halliday (1987, cited in Freidson, 2001) the tasks must be sufficiently distinctive for the optimal cognitive basis for a discipline to burgeon, which is obviously not the case.

I find this downgrading phenomenon extremely thought-provoking. Instead of being categorised as more sophisticated and specialised, the knowledge underlying medical interpreting is instead downgraded. Clarke and Kredens (2018, p. 20) have already reported on such a paradoxical and absolutely counterintuitive phenomenon by drawing a parallel between a paramedic and an FL expert:

> While a paramedic can graduate to becoming a doctor through further training, for a linguist choosing to act as an expert witness the progression is in the opposite direction, i.e. from an independent, fully fledged to an ancillary role, and our findings suggest that this identity shift is a complex one. (Clarke & Kredens, 2018, p. 20)

In my opinion the exact same thing happens with interpreters: while professionals belonging to other categories experience career development (e. g. literary translators, sworn translators and interpreters, scholars in Translation and Interpreting field, etc.), medical interpreters retrogress in their transitioning from self-fulfillment, self-reliance and professional autonomy to becoming practitioner's assistant, auxiliary tool for "helping" others.

10.2.2.3.Polyglotism in hybrid profiles

All the above presented job advertisements have one requirement in common for their respective positions: polyglotism. Foreign language knowledge is "mainstreamed" into the modern labour market as some commonplace prerequisite, an extra asset, rather than the basis of a highly sophisticated profession. The quantity of languages (specially adverts N°4, 7, 9, 11) is really astonishing. The job advertisements clearly showcase the universalisation of English.

Apparently, the employers do not actually care about interpreting *per se*, as they seek to offhandedly get plurilingual personnel to carry out tasks they are not even required to have a formal qualification for (advert N° 1, 2, 5, 6). In these job advertisements foreign language proficiency is depicted as an auxiliary tool to carry out other tasks.

Thus, the problem of MI is not the internal competition, which can be solved by "restricting supply of professional practitioners" or the external competition, which can be solved by barring

the outsiders from entering the marketplace using monopoly, social closure and credentialism. Obviously, the external competition, who is settling for lees, needs to be curbed in order to prevent the availability of surfeit of cheap labour from resulting in "low average income for the profession as a whole" (Freidson, 2001, Professional Control of supply section, § 1-3). However, the main problem is the emergence of these hybrid profiles, not the fact that non-professionals are employed to adopt these profiles. We cannot blame the employers for not hiring professional MIs when they are convinced they do not need MIs, but rather other figures. Thus, in this case professional interpreters may not only be ostracised by non-professional amateurs in the absence of licencing, but also the whole MI niche is being ousted from its natural niche and replaced by another emergent occupation. It goes far beyond the mere recognition or non-recognition of the sophistication of the unique, distinctive, codified and officialised knowledge underlying MI differentiating MIs from amateurs, but rather the under recognition of the social and economic value of the whole concept of MI and of the profession as a whole. The question is should the university education adapt to these market demands?

10.2.2.4. Dichotomised reaction of the prospective recruits

A series of comments ensued the job advertisement Nº15 posted on Facebook[83], which are worth breaking down. These comments belong to two different groups of people. The first group is comprised by people, who 1) underestimate their the complexity of the process of interpreting; 2) overestimate their ability to interpret; and 3) view bilingualism as the synonym for interpreting. For example:

- *Hola soy alemana puedo ayudar con la traducción!* [Hi I am German I can help with the translation!]
- *Puedes publicarlo en las páginas de la EOI*[84] *de Madrid* [You can publish this on the Official School of Languages of Madrid webpage]
- *Yo hablo un poco iría casi gratis si es a Alemnia* [...] [I speak some German, and if we talk about moving to Germany I'd go almost for free]
- *Estoy en Sevilla, soy bilingüe español alemán, para Sevilla podré* [I live in Sevilla, I am bilingual Spanish German, I could do it if it's in Sevilla]
- *Soy emfermera hablo aleman y español bellingue* [sic] [I am a nurse I am bilingual in German and Spanish]
- *Hola Soy medico, hablo Español perfecti [sic] y akeman [sic] B1, estoy en Düsseldorf.* [Hi I am doctor, I speak perfect Spanish and have a B1 level of German, I live Düsseldorf]

The second category of responses can be attributed to a person, who disapproves of the recruitment of non-professionals:

[83] The post can still be found online: https://www.facebook.com/117853405058815/posts/1516478655196276

[84] Escuela Oficial de Idiomas (Official School of Languages) is a network of non-university level centres which allows the adult population residing in Spain to learn foreign languages and to obtain a certificate attesting to the level of linguistic competence they possess. The EE.OO. II (Official School of Languages) is regulated by the Ministry of Education and Vocational Training as well as by educational administrations.

- Lo que necesitáis son intérpretes profesionales, no voluntarios que hablen alemán y español. ¿O se pedirían voluntarios para operar a corazón abierto o para defender a alguien en un juicio? Me parece que no. Busca en AIIC, IAPTI, AIETI o en LinkedIn. Ahí encontrará intérpretes profesionales. [What you need are professional interpreters, not volunteers who speak German and Spanish. Or would you ask for volunteers to perform an open-heart surgery or defend someone in a trial? I don't think so. Consult AIIC, IAPTI, AIETI or LinkedIn. There you will find professional interpreters.] (Vega-Alvares, 2020).

The author of this comment is aware of the fact that the employers are amenable to the idea of employing those candidates who capitalise on their bilingualism, rather than hiring those who capitalise on formal accreditation. This particular comment showcases the frustration that the commenter feels when he/she realises that the workplace reality and the work performance fall short of their expectations, that an accreditation may be considered an asset at best, but normally never a requirement. This remark embodies the struggle for dignity or the need to dignify the profession. We do not know whether the person who wrote the comment is a professional interpreter, however his/her remark expreses what a professional interpreter may feel when they learn that after a "longer than average period of vocational training or schooling", after having learnt how to do "relatively complex discretionary work in which they take great interest", after having started to "see their work as a long-term career", after having become "committed to their body of knowledge and skill", after having invested time and monetary resources in that extensive and expensive training, non-professional outsiders are still preferred over professionals (Freidson, 2001, Monopoly, Social Closure and Disciplinary Community section, § 1). According to Swartz, interpreters often feel "worthless, and never recognised for their hard work":

> Earlier research on job satisfaction in the general population found that the individual's degree of contentment depends on the actual or perceived gap between work performance and expectations (e.g. Locke, 1976; Straw and Ross, 1985): the closed to the desired level of performance, the higher the satisfaction. (Swartz, 2015, p. 222, cited in Pöchhacker, 2015)

This feeling of irrelevance, unimportance and, most importantly, alienation is due to the trivialisation of MI. Thus, the T&I graduates might experience frustration due to the "sunk costs" or "side bet of time and loss of earnings" (Becker. 1970, pp. 261-73, cited in Freidson, 2001, Stratified Career Lines section, § 1) because they have undergone a training which may be perceived as useless in terms of finding a job in this very specific context of medical interpreting in private healthcare in the Valencian Community. Universities, as we have seen with the job advertisements, are not called upon to provide manpower for translation and interpreting services.

10.2.2.5. The official stance of the corresponding cognitive authorities

The faculty "institutionalizes the cognitive authority of the profession", and constitutes an "officially recognized authority of higher education itself [...] provid[ing] professions with a powerful resource by which to maintain and expand a defensible jurisdiction, a resource that encourages the systematic refinement, growth, and legitimation of their discipline" (Freidson, 2001, The Control of Knowledge section, § 5).

In some cases the faculties can be accused of focusing more on "abstract concepts, theories and principles as well as highly esoteric procedures and techniques" (Freidson, 2001, The Control of Knowledge section, § 7), thus insulating themselves "from the everyday demands of consumers and the variety of work settings, each of which has its own contingencies bearing on what work must be done and limiting how it can be done" (Freidson, 2001, The Control of Knowledge section, § 7). The standards of practice brought forward and supported by the university are not always mirrored in the "impurity of practical affairs" (Freidson, 2001) of the employers who follow the rules set by the market demands, and whose main aim is not to observe the recommendation of the scholarly community, but to satisfy their own demands as interpreting service consumers.

However in this case more and more Spanish universities start to offer double degrees, which are starting to gain popularity among Spanish undergraduates. A number of Spanish universities are opting to adapt their curricula to the current market demands by embracing and promoting dual/double degrees instead of pursuing professionalisation of MI on the basis of the recognition of this professional category by the EU, ISCO-08 and CNO-11. Dual Degree Program in Translation and Interpreting, and International Communication/ Bachelor's Degree in Global Communication[85] offered by the Universidad Pontífica Comillas along with the The Double Degree in Translation and Interpreting and Law[86] offered at the university of Salamanca [87] constitute the most relevant examples.

It is not clear whether these bureaucratic organisations (private hospitals and clinics) seek to change the prospective education, whereby the knowledge of the past is being adjusted and tailored to meet the need of the generations to come (Dewey, 1916 in Chouc and Calvo, 2010). It is not clear whether, after having scrutinised the employment rates of the T&I graduates, the National Agency for Quality Assessment and Accreditation in Spain (ANECA) will end up accommodating university curricula to the market prospects, the society needs and the employers' needs. However, the faculties are adopting this approach in order for their students to become become "empowered individuals who are useful for society and can manage transformation and innovation", rather than "passive containers of the knowledge". For the time being, in order to fit in different existing "productive profiles" interpreters must breach the patients' right to quality medical care and violate their respective code of ethics (Chouc & Calvo, 2010).

[85] For more information, please visit https://www.comillas.edu/en/degrees/dual-degree-program-in-translation-and-interpreting-and-international-communication-bachelor-degree-in-global-communication-ti-com

[86] For more information, please visit: https://www.usal.es/doble-titulacion-de-grado-en-traduccion-e-interpretacion-y-en-derecho and https://www.usal.es/files/folletos/dg_traducinterp_derecho.pdf

[87] For more information, please visit: https://www.usal.es/doble-titulacion-de-grado-en-traduccion-e-interpretacion-y-en-derecho

11. UNPACKING PROFESSIONAL ETHICS

This chapter will be dedicated to scrutinise professional ethics. The main purpose of professional ethics is to assure the prospective clients that they can trust the quality of the services being provided by the members of the profession in question. This implies that the clients would be able to claim liability and the professionals would own up to any disorderly conduct, provided that it has been proven as disorderly, thus incurring exclusion from membership, lawsuits, compensations, etc.

The codes of conduct are deontological instruments "drafted by a professional association to regulate behavior and provide an ethical framework that outlines the professional standards that hold interpreters accountable" (Swabey & Mickelson 2008; Phelan, 2020b, p. 87, cited in Pokorn & Mikolič, 2020, p. 82). Professional ethics would also imply that professionals would have to abide by a number of general norms of action, which they would have to be cognizant of when exercising discretion. It should be noted though that there is a difference between the terms "ethics" and "deontology":

> When we use the term "ethics" on its own, it refers to relations between Self and Other (Pym 2001:133) and depends on the individual practitioner's integrity. In contrast, the term "deontology" refers to normative ethics that are typically expressed in codes of ethics (Lambert 2018:270), which define the rules and regulations that practitioners are obligated to follow (see Baixauli-Olmos 2017). (Pokorn & Mikolič, 2020, p. 82)

Hence, in this section I am going to address both normative ethics or deontology[88], also referred to as "practice ethics" which regulate professional codes by "guid[ing] and judg[ing] the conduct of professional practitioners at work", as well as "institutional ethics" (Freidson, 2001, Institutional Ethics section, § 1). According to Freidson, "Practice ethics deal with the problems of work that are faced by individual practitioners, addressing ethical issues familiar to everyone but which have assumed exotic guises that need sorting out and recognizing" (Freidson, 2001). "Institutional ethics", on the other hand,

> are rather different. They deal with the economic, political, social, and ideological circumstances which create many of the moral problems of work. The issues with which they are concerned include the way practice itself is financed, administered, and controlled in the concrete places where professionals work, and the social policies which establish and enforce the broader legal and economic environment within which practice takes place. Institutional ethics are concerned with the moral legitimacy of the policies and institutions that constrain the possibility to practice in a way that benefits others and serves the transcendent value of a discipline. (Freidson, 2001, Institutional Ethics section, § 1)

The fact that medical interpreting has not been regularised in the VC makes the compliance with normative ethics encapsulated in deontology codes also known as codes of conduct

[88] Stemming from Ancient Greek term standing for that which is right, proper, necessary, etc. and τα δέοντα meaning something that has to be done, a set of prescribed actions or measures that must be taken *in a given situation*. Source: https://en.wiktionary.org/wiki/δέον

extremely difficult if not impossible. The organisationalational aspects of the professionalisation of this occupation which belong to society's licence and mandate are severely underdeveloped. Given that the society in general and the clients in particular view interpreting as an extra asset, which enhances employability *in lieu* of mystified activity grounded in the codified body of specialized formal knowledge, the clients are not aware of the fact that they hinge upon the interpreters' specialized skills to solve their how-to problem. The complexity of being able to accurately apply one's specialized skills in unique situations that are difficult to standardize, in other words the complexity of the exercise of discretion by employment of episteme (codified knowledge base achieved through attestable licence) and *Phronēsis* (wise application of this knowledge in unique situations and contexts through complex decisions) is not being recognised. Consequently, the performative criteria that an activity must fulfil to achieve the coveted label of profession, thus, demonstrating important social function prove insufficient in the case of medical interpreting in the relevant geographical area. Skaaden maintains that:

> Licence and mandate are thus society's measures for authorising individuals to carry out a specific task according to certain standards. Professional trust in this manner bridges the performative and organisational aspects of professionalisation in that professions 'ask for the public's trust and in doing so, generate a set of legitimate expectations'. (Eriksen 2015, p. 3 as cited in Skaaden, 2019, chapter 3.4.3 The exercise of discretion and trust, § 2)

Hence, this section of the thesis will seek to fill the lacuna related to the concept of professional trust, it will endeavour to deconstruct the main principles of impartiality and accuracy of rendition, and it will prove that practice ethics (also called normative ethics encapsulated in the deontological codes of conduct) cannot be fulfilled if the institutional ethics do not allow it.

11.1. TRUST

Leaving your health and reputation "'in good faith' implies an expectation that the trustee will take appropriate care of it" (Skaaden, 2019, chapter 3.4.3, § 1). By letting the trustee do their job, the client (the giver of trust) "always transfers *de facto* discretionary powers over something to the [...] trustee "(Grimen, 2008b, p. 198 as cited by Skaaden, 2019, chapter 3.4.2, § 1). In the case of medical interpreting, the patients entrust interpreters with the discretionary power over their health state, whereas the physicians grant them discretionary power over their professional reputation. This is a weighty responsibility.

"Professional ethics serve both to secure the welfare of the client and the livelihood of the practitioner" (Skaaden, cited in Phelan et al., 2019, chapter 3.1 Why do we need professional ethics?, § 8), but in this case the two tenets are not mutually complementing, but rather mutually excluding because in order for a position to secure the livelihood of the practitioner/interpreter, the latter has to gloss over the welfare of the client by taking up tasks s/he is not competent in.

If we view professional ethics through the prism of philosophy, we will see that, as Kermit (2002) also argues, the concept of "good" in the Aristotelian sense lies at the very core thereof: "the ethical norms of professions refer to what is 'good' behaviour in the sense of 'good at', 'virtuous' or 'capable' rather than 'good to' in the sense of 'kind'" (Skkaden in Phelan et al., 2019, chapter 3.1 Why do we need professional ethics?, § 6). Skaaden and Kermit (2019 in Phelan et

al., section 3.1) contend that this notion of "being good at something" denotes "excellence", top quality or mastery achieved through of the advanced training:

> Professionals must strive for virtue – in terms of 'excellence' – in their practice to deserve the trust of their clients. It follows that because practicing professionals rely on their clients' trust, they must deliver to the best of their ability according to a norm. Otherwise, the reputation of their profession will suffer, and their livelihood may be threatened. (Skaaden, cited in Phelan et al., 2019, chapter 3.1 Why do we need professional ethics?, § 6)

In the light of this ideation, Kinsella and Pitman (2012a, p. 2 as cited in Skaaden, 2019) contend that the virtue of excellence in the sense of high quality of performance represents the mastery of the "knowing how" to apply the acquired knowledge (episteme) to a practical problem in a particular context.

In other words, the virtue of excellence is accomplished through *Phronēsis*. Thus, the virtue of high quality performance is the result of the interconnectedness between professional ethics and the exercise of discretion, as well as the clients' trust that is thereby gained (Skkaden in Phelan et al., 2019, chapter 3.1 Why do we need professional ethics?, § 6).

According to Skaaden a clear delimitation of tasks is an absolute *sine qua non* precondition for the client to gain trust in the profession and professional as well as for the occupation to complete professionalisation: "The observation relates to the fact that for professionalisation to take place, the task in question must be clearly delineated" (Skaaden, 2019, section 3.2 What is a profession?, § 2). In view of the fact that clients lack competence and therefore are unable to control the quality of the specialized service they are being provided with by a member of an occupation, it is essential that the society and the governmental authorities grant professional trust through licence and mandate, whereby it is guaranteed that quality services are being produced within the practitioner's specific area of expertise (Skaaden, 2019, chapter 3.5, § 1). A licence must guarantee that the practitioner successfully underwent a several-year-long university education leading to accreditation of his/her knowledge and skills which would allow for the development of professional identity and the monopolisation (exclusionary market shelter) of a given societal function that can no longer be carried out by laypeople (Skaaden, 2019, chapter 3.5, § 1).

According to the classification provided by Ozolins (2000, 2010, as cited in Skaaden, 2019, chapter 3.5.1, § 1), Spanish "spectrum of response" to the need of medical interpreting services can be described as "neglect" in the case of public hospitals and outpatient clinics, and as "*ad hoc* solutions" in the case of private settings[89]. Spain is still far from reaching the "state of comprehensiveness", which implies policy planning, concurrent improvement of training facilities, refinement of university courses, academic degrees, research programmes, regularised accreditation tests (credentialism) and organised licencing (Ozolins, 2000). Moreover, according to Giambruno (2014, as cited in Skaaden, 2019, chapter 3.5.1, § 2) the attitude towards translation and interpreting in general across the EU member states "adds to the impression of reluctance".

[89] According to Ozolins (2000, p. 22) classification of an "international spectrum of response regarding the organisational aspect of the profession of interpreting in the public sector" is constituted by four stages ranging from 1) Neglect; 2) Ad hoc solutions; 3) Generic language services; 4) Comprehensiveness.

Given the double allegiance of the occupation of medical interpreter, the subject of professional trust is extremely complicated. The patients trust the doctor and the clinic or hospital. Medical staff does not trust professional graduated interpreters with the conveyance of mystified expert knowledge during the encounter in front of the patient, but they do paradoxically trust layperson assistants, who have been hired to carry out routinised medical tasks before and after the encounters. Their official designation is thus that of an international/multilingual nurse/medical assistant. Consequently, medical professionals would normally seek to control the process of (information) gatekeeping in an attempt to avoid unnecessary identity negotiation and in an attempt to project the image of the only source of highly mystified and otherwise inaccessible expert knowledge, even though the "medical assistants" will end up "organising the treatment".

I personally find it fascinating how physicians trust the person (not the member of a profession, for it is not the professional trust, but mere human trust) with duties or tasks requiring medical training, and yet they do not trust these multilingual assistants with the interpreting during the encounter even in spite of the doctor's poor language proficiency. The rationale behind this behaviour might be explained by possible fears of losing prominence coupled with physicians' swollen, overestimated linguistic repertoire and foreign language proficiency. This situation leads to a number of patients' rights being compromised.

The fact that physicians may be often found reluctant to let interpreters employ their discretionary judgement in interpreting during the encounter may be the smoking gun of professional distrust towards medical interpreting. It may be caused by problems that the physician might have previously experienced by working with non-professional interpreters. It may also be due to the fact that professional interpreters have not built the concept of professional trust towards their performance yet. Some physicians may show themselves more inclined towards trusting the person and the personal qualities rather than the professional an professional qualities. It may be due to the fact that bilingual people are thought to be more proficient in the foreign language than non-bilingual graduates.

> A fundamental question for any profession relates to the trust the clients invest in its practitioners' exercise of discretion. It follows that a multiplicity of conflicting roles fail to provide a base for professional trust. In order to gain their clients' trust, the profession must determine what virtue, thus, quality in interpreting should imply. Regardless of how one chooses to restrict the domain of the interpreters' exercise of discretion, if clients do not know what to expect, their trust will dissolve. Moreover, an extensive domain for the interpreter's exercise of discretion will concurrently narrow the domain of the professional in charge of the institutional encounter. Consequently, the rights of their patients and clients will suffer. Incidents and examples discussed in this book where layperson interpreters apply their agency to take over the doctor's task in identifying a patient's symptoms. (Phelan et al., 2019, chapter 3.6 Conclusion: ethics, education and professional integrity, § 4)

The boundaries between those tasks which do fall within the interpreters' remit and those tasks that should under no circumstances come under the jurisdiction, competence and purview of interpreters are so fuzzy and vague that even patients sometimes confuse the interpreter with the doctor, and yet paradoxically both patients, medical personnel and hospital management trust these (layperson) interpreters with their health, life and reputation. To give one example, some private medical facilities in the are of the VC require their multilingual personnel to say

"international medical assistance, how may I help you?" when receiving a phone call form patients. That phrase alone has often led the patients to think that they were being listened to and assisted by a doctor or a medical worker.

Also, the patients must have thought they were being seen by doctors instead of multi-purpose multilingual staff as their medical history was being taken, because it is normally the doctor who has to painstakingly fill out the anamnesis record. Thus, the patients trust the medical facility they have decided to undergo the procedure at, and do not realise that the management has adopted a "heuristic" approach instead of a more trustworthy and reliable solution. Patients trust that the person in front of them is indeed a professional who meets all the eligibility criteria laid down by the employers.

Normally we would think that the livelihood of professionals, who approach both tasks and clients with an altruistic rather than an egotistic attitude, rests on the trust their clients have in their specialised competence, but this is clearly not the case. I personally fail to comprehend what the clients and the purchasers of this service ground their trust in, but they certainly do not place their trust neither in the profession of medical interpreting, nor in medical interpreter as professional. I presume that this happens because it is not a conventionalised profession, and because they do not believe that the knowledge behind medical interpreting is so complex that it would require a specialised education to apply this knowledge to a complex practical problem.

Clients or patients would thus put their trust in the doctors and the healthcare facility: they would trust that the healthcare providers took their time and effort to painstakingly select only those workers who would render a service of highest quality by doing *only* what they know how to do best. Because again, it should have already become incipient that the clients cannot control the quality of the service themselves for they lack specialised competence to assess it:

> The emphasis on training relates to society's need to secure high-quality services as represented by the professions' 'specialised competence' and 'attendant fiduciary responsibilities'. Because clients lack the specialised competence and cannot control the quality of the services themselves, society must rely upon licence and mandate to assure quality service (Molander and Terum 2008: 18–20). For the established professions, society secures its need for quality service through organised education in that the completion of education leads to authorisation, which can be revoked in the case of ethical misconduct. (Skaaden, 2019, chapter 3.2 What is a profession?, § 2)

Apart from not being competent enough to assess the quality of medical interpreting, rarely do the patients take legal action against medical malpractice due to language barriers as it is difficult to document because of the confidential nature of the encounters (Skaaden, 2019, chapter 3.5.1, § 3). I do not consider the confidential nature of the encounters to be the only reason for legal stagnation on the part of the patients. I presume that they may not even realise that medical malfeasance resulting from language barriers has taken place.

To recapitulate, the livelihood of practitioners and the welfare of clients constitute two cornerstones of profession. But given that medical interpreting is practically inexistent in the Valencian public healthcare sphere and extremely distorted in private sphere, we can draw the conclusion that there is still a considerable way to go to achieve the coveted label of profession and trust in this profession.

I would like to conclude this section by posing the following rhetoric question: is that possible that the most famous premise in medicine "*ἐπὶ δηλήσει δὲ καὶ ἀδικίῃ εἴρξειν* [to abstain from doing harm]", whereof the famous medical creed "*primum non nocere*" has originated (Wikipedia, 2021)[90], be accomplished in the light of multiplicity of conflicting roles taken on by interpreters, lack of professional and task discretion and lack of professional trust? Can the *first, do no harm* tenet be safeguarded in spite of bilateral interprofessional encroachment, whereby non-proficient therapists choose to communicate in a language they do not master and interpreters in turn choose to engage in counselling as if they were doctors themselves? As we have seen, the lack of professional trust is diagnostic of the lack professional recognition and acknowledgement. This happens because relevant social actors are convinced that any person who claims foreign language knowledge can and should be trusted. Thus, there is not distinction between the purported foreign language knowledge and professional foreign language proficiency. This is why the end service users choose to trust in the allegedly foreign language proficient people, rather than in professionals with proper credentials.

11.2. CORE PRINCIPLES OF PROFESSIONAL ETHICS OF MEDICAL INTERPRETING: ACCURACY OF RENDITION AND IMPARTIALITY

In the case of medical interpreting in private healthcare settings located in the VC, large percentage of interpreters are not acquainted or familiarised with the existing international codes of ethics due to the fact that they did not undergo a professional training. University graduates in T&I, despite their familiarization with the international codes of ethics, cannot apply them to their day-to-day workplace reality because the institutional ethics (economic, political, social and ideological environment or circumstances they find themselves in) do not allow them to exercise discretion in adherence with the practice ethics, that "deal with the problems of work that are faced by individual practitioners addressing ethical issues familiar to everyone but which have assumed exotic guises that need sorting out and recognising" (Freidson, 2001, Institutional Ethics section, § 1). Hence, Freidson suggests that "practice ethics" which the codes of ethics and codes of conduct are subsumed under "may not be the most essential part of professional ethics" (2001.):

> This is not because I do not consider individual ethics important for the performance of all kinds of work, but because I believe that the economic, political, and social institutions which permit, even actively encourage, ethical behavior are ultimately more important. Even when those called professionals are something more than average people, few can be immune to the constraints surrounding the work they do. It is the institutional ethics of professionalism that establishes the criteria by which to evaluate those constraints. If the institutions surrounding them fail in support, only the most heroic individuals can actively concern themselves with the ethical issues raised by their work. Professionalism requires attention to the ethical status of those institutions. (Freidson, 2001, p. 12)

[90] "The physician must ... have two special objects in view with regard to disease, namely, to do good or to do no harm" (book I, sect. 11, trans. Adams, Greek: *ἀσκέειν, περὶ τὰ νουσήματα, δύο, ὠφελέειν, ἢ μὴ βλάπτειν*" from Hippocratic Corpus in *Epidemics* being the closest approximation. Sourse: https://en.wikipedia.org/wiki/Primum_non_nocere

This statement is extremely important because it recognises that a professional cannot be expected to adhere to the code of conduct when the current economic, social and ideological environment implies that he/she must comply with the current market demands and carry out tasks described in the job adverts they have decided to applied for. These market demands and sociopolitical circumstances are the ones that in fact dictate the guidelines and the behaviour protocols, not the codes of ethics. And this is why I am not going to analyse the existing codes of ethics in this thesis, because all tenets they contain are not going to be complied with as long as the occupation is not properly regularised. Thus, interpreters in the context of medical tourism may be able to discern between good and bad solutions within their respective field of expertise (Skaaden, 2019, chapter 3.2.1 Professions and the exercise of discretion, § 1), but they cannot apply these "good" solutions according to the norms, standards and values manifested in the international codes of ethics because it is simply not their job.

Thus, the interpreter does not actually have the discretionary power and the autonomy of personal judgement, assessment and decision-making, because all of these faculties are subject to the drawbacks of institutional ethics. Interpreters cannot (be expected to) reject an assignment only because it is not ethical: "still, interpreters are in practice often met with expectations from clients on both sides of the table to perform services that not only violate their code of ethics, but also exceed their area of expertise by far" (Skaaden, 2019, chapter 3.3.2, § 5). The interlocutors' expectations "go far beyond the interpreter's area of expertise" (Skaaden, 2019, chapter 3.3.2, §6). Hence, the interpreters end up yielding to demands and carry out the tasks that are being allocated to them. The disconsciousness of both graduates and layperson interpreters leads to a daisy chain where the interpreters are required by the employers to undertake assignments (far) beyond their scope of expertise, which they acquiesce to, thus, hindering professionalisation, professional trust and recognition.

The principle of accuracy in rendition is not being complied with neither by self-proclaimed intercultural mediators in public sphere, as they are expected to accommodate and adapt the discourse and be an active participant rather that a faithful conduit, nor is it conformed to by in-house interpreters, who instead of bilaterally rendering the utterance in triadic encounter take up the role of international medical assistant and dyadically instruct the patient basing themselves upon the limited medical knowledge learnt through routinised undertakings. The principle of impartiality is also being bypassed by both figures: on the one hand intercultural mediators identify themselves as helpers and advocates of the patients whose voice they end up stealing, on the other hand, in-house interpreters act *qua* co-diagnosticians by taking up tasks which are typically associated with physicians, thus "helping" the providers (Hsieh, 2006, pp. 924, 935; Angelelli, 2004, p. 2).

"In her [Angelelli's] proposed mediated approach, the interpreter abandons the core principles of accuracy and impartiality and gets involved in deciding on what to render and what to omit or add (ibid.: 75–77)" (Skaaden 2019, chapter 3.3.1 2, emphasis in the original). Thereby, "we notice that the 'visible' interpreter [...] does not promote communication between doctor and patient. Rather, the interpreter here expands the distance between the interlocutors" (Angelelli, 138 as cited in Skaaden, 2019, section 3.3.1, § 3). Hale (2008, p. 111 as cited in Skaaden, 2019, chapter 3.3.1, para 3) also decries the interpreter's gumption to "help" as it "more often than not [...] gets

in the way". Some scholars believe that accuracy of rendition as well as impartiality prompt invisibility of the figure and obfuscation of the role of medical interpreters (see De Souza, 2016). After subjecting a mediated approach, whereby the interpreter manifests both "visibility" and "agency", to rigorous scrutiny, Angelelli has identified three patterns of conduct of intercultural mediators: that of a "detective", that of a "miner" and that of a "multi-purpose bridge" (as cited in Skaaden, 2019, chapter 3.3.1 § 2).

> Obviously, interpreters are not 'invisible'. In onsite interpreting in particular, the practitioners must be aware of the 'space' they occupy within the micro-cosmos of the dialogue and be ready to apply strategies in order 'not to get in the way' of the interlocutors. Interpreters who are unaware of their specific position in the dialogue or take it upon themselves to act as advocate risk occupying unrestricted space in exercising their discretion. They thereby appear to be 'invincible' rather than 'invisible' (Skaaden 2018a: 11–12). Metzger (1999: 204) draws attention to the interpreter's interactional strategies when she determines that her critical exploration of the principle of neutrality 'has revealed that interpreters have the power to influence discourse'. What remains, she adds, is to examine 'the interpreter's ability to not influence interactive discourse'. The realisation necessitates 'more research regarding an interpreter's ability to limit or constrain their influences in interpreted encounters', Metzger concludes (ibid.: 204). (Skaaden, 2019, chapter 3.3.3 Role: participant status and occupational function, § 5)

In some private hospitals and clinics located within the study-relevant geographical area, some in-house interpreters decide to "help" the overburdened doctors on their own initiative. The rationale and the justification behind such "gumption" is the willingness to belong to and be a part of the team. However, in a number of other medical facilities, in-house multilingual staff members are required and expected to take on responsibilities and duties which would normally fall within doctors' purview in spite of lacking appropriate medical training. Pursuing a profit-making objective, the managers of these medical institutions spur the genesis of mixed or hybrid profiles, where bi- or multilingual workers carry out medical tasks. The fact that these are private enterprises, whose monthly salaries the employees hinge upon, reduces the application of the principle of impartiality to zero.

This reminds me of an article about "the translator who alerted Dénia Hospital to the effects of Metamizol in patients of English and Scandinavian origin" (López, 2018). The case of this interpreter in particular is in my opinion the illustrative example *par excellence* of Angelelli's "detective" and of interprofessional navigation or role negotiation, which may be qualified as either fruitful interoperability or interference and intrusion. Thus, even The Times (Ungoed-Thomas, 2018) has issued an article featuring the story of Cristina García, a medical interpreter from Alicante (or "medical translator" as she is being referred to by the media), who carried out her own investigation into the side effects of metamizole – the active ingredient of the drug whose commercial name is Nolotil – used for analgesic and antipyretic purposes (Ferrer, 2018).

Her research set out with the aim of discovering what might have caused severe agranulocytosis or neutropenia – acute shortfall in granulocytes, a type of white blood cells essential for infection prevention – manifested in a number of British patients whom she assisted with interpreting during their medical encounters across the geographical area of Xàbia and the whole Marina Alta region. She claimed to have registered over 100 cases of agranulocytosis and neutropenia, 10 cases of fatal pathologies, and other terrible cases such as amputations (Losada, 2018). Cristina

García – a teacher and a translator – has been accompanying patients of British origin to medical appointments for several years. She claims to have acquired comprehensive knowledge in the field of healthcare (Ferrer, 2018), which along with situations she had to cope with in real life has allowed her to detect the side effects produced by metamizole.

García posits that these adverse events may range from pruritus or itchy throat to sepsis. Thus, these cases have been brought to the attention of the management of the Hospital of Dénia and also to the attention of Pharmacovigilance (Farmacovigilancia), the system of pharmaceutical surveillance of reactions to medicines, which is regulated by the Spanish Medicines and Health Products Agency (Agencia Española del Medicamento).

She was intent on visiting the rest of the hospitals located in the same area, as well as local pharmacies to alert them to the dangerous adverse reactions that British patients may end up developing after the intake of metamizole. The management of the Hospital of Dénia has shown to be fully cognisant "of international exercise of caution regarding the administration of the generic metamizole, and given the high percentage of British and Scandinavian residents in Marina Alta, a warning (not a ban) has been issued for the practitioners to assess the administration of another common painkiller" in the case of the patients with the aforementioned ethnical background (Ferrer, 2018).

The hospital administration added that it is the Spanish Medicines and Health Products Agency (Agencia Española del Medicamento) who either clears and approves a drug or a device or withdraws the product from the market due to massive health issues. Nevertheless, in an article issued in 2018 by Xàbia.com García explicitly indicates that she *gave recommendations* to the hospital administration: "*Marina Salud en abril emitió una nota interna con mis recomendaciones* [In April Marina Salud issued an internal notice containing my recommendations]" (Ferrer, 2018). Ms. García drew on Facebook platform to garner information on potential cases and on the 6th of July 2018 she met with Spanish Medicines and Health Products Agency (AEMPS) and presented them with the data she had painstakingly canvassed: "*Al final, el 6 de julio pude reunirme con ellos y hemos estado todo el verano trabajando y analizando los casos* [I was finally able to meet with them on July 6th and we have been working and analysing the cases all summer]" (Ferrer, 2018).

She acknowledges that "hay médicos que me dicen que yo no he descubierto nada, que ya se sabía que el metamizol tenía estos riesgos. No soy experta, es verdad. Pero ya hay expertos que lo están estudiando [there are doctors who tell me that I haven't discovered anything, that it was already known that there were these risks associated with metamizole. It's true, I am not an expert. But it is now being studied by the experts]" (López, 2020). We see that there is a conflict between the doctors and Mr. García, because some physicians may construe this over-involvement as interference or encroachment.

Another extremely prominent role taken on by Cristina García is that of an advocate. Please note how she advocates for "her" patients. She narrates that, before being admitted to a hospital, a patient asked not to be given Nolotil due to allergy. It has been confirmed that they will not receive this medication, they get admitted and the doctor ends up prescribing Nolotil. However, when this patient requests the clinical history [...] they note that it had disappeared from their record that they had been given this medication (López, 2020).

Another case is that of a mother form Castellón whose son has suffered severe intestinal bleeding with kidney complications after having been treated with Apirofeno and Metalgial. An allegedly healthy child was running fever when his mother took him to an outpatient facility (Centro de Salud) where he was given the above mentioned medication. Back at home the child began to vomit and ended up fainting. He was then rushed into the Castellón General Hospital (Hospital General de Castellón) where his condition was deemed very serious, but the diagnosis does not mention these drugs[91]. Thus, his mother is now trying to determine whether these drugs have originated the haemorrhage with the help of Cristina's team.

So, we can see that Ms. García's role as an advocate and "miner" and "detective", which culminated in her being nicknamed as Xàbia's Erin Brockovich (López, 2020), has now changed to that of an activist (Gil, 2018), which constitutes a completely different professional profile. Moreover, her new profile has shifted from patient's advocate to physicians' accuser as she started decrying the fact that "los médicos siguen recetando nolotil a pacientes ingleses [physicians continue to prescribe Nolotil to English patients]" (López, 2020), and exposes what could be qualified as medical and pharmaceutical negligence or malpractice. Thus, blame and reproach shift into legal accusation enacted by filing a class action lawsuit against manufacturers and distributors of the drug in pursuit of a 500 million euros compensation (Gil, 2018).

Resuming the topic of interpreters in private healthcare centres, we cannot be talking about unbiased and disinterested behaviour when we financially depend on one of the parties. The principles which appear in the international codes of ethics as well as in the ISO 13611[92] have not been conventionalised neither in the context of medical tourism, nor in the context of public healthcare settings, therefore professional interpreters will find it difficult to balance their judgements due to the aforementioned reasons, whereas the non-professional intercultural mediators may not even try to do so owing to unawareness thereof and unfamiliarity therewith.

As a result, another quite worrisome question arises regarding the extension of the purview of both the interpreters, be it graduates or layperson, and those who proclaim themselves intercultural mediators. Who determines the extension of the interpreters' field of expertise? Skaaden poses the question in the following way:

> How do we delineate the extension of the domain within which the interpreter exercises discretion? [...] In other words, for which areas of expertise should the clients trust the interpreter to take on responsibility? [...] From the perspective taken here, the controversy in the field over the values of its core ethics appears as a controversy over the extension of the domain within which the interpreter is to exercise discretion. Should interpreters limit their services to rendering and coordinating others' talk, in line with the directly interpreted approach? Or should interpreters engage in cultural mediation in terms of 'advocate' and 'co-diagnostician', as proposed by the mediated approach?. (Skaaden, 2019, section 3.3, § 1 and Phelan et al., 2019, chapter 3.6 Conclusion: ethics and professional integrity, § 3)

These questions are extremely complicated, and the answer thereto must be very carefully pondered as it is not as easy as it seems. The following sections on the institutional ethics and

[91] I do not know whether the author meant that there is no mention of the intake of the drugs or no mention of the possible relation/association to these drugs.
[92] International Standard ISO 13611 Interpreting – Guidelines for Community Interpreting.

practice ethics will seek to delve deeper into the current ethical problems that MIs in the VC have to face on daily basis, and will endeavour to provide possible solutions.

11.3. INSTITUTIONAL ETHICS

Situational environment is another type of context we need to pay attention to. A hospital, a clinic, a public healthcare centre, a walk-in clinic, any medical setting, be it public or private, or any institutional environment in which the central knowledge being exercised is other than knowledge underlying translation and interpreting will constitute a "secondary institutional sphere" (Halliday as indicated in Freidson, 2001, section 7, subsection The Variety of Institutional Spheres, § 1) for translators and interpreters. Given that medical interpreting takes place at the "secondary institutional sphere", the knowledge and skill of interpreters does not constitute the central authority, since it is a medical institution at which medical staff, namely doctors and nurses, exert central knowledge authority in highly orchestrated and hierarchical interaction. Thus, medical interpreters do not engage in their occupational activities in a "primary institutional sphere" (Freidson, 2001) where the authority of their discipline's knowledge is central.

Therefore, MIs need to be situationally cognizant, as medical profession has developed its distinctive ritualities governing its institutional relations. These ritualities are characterised by communicational, terminological (the jargon or characteristic verbiage) and expertise asymmetry between the experts and laity[93] (Freidson, 2001). Also, such ritualities partially contribute to discursive construction of institutionalisation, influencing the extent of leverage of the authority of the central discipline. Therefore, those interpreters who work in secondary institutional spheres, and in medical sphere in particular, need to possess excellent ability of savoir-faire based on the appropriate code of conduct or code of ethics which would take into account the particularities and specificities of each setting.

In the case of practicing in a medical facility, MIs will need to adopt two codes of ethics: their own and partially the code of ethics that medical professionals abide by, or at least the main tenet of "do no harm". Hence, the interdisciplinary working climate makes it much more difficult for inchoate occupations/professions to delimit their jurisdictional boundaries due to the fact that full-fledged dominant professions exercising authority in their primary institutional spheres end up succeeding in contesting ownership over medical interpreters' expertise.

Every member of every profession may be subjected to institutional ethics and may occasionally end up disregarding practice ethics, which the codes of ethics and conduct are subsumed under. But the question is up to what extent will their profession's legal regulation and regularization allow them to deviate from their respective standards of practice or ethical principles. In

[93] Laity here must be understood as a complex concept, because it is neither confined to the "functionally illiterate" populace, nor does it refer to "marginally illiterate" layers of the population, it refers to all those people who are not experts in the field in question. It can be "educated middle class", which in spite of being educated cannot "make fully informed choices" due to the complexity and specialisation of expertise. "While it is true, as Giddens noted, that "technical expertise is continuously reappropriated by lay agents as part of their routine dealings with abstract systems, [nonetheless] no one can become an expert ... in more than a few small sectors.... The lay person – and all of us are lay persons in respect of the vast majority of expert systems – must ride the juggernaut" (Giddens, 1990, p. 144-145, cited in Freidson, 2001, Credentialism section, § 4).

my opinion, members of very few professions (if any) can nowadays be considered immune to the influence that the institutional ethics wield. However, members of those occupations which have not been regularized yet may be found particularly vulnerable and susceptible to the pressures of the social, economic and political environment they find themselves immersed in.

Consequently, professional interpreters in Spain, who have completed an academic degree, do not hold the social control of the expertise. They do not have the autonomy of profession and therefore cannot exert task discretion in the institutions where they practice by rejecting unproper expectations or assignments. Needless to say, graduate translators and interpreters in Spain do not enjoy the monopoly established through the mechanism of social closure in the professional labour market, which "is intended to include only those who have effective command over a defined body of knowledge and skill, so that some method must be used to determine qualifications for admission and the right to practice" (Freidson, 2001, Credentialism section, § 1). But the problem is that this body of professional knowledge remains undefined.

And this is exactly the reason why the role of MIs in countries such Australia,–the first country in the world to establish a National Accreditation Authority for Translators and Interpreters (NAATI) (Hale et al., 2012 cited in Crezee et al., 2020)–, is still misunderstood (Crezee et al., 2020). Despite a more advanced professionalisation manifested through a well-developed accreditation system and a rather well-defined code of ethics (AUSIT) there are still conflicting expectations regarding the role and the functions of MIs as medical professionals still have latitude to impose "order" in a way they see fit. The research of Crezee et al. (2020) showcases how the health professionals expect in-house MIs to exceed their role boundaries and abide by the specific in-house guidelines (including calming the patient down, helping the patient complete their paperwork, taking over part of the healthcare professionals' own role and tasks, explaining medical procedures without the doctors' involvement, engage in unilateral interpreting by not rendering patients' utterances, explaining the meaning of technical jargon, avoid making notes *inter alia*). This only corroborates Freidson's concept of the salience of "institutional ethics" and its impact on professional performance.

Crezee et al. (2020) holds that the in-house MIs, who are considered to be a part of the healthcare team are more susceptible to act as "institutional gatekeepers" adhering to the guidelines established by the medical centre for which they work, even though the latter diverge from the tenets displayed in the codes of ethics. However, if/when MI "resists following 'unilateral' rules", healthcare professionals tend to "respond in aggressive manner [...] showing offence and ill feeling", as they "do not appreciate being reminded about the [MIs'] role boundaries" (Crezee et al., 2020). Australian healthcare professionals tend to treat MIs as "healthcare assistants rather than impartial interpreting practitioners" even in spite of their advanced professionalisation (Crezee et al., 2020). "This may indicate that interpreters feel they are not perceived on par with other staff working in hospitals", as they believe that "their emotional wellbeing [is not being] taken seriously by their employer" (Crezee et al., 2020). MIs are not even allowed to explain their role before the appointment or at the introductory stage thereof (Crezee et al., 2020).

According to Moser-Mercer (1996, p. 44, cited in Skaaden, 2019, chapter 3.5.3 Professional trust and virtue or quality in performance, § 2) an optimum quality is "the quality that an interpreter can provide if external conditions are appropriate". By external conditions Freidson means

institutional ethics and Watson (2006) describes them as "the micro-politics of the setting" (as cited in Clarke and Kredens, 2018, p. 84). These "external conditions" play a far more important role in the exercise of phronesis than the adherence to the correspondent code of professional ethics. This is what Freidson himself has to say about the importance of institutional ethics:

> This is not because I do not consider individual ethics important for the performance of all kinds of work, but because I believe that the economic, political, and social institutions which permit, even actively encourage, ethical behavior are ultimately more important. *Even when those called professionals are something more than average people, few can be immune to the constraints surrounding the work they do. It is the institutional ethics of professionalism that establishes the criteria by which to evaluate those constraints.* If the institutions surrounding them fail in support, only the most heroic individuals can actively concern themselves with the ethical issues raised by their work. Professionalism requires attention to the ethical status of those institutions. (Freidson, 2001, p. 12, emphasis added)

And the following excerpt contains a comprehensive definition that Freidson offers to define this absolutely essential concept:

> [Institutional ethics] deal with the economic, political, social, and ideological circumstances which create many of the moral problems of work. The issues with which they are concerned include the way practice itself is financed, administered, and controlled in the concrete places where professionals work, and the social policies which establish and enforce the broader legal and economic environment within which practice takes place. Institutional ethics are concerned with the moral legitimacy of the policies and institutions that constrain the possibility to practice in a way that benefits others and serves the transcendent value of a discipline. (Freidson, 2001, Institutional Ethics section, § 1)

Thus, it is important that we understand that interpreting quality does not hinge on the virtues of the interpreter alone (Dean & Pollard, 2013, cited in Skaaden, 2019, chapter 3.5.3, § 7). Other meta-linguistic factors of the surrounding circumstances may have a bearing on the interpreters' ability to accomplish high quality renditions.

The above mentioned circumstances proposed by Freidson (economic, political, social, and ideological), encapsulate different environmental, interactional (interpersonal, intrapersonal) and paralinguistic categories (Dean & Pollard, 2013, cited in Skaaden, 2019). Thus, one of the factors of utmost importance is how interpreters are treated by their colleagues (both graduates and layperson) and clients or service purchasers, who, in this case due to double allegiance, are represented by patients and their respective family members on the one hand, and service providers (medical staff, management staff and administration staff) on the other hand.

Hale also highlights this psychological aspect by stating that: "Working conditions, including the way they are treated by the other participants and the way those participants express themselves, will also affect performance" (Hale, 2008, p. 119, in Skaaden, 2019, chapter 3.5.3, § 6-8). In my opinion, the way interpreters are treated by the social actors they are surrounded by in their workplace is highly topical and it certainly deserves to be addressed and discussed in-depth in a separate analysis.

Many works and studies have been dedicated to the issue of psychological burden of working in a hospital, as well as the stress and burnout that such a position may imply, nevertheless few research studies have tackled the psychological burden of belonging to an unrecognized, underrepresented and constantly demeaned occupation in an institutional sphere of highly

hierarchical positions each pertaining to fully established and traditionalized ideal typical historic professions.

This, is tightly and intrinsically connected to 1) the awareness of who an interpreter is; 2) cognizance of how to work with an interpreter; and last, but not least 3) clear understanding and familiarisation with the jurisdictional boundaries between tasks including eligibility and liability for each of these tasks and how these boundaries are being negotiated with other specialisations (the very core of the occupational division of labour), whereby social shelter is reinforced. So, this section will be dedicated to institutional ethics which not only have a significant or special bearing on medical interpreters' performance, but govern and regulate these three key aspects of medical interpreters' practice.

Therefore, there is no sense in discussing the non-compliance with the code of ethics or code of conduct that medical interpreters should abide by, because if the social, legal, political, economic and workplace environment makes it impracticable, inoperative and unfeasible to adhere to the guidelines displayed in these codes of ethics, than the professional cannot be blamed for not complying. Thus, it would make much more sense to discuss how institutional ethics work in the case of medical interpreting in the VC, instead of breaking down all the international codes of ethics which nobody abides by.

In the particular case of medical interpreting in private healthcare facilities in the VC, the moral implications subsumed under the umbrella term "institutional ethics" should raise huge concerns. Some authors have already decried "poor working conditions for professional interpreters working in this field, who receive low salaries, are assigned tasks other than interpreting, and have little support and resources" (Cox & Lázaro, 2016, p. 36).

But the fact that not only was nobody "policing the degree of [interpreters'] permissible participation" (Rudvin, 2005, p. 171) and involvement in medical processes, but the caregivers were also welcoming and encouraging such overinvolvement that interpreters had no other choice but to accept – was quite intriguing.

In the private medical sphere the healthcare providers are "service purchasers" or "grantors" (García-Beyaert, 2015, pp. 45-46), who finance the practice. Therefore, the in-hose interpreters, both layperson and professional, are contingent on the ideology of the "grantors", who in this case are both "decision-makers" and "resource-holders" (García-Beyaert, 2015, pp. 45-46). The fact that the practice is financed by private medical centres may sometimes denote abusive and even traumatic bonding between the employer and the employee, which is reinforced by a) the fact that professional interpreters have no legal basis or constitutional foundation to draw on in case of being willing to object to some policies and to defy the employer's ideology; b) the fact that they cannot disclose information about the nature of their practice because they are bound by a contractual agreement grounded in data protection law.

This financial dependence on the ideology and the policies of the employer(s) may lead to serious moral and ethical dilemmas, which may make cognizant interpreters question the legitimacy of the approaches adopted by the company as well as the moral legitimacy of the assignments they are required/expected to undertake. We must keep in mind that institutional and state-sanctioned power is less arbitrary, whereas private institutional power is more autocratic. Thus, "institutional power is precisely that power by which an individual is mandated by a public

body to take decisions for other individuals. That power is enacted partly according to strict conventions and in part the subjective interpretation of those conventions" (Rudvin, 2005, p. 162).

Lay person interpreters, on the other hand, do not seem to care about "the policies [...] that constrain the possibility to practice in a way that benefits others and serves the transcendent value of a discipline" (Freidson, 2001, Institutional Ethics section, § 1). I call it marginalisation of professional interpreters, due to the fact that professional interpreters may constitute a voice of dissent, but it will be sidelined, silenced and replaced by those who value their income more than professional integrity and the legitimacy of the workplace demands.

According to Hale (2008, p. 99, as cited in Skaaden, 2019, chapter 3.3.3, § 4): "a multiplicity of conflicting roles leads to confusion among users of interpreting services and to insecurity among practicing interpreters". In addition, interpreting quality may have implications beyond the interpreters' jurisdictional boundaries by altering the discretion exercised by the members of the established traditional professions who the interpreters serve (Phelan et al., 2019, chapter 3.6 Conclusion: ethics, education and professional integrity, § 6).

In nuce, medical interpreting has not been regularised yet, therefore employers opt for a rather heuristic approach by hiring layperson interpreters, which also translates into a better compliance with the expectations, policies and ideologies. The receivers (the end-users of the service) are often unacquainted with the quality standards that every professional interpreter must abide by. Thus, even though they might perceive poor quality they still nod their acquiescence because they find themselves in dire need and have no other choice. Nevertheless, even though consumer confidence is at a low ebb both medical workers and patients still avail of their services because there is simply no other alternative.

Thus, the basis upon which patients place their trust in a layperson or non-professional interpreters is incomprehensible, as well as the basis upon which medical staff and clinic/hospital administration places their trust in self-taught or learned on-the-job employees, some of whom lack tertiary education, is also inexplicable. Due to a specific nature of interpreting, interpreters' allegiance is always double, because "the interpreter always has two clients – speaker and listener – who equally" hinge upon "the interpreter's skills to solve their mutual problem of how to communicate verbally" (Skaaden, in Phelan et al., 2019, chapter 3.2 What is a profession? § 9).

In many cases, MIs practicing in the study-relevant area are not expected to confine their practice to interpreting, but are rather impelled to and required to undertake complex medical tasks on their own. And thus the question arises as to why physicians would depute interpreters, be it professional or non-professional, to act *qua* medical staff, entrusting them with medical responsibilities and how such interoperability would affect their own practice. Because we must not forget that the interpreters' professional ethics as well as their compliance or non-compliance therewith may (and certainly do) "affect the work and integrity of their clients who are themselves professionals – often practising in the established professions of medicine and law [...]" (Skaaden, in Phelan et al., 2019, chapter 3 Ethics and Profession, § 3).

Moreover, the client's welfare, wellbeing and health state are usually also affected *directly* by the *modus operandi* (both ethical and professional) of the interpreter (Skaaden in Phelan et al., 2019, subsection 3.1 Why do we need professional ethics?, § 3). As it has already been stated in the previous sections of this thesis, interpreters as well as physicians, nurses, teachers and priests

are directly involved with people, not buildings (architects), finances (bank workers), etc. The sheer amplitude of the assignment repertoire allocated to some interpreters is quite impressive, not to mention the responsibilities it implies. I contend that it might be due to the fact that the action protocols and guidelines have been routinised up to a considerable extent allowing for memorisation and rote learning, although we are talking about a rather broad range of complex tasks.

This type of interoperability might be beneficial when it comes to time saving: delegation of routinised tasks will allow the physician to conduct consultations with a larger number of patients, which may ultimately result in higher revenues due to increasing number of patients on the one hand, and substantial cost savings owing to the fact that administrative assistants' workforce implies lower wage.

These circumstances spur proliferation of new breeds of linguists such as layperson bilinguals or pseudo bilinguals, intercultural mediators, medical staff doubling as interpreters, and other types of *ad hoc* self-professed interpreters. Neither the actual competences of the newcomers, nor the practice, performance or work itself are subjected to any control.

As regards administration, it is worth noting that the *administrative authority with supervision functions* (Freidson, 2001) is rarely exerted by professional interpreters, but, as my research is intent on showing, rather by persons belonging to other departments such as doctors or public relations managers. A hospital constitutes a secondary institutional sphere for interpreters because it is the doctors who exert the top authority in their own primary institutional sphere whereas interpreters work in the context of the other professions. The scope of the authority exercised by medical staff is all-consuming and it clearly restricts the capacity of our occupation to exercise influence of any kind. Given that medical interpreting cannot be construed as a decontextualised activity, therefore the do-no-harm creed should be also applicable to interpreters.

There are no "social policies which establish and enforce the broader legal and economic environment within which practice takes place". "Moral legitimacy of the policies and institutions that constrain the possibility to practice in a way that benefits others and serves the transcendent value of a discipline" is a topic that undoubtedly merits further inquiry, therefore I shall revisit it in the third part of this thesis, where I shall be breaking down the interviews and questionnaires that I have managed to canvass (Freidson, 2001, Institutional Ethics, § 1).

Interpreting in private medical sphere in the geographical area of interest is completely subject to business rules of large private firms operating and providing services within the context of free competition. The aim of the free market and of the ideal-typical bureaucracy is to standardise the procedures and "reduce discretion as much as possible so as to maximize the predictability and reliability of its services or products" (Freidson, 2001, Institutional Ethics section, § 4). By hiring non-professionals private companies would ensure that non-professionals would carry out the tasks that are beneficial for the company, thus "maximizing gain at the expense of the quality of their work and the broadest possible distribution of its benefits" (Freidson, 2001, Institutional Ethics section, § 5).

> Because the service provider is at that moment a public body, a professional subject rather than a "private subject," s/he is in that moment not generally personally accountable for or responsible for any mistakes, delays, misinterpretations, damage that his/her service or lack of it might have for the

> other party. This may profoundly affect his/her motivation in providing service and the speed and quality with which it is done. Furthermore, the numerical relationship alone (individual client versus group institution) is a source of significant actual and psychological strength for the service provider. (Rudvin, 2005, pp. 163-164)

Willing to maximise returns and inspired by profit motive, managers or other types of administrative authorities from a number of for-profit private facilities overtly impel their in-house interpreters to accept hybrid profiles.

This type of maximization of profit may be qualified as "antithetical to the institutional ethics of professionalism, as is a political economy which protects and stimulates it" (Freidson, 2001, Institutional Ethics, § 5):

> When maximizing gain is the dominant goal, attention and effort are directed toward *the most profitable activities* and away from the less profitable, *whatever their benefit to others*. When work is organized by the *free market*, the maximization of gain follows from its logic, but *because professional work is sheltered from ordinary market processes, maximizing gain is clearly a violation of the terms legitimizing that shelter.* (Freidson, 2001, Institutional Ethics, § 5)

Medical interpreting in the VC is not sheltered form "ordinary [free] market process[es]". Free competition may imply trans-professional encroachment, duty and role inversion, professional role and identity usurpation, de-professionalisation, high turnover of staff, higher job insecurity, precarious work conditions, and low wages regardless of the fact that all these factors may very well maximise the gain of the company by compromising quality. Rudvin (2005, p. 162) pinpoints that the institutionalisation of a discipline is accomplished and socially produced through discourse, whereby power positioning and negotiation governs "interpersonal asymmetry in verbal communication".

> The interpreter's role is closely tied to a number of factors: institutional infrastructure; the interpreter's specific mandate and job-description; professional codes of ethics that are determined either at the state-public level; the professional association or the individual institution as well as the development of the discipline and profession locally. It also affects and is governed by the power relations embedded in each institutional domain. (Rudvin, 2005, p. 175)

The client's vulnerability and the experts' power both *behind* and *in* discourse is exacerbated through "situational and context-based" strategies used to "openly challenge and /demonstrate control" (Rudvin, 2005, p. 165). Thus, the real power struggle rarely takes place: "in the public institutional domain, however, rather than a struggle it is often such a blatant unilateral display of hegemonic power played out so effectively that it hinders the interlocutors from actively engaging in any real reciprocal struggle" (p. 165). Therefore, Rudvin reformulates "Foucault's notion of 'patriarchal gaze'" into "institutional gaze" (p. 165). Of course the Rudvin's power *in* discourse is anchoring the above described power *behind* discourse.

11.4. PRACTICE ETHICS

The most apparent and patent purpose or function of a code of ethics is not to "create manual of administrative procedure" or to institute "regulations embodied in law", but rather to "provide

guidance for practitioners" (Freidson, 2001, Trust and Ethics section, § 2). These guidelines serve to clarify systematically arising ethical issues, both of general and more concrete nature:

> The general principles underlying such codes are not much different from those of everyday life, for they proscribe lying, cheating, stealing, exploiting others, killing, and other sins familiar to us all. But while in everyday life the Ten Commandments and civil and criminal codes may be sufficient guide, for professions there is a genuine problem of determining how they apply to the special circumstances surrounding their specialized practices. (Freidson, 2001, Trust and Ethics section, § 3)

This guidance is perceived by the practitioners as a moral compass, code of morals, standards of conduct or sacred covenant they should abide by in order to maintain a good standing, reputation, professional honour and uprightness. It also constitutes a benchmark and professional quality assurance. But these guidelines cannot be standardized, methodised and synchronized with the workplace reality up to an extent where all situational idiosyncrasies are predicted.

The codes of ethics may mirror a general standard of practice, but the professionals will still have to exercise discretion in each unique situation. Therefore, it is important that the person who is supposed to follow the rather general standards of practice be a professional and use their professional judgement instead of personal convictions.

Professional self-identification is absolutely essential for proper role, duties and responsibilities demarcation.

> The largest part of professional codes of ethics performs that translation function, dealing with the use of specialized skills in circumstances not familiar to lay people but involving familiar sins. (Freidson, 2001, Trust and Ethics, § 3-4)

According to Freidson, the nature of work of all disciplines provides "opportunities" and fertile grounds for conflict of interest (Freidson, 2001, Trust and Ethics, § 4). Therefore, "in order to create and sustain trust" all actions and circumstances where abuse of power and authority (whereby practitioners use their position of power in pursuit of self-interest) must be carefully stipulated and condemned in the codes of ethics. These types of binding documents must repudiate all sorts of behaviours which seek to "generate profit beyond the value of the work that is performed" by capitalising on their privileged position. Thus, the possibility of conflict of interests can be viewed as a "critical test of professionalism" and it might be used to strategise the legitimation of professional institutions (Freidson, 2001, Trust and Ethics, § 4) as well as institutionalisation as Ben-David views it:

> [I]nstitutionalization will mean the acceptance in a society of a certain activity as an important social function valued for its own sake; the existence of norms that regulate conduct in the given field of activity in a manner consistent with the realization of its aims and autonomy from other activities; and finally some adaptation of social norms in other fields of activity to the norms of the given activity. A social institution is an activity that has been so institutionalised. This definition is to be distinguished from that usage, which also includes in "institution" the actual organization of social activity in a given field. (Ben-David, 1984, p. 7)

The above mentioned definition of institutionalisation concurs with the depiction provided by Berger and Luckmann in 1966 which I also find highly enriching:

> The socially constructed world is internalized in individual consciousness. [...] what is important is the relationship of the phenomenon to the objectively available typifications of conduct. [...] We can properly begin to speak of roles when this kind of typification occurs in the context of an objectified stock of knowledge common to a collectivity of actors. Roles are types of actors in such a context. It can readily be seen that the construction of role typologies is a necessary correlate of the institutionalization of conduct. (Berger & Luckmann, 1966, p. 91)

The opportunity to showcase condemnation of the pursuit of selfish advantage (self-interest) through malfeasance in office which implies malpractice and dereliction in the performance of official duties of the practitioner will help justify a monopoly over practice (Freidson, 2001, Trust and Ethics section, § 4-5). Nevertheless, according to Freidson, the code of ethics alone by itself will not suffice to induce general public's commitment, comprehension and amenability to trust in a profession. It will not allay mistrust, suspicion, misgiving and scepticism of the general public. The populace will remain adamant about the fact that professionals are willing to put the client's interests before their own, which will place the professionals in a less favourable position.

A code of ethics is definitely aimed at projecting a public image of professionals "based upon client service overriding the baser desires of self-interest. The principle of altruism underpins the code of ethics and practice which provide regulatory guidance" (Mungham & Thomas, 2016, Solicitors and Clients: Altruism or Self-Interest? Section, § 1). Nevertheless, these tenets will be reduced to mere rhetoric if no vigorous yet sensitive enforcement mechanisms are put in place to trace, locate and investigate violations and apply corrective measures (Freidson, 2001, Trust and Ethics section, § 4-5). According to Freidson (2001), codes by themselves have no meaning and no sense unless they are supported by professional institutions.

We must be fully aware of the fact that codes of ethics cannot be perceived as boilerplates, for they are not blueprints of law bills even though they do indeed include some general precepts, dogmas or premises that reflect ethical issues, which in case of non-compliance may lead to violation of law. But basically these codes are constituted by tenets which in case of non-compliance may only lead to violation of trust whereafter no legal liability, accountability or consequences will ensue (Freidson, 2001).

For example, there is a series of deontological documents for community interpreters[94], for healthcare/medical interpreters[95] and documents on the ethical positioning of intercultural mediators[96], whose thorough analysis can be found in Pokorn and Mikolič Južnič (2020, pp. 92-93), as well as specific quality standards such as ISO 13611 (2014) on Guidelines for Community

[94] Code of professional conduct issued by NRPSI CPC (2016), Code of Ethics for Community Interpreters issued by COE in Ireland and Finland (2010), PSI: Minimally Required Competence in terms of Knowledge, Skills and Attitudes issued by ENPSIT (European Network for Public Service Interpreting and Translation) and National Standards of Practice for Interpreters in Healthcare issued by HIN Canada in 2005 just to mention a few (Pokorn & Mikolič, 2020, p. 92-93)

[95] California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles & Intervention issued by CHIA in 2002, Code of Ethics for Medical Interpreters issued by IMIA in 2008, IMIA Guide on Medical Interpreter Ethical Conduct (2010) and National Standards of Practice for Interpreters in Healthcare issued by NCIHC in 2005 just to mention a few (Pokorn & Mikolič, 2020, p. 92-93)

[96] Intercultural Mediator Profile and Related Learning Outcomes issued by TIME in 2015 and Health Evidence Network Synthesis Report 64. What are the roles of intercultural mediators in healthcare and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region? WHO (Regional Office for Europe) 2019 (Pokorn & Mikolič, 2020, pp. 92-93)

Interpreting and ISO 21998 (2020) on Interpreting services–Healthcare interpreting–Requirements and recommendations[97], but none of these standards of practice is being fully complied with in the case of interpreting in private medical sector of the Valencian Community. Upon thorough perusal I have identified a number of precepts which are not being currently complied with in the study-relevant context. Therefore I believe it is necessary to break these precepts down in order to shed light on their intimate interconnectedness with and heavy dependence on the institutional ethics.

Thus, according to one of the guidelines, the community interpreter has to be provided with a break in the case of long assignment (>60 min of consecutive interpreting and >15-30 min of simultaneous interpreting) in order to avoid severe quality impairment caused by fatigue, which may potentially lead to dire consequences (ISO 13611, 2014, p. 9). Angelelli has documented that this guideline is being flouted in some medical centres:

> Another option discussed by providers (ES Sites 6 and 7) is to hire full-time interpreters, so that they can be on staff. However, this practice is not frequent. As part of our observations we shadowed these interpreters for a day in a private clinic. The interpreter worked non-stop in five languages. (Angelelli, 2015, p. 74)

During my own professional experience I have experienced that in numerous occasions medical workers could not help interrupting the interpreter, thus failing to allow the interpreter to finish his/her interpretation, which indicates that they have been flouting a recommendation put forward in the fifth section of the ISO 13611 on *Recommendations for clients and end users* (2014, p. 10).

No effort was made by some medical facilities to "minimize possible noises, interferences, interruptions, etc." (ISO 13611, 2014, p. 10). Pellicer-Vidal also corroborates this fact:

> The procedure for each interpretation was similar, the hospital has a pager that can be contacted from within the hospital premises. This device is similar to a mobile phone and those who left their chair in the admitting department had to carry the pager in case the hospital required another interpreter. The pager emits a very strident sound and it is common for it to go off constantly, even during an interpretation. The protocol was to always respond when the pager went off, apologise to the patients, and go to the next interpretation as soon as possible. Also, if the call came from more urgent sections such as ICU or A&E, we had to leave the consulting room and literally run to get there as soon as possible. (Pellicer-Vidal, 2016, p. 4, my translation)

With regard to the responsibilities of the interpreting service providers to the client, the provider must ensure that all incumbents are "qualified professionals capable of performing the specified tasks" and "free of any penal and/or criminal records" (ISO 13611, 2014, p. 10). As the third part of this thesis will seek to prove, these tenets are currently not being complied with.

[97] I am fully aware that there are more international standards concerning Translation and Interpreting, such as ISO 20539:2019, Translation, interpreting and related technology — Vocabulary; ISO 20109:2016, Simultaneous interpreting — Equipment — Requirements; ISO/TR 20694:2018, A typology of language registers; ISO/PAS 24019:2020, Simultaneous interpreting delivery platforms — Requirements and recommendations; ISO 17100:—2), Translation Services — Requirements for translation services; and ISO/TS 18864:2017, Health informatics — Quality metrics for detailed clinical models. Nevertheless, in this thesis I have decided to break down only the most study-relevant standards, which are ISO 13611 (2014) and ISO 21998 (2020), which encompasses all of the aforementioned standards.

Moreover, Pellicer-Vidal who did her placement at the privately managed public hospital located in Denia in 2016 (Hospital Marina Salud), also corroborates the ongoing struggle between professional interpreters willing to occupy their niches and polyglot amateurs who try to oust them therefrom:

> The specific training in interpreting skills came in helpful during the placement and I have really applied much of the knowledge we have learnt during the degree, which gives an added value to our services and also makes us stand out from the rest. One of the current problems is that all those who work as translators in the health centre where I did my placement are people with no specific training, who have knowledge of the language and who are able to get by in the health field because the terminology is recurrent. For us as translators there are market opportunities in this field, but the low salaries paid to administrative staff are not comparable to what should be paid to a translator with a university degree. (Pellicer-Vidal, 2016, p. 11, my translation)

This excerpt confirms Rudvin's statement that "interpreting is a relatively low- status job and extremely poorly paid" and that this lack of professional power, status and prestige may translate into a rather condescending attitude of medical professionals towards medical interpreters. "Moreover, an interpreter reduced to such a low-status profile will be given less leeway for active participation and manoeuvring in the communication encounter" (Rudvin, 2005, p. 171).

With regard to police records or register of convictions, it was publicised by 20 minutes newspaper (Fernandez, 2008) that Seprotec Multilingual Solutions, local recruitment for-profit company in charge of the externalised community interpreting services, had indeed been sending to the Spanish National Police so-called "translators" with criminal records. Thus, the premises mentioned above are not being properly upheld, but rather overridden by the procurement managers.

The section on the *Role and responsibilities of community interpreters* in ISO 13611 (2014) foregrounds the salience of "accept[ing] only those community interpreting assignments in which [interpreters] are able to perform at the level of professionalism set by this International Standard" as well as "refus[ing] to carry out duties for which they lack the appropriate education, training, qualifications, or credentials (e.g. replace a physician or a nurse by taking down a patient's history, instead of interpreting their questions)". As maintained by Atkinson and Crezee (2014, pp. 74-77), MIs should develop a "psychological skill" –conscious, constructive and metacognitive self-awareness and self-assessment–, whereby they would measure and manage their "self-efficacy", "explanatory style", and "control of work". This skill would help them manage "self-blame", "anxiety", lack of confidence or stressful situations in general, but "[h]aving occupational self-efficacy at an optimal level also means that people will not attempt things which are technically too difficult for them—in other words, where there is a high probability of failure" (p.77).

Further down another precept reads as follows: "Community interpreters should [...] restrict their role to [...] interpreting without offering opinions or advice (even when requested to do so) or acting as an advocate" (ISO 13611, 2014, p. 11). This same precept is mirrored in the IMIA (International Medical Interpreters Association, 2006): "Interpreters will refrain from accepting assignments beyond their professional skills, language fluency, or level of training".

The fact that the authors of international standards and norms are so unrelenting on this premise can be explained by its interrelatedness with another precept exhibited in ISO 21998

(2020, p. 10): "follow the medical ethical tenet of doing no harm to health". However, it must be noted that none of the existing codes of conduct/ethics seem to address the "duty of care" dilemma: "whilst being good medical practice, it falls outside of the" international MIs' codes of ethics (Crezee & Jülich, 2020, p. 218). The law as well as the professional codes of ethics and conduct must be very specific about the interpreting and interpretation of the paralinguistic and non-verbal message (e.g. indicating deceit or intentions of self-harm, suicide, serious underlying (mental?) illness, etc.) (Crezee & Jülich, 2020, p. 218). The "confidentiality" tenet must be defined taking into account the "duty of care" concept.

The establishment of hybrid profiles in the public and private medical facilities located in the VC demonstrated that the above mentioned precepts are not being fulfilled. Hsieh (2007) and Angelelli (2011) have also reported on similar occurrences.

According to the HR standard 01.02.01 hospitals should define the qualifications to be held by hospital personnel in accordance with the responsibilities contained in each work center, which would imply that healthcare organisations must document evidence demonstrating the level of language competence, training and experience of all interpreters (Angelelli, 2011). Based on the standard HR.01.02.05, the hospital must verify the competencies of applicants prior to recruitment and document the fact that the candidate has the necessary training and experience to undertake the work (Angelelli, 2011). As we have seen throughout the whole study, the employers seem to disregard the above mentioned guidelines, which subsequently precludes interpreters' compliance with the codes of ethics.

> Scholarly literature on ethics in interpreting has repeatedly argued that there is a common mismatch between the reality of the interpreters' working environment and the principles expressed in codes of ethics and standards of practice (e.g., Mikkelson 2000; Inghilleri 2005; Angelelli 2006; Marzocchi 2005; Ozolins 2014a; Drugan 2017; Pokorn 2017). (Pokorn & Mikolič, 2020, p. 82)

Hence, if members of an occupation during the professionalisation process or professionals are intent on laying successful claim to professional autonomy and to independence of judgement and action, and are willing to justify trust in that independence, they must ensure that: "Should [professionals] deviate from the rules of conduct then sanctions can be imposed by the profession" (Mungham & Thomas, 2016, Solicitors and Clients: Altruism or Self-Interest? Section, § 1). According to Mungham and Thomas, caveat emptor should be preserved for the marketplace and not for the professional's office: "The purpose of self-regulation and the code of ethics is to protect the public from the vagaries of caveat emptor" (Mungham & Thomas, 2016, Descriptions of the Legal Profession subsection, § 8). Moreover:

> In exchange for this public commitment the profession receives special treatment from the state, the community and the client. It is allowed by statute to undertake certain paid work to the exclusion of all others; it is a self-regulating body; its members are of high status and their financial rewards are considerable [...] This position of service is also offered as the primary justification for the special privileges enjoyed by the profession [such as self-regulation, self-control and autonomy, whereby] "only the professionals themselves are properly qualified for the task. (Mungham & Thomas, 2016, Solicitors and Clients: Altruism or Self-Interest? Section, § 1, 8-9)

In other words, a code of ethics as well as its implementation and enforcement should demonstrate that the professionals are not concerned with self-interest and individualism, but rather

with common good and welfare of the client. By placing client before self in compliance with the altruistic model and by operating in accordance with these public statements and rules of practice, professionals will be provided with state protection by means of instituting occupational closure or monopolistic and restrictive fashion of practicing a profession (Mungham & Thomas, 2016, Descriptions of the Legal Profession subsection, § 9):

> In order to protect the public from the charlatan or the quack, entry into the profession must be guarded, its standards policed, and its rules of practice defined in the first instance by the profession itself... The ground rules of completion are designed for the interests of the public and not for the interests of the profession alone. (Hailsham 1971). (Mungham & Thomas, 2016, Solicitors and Clients: Altruism or Self-Interest? Section, Descriptions of the Legal Profession, § 7)

In conclusion, it should be noted that the adherence to a code of conduct and service for the public good, along with a number of other traits, constitute essential facets of a profession:

> Millerson in The Qualifying Associations took the work of twenty-two scholars on the professions, including Carr-Saunders, Marshall, Parsons, the Webbs, Tawney and Whitehead. He extracted the constant characteristics of their work to see which were considered essential to a profession. The common features were found to be: skill based upon theoretical knowledge; training and education; demonstration of competence by passing a test; integrity maintained by adherence to a code of conduct; a professional organisation and service for the public good. Underlying these definitions is the sentiment that the professional is a noble, independent individual who places public duty and honour before all else. (Mungham & Thomas, 2016, Solicitors and Clients: Altruism or Self-Interest? Section, Descriptions of the Legal Profession, § 11)

All of the aforementioned concepts should carry a prescriptive character if the ultimate goal is to professionalise. Professional trust can be gained only if all the tenets of the professional codes of ethics and standards of practice are properly regularised by statutory regulations. "Part of the purpose of such codes is without doubt to persuade the public that the formulation of ethical standards justifies trust" (Freidson, 2001, Chapter 9 The Soul of Professionalism, Trust and Ethics section, § 1-2).

Thus, we can see that the concepts of *trust* and *ethics* are inextricably linked, especially against the backdrop of professionalization of medical interpreting and, in my opinion cannot be scrutinized separately. The special nature of knowledge and skill underpinning professions requires the general public, including both the prospective clientele as well as the state, to trust in good intentions and best endeavours of professionals. According to Freidson (2001, Trust and Ethics section, § 1), many sociology theorists (although the views on this topic are polarised) claim that professionals prioritise the wellbeing, the good or the welfare of their clients/the public and place it "over their own economic self-interest":

> Apart from the assumption of good intentions, the increasing complexity of specialized knowledge and skill as well as the problems entailed in their practice has led to an enormous growth in the attention given to the way intentions are translated into action in the various professions – attention, that is, to ethics. (Freidson (2001, Trust and Ethics section, § 2)

Last but not least, I would like to conclude this section by citing Angelelli, who posits that all the principles established in the ethical codes and in the "standards of practice" must have empirical foundations and be evaluated from the practical point of view and must not be

presupposed or imposed (Angelelli, 2008, p. 159). Without empirical foundations, the documents developed by professional associations generate professional ideology, which often clashes with workplace reality (Angelelli, 2008, p. 158). I believe that the tenets itemized in international codes of ethics such as IMIA for example are simply not viable in the case of MI in the private centres of the VC due to aggressive politics of institutional ethics and power asymmetry described in the previous section.

12. PROFESSIONALISATION OF MEDICAL INTERPRETERS

12.1. Process of professionalisation

Although this particular topic of professionalisation has been the focus of much scrutiny, it has been mostly looked at through the prism of public service interpreting, while this chapter will seek to approach this topic from two different perspectives: public healthcare and private healthcare. The consideration of the theory of knowledge as the linchpin of all stages of and routes to professionalisation provides a novel insight into why the university diplomas in T&I are not being adjudged diagnostic of quality and proficiency?

I firmly believe that the true impasse of the professionalisation of MI may not be due to the fact that this is a newly emergent occupation, but rather the fact that it is not seen as an occupation requiring professional skills or formal education. So, it is my contention that the so-called inchoate nature of this occupation is just a red herring taking readers' attention away from the focal point of people's failure to grasp the complexity of its underlying knowledge. The conceptual tripwire consists in believing that every self-proclaimed bilingual or every *soi-disant* fluent/proficient speaker can have and do the job. Nevertheless, as maintained by Ann Corsellis: "No one can be 'nearly' a brain surgeon or 'nearly' an interpreter" (in her interview to Valero, 2018, p. 98).

Berger and Luckmann (1966, p. 95) argue that: "the social distribution of knowledge entails a dichotomization in terms of general and role-specific relevance". Such distribution is accomplished through the division of labour (Berger & Luckmann, 1966, p. 95). According to the same authors "The multiplication of specific tasks brought about by the division of labour requires standardized solutions that can be readily learned and transmitted" (Berger & Luckmann, 1966, p. 95). This implies the need for academisation and disciplinarisation of an occupation, whereafter standardised education in the field may ensue.

Thus, the specialists "will have to know whatever is deemed necessary for the fulfilment of his particular task" (Berger & Luckmann, 1966, p. 95). In order to ensure proper task allocation and eschew unnecessary contentions over task ownership the organisationation of a society must allow for role-specific knowledge accumulation as well as the possibility of concentrating on each individuals' specialties. Thus, each role will "carr[y] with it a socially defined appendage of knowledge" (Berger & Luckmann, 1966, p. 95), which will contribute the specialists' identification and recognition by the laity:

> While the specialists are defined as individuals who know their specialties, everyone must know who the specialists are in case their specialities are needed. The man on the street is not expected to know the intricacies [of every specialty but] what he must know, however, is which [specialist] to call upon if the need for either of these services arises. (Berger & Luckmann, 1966, p. 95)

Thus, the role of the medical interpreter does not carry with it a socially defined appendage of knowledge, which results in "the man on the street" not knowing which specialist to call upon

if the need for language provision arises. Under the most reasonable scenario, the average adult will strive to find a doctor or a medical worker who speaks either English or his mother tongue.

As I have tried to demonstrate throughout this thesis, this field is plagued by "competing coteries of experts", which leads to "practical difficulties" (Berger & Luckmann, 1966, p. 96) as well as confusion and de-professionalisation.

This happens because interpreters/actors have not been typified as such (role performers). In other words their role standards (quality standards) have not been socially defined, therefore, their conduct is not susceptible to enforcement or to compliance with this role and the corresponding quality standards. "As soon as actors are typified as role performers, their conduct is *ipso facto* susceptible to enforcement. Compliance and non-compliance with socially defined role standards cease to be optional [...] [T]he role represents an entire institutional nexus of conduct" (Berger & Luckmann, 1966, p. 92).

Accordingly, in order for a prescriptive role to come into being and become properly institutionalised, the previous processes of habitualisation, objectivation and internalisation of routinised behaviours should have occurred. As reported by Berger and Luckmann (1966, p. 92.): "Roles appear as soon as a common stock of knowledge containing reciprocal typifications of conduct is in process of formation [...] prior to institutionalization [...]". In the VC the role of medical interpreter, both in public and private facilities, has not been habitualised, routinised, objectified, typified, or internalised yet. Therefore, no standards of role performance accessible exclusively to potential performers of the roles in question have been crystallised yet into the social consciousness.

Consequently, none of the putative actors taking on the role of interpreter, or health care providers who disregard the need for quality interpreting can be held accountable for flouting the quality standards, one thereof being "verif[ication] of the credentials of all performers" (Berger & Luckmann, 1966, pp. 91-92).

12.2. MODELS OF PROFESSIONAL DEVELOPMENT: SOCIOHISTORICAL PERSPECTIVE

In line with the above mentioned orientation it is worth noting that there are two main routes to professionalisation according to the comparative socio-historical perspective: top-down, also known as 'reform from above' and bottom-up (Siegrist, 1990, p. 46 as cited in Neal & Morgan, 1998). The former is characterised by the "active interventionist role" of the state in initiating, sanctioning, administering, structuring, training and establishing new professions (Siegrist, 1990, p. 46 as cited in Neal & Morgan, 1998), whereas the latter model implies that "spontaneous activities at the occupational level", such as "voluntary associations" burgeoned to the extent of becoming "professional bodies" (Macdonald, 1993, p. 72 in Neal and Morgan, 1998, p. 9). This socio-historical or "evolutionary" (Hughes, 1958 in Neal and Morgan, 1998, p. 11) approach allows us to identify the common patterns, stages or "rites of passage" Wilensky (1964 in Neal and Morgan, 1998, p. 12), which constitute a typified sequence of occurrences contributing to the metamorphosis which an occupation has to undergo in order to become a profession.

12.2.1. Bottom up model

According to Wilensky's bottom-up model, the sequential pattern leading to the completion of professionalisation process is built upon the following phases (Wilensky, 1964, pp. 142-146, in Neal & Morgan, 1998, p. 12):

1. Becoming a "full time" job instead of remaining a "piecemeal" employment or *interim* solution
2. Establishment of a "training school" by the early recruits, an occupational association or the client public. If these training schools did not begin within universities, the professionals-to-be would seek to liaise with universities in order to guarantee the burgeoning of "study courses, academic degrees and research programmes to expand the knowledge base"
3. Founding of professional associations by those who have been pushing "prescribed training" and those who happened to be the first to complete it.
4. Unceasing "political agitation for protection by law", whereby "legal protection of the title would be the aim", especially in the case of those occupations whose "area of competence was not clearly exclusive. [...] Where definition of the area of competence was clearer, then the mere performance of the act by a non-qualified person would be declared a crime [...]"
5. Adoption of the following rules:
   a) To bar the access to "the unqualified and the unscrupulous"
   b) To minimise "internal competition"
   c) To "protect clients"
   d) To lay down standards and requirements in a form of a formal code of ethics, that would serve as embodiment of the "service ideal"

These stages perfectly epitomise a bottom up model of professionalisation, whereby the members of an occupation are the ground breakers and the exponents of professionalisation of their respective occupations. The UK, for instance, has been traditionally adopting the bottom-up model to professionalise the occupations of public interest by following this pattern:

- Becoming full-time
- Refinement and formalisation of training
- Establishment of professional associations
- Mandatory qualifying examinations to ensure high levels of competence
- Political agitation for legal protection and statutory regulation of the expertise ownership
- Prescription of university education and vocational training as an academic route to qualification
- Commitment to continuous professional development

However, not all the countries have been following this professionalisation model.

12.2.2. Top down model

Some sociologists may find the 4º stage of Wilensky's sequence a mainstay of professionalisation processes and they would foreground the importance of support provided by the state.

Fleischmann (1970 as cited in Neal and Morgan, 1998), for example, is one of the most famous advocates of the top-down professionalisation approach. His model is grounded in the active interventionist approach of the state, consisting of the implementation of statutory regulations concerning:

1) Training
2) Licence to practice
3) Code of practice
4) Cameralist system under public law involving mandatory membership of a professional chamber
5) Statutory rules of conduct

Germany has been reported by Neal and Morgan to have traditionally followed this top-down approach to professionalisation:

- Becoming full-time
- Sharpening the definition of the occupation's public profile
- Licencing imposed by high status civil servants
- Prescriptive completion of university training (academic degrees)
- Establishment of professional associations
- State control in combination with self-regulation
- Rationalisation and control of labour markets by civil service administrations

The upcoming sections will be dedicated to ferreting out different prospects of professionalisation in two different types of healthcare settings of the VC: public and private medical facilities.

12.3. IMPLAUSIBLE PROSPECTS OF PROFESSIONALISATION IN THE PUBLIC SPHERE

MI in Spain should not be subsumed under the umbrella category of public service interpreting, as it could lead us down a blind alley. The salience of heterogeneity of foreign-speaking patient profiles and the grantor/resource-holder profiles in Spain cannot be dismissed. Therefore, one should distinguish public healthcare centres from private facilities. The end users of the public healthcare centres can be divided into the following groups:

- EU citizens who undergo non urgent medical procedures for free in public facilities (fraudulent health tourism)
- Those who develop a condition or suffer an accident when already abroad (requiring unscheduled emergency medical assistance)
    - Undocumented, non-regularised immigrants (not subject to tax liability)

- Foreigners with a valid residence permit granted under the general foreigners' regime and Ley 14/2013 on support for entrepreneurs and their internationalization
  - Migrant workers (also referred to as economic migrants) regularised in accordance with Regulation 1408/71)
  - International residents on regular basis (also referred to as social migrants)

However, all healthcare institutions in Spain and elsewhere, be it public or private, share the power "to decide over the other person's life, according to [...] state-sanctioned parameters, but are subject nonetheless to individual interpretation" (Rudvin, 2005, pp. 163-164). This means that according to the lack of state-sanctioned parameters regarding language provision services, the procurement managers of both public and private healthcare institutions may construe the role, need and importance of MI differently:

> Because the service provider is at that moment a public body, a professional subject rather than a "private subject," s/he is in that moment not generally personally accountable for or responsible for any mistakes, delays, misinterpretations, damage that his/her service or lack of it might have for the other party. This may profoundly affect his/her motivation in providing service and the speed and quality with which it is done. Furthermore, the numerical relationship alone (individual client versus group institution) is a source of significant actual and psychological strength for the service provider. (Rudvin, 2005, pp. 163-164)

In conformity with the EU statutory health insurance systems and the Real Decreto-ley 7/2018 [Real Decreto-ley 7/2018] on universal access to the National Health System, free healthcare is intended to be universalised. By returning the health SIP card (*Sistema de Información* Poblacional [Population Information System] or Social Security health card) to illegal immigrants, the government will have to prepare an annual budget of 500 million euros. And by extending the health card to all Europeans residing in Spain this expenditure would rise by a further 600 million a year. Thus, the total annual amount of public spending on free healthcare for foreigners per year amounts to 1.1 billion, which has already been declared insurmountable (Vigario, 2018).

The health reform (Real Decreto 16/2012) put in place by the former government (*Partido Popular* or People's Party) sought to put an end to the health paradise that Spain was at that time for foreigners, although it ended up affecting immigrants in an irregular situation as well. After the implementation of the restrictive Real Decreto 16/2012 reform of healthcare for foreigners the authorities proceeded to withdraw the health card from illegal immigrants, a measure which, according to the Ministry of Health at the time, affected 153,000 people (Real Decreto 16/2012), even though primarily this health reform was targeting the health tourism fraud or fraudulent health tourism (turismo sanitario fraudulento). This phenomenon consisted in European citizens being able to take advantage of the EU and Spanish legislation by travelling to Spain in order to undergo surgery free of charge and without having to deal with long waiting lists.

Hence, both the immigrants, who are not registered with the Social security, and the EU citizens seeking to undergo free and prompt surgery and other non-urgent planned procedures in Spanish public facilities may have regained the opportunity to do so thanks to the Real Decreto-ley 7/2018. However, providing healthcare to all, including those who do not pay taxes, is an "unsustainable cost for public healthcare" ("Gasto insostenible para la Sanidad pública"). Thus,

MI would suppose an even much greater monetary burden for the Social Security system in Spain. Having to pay for MI services on the top of 1.1 billion would simply be deemed an untenable situation.

As it was reported by Ortega-Herráez & Blasco-Mayor (2018), there used to be a figure of a "hostess" or "stewardess" around 2004-2010 in the VC, who used to interpret for patients among other (extremely incongruous) tasks, but this profile had to be terminated due to state budget cutbacks. Angelleli (2015) also reports on this occurrence:

> Language support for the foreign population has not been developed by any legal instrument in any of the regions other than the recently passed Organic Law 5/2015 that transposes Directive 2010/64/EU on the right of interpreting and translation in criminal proceedings. Different mechanisms that were put in place in the course of an immigration peak some 15 years ago, such as face-to-face interpreters or telephone interpreting in hospitals and the social services, have now been terminated or severely cut down in most regions because of cuts in public expenditure. [...] In regions with a large expatriate British or German population, such as the Valencian Community, there are groups of native volunteers who speak Spanish and interpret in hospitals. (Angelelli, 2015, p. 61)

Spanish politicians depicted interpreting as an expendable luxurious detail instead of an urgent need (Chiva, 2017, p. 15). This is exacerbated by the way in which foreigners are perceived by the host society and by the way in which this perception is entrenched by the dominant groups and the media. According to Rudvin (2005, p. 166): "a temporary status (until s/he has acquired host-country citizenship), a migrant status, and the status of a non-citizen, or 'second-rate' citizen" all denote a position of inferiority, which is problematic because public opinion is crucial for the social recognition of an occupation, especially in those cases where it is the general public who is the *grantor* of the service.

As maintained by García-Beyaert (2015, p. 54), the state in this particular case would act qua a regulator or manager of public funds, thus earmarking this budget for "the common good" – foreign language provision service– by allocating it to public healthcare providers in order to cover the needs of non-Spanish speaking patients in public facilities.

The general public would be the "grantor" and the "resource holder" (García-Beyaert, 2015, p. 46) without even being the receiver/end user of the medical interpreting service. Spanish population at large or Spanish society does not have the need for cross-linguistic and cross-cultural communication. There is a need for this service to be delivered, but the regular taxpayers will never be the ultimate users thereof. Therefore, general public's take on an occupation is pivotal for its recognition:

> The prerequisite for all other institutions of professionalism is official recognition that the occupation uses in its work a complex body of formal knowledge and skill that commands abstract concepts or theories and requires the exercise of a considerable amount of discretion. The general public's views of that occupation can facilitate and support such recognition, as can the views of some influential elite, but recognition and support from the state or some other paramount power is essential. When so recognized, an occupation is in a position to control its own work rather than be controlled by consumers or managers. (Freidson, 2001, Training Programs section, § 1)

Consequently, public interest must be a vested interest, but instead, such social phenomena as the othering[98] and the ghettoising of some social minorities, triggered by the press and the mass media, may impinge on the foregrounding of the linguistic needs of these minority groups in medical or legal context. The general public's view is very important because it is the general public who finances the public services in Spain. The general public is a pivotal "external player" in professionalisation, it is the grantor as well as the major resource holder, who finances social services via the taxes paid by the people. Therefore, depicting immigrants, migrants and foreign or European residents as undeserving opportunists who impose on the Spaniards' generosity and goodwill will not help raise awareness of these people's linguistic needs.

Consequently, given that the linguistic needs of the non-Spanish speaking populace are not being factored in, their basic rights to access quality healthcare are being undermined. Thus, the question arises as to who is going to be held accountable and liable if crippling injuries are inflicted on the patient due to miscommunication or misinterpretation? Back in 2014 the Andalusian Health Advisory Council was drawing up a proposal for a unified compensation scale for health damages (Sánchez Fierro, 2014), which Spanish legislation is currently lacking. The aim is to bring legal certainty to civil liability proceedings in this area. The 26th Congress on Health Law organised by the Spanish Association of Health Law (Sánchez, 2019), which took place in 2019, began with a debate regarding the scale of health damage, which would help grade medical performance. The experts agreed that it is a measure that would guarantee legal certainty and establish equality criteria based on technical and scientific aspects, based on a scale designed for each pathology, which would include a score according to severity and after-effects.

Among the benefits that the scale would bring were a decrease in litigation and a quicker solution to compensation problems. Until now, due to the absence of single criteria, it was difficult for the parties to reach out-of-court settlements. Raquel Murillo, deputy general manager and director of the Civil Liability Branch of Agrupación Mutual Aseguradora (AMA), indicated that "Issues such as the previous condition of the patient or the existence of certain specific sequelae justify in themselves the need for a specific health injury scale" (emphasis added). Dr. Romero, president of the Consejo General de Colegios Oficiales de Médicos de España (General Council of Medical Associations of Spain), defended the need for a specific damage scale for the health sector that quantifies the adverse effects of medical and health interventions.

As maintained by Dr. Romero: "Errors are committed by doing "something wrong" or "by not doing the right thing", but others "are inherent to the diagnostic processes, treatments, preventive and rehabilitative interventions" (Sánchez, 2019). According to the doctor, these adverse effects of medical and health interventions have, according to available estimates, a very significant impact on health, the organisation of health services and the economy. It is therefore "a priority global public health problem" that has led to an "increase in actions aimed at improving *patient safety*" (Sánchez, 2019).

But what if inaccurate interpreting lay at the root of some of these adverse events and sequelae. What if in the case of foreign-speaking patients the "doing wrong" or failing to "do the right

[98] The term "othering" stems from the philosopher Emmanuel Lévinas' discussions on the relations between Self and Other (Finkielkraut 1997 [1984], p. xiv–xv, as mentioned in Skaaden, 2019).

thing" was not actually the physicians' fault? What if physicians' decision-making process was contingent upon or hinged upon an accurate interpretation? What if the patient cannot get attended to because they do not speak the language? What if a language barrier was precluding the "first do no harm" premise from being complied with? According to Watt (2008) "80% of the diagnosis depends on oral communication" (cited in Cox & Lázaro, 2016, p. 34), and therefore, "medical mishaps in the ED[99] often result from vulnerable communication processes" (Eisenberg et al., 2005, p. 390, cited in Cox & Lázaro, 2016, p. 34), such as deficient history taking due to language barriers (Burley, 2011, cited in Cox & Lázaro, 2016, p. 34). The cases described in detail in Singh (2018), Quan (2010) Bernstein, Graham, Jacobs, Ku and Flores are the epitomes of the consequences which may ensue due to poor communication. So, who is going to pay for the overuse of emergency services, unnecessary hospitalisations, and all complications ensuing deficient communication?

I honestly believe that it is highly implausible that medical interpreting will be considered as a possibility in the foreseeable future. The reason being that neither Spanish society at large, nor the relevant social actors see social value in MI in terms of curtailing healthcare costs by decreasing the incidences of medical errors, unnecessary tests, hospitalisations and lawsuits, and in terms of safeguarding the basic human right to quality care.

12.4. ATTRACTIVE PROSPECTS OF PROFESSIONALISATION IN THE PRIVATE HEALTHCARE

There is an ever increasing demand in language provision in the field of private healthcare in the VC. This is why this occupation has already become a full-time job, although for the time being it is the case only for a limited number of private medical facilities. The prospects of professionalisation in the private sphere are much more reasonable than in the public sphere. The end-users of private healthcare centres can be subdivided into the following categories:

- Affluent elderly population (expatriates) who seek foreign retirement as long-term residents in Spain
- International travellers who visit Spain out of the peak tourist season
    - Business tourists
    - Regular tourists
- Traditional high season travellers
- Those who intentionally seek to undergo a planned elective treatment which became the main purpose for their journey abroad otherwise referred to as medical tourists

The general public is no longer the "resource-holder" (García-Beyaert, 2015) of the service, which is why the situation in Spanish private medical sphere differs radically and substantially from the situation in public sphere. The private healthcare providers such as the directors and managers of private hospitals and clinics become in this case the main decision-makers and "resource holders" (García-Beyaert, 2015), who totally control the budgetary accounting and decide what to spend on and how much. The owners of private healthcare facilities become the primary

[99] Emergency department.

grantors of the service. They have a vested interest in enhancing their competitiveness as well as the marketability of the service they offer. They invest in MI service in order for their medical centre to become more appealing to the patients. After capital recovery the facility is expecting to earn a profit on this investment.

The patients are secondary "resource holders" (García-Beyaert, 2015) as well as receivers or end-users of the service. They also have the purchasing power and therefore they generate substantial revenues by injecting substantial amounts of capital into Spanish economy. They are users of private healthcare services, hotel and catering industry, rental industry, entertainment industry, etc. Without tourists and medical tourists not only private hospitals' and clinics' benefits would plummet, but the whole economy would plunge. And this is exactly what we all have witnessed recently. Covid-19 crisis perfectly epitomises the degree of the country' dependence on tourism. Private medical institutions unlike public medical centres do have a budget to endow professional medical interpreting service expenses in pursuit of profit, greater competitiveness and commercial appeal, yet their procurement managers still prefer to hire lay entrants to the profession.

Private medical clinics in the VC are interested in providing interpreting services, but not in providing quality interpreting services. The problem is that the employers choose to remain oblivious regarding the difference between professional and layperson MI. Due to the lack of proper occupational regularisation, nobody is going to be held accountable in the case of corporate malfeasance or poor quality of the service delivered. Nobody is going to bear responsibility in the case of professional misconduct or negligence. The lack of task discretion constitutes an enormous problem, because in their eagerness to make profits, many employers expect MIs to perform a series of tasks that fall outside the purview of this discipline. Dialogue or liaison interpreting in medical sphere "became associated with lower standards of training and assessment (if any) and with a lesser defined role where, for example, the interpreter might take on additional roles [...]" (Valero, 2018, p. 93).

Despite being fully cognisant of the sheer volume of international tourists visiting Spain, and despite promoting tourism in all its forms, the government fails to attend to and accommodate linguistic needs of the tourists. Neither Directive 2011/24/EU, nor Regulation (EC) Nº 883/2004 have provided clear guidelines and advice on appropriate language provision for the government to take heed of. Thus, "In the absence of formal language guidance in EU legislation, in most observed cases appropriate language services are not provided for patients who do not speak the language of the Member State in which they seek healthcare" (Angelelli, 2015, p. iv). Correspondingly, the volume of patients seeking medical assistance overseas is exponentially incrementing, thus, drumming up interest among health policy decision makers. Yet "there is little information available on the safety and patient-centredness of cross-border care and neither governments nor citizens have an explicit basis for comparing healthcare delivery in Europe" (Groene at al., 2009, p. 15). The provision of cross-border care and patient-safety did receive policy attention, but some legal, financial and administrative issues as well as their implications for patient care still remain pending (Groene at al., 2009).

Despite the extensive body of international and domestic legislation[100], no statutory provisions have been put in place to regulate language provision in Spanish private hospitals and clinics. The EU has been known for its emerging role in pan-European harmonisation of administration, training, and licensing of professionals (Neal and Morgan, 2000, p. 9). Certain directives issued by the EU have been intended to alter the usual relationship between the professions and the state (Neal & Morgan, 2000). Such intervention by the EU has been classified as Euro-professionalisation (Neal & Morgan, 2000).

> It is argued that while European Union institutions play an increasingly important role in the *development of the professions*, they effectively favour the German approach. They do this in two ways. First, through transparency regulations such as Directive 89/48/ EEC such institutions undermine the autonomy of national professional bodies, while increasing their own power to determine the structure, administration, accountability, and training within these professions. Second, they have recently adopted an extreme version of 'professionalization from above' by deciding to establish the existence of a completely new, and quite controversial profession – that of the eco-auditor. (Neal & Morgan, 2000, p. 10)

In the absence of proper statutory regulations ensuring a safe haven or an exclusionary market shelter that would protect the occupation from free competition, indiscriminate eligibility to access the profession "exert[s] downward pressure on the price of [...] services" being provided (Neal & Morgan, 2000, p. 20). Thus, MI in the VC remains unprotected "from an unwelcome swelling of their numbers [...] and from a consequent depression in their earnings" (Neal & Morgan, 2000, p. 22).

The recruitment of professional interpreters for private medical centres should *not* be stymied by the lack of professionals with the language combinations including predominantly English, German, French, Scandinavian languages, Italian, Dutch or Russian. The professionals with these language profiles are relatively easy to find as opposed to the exotic language repertoire being deployed in some public hospitals (e. g. Ewondo, Bulu, Bangangté, Duala, Basa, Fang, Zulu, etc., just to mention a few) (Elidrissi, 2018).

Therefore, the uncertainty over the patients' linguistic profile is rare because the linguistic needs have been very well defined in the case of the private hospitals and clinics mentioned above. Yet even under these premises the procurement managers of private facilities still prefer to furnish with an income lay bilinguals rather than competent interpreters. The status of MI is being constantly challenged by alternative solutions, which I have already described in the

[100] Standards for equity in healthcare for migrants and other vulnerable groups, MED TF of The HPH network of WHO (2014), Europe – Amsterdam Declaration Towards Migrant Friendly Hospitals, Migrant Friendly Hospitals Project (2004), Council of Europe: Recommendations – Health and Quality of Life (2000), Office of the United Nations High Commissioner for Human Rights: Human Rights and Biotechnology (2002), A Declaration on the Promotion of Patients' Rights in Europe: Principles of the Rights of Patients in Europe: A Common Framework Amsterdam Declaration of Patients' Rights, Endorsed by the World Health Organization European Consultation on The Rights of Patients, 28-30 March 1994, Universal Declaration of Human Rights (1948-1998), Charter of Fundamental Rights of the European Union (2000/C 364/01), CHAPTER III – Articles 20 – 21, CHAPTER VI – Articles 47 – 50, European Convention for the Protection of Human Rights and Fundamental Freedoms, November 1950 (Articles 5 and 6), Universal Declaration of Human Rights, December 1948 (Articles 1-11), The Charter of Fundamental Rights of the European Union, The Treaty on the Functioning of the European Union, The Regulation (EC) 883/2004, The Directive 2011/24/EU, Article 43 of Spanish Constitution, Real Decreto 1030/2006, Ley 15/2008, Ley Orgánica 4/2000, Ley 41/2002, Ley 16/2003, Ley Orgánica 3/1986

previous chapters. The few professional interpreters who work at private facilities received neither higher esteem or appreciation from their colleagues, nor higher rewards or salary commensurate with the performance delivered with far higher quality.

The esoteric character of their knowledge is being totally disregarded. The lack of sophisticated mechanisms of patronage lead doctors, nurses, paramedical, physiotherapists, psychologists, scientific workers, support staff, ambulancemen, administrators, etc., to perceive medical interpreters as their helpers rather than their co-workers or colleagues. Therefore, interpreters increasingly find themselves obligated to engage in extra-professional activities as little regard is being paid to their jurisdictional boundaries. Many clinicians prefer to struggle using broken English as *lingua franca* rather than avail themselves of the professional interpreting services, thus underutilising the opportunity to have an accurate conveyance of meaning contributing to patients' safety. All these factors leave an imprint on the interpreters' professional self-esteem and self-image.

12.5. BOTTOM-UP PROFESSIONALISATION MODEL FOR MI

This section will look to analyse the stages of professionalisation which I deem applicable to MI in Spain. I shall anatomise every stage of the bottom-up model in order to ferret out the level of advancement of each of these stages. It is my contention that the current *status quo* of medical interpreting is not even that of a semi-profession. A number of private medical centres located in the VC, who do offer MI services to their foreign patients do not follow the high road business model. The procurement managers of the private medical centres rather opt for cost minimisation model which entails high turnover, lack of decent compensation, flagrant disregard for diligence and sophisticated qualification, precarious working conditions and underpayment. Angelelli (2015, p. 74) has also documented the foregoing occurrences, thereby lending credence my own professional experience:

> Another option discussed by providers (ES Sites 6 and 7) is to hire full-time interpreters, so that they can be on staff. However, this practice is not frequent. As part of our observations we shadowed these interpreters for a day in a private clinic. The interpreter worked non-stop in five languages. The interpreter earns €1200 euros per month for an 8-hour day. [...] In one private clinic that has five staff interpreters, we interviewed the supervisor (ES Informants 9 and 10). Based on our observations, we asked about workload, breaks, pressure, fatigue etc. Even when the administrators were aware of the overload of some of their interpreters, they explained "to be able to hire staff interpreters, the clinic must have sufficient demands". (Angelelli, 2015, p. 74)

Having said that, it is my contention that there exists certain theoretical parsimony with regard to the possible rationale behind this stagnation. I am convinced that the underestimation of the theory of professional knowledge can only lead to myopic attempts to professionalise. The magnitude of this problem is far greater than its lack of legal regulation and regularisation. The standstill of the professionalisation process is due to the lack of recognition of the occupation's indispensability, the uniqueness of its professional knowledge, and the esoteric specialisation. The crux of the problem is that layperson interpreters are allowed "to carry out some of the most dangerous tasks of our society – to intervene in our bodies [...]" without a second thought, when this should be reserved for members of regulated professions who are holders of the corresponding licence:

> The professions are licensed to carry out some of the most dangerous tasks of our society - to intervene in our bodies, to intercede for our prospects of future salvation, to regulate the conflict of rights and obligations between social interests. (Hughes, cited in Dingwall, 2016, Introduction section, § 10-12)

In other words, medical interpreting, as well as medicine, deals with human beings (Horobin, 2016, Professional Charisma, § 2-6) and this is why its professionalisation, regularisation and licencing is so urgent and vital, unlike that of other occupations who do not deal with human organisms, health, life, freedom, rights, etc. The relevant "external players" (García-Beyaert, 2015) fail to fathom out the crippling, irreparable damage that may be inflicted upon non-Spanish speaking patients by these amateurs.

According to Corsellis (2015, pp. 111-112) the professionalisation process of PSIT interpreters should be conducted by the interpreters themselves, by the front-line public service providers and by the academia. Interpreters are "intelligent, resourceful people who know their profession and are proud of it" (Corsellis, 2015, p. 111). Academics have "gone a good way to protecting standards for training PSITs" (Corsellis, 2015, p. 112), drawing up standards of practice (ISO 13611 and ISO 21998), and expanding the knowledge base by promoting different "academic degrees" such as Bachelor's degrees, Master's Degrees, all sorts of different postgraduate degrees, diverse "study courses" and, of course, "research programmes" (Wilensky, 1964, pp. 142-146, in Neal & Morgan, 2000, p. 12). The problem is that all these attempts and initiatives set out in papers and conference presentations "disappear in the light of the day" and workplace "reality" (Corsellis, 2015, p. 112), and this is exactly why medical interpreters cannot rely solely on themselves and the academia to professionalise.

As I have already explained in the chapter on institutional and practice ethics[101], academics and scholars cannot expect interpreters to adhere to the codes of ethics and standards of practice learnt at the university, because 1) they operate in a secondary institutional sphere (medical facility), and 2) they need to conform to "economic, political, social, and ideological circumstances which create many of the moral problems of work" (Freidson, 2001, Institutional Ethics section, § 1). Therefore, the occupation is in desperate need of intervention on the part of service receivers. The end-users would contribute greatly to the observance of practice ethics with their understanding and support. Corsellis (2015, p. 111) argues that "the public service employees are therefore in an informed position to put pressure on their own authorities to fund, deploy and employ PSITs effectively" (Corsellis, 2015). According to Corsellis:

> Front-line public services mostly appreciate both the need for good interpreting, and the skills sets needed to do it. While some doctors and so forth may still say that children and family members make satisfactory interpreters, even they are learning that is not the case. From their close contact with the public, they are beginning to understand the time it takes to learn an official language to a level where reliable communication can take place and that, in the meantime, assistance is required. There is an increasing awareness of the risks of inadequate interpreting, not just to other language speakers but also to providers of public services themselves, who have a professional responsibility for their decisions and are accountable for them. Where those decisions are based on inaccurate information, because decisions have been made deliberately to engage sub-standard interpreting and

[101] For more information, please re-visit the chapter *Unpacking Professional Ethics.*

> translation, they are at risk: at risk from litigation and from disciplinary actions within their own professions. (Corsellis, 2015, p. 111)

Even though I totally agree with Corsellis, I strongly believe that the patients also play a primordial role in bringing pressure to bear on authorities to fund and deploy medical interpreting services effectively. They are also receivers of the service and therefore they need to pronounce on the subject, but they will not say anything because they just do not realise that they need a qualified and competent interpreter to enable communication with the medical staff.

Not a pseudo-bilingual medical professional, who alleges that he/she is proficient in a language, not a bilingual receptionist, not a family member, not Google Translate. They need to come to realisation that they are entitled to receive medical information on their health state, and that in order for that to happen they need a competent interpreter.

Thus, the following is the anatomy of the steps that need to be taken in order for this occupation to be labelled as 'profession'. Neither the pan European, nor the domestic government officials, decision-makers or policy-makers have shown themselves keen to play an active interventionist role in the initiation, sanctioning, structuring, administration, regularisation and training of the professional body of medical interpreters. Therefore we cannot be talking about top-down professionalisation model that has traditionally been deployed in countries such as Germany, for example. Thus, the bottom up model preferred by the UK is for the time being the only viable option to achieve the coveted label.

1. To be in demand and become a full time job

As maintained by Angelleli, "Another option discussed by providers (ES Sites 6 and 7) is to hire full-time interpreters, so that they can be on staff. However, this practice is not frequent" (2015, p. 74).

It is noteworthy stating that, in spite of having professional interpreters to avail themselves of, numerous doctors practicing in private health sphere refuse to benefit from this service and prefer to struggle while fumbling for the right word without being willing to recognise that they have a basic grasp of the language they are intent on using and are, therefore, in need of professional help. It is my contention that this attitude might have little to do with egocentricity or overconfidence of the doctors, but rather with their failure to realise and recognise that they do not possess the specialised body of knowledge and skill to communicate in a language that is not their own. I believe that doctors' lack of recognition of the complexity of successful communication in a foreign language is the most important aspect to factor in when deconstructing lack of demand for qualified interpreters.

A number of private hospitals and clinics in the Valencian Community have been putting in house interpreters on the payroll, however other alternatives such as bilingual clinicians and plurilingual non-clinical staff are in great demand. Medical interpreting services in public sphere are inexistent, but profiles such as intercultural mediator, public relations, or international medical assistant have started to mushroom and gain popularity very quickly. Thus, we are witnessing a within-occupation profile heterogeneity being normalised, whereby hybrid profiles (intercultural mediator, medical assistant, international nurse, public relations, stewardess, etc.) first plague our niche and then hijack our attempts to professionalise. As stated by Ann Corsellis:

> I hope that we can also look to the future and think about what interpreters and translators might do to build their own professional frameworks to achieve the status, structures and standards they want and need. There is a real concern that, if interpreters and translators don't do that for themselves, someone else will do it to them and get it very wrong. (Valero, 2018, p. 92)

2. Formalisation of knowledge or consolidation of formalised training

Professional traits include high proportion of training in school, but university affiliation is absolutely essential. The teachers are usually full-time lecturers strongly committed to research in the field of the occupation in question and they would always practice the occupation/profession that they teach about. In Spain interpreting and translation are two disciplines whose expertise is indeed covered by the current University curricula. Educational institutions such as Universities play an important role in the production, reproduction and classification of knowledge:

> Hence the production and reproduction of knowledge - legal, medical, religious, educational and so on - will become the *leitmotiv* for a sociology of professional education. We must recognise that all educational knowledge - be it that of primary schools or universities - is in a sense *arbitrary*. There is no absolute, pre-given corpus of knowledge which self-evidently presents itself as a 'curriculum', and which is inherently endowed with order, sequential organisation and so on. The curriculum is a device whereby knowledge is classified and combined: it is a cultural imposition. [...] Educational knowledge separates what is thinkable from what is unthinkable; it identifies what is deemed important and attempts to distinguish it from what is trivial; it marks out what is introductory from what is specialised and advanced; it may construct an essential 'core' as opposed to the peripheral or optional. [...] Bernstein's own major contribution to the field is based on his notions of 'classification' and 'framing' "of knowledge of which he says: 'Classification ... refers to the degree of boundary maintenance between contents 'and' ... frame refers to the degree of control teacher and pupil possess over the selection, organisation and pacing of the knowledge transmitted' (1971, pp.49-50). (Atkinson, 2016, The Reproduction of the Professional Community, § 36, emphasis in the original)

Spanish Universities do offer academic degrees such as 4-year-long Bachelor's degrees, 1-year-long Master's degrees, different postgraduate degrees, study courses, research programmes, etc., in Translation and Interpreting as well as in medical Translation and Interpreting, but the diploma in these academic degrees does not give their holders the priority over lay person *soi-disant* bilinguals. The problem, however, is that no unified standards for educational programmes in MI have been established yet. As far as healthcare interpreting in Spain is concerned, there are still no official requirements regarding the level of training of its practitioners, and different training proposals for healthcare interpreters are offered by different Spanish institutions or entities such as universities, private companies, and NGOs (Álvaro-Aranda & Lázaro-Gutiérrez, 2021, p. 69). It is worth noting that some universities (e.g. Universidad Jaume I) are starting to incorporate courses in intercultural mediation into their curricula or plans of study (Álvaro-Aranda & Lázaro-Gutiérrez, 2021, p. 72), thus yielding to the ongoing expertise usurpation, and furthering the confusion in the division of labour and blurry jurisdictional boundaries.

In spite of having invested in their university education, the T&I graduates are far from exercising their privilege and reaping benefits in the form of economic payoff and dominant prestigious position because their knowledge and skill are equated to the knowledge and skill of any lay bilingual. Thus, graduated interpreters and translators do not enjoy any exclusive prerogatives such as state sanctioned market shelter. Moreover, headlines such as "*Se busca médico (con tres*

idiomas) para tratar a turistas sanitarios [Doctor (with three languages) wanted to treat health tourists]" epitomise the welcoming attitude towards alleged bilingual medical workers (Pascual & García, 2017). Angelelli also reports that procurement managers of a private hospital avowed that:

> Doctors and nurses are recruited also because they understand and speak two or three languages. For less common languages, we contact foreign consulates… who sometimes refuse to help. In most cases, communication is not a major problem… We manage in English. We always manage. English is like a wild card (comodín). For consent forms for example, we simplify the language to make it more accessible, especially when the "translator" is a child who then needs to explain it to the family member. (ES Inf 7). (Angelelli, 2015, p. 61)

New emerging profiles such as personal medical assistants (*asistentes personales sanitarios APS*) (Pascual & García, 2017) spurred by medical tourism, and intercultural mediators burgeoning in the public sphere are luxuriating in the medical interpreters' niche or stratum without having even had to present credentials attesting to their expertise. Formalised training should have become an exclusionary mechanism of social closure leading to a monopolised supply of particular formal knowledge-based skills. Corsellis has stated that PSITs "might have to aim at statutory regulation and protection of title", which would regulate the occupation's social presence (Valero, 2018, p. 97). The term title should refer not only to a job title or a position in an organisation, but also to the qualifications and social rank, thus denoting professional status. A diploma in T&I does not grant the university *alumni* exclusive ownership over this area of competence. Thus, the specialised body of knowledge has indeed been disciplinarised and formalised, yet university education is definitely not a prerequisite for the exercise of competence.

3. Persistent political agitation. Comparing medical and legal fields

It has been clearly stated in the Directive 2011/24/EU of the European parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, that a *high level of protection of human health and high levels of social protection* should be prioritised (art. 2, 3).

> As recognised by the Council in its Conclusions of 1- 2 June 2006 on Common values and principles in European Union Health Systems [...] there is a set of operating principles that are shared by health systems throughout the Union. Those operating principles are necessary to ensure patients' trust in cross-border healthcare, which is necessary for achieving patient mobility as well as a high level of health protection. In the same statement, the Council recognised that the practical ways in which these values and principles become a reality vary significantly between Member States. (Directive 2011/24/EU, 2011, art. 5)

The statement of common values and principles sets out "The overarching values of universality, access to good quality care, equity, and solidarity" (Council Conclusions on Common values and principles in European Union Health Systems, 2006). These values highlight the necessity of patient-centeredness and responsiveness to individual needs of the patients:

> Universality means that no-one is barred access to healthcare; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability

> to pay. (Council Conclusions on Common values and principles in European Union Health Systems, 2006)

Even though the Directive 2011/24/EU as well as Council Conclusions on Common Values and Principles in European Union Health Systems require that Member States find "practical ways" to reify and pragmatise these principles, none of these documents does actually stipulate what "practical ways" could the Council be referring to, nor does it mention what mechanisms would materialise and facilitate universalisation of care. Cross-border healthcare is supported by the EU as well as by Spanish government, but language barriers do not seem to constitute a matter of concern whatsoever. Communication is key in medicine and yet the failure to communicate does not seem to galvanise authorities into action. MI should have been regularised under the aegis of the EU and the WHO as key supragovernmental institutions, thus leading to the top-down Euro-professionalisation, nevertheless, no interventionist actions have been taken with regard to this occupation. On the contrary, The Directive 64/2010/EU of the European Parliament and of the Council of 20 October 2010 on the right to interpretation and translation in criminal proceedings (European Parliament & Council of the European Union, 2010), does recognise the salience of the quality of interpretation and translation:

> Member States shall take concrete measures to ensure that the interpretation and translation provided meets the quality required under Article 2(8) and Article 3(9). (Article 5 (1))

> In order to promote the adequacy of interpretation and translation and efficient access thereto, Member States shall endeavour to establish a register or registers of independent translators and interpreters who are appropriately qualified. Once established, such register or registers shall, where appropriate, be made available to legal counsel and relevant authorities. (Article 5 (2))

Corsellis (2015, p. 104) advocates for a series of "structures normal to any professions" such as "national examination bodies" and national, independent professional registers of public service interpreters and translators:

> Professional registers are independent, not-for-profit, voluntary or statutory bodies which register, and make freely available, the details of individuals who have met their criteria and agree to profess/observe a specified code of con- duct/ethics. The criteria include: qualifications at the recognised minimum graduate level; proven, relevant experience and security clearances. Standards are maintained through regular re-registration requirements. (Corsellis, 2015, p. 104)

Nevertheless, despite this recognition of the importance of interpreting and translation in criminal proceedings by the EU, no further regulations regarding the strategies of implementation and enforcement of this Directive had ensued. As maintained by Corsellis:

> Following these Directives, there has been a sort of expectation that "they", at government level, would take on board responsibility for legal interpreting and translation because of the legal requirements, pressing social need and public good. In fact, responses from governments have been variable in terms of solid, practical delivery, despite expressions of good will which may or may not be sincere. (Corsellis, 2015, p. 108)

Thus, Spanish government for instance opted for outsourced management of interpreting services provided in legal proceeding, which has clearly instigated de-professionalisation, professional precariousness, job instability and insecurity, financial and occupational vulnerability.

Many professional interpreters have lapsed due to severe underpayment issues and now only state-regulated registry bypassing intermediaries between free-lance interpreters and end-consumers may help lure professional interpreters back in. Corsellis states that:

> Unless sufficient resources are allocated to the public services, this usually leads to lowering interpreting standards, working conditions and fees, which have had disastrous results. Since the introduction of outsourcing in the UK, over one thousand qualified legal interpreters have felt obliged to refuse to take work from the commercial companies involved. (Corsellis, 2015, p. 110)

It should be stressed that outsourcing or outsourced management of public service interpreting does indeed lead to de-professionalisation of court and police interpreters in Spain. The clearest example thereof would be an article published in 20 Minutos newspaper (Fernández, 2008), where it was reported that Seprotec Multilingual Solutions, local recruitment for-profit company in charge of the externalised public service interpreting services, had been sending to the Spanish National Police so-called "translators" with criminal records.

Seprotec was accused of entrusting criminal offenders with language provision in highly sensitive contexts and situation where people's live and freedom was at stake. One of these "translators" was reported to have committed 2 crimes of falsification/forgery of documents and 1 offence of illicit drug trafficking among other crimes and offences (6 in total). Police executed the arrest warrant that has been previously issued by competent authorities to capture the so-called "translator". But this was not a singular case, "at the time when [the 2013] contract was let, Seprotec was subject to investigation by the antifraud agency of Catalonia for allegedly falsifying information regarding the qualifications of up to 90% of their pool of interpreters in order to win the tenders" (Tribunal Superior de Justicia de Cataluña, 2013 in García-Beyaert, 2015, p. 53). It became known that Seprotec has received 2.6 million Euros in 2008 and 10 million Euros in 2013 (BOE 2013 as cited in García-Beyaert, 2015, p. 53) from the Ministry of the Interior for the purpose of the translation and interpreting service delivery. Seprotec was also reported to have been paying only 10 Euros per hour to its alleged translators and interpreters, when the Company was charging the Ministry of Interior 45-48€ per hour. Thus, even though the outsourced management does not constitute a problem in the study-relevant field of private medical interpreting (yet?), it is a fact that such service externalisation and privatisation only fosters precariousness, subpar working conditions, and de-professionalisation. According to García-Beyaert (2015, p. 53), even though such "outsourced management by a private company has not proved ideal", "the policy-makers have shown little sensitivity". "Despite criticism of the lack of guarantees for quality in the original contract (which focused on language ability and devoted little attention to interpreting skills), the requirements for competence in interpreting completely disappeared from the 2012 new request for tenders" (García-Beyaert, 2015, p. 53). She stated:

> The right to an interpreter in criminal proceedings is generally granted and supported by [...] legislative precepts in different countries. [...] Yet the maturity of court interpreting as a professional activity is in many jurisdictions clearly below ideal standards. There is far too often a gap between, on the one hand, the widespread and historic recognition that language assistance (in criminal proceedings) is necessary for procedural fairness in the presence of language barriers and, on the other hand, the recognition that, in the presence of language barriers, ensuring effective communication involves

> sophisticated measures (infrastructure) and skills (interpreters' expert abilities). (García-Beyaert, 2015, p. 52)

In spite of ensuring the right to interpreter in criminal proceedings (guaranteeing the interpreter's physical presence in the courtroom), the current legislation in Spain lacks specifications regarding the actual delivery of this service showcasing minimum requirements to be fulfilled by the applicants, thus, failing to acknowledge the quality of the interpreting being delivered as a determinant factor of procedural fairness of trials.

In the case of medical interpreting, linguistic barrier to communication in the medical settings is not even mentioned in the Directive 2011/24/EU. Neither the EU, nor the Spanish state have ever become vocal about the existing language dilemma, and therefore now we need to resort to the bottom-up model. According to Corsellis: *"Only interpreters can create these structures for themselves. Interpreters are too important [...] to be without a protective enabling structure"* (Valero, 2018, p. 97, emphasis in the original). But as stated by Corsellis, in order for medical interpreters to start persistent political agitation,

> *There would need to be a critical mass of qualified, registered interpreters for statutory regulation to be put in place. There would be no point in legislating that only people with specified skills and experience could be engaged, when there were not enough of them.* (Valero, 2018, p. 97, emphasis in the original)

So, once a critical mass of qualified and competent experts has been congregated, "they would provide a viable alternative to short-term solutions and, equally importantly, be responsible for their own profession with sufficient weight to withstand, for example, any judiciary which lacks integrity and independence" (Corsellis, 2015, p. 111). Sasso and Malli (2004, p. 49, in Corsellis, 2015, p. 109) argue that perhaps interpreters should rather triage their priorities and first zero in on building the profession by "defining the professional structure and process of training, certification, enforcement, membership and role definition". Sasso and Malli contend that perhaps public service interpreters should stop being dependent on political reluctance to implement correspondent legislation, because: "Perhaps the question is not whether the industry needs public policy, but whether it is, indeed, needed at this point in our evolution" (2004, in Corsellis, 2015, p. 109). The problem that I personally see here is the fact that our occupation has been plagued by other emerging profiles portrayed in this thesis. We cannot afford to wait and see how intercultural mediators, international medical assistants, personal medical assistants, public relations, (pseudo)bilingual medical staff, (pseudo)plurilingual administration and auxiliary non-clinical staff, social workers, etc. claim ownership over our expertise and competence, ostracise us and usurp our niche. We desperately need the state to intervene as soon as possible in order to protect this profession. This occupation cannot hinge upon political whim as these new incipient profiles branch out and become popular and fashionable at an exponential pace.

Thus, as I have indicated earlier, there are four major groups that should seek political and legislative protection of the title. Following the taxonomy set out by García-Beyaert (2015), the first group is comprised by the medical interpreters as providers of the service and key internal players. The second group is constituted by the academics and scholars of Translation and Interpreting. They are key internal players as well, as they create proper academic and scientific environment for the new ideas to germinate, thus expanding the formal body of specialised

knowledge of the discipline. The third group is represented by the receivers of the service (key external players): health professionals and patients.

All together we must seek professional recognition, state patronage, statutory regulation, legal protection and licence that would guarantee exclusive ownership over our area of expertise and competence. Clear jurisdictional boundaries and unambiguous delimitation of the area of competence are key to ensuring market closure. It is absolutely essential that the profession is protected by law, whereby "legal protection of the title would be the aim", especially in the case of those occupations whose "area of competence was not clearly exclusive. [...] Where definition of the area of competence was clearer, then the mere performance of the act by a non-qualified person would be declared a crime" (Wilensky, 1964, pp. 142-146, in Neal & Morgan, 1998, p. 12). It is key that the social presence of an occupation is duly enshrined in the corresponding legal instruments, therefore policies must be created to safeguard exclusionary market shelters, which would eliminate unqualified and unscrupulous amateurs from entering the profession. Clear prevalence of academic degree over alleged bilingualism should be established. In order to reduce internal competition and ensure decent livelihood wage floor should be consolidated. Only once these measures have been taken can we start talking about safety and well-being of service receivers and welfare of medical interpreters. All the aforementioned measures are key to guaranteeing that a medical setting, even though it may be a private facility possessing "greater opportunities to exploit commercial relationship" (Mungham & Thomas, 2016, Solicitors and clients: Altruism or Self-Interest? Section, § 1) will not disregard patients' needs to the detriment of the patient. "Caveat emptor may operate in the market place but not in the solicitor's office" (Mungham & Thomas, 2016).

4. Code of ethics and standards of practice

"The purpose of self-regulation and the code of ethics is to protect the public from the vagaries of *caveat emptor*" (Mungham & Thomas, 2016, Solicitors and clients: Altruism or Self-Interest? Descriptions of the legal profession section, § 8). But the question is how far can professional medical interpreters go to guarantee adherence to their code of conduct? As the empirical part of this thesis will seek to demonstrate, professional interpreters in the study-relevant context cannot deliver to the best of their ability acting within the purview of their competence and professional jurisdictional boundaries, because the institutional ethics, the financial dependence, and most importantly disregard, confusion and illiteracy concerning our occupation and its standards of practice make it impossible to remain faithful to the correspondent professional values and principles.

There is a number of different codes of conduct and standards of practice that can be applicable to medical interpreting and which were intended to serve the purpose of protecting participants from *caveat emptor*. Some have been drawn up to systematise language provision on public services, some are meant to be deployed specifically in healthcare sphere. Some are international whereas the purpose of others is to be used at local level. There is also a plethora of different standards of practice related to translation and interpreting in one way or the other. The following are the standards of practice drawn up by the ISO, International Organization for Standardization:

- ISO 20539:2019, Translation, interpreting and related technology — Vocabulary
- ISO 20109:2016, Simultaneous interpreting — Equipment — Requirements
- ISO/TR 20694:2018, A typology of language registers
- ISO/PAS 24019:2020, Simultaneous interpreting delivery platforms — Requirements and recommendations
- ISO 17100:2015, Translation Services — Requirements for translation services

The most study-relevant standards of practice, which encompass all of the aforementioned standards are the following two:

- ISO 13611:2014 Interpreting — Guidelines for community interpreting
- ISO 21998:2020 Interpreting services — Healthcare interpreting — Requirements and recommendations

As regards codes of ethics and codes of conduct, Pokorn and Mikolič (2020) have conducted an exhaustive analysis on different codes of ethics on international level which may be found in their paper *Community interpreters versus intercultural mediators Is it really all about ethics?* They have examined deontological documents for community interpreters: Code of professional conduct issued by NRPSI CPC (2016), Code of Ethics for Community Interpreters issued by COE in Ireland and Finland (2010), PSI: Minimally Required Competence in terms of Knowledge, Skills and Attitudes issued by ENPSIT (European Network for Public Service Interpreting and Translation) and National Standards of Practice for Interpreters in Healthcare issued by HIN Canada (2005) (Pokorn & Mikolič, 2020, pp. 92-93).

They have also analysed deontological documents for healthcare interpreters: California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles & Intervention issued by CHIA (2002), Code of Ethics for Medical Interpreters issued by IMIA (2008), IMIA Guide on Medical Interpreter Ethical Conduct (2010) and National Standards of Practice for Interpreters in Healthcare issued by NCIHC (2005) (Pokorn & Mikolič, 2020, pp. 92-93).

Then the above mentioned codes of conduct have been stacked up against the documents on the ethical positioning of intercultural mediators, which include Intercultural Mediator Profile and Related Learning Outcomes issued by TIME (2015) and Health Evidence Network Synthesis Report 64 WHO (Regional Office for Europe) 2019 (Pokorn & Mikolič, 2020, pp. 92-93).

Pokorn's and Mikolič's work clearly demonstrates that the emerging profile of intercultural mediation is not only gaining popularity but also actually ousting medical interpreters from their own niche. Therefore, I agree with Corsellis in that: "There is a real concern that, if interpreters and translators don't do that for themselves, someone else will do it to them and get it very wrong" (Valero, 2018, p. 92). I strongly believe that a national code of ethics must be drawn up by medical interpreters, academics, scholars and members of professional associations. Key external players' opinions must be carefully examined and taken into account in order to create a code of conduct that would benefit all. Nevertheless, we must not forget that practice ethics cannot be fully complied with up until the profession is recognised as such by the institutional sphere where it is being performed. The "economic, political, social and ideological circumstances" (Freidson,

2001, Institutional Ethics section, § 1) may render it impossible to adhere to the moral and ethical dogmas that the interpreter may wish to observe. Thus, the guidelines to good practice (or practice ethics as Freidson (2001) calls them) must be nationally or internationally recognised (Corsellis, in Valero, 2018, p. 95).

5. Professional associations

Another stage that can be unleashed as a solution to de-professionalisation is the creation of professional associations. Freidson explains that indiscriminate eligibility for entry might not be the optimal option:

> Formal professional associations based on a truly inclusive community of interest do not often exist in reality, however. Many include only elite, unusually successful and distinguished practitioners, in some cases by virtue of deliberate restriction of membership and in others by the inability of lesser practitioners to bear the cost in time and money that membership requires. Assuming that an association represents primarily what its active members perceive to be their interests, we can also assume that the desires of the members of exclusive associations are probably not likely to reflect those of the entire professional community. Their standards are likely to be more demanding and narrow than those of others. My impression is that in the early stages of the development of professional associations the active membership (which is not the same as all who practice the discipline) is composed largely of elite practitioners. Their concern is less to raise their status by a "collective mobility project" (Larson 1977) than to preserve and solidify their official and public status, in part by gaining state recognition and support, and in part by preventing the decline in status that might occur if practitioners of more humble origins become members. (Freidson, 2001, The Composition of Professions, § 2)

National statutory non-for-profit professional registers as well as professional associations play a key role in adopting "transparent disciplinary procedures where breaches of its code are alleged" (Corsellis, 2015, p. 104), thereby guaranteeing *non-caveat-emptor* approach to professional activity.

I firmly believe that the whole process of professionalisation must be accompanied by a strong feeling of professional self-regard, self-esteem and dignity. As professional medical interpreters we must make sure that the end-receivers of our services come to the realisation of the fact that apart from an extensive and highly sophisticated body of formal knowledge and excellent language command, certified interpreters ought to be excellent communicators exceptionally skilled at conveying somebody else's ideas and messages. Therefore, one should understand that it is not a body of specialised knowledge, which includes language proficiency, that makes an interpreter an interpreter, but rather the mystique of being an excellent communicator. Thus, the end-users will put their trust in the interpreters' communication skills with only one clear expectation: successful communication. It is essential that the end-users understand that not only must the interpreter be talented and gifted language learner or user, but he/she must also be adept at conveying and negotiating meanings cross-linguistically and cross-culturally with maximum accuracy and diligence. Professional medical interpreters as well as academics of the field of T&I, medical staff and patients should become vocal and reject short-terminism in tackling language barriers. Together, we must urge the state to unleash effective long-term solution to tackle language barriers in healthcare, and the only safe and reliable solution is professional, certified, accredited, registered interpreters and translators. Only an exhaustive regularisation of the occupation's social

presence will protect users from *caveat emptor* and furnish the possibility of having a legal recourse and protection in the case of alleged breach of law or code of conduct.

As I have explained in previous chapters, these steps or stages of professionalisation following a bottom-up sequence can only be accomplished through occupational or social closure. According to Weeden (2002, p. 69), occupational closure consists of five key strategies or devices: 1) licensing, 2) formal educational credentialing, 3) voluntary certification, 4) representation of association, and 5) unionisation. The implementation of these strategies requires deployment of the following mechanisms: 1) supply restriction, 2) increase in demand, 3) channelling demand to the occupation, and 4) signalling quality of service. Thus, according to this author, licensing is a state-endorsed and state controlled enforcement of supply-side restrictions, whereby the state grants permission 1) to identify oneself by an occupational title by meeting predefined set of eligibility criteria, and 2) to practice particular set of skills (Weeden, 2002, p. 62), which when undertaken by a non-qualified person would be declared a crime (Wilensky, 1964, pp. 142-146, as cited in Neal & Morgan, 2000, p. 12). "Licensing allows an occupation to claim that its practitioners meet a minimum level of technical competence and moral superiority" (Weeden, 2002, p. 68). Hence, the constant political agitation (Wilensky, 1964) must lead to licensure, whereby the professionalisation of an occupation is being justified to lawmakers and the general public on the grounds that:

- It would protect consumers from incompetence and malfeasance, especially in the cases of occupations where customers/clients cannot make fully informed choices (in this case due to social marginalisation and heath illiteracy, as well as due to the complexity and esoteric character of the knowledge and skill embedded in the profession) leading to knowledgeable decisions and conscious judgement of the situation. Some kinds of work are just too sophisticated for the untrained to understand, but many times this work is performed in circumstances where the wrong choice can be fatal.
- Therefore, a licence is meant to protect consumers in life-threatening conditions (related to the consumers' life, health and wealth) because in spite of the consumers' willingness and inclination to make a time-consuming and considerable effort to command the knowledge of the particular subject matter, its quantity, complexity and opacity will end up hindering the competency and competence acquisition.

The mechanisms used to implement the licencing strategy are the restriction of supply, the channelling of the demand directly and exclusively to the members of the profession/occupation in question, and signalling quality of service.

Labour supply is restricted in order to generate "an artificial scarcity of individuals who have the legal, technical, or socially recognized ability to perform the bundle of tasks provided by that occupation" (Weber, 1978; Larson, 1977; Freidson, 1994, pp. 80–83; Parkin, 1979, pp. 44–71; Collins, 1979, pp. 56–58; Sørensen & Kalleberg, 1981, cited in Weeden, 2002, p. 61).

Given that the magnitude of the overall demand for a service is insufficient to increase demand for a particular occupation (Weeden, 2002, p. 66), the occupation must guarantee "demand for the services it alone can claim" (Weeden, 2002, p. 66). In other words, "the occupation must defend the demand for its services from encroachment by other occupations" (Abbott 1988,

in Weeden, 2002, p. 66). According to the author, this may be effectuated via a licence which includes detailed itemisation, stipulation and delineation of tasks falling under purview of the occupation in question. Thus, such licence not only protects the title, but also patents the tasks and keeps them within the jurisdictional boundaries which the occupation claims ownership over. The goal is to induce potential consumers to build up trust in the professionals' efficiency, reliability and safety, which can be provided only by the licenced occupation members alone (Weeden, 2002, p. 66). Occupation-specific demand may also be marketed by the occupational associations. All these techniques will help channel the demand exclusively to the licenced members meeting the predefined set of criteria.

Weeden maintains that by signalling to prospective consumers that practitioners' training predetermines, creates the conditions and lays down the framework for quality, efficiency, efficacy and effectiveness in performance, "occupational agents impose on the world a vision of their (desired) position in the social division of labor" (Bourdieu 1987, pp. 10–11; Scott 1992, p. 139, cited in Weeden, 2011, p. 66).

> A successful quality-of-service signal, in turn, increases the price consumers are willing to pay for an occupation's services beyond that expected from the intersection of supply and demand. [...] As a member of the Professional Association of Resume Writers (1998) explains, "once [clients] are convinced that you are a professional, they'l [sic] readily accept your quoted price." (Weeden, 2002, p. 67)

Weeden also provides a few highly illustrative examples whereby she demonstrated that the discourse used by The Opticians Association of America (1996), the National Bureau of Professional Management Consultants (1998), the Society of Clinical and Medical Electrologists (1999) and American Purchasing Society (1998) clearly mirrored their desiderata for 1) professional recognition, which may be achieved through "a broader understanding and acceptance" of its "indispensab[ility] to the health and welfare of the public", for 2) "state-based licensure" intended for "stem[ming] the rising tide of unqualified consultants passing themselves off as experts to unsuspecting businesses and improve the image of consultants as employed white-collar workers", and for 3) separation of "the highly-skilled and well-trained practitioner from the few amateurs who gave the profession a bad name" (Weeden, 2002, pp. 67-68).

Thus, whereas the licence is granted under the aegis of the state itself to the profession that thereby enjoys state patronage and endorsement, as well as law enforcement strategies safeguarding its licencing status, the non-state mandated voluntary certification and educational credentialing turn occupational incumbents into exclusionary gatekeepers of their profession (Redbird, 2017, pp. 600-624) and constitute key prerequisites for licensure. Nevertheless, formalised educational credentialing is always obtained exclusively through a formal educational system and it has always been the key precondition for licencing, whereas voluntary certification is normally conferred by the occupational organisations or associations and they do not constitute a prerequisite for licencing for the majority of occupations. I shall start by explaining formalised educational credentialling as this particular closure strategy along with licencing and unionisation constitute three major pillars of social closure, whereas the two remaining closure strategies –occupational association and voluntary certifications– constitute adjuvant devices. Thus, according to Weeden: "Educational credentialing refers to the use of the familiar symbols or markers of

knowledge (e.g., grade levels, diplomas) conferred by formal educational institutions to monitor entry into occupations" (2002, p. 61).

> While other forms of closure such as certification and educational credentialing are voluntary in nature, only licensed occupations have a legal underpinning such that *only those* that meet the criteria can practice (or undertake certain occupational tasks). To achieve the supply-side restrictions described by the theory, occupations engage in boundary-setting activities over occupational tasks and commit considerable resources in their attempt to persuade the public, the state and legislators that licensing is in the public interest. (Williams & Koumenta, 2019, pp. 711-737)

According to Weeden: "Licensure is often justified to lawmakers and the public on the grounds that it protects consumers from incompetence or malfeasance in occupations where incompetence and malfeasance are difficult for consumers to judge and can threaten consumers' health, wealth, homes, or other valued 'goods'" (2002, p. 62). Nevertheless, I would like to clarify that there are two different standpoints on credentialling, which I believe are extremely important for the subject matter of this work and, which I shall get back to in the third part of this thesis where I shall analyse the answers of my respondents regarding the need of formal education, but at this stage of investigation it is important to distinguish that there is clearly a disjunction as to what credentials actually mean to different social interactants:

> One view posits that educational credentials certify the acquisition of real skills, and, as a result, any restrictions on opportunities to attain these credentials—whether through the influence of accrediting boards, the scarcity of native ability, or the "considerable expenses and long period of gestation" (Weber 1978, p. 1000) training entails—will shrink the pool of candidates who have the skills necessary to perform an occupation's tasks (Parkin 1979; Sørensen 1996; Wright 1979). [...] An alternative perspective argues that educational credentials are only loosely, if at all, related to the knowledge a person needs to be competent or productive in an occupation (Collins, 1971, pp. 1005–7; 1979, pp. 12–21; Berg, 1970; Jencks, 1979, p. 192). Instead, these credentials serve as a largely arbitrary "cultural currency" that buys membership into a particular club (Collins, 1979, p. 189; Bourdieu, 1984; Parkin, 1979). (Weeden, 2002, p. 61)

Thus, Abbott may recognise that there is a link between credentialling and formal academic body of specialised knowledge, but this author apparently disassociates academic knowledge and a credential attesting to the acquisition of such knowledge from the praxeological *Phronēsis* or practical application of skills in unique situations: "this link legitimates the occupation's work by tying it to values of efficiency and rationality, and also allows its practitioners to benefit from the 'public's mistaken belief that abstract professional knowledge . . . implies effective professional work'" (Abbott 1988, p. 54, in Weeden, 2002, p. 68).

Another extremely salient question is whether this formally acquired body of specialised, formalised and codified knowledge is actually needed/is perceived as needed to successfully perform relevant tasks; whether the acquisition of this knowledge leads to overqualification for the position (provided that the complexity of tasks is being underestimated); and whether the complexity of the occupation's knowledge base (knowledge & skill sophistication) is linked with the success or failure of the occupation's professionalisation and the earnings (Weeden, 2002, p. 55). In concur with Weeden in that the "uneven distribution" of social closure mechanisms and the subsequent underestimation of professional value as well as severe under-remuneration are a consequence of the "variations in occupations' core knowledge and skills" (Weeden, 2002, p. 69).

> According to the received wisdom, professions are better able to create and defend labor market barriers because of the "special" knowledge and skills at the core of these occupations (e.g., Larson 1977; Abbott 1988; MacDonald 1995). There is far less agreement concerning which characteristics of professional knowledge are the most relevant. Indeed, Larson (1977, p. XVII) argues that professional closure projects are little more than "an attempt to translate one order of scarce resources—special knowledge and skills—into another—social and economic rewards." It is less clear from this literature whether these same features of an occupation's knowledge base are expected to affect returns from closure, but this hypothesis is certainly reasonable. On the supply side, convincing claims to a particular type of knowledge may allow an occupation to push for licensing or credentialing criteria that exclude a substantial number of potential competitors. On the demand side, such claims may be necessary for the occupation to successfully channel demand or send a particular signal about the service its members perform. One would thus expect the returns to closure to be greatest in the professions and, moreover, for these differential returns to be related to the professions' generally high levels of cognitive skill complexity. (Weeden, 2002, p. 70)

By way of conclusion, it is worth stressing that formal educational credentialing is particularly useful for restricting supply to the select coterie of those eligible and broadcasting quality-of-service signal intended to increase the price that the consumers are willing to pay for a high-quality professional service.

As in the case of licencing and educational credentialing, unionisation is the third and the last strategy or device to successfully implement supply-side restrictions. Weeden highlighted the salience of this recourse by stating that: "state-sanctioned collective bargaining and the threat of the withdrawal of labor, the defining features of union organization, fundamentally alter the conditions of employment" (2002, p. 63). Additionally, as cross-referenced in Weeden, unions have been documented to achieve a major impact on the wages of union members and consequently "through wage spillover effect" on the remuneration of non-union members (Freeman & Medoff, 1984, pp. 150-161; Pencavel, 1991, pp. 16–30; Curme & Mac-Pherson 1991, cited in Weeden, 2002, p. 63). According to the above mentioned authors, the employers would chose to offer better rates of pay in order to reduce high turnover of staff and "the outflow of personnel" (Weeden, 2002, p. 63).

According to a newspaper's article issued in 2012 ("Una revolución en los colegios profesionales", 2012), in Spain, *la Ley de colegios y servicios profesionalesthe* [Law on Professional Unions and Services] (which came into force in 1974) is pending a reform that has been stalled since 2015 and which, in spite of having been declared as a matter of urgency by the EU, for the time being can neither be found on Spanish political agenda, nor has been assigned a date of review on our country's government's calendar. This new regulation has been long awaited in Spain because in 2012 there were 1,650 professional unions (*colegios profesionales*), housing a total of 1.5 million professionals, registered in this country ("Una revolución en los colegios profesionales", 2012). This datum showcases an exponential growth of developing occupation throughout the recent history. As maintained by the authors of this article, the main objective of the new regulation being prepared by the government, is to improve competitiveness in the sector by eliminating the unjustified and disproportionate barriers generated by these services.

This improvement in competitiveness could have a considerable impact on economic activity, given that professional services account for almost 10% of national GDP. The modernisation of the current unionisation structure was designed to include three major liberalisation measures:

reduction of professional unions in number, cancellation of compulsory membership for most professionals (!) and reorganisation of the activity reserves, which is extremely difficult to achieve in the case of occupations with numerous and diverse ramifications and competence/competence/jurisdictional boundaries overlap ("Una revolución en los colegios profesionales", 2012).

The rationalisation of the number of professional unions leads to their elimination in cases in which their maintenance may no longer be justified. This austerity measure was designed to curb unnecessary expenditures on the basis of annulment of compulsory membership of almost all professions with the exception of doctors who do not work in the Social Security system, practising lawyers and, probably, architects. It is argued that such modernisation would transform the former unions into professional associations. The discontinuation of compulsory membership will make the survival of the unions conditional on the provision of services that are sufficiently useful and effective to justify the payment of a subscription fee by professionals.

The elimination of some activity reserves will complete the liberalising line that the National Competition Commission has advocated on more than one occasion. All this is intended to result in the overall improvement of the professional services market in Spain, as well as in an increase in its competitiveness and in a sufficient rationalisation of the control over the exercise of the professions.

Of course these measures would have a detrimental effect on professionalising occupations such as medical interpreting because the downgrading of unions to occupational associations or organisations, which in Weeden's opinion would still constitute a closure strategy even though it will not restrict labour supply, will mean that members of these associations will not have legal authority or they will not be able to exercise a legal authority to 1) strike and 2) bargain collectively with employers, the general public, the state, the decision-makers, etc. (Weeden, 2002, p. 64-65). The main difference between formalised credentials and unionisation vs. representation by associations and voluntary certification is that the former pair of devices restrict supply, whereas the latter pair of strategies do not restrict supply. Also the latter tactics may purport to channel demand directly to the occupation and broadcast quality signalling, but it is not clear whether and to what extent these techniques are actually beneficial for professionalisation.

Occupational organisation may issue voluntary certifications, which may allow occupations to delimit and "claim ownership over their core tasks" if properly marketed (Weeden, 2002, p. 66). As maintained by Weeden, voluntary certifications are not obtained through formal education system, they are insufficient to practice a state licenced occupation even though they may constitute a precondition for licencing (pp. 66-67). Only the formal educational credentials such as diplomas conferred by higher educational institutions may be viewed as instruments to restrict supply and signal quality, in that voluntary certifications obtained through "specialised coursework" such as workshops and online education, "demonstrable experience", "subscription to a code of ethics", "passing score on a written or practical exam", etc. cannot be considered high-end mechanisms which guarantee quality and "important markers of competence" (Weeden, 2002, pp. 64-65). In the overwhelming majority of cases the skills which make a practitioner eligible for such a certification are learned on-the-job, which casts growing suspicion on its effectiveness as a screening tool. Thus, this device is recognised by relatively few as it is believed to be a "sham" (Weeden, 2002, p. 64).

In conclusion, there is clearly an exponential increase in demand for language provision services, however, this demand is not channelled to the occupation, the supply is not restricted to the occupation, and the employers are not interested in the quality of service. This is due to the fact that the mechanisms of implementation of occupational closure strategies (licencing, formal educational credentialling, unionisation, representation by associations, voluntary certification) have not been put in place. The reason being that MI lacks the broad public concern and interest. Apparently, medical interpreting does not represent a discipline "whose tasks bear on issues of widespread interest and deep concern on the part of general population" (Freidson, 2001, The Contingencies of Knowledge section, § 2). It seems that medical interpreteing is not viewed as a "core discipline", whose "bod[y] of knowledge and skill [...] address perennial problems that are of great importance to most humanity" (Freidson, 2001, The Contingencies of Knowledge section, § 2). MI also lacks support of general population misled by scepticism and indifference, which leads to the usurpation of expertise by another more popular discipline (intercultural mediation, personal healthcare assistant, etc.). This occupation is absolutely contingent on the needs, demands and expectations of the employers in private healthcare settings, resulting in multitasking and hybridised profiles and roles. Medical interpreting paradoxically is not believed to be of great social and functional value.

13. FREIDSON'S PROFESSION AS A FOLK CONSTRUCT WITHIN THE PARADIGM OF BURR'S SOCIAL CONSTRUCTIONISM

In light of the sociology of professions and the sociology of knowledge this and the following chapters of this thesis will be entirely dedicated to the investigation of the phenomenology of medical interpreting as a profession *in statu nascendi*. Given that the procedural conventions of professionalisation are not universal recipe-type instructions that can be easily followed by members of any occupation, but rather an approximation to posible mechanisms of professionalisation, I shall seek to deconstruct this term as "an intrinsically ambiguous, multifaceted folk concept" (Freidson, 2016, Pursuing the Folk Concept section, § 1).

> Whereas a theory of occupations would be concerned with developing a genuinely abstract theory which attempts to be exhaustive in its applicability, a theory of professions, relieved of the task of broad generalisation, would attempt instead to develop better means of understanding and interpreting what is conceived of as a concrete, changing, historical and national phenomenon. [...] Given the nature of the concept, such a theory is developed by recognising that there is no single, truly explanatory trait or characteristic - including such a recent candidate as 'power' - that can join together all occupations called professions beyond the actual fact of coming to be called professions. Thus, profession is treated as an empirical entity about which there is little ground for generalising as an homogeneous class or a logically exclusive conceptual category. (Freidson, 2016, Pursuing the Folk Concept section, § 1)

The fact that the very concept of "profession" is viewed by Freidson as rather an kaleidoscopic, country or region specific, nation-bound, popularly understood, empirical phenomenon is extremely important for this thesis, in that I do not intend to define profession as a universal concept, but to rather view it as a folk concept encoded in discourse, non-verbal behaviour and social practices. And only by thoroughly examining is as a folk-social construct, will I be able to calibrate the extent to which medical interpreting has become a profession and thus, to ascertain what still remains to be done to position ourselves as professionals.

Before being able to properly calibrate this extent it is important to set the scene by first understanding the context of the empiric research of this thesis. The nestedness of the medical tourism phenomenon, as well as other migration-related socio-demographic phenomena in the VC, highlight the folk character of MI, because the *status quo* of MIs in private hospitals and clinics with high foreign patient load is rather different from public facilities, which are bereft of any language provision services whatsoever. In our case, it is us the interpreters who seek "the rewards of a professional label" in order to counteract the deviation (hybridisation) of the "terms, conditions and content of the jobs [employers or clients] wish done" and "see[k] to control" (Freidson, 2016, The Theory of Professions, The Phenomenology of Profession section, § 1). As we have seen neither the "government agencies", nor the "general public see[k] to create a systematic means by which to classify and account for the occupations of the labour force" (Freidson, 2016, The Theory of Professions, The Phenomenology of Profession section, § 1). Given that our bottom-up approach to professionalisation is not "authoritative" (top-down), it may be written off as "invalid or unimportant" (Freidson, 2016, The Theory of Professions, The Phenomenology

of Profession section, § 1). This may be due to power relations and power inequalities manifested in discourse, therefore social constructionism is the most suitable research strategy for this purpose:

> If 'profession' may be described as a folk concept, then the research strategy appropriate to it is phenomenological in character. One does not attempt to determine what profession is in an absolute sense so much as how people in a society determine who is a professional and who is not, how they 'make' or 'accomplish' professions by their activities, and what the consequences are for the way in which they see themselves and perform their work. (Freidson, 2016, The Theory of Professions, The Phenomenology of Profession section, § 1)

So what is it that anchors some occupations at the top of the socially meaningful occupational taxonomy? If the passive state apparatus limits itself to a *laissez-faire* philosophy, whereby only a finest apologia could justify state sanctioned creation of exclusionary market shelter as one of the prerogatives of the title, what can the members of a recent occupational profession do to gain protection from competition in the open labour market apart from trying to follow the bottom-up stages of professionalisation? Why and how is this status being withhold from some occupations? From my personal standpoint, the most plausible, rational and universally applicable explanation is social constructionism.

Therefore, in this chapter I shall try to determine how the ethnography of the term "profession" is being socially constructed in relation to medical interpreting. The archaeology of knowledge which undergirds the activity of MI is moulded and sculpted at the universities, which indicates that this occupation has become an academicized discipline, but, as it was indicated in Gavlovych and Blasco-Mayor (2000, p. 5), the professional identity of medical interpreters in the workplace reality in the study-relevant area against the backdrop of medical tourism and other socio-demographic phenomena are yet to be consolidated through the process of professional socialization and discursive identity construction.

Thus, a major emphasis is going to be laid on the process of intersubjective identity negotiation within the paradigm of social constructionism. Of course in this case I am going to be focusing on the professional identity and how the official, legal use of the title is negotiated and accomplished in everyday work life. After having perused literature on different sociological approaches, I found that some renowned sociologists (Horobin, 2016; Johnson, 2016) have introduced what phycologists call "social constructionism" into their sociological research. Horobin, for instance, states that "the spokesmen of professional and professionalising occupations formulate and reflexively construct their work, just as members of those occupations accomplish profession in their day-to-day work and contact with other occupations" (Horobin, 2016, Professional Mystery: The Maintenance of Charisma in General Medical Practice, The meaning of Profession section, § 3).

Thus, he is talking about professional socialisation in the sense of social interaction with other professionals. By "reflexively construct[ing]" and by "accomplish[ing] profession" both in the "day-to-day work" and through the interoperability "with other occupations" the aspirants to be called professionals negotiate their status by engaging in a struggle to anchor their position in the workplace reality (Horobin, 2016, Professional Mystery: The Maintenance of Charisma in General Medical Practice, The meaning of Profession section, § 3). Interpreters endeavour to locate

themselves within a particular discourse within the framework of a particular social interaction. "Glaser and Strauss (1971; Strauss 1978) also draw our attention to the constant need to reconstruct our self-images and personal histories in the light of recent and current happenings" (Johnson, 2016, Professional Careers and Biographies, Careers and Biographies section, § 4). Accordingly, the paradigm within which the results of my investigation must be construed is social constructionism.

13.1. SOCIAL CONSTRUCTIONISM: DEFINITION OF THE CONCEPT

Social constructionism (henceforce SC) "is a relatively new term in the social sciences, especially psychology" (Burr, 2015, p. 222), but the thrusts that have cohered around this concept had been already used in a number of disciplines throughout history, namely in sociology, philosophy and linguistics (Burr, 2015). Kant, Nietzsche and Marx had a considerable bearing on the burgeoning of social constructionism. These philosophers averred that knowledge is not premised on "external reality", but rather is the result of thought (Burr, 2003, pp. 12-13).

George Mead introduced the theory of Symbolic Interactionism in 1934. According to this hypothesis every individual constructs their own and each other's identities through social interaction in their everyday encounters with each other. In 1950s and 1960s, this sociological trend with philosophical roots spawned the development of ethnomethodology, a sub-discipline of sociology, whereby scholars and scientists sought to fathom out the process of construction of social life by ordinary people.

Berger and Luckmann (1966) opted for a microsociological approach to Symbolic Interactionism, which posited that human behaviour cannot be decontextualised from social interaction. Kenneth Gergen (1973) stated that all knowledge is concomitant of "a particular historical period and of particular cultural location" (cited in Burr, 2015, p. 222-226). The key of social constructionism is the real-world contexts grounded in the society's cultural baggage, economic conditions and power relations without which human conduct is bereft of meaning, structure and content (Gergen, 1973, cited in Burr, 2015, p. 222-226).

According to Gergen (2010, in Burr, 2015, p. 222-225) reductionist approach[102] engenders "fatalistic thinking", whereby physiological predisposition is to blame for the above mentioned phenomena instead of the personal agency of the perpetrators. Thus, reductionism denies that people's choices are being conditioned by the powers that be and that people are conditioned to behave in the way they do though discourse.

SC, on the contrary, is an iconoclastic approach that opposes other orthodox paradigms by viewing discourse as the main tool for knowledge and consciousness construction instrumentalised by the "sociocultural forces" or the powers that be (Burr, 2003; 2015). "All knowledge is derived from looking at the world from some perspective or other, and is in the service of some

[102] Gergen (2010 in Burr, 2015, p. 222-225) categorically denies the reductionist approach which upholds essentialism and determinism of mainstream psychology. Reductionism seeks to explicate complex phenomena, such as poverty, alcoholism or criminal behaviour from the perspective of societal structures, psychological factors (intelligence or personality), biological determinism (genetic inheritance, brain architecture) or neuroscience, which integrates psychology, biology, neurology and genetics.

interests rather than others" (Burr, 2003, p. 6). Accordingly, our knowledge of the world and our understanding thereof is "a product of human thought rather than grounded in an observable, external reality" (Burr, 2015, p. 222). Mead argues that "people construct and negotiate identities for themselves and others through their everyday social interactions with each other" availing themselves of language, which he views as "a system of socially shared symbolic meanings" (Burr, 2015, p. 222).

Social constructionism problematises the idea of taken-for-granted ways of understanding the world and ourselves (Burr, 2003, p. 3), whereby our objective, unbiased, final and true "observations of the world unproblematically yield its nature to us" (Burr, 2003, p. 3). Social constructionism challenges the idea of solipsism, because without language and society people would be solipsistic vacuums. As beings of the social world, the individuals as well as their personal and professional identities and their realities are constructed by spacio-temporal circumstances or the historical context as well as the discourses of the Ortega y Gasset's 'mass society'. Thus, no self-analysis can be conducted without taking into consideration the 'mass society['s]' conditioning of individuals. Consequently, every profession's being-in-the-making will be contingent upon the *res gestae* that have been accomplished within a historically constructed approach to professionalisation (top-down, bottom-up, etc.). A profession is a 'culturally shared representation of the world', which has a 'far-reaching implications for how we treat people' (Burr, 2003, p. 61).

The epistemological position of social constructionism is that of relativism or perspectivism, which is the opposite of positivism and empiricism (Burr, 2003). Burr (2003, p. 4) opines that our versions of knowledge are fabricated and our understandings negotiated through the daily interactions between people: "Social constructionism denies that our knowledge is a direct proception of reality (p. 6).

The main thrust of social constructionism philosophy posits that practically anything can be viewed from different vantage points, thus advocating for multi-perspectivism, but the perspective that is being pushed and accepted as correct "is more a matter of politics and power than of some attribute of the perspective itself" (Burr & Dick, 2017, p. 59-80). Both parties discursively negotiate their solipsistic perspectives by means of the "performative role of language" (Burr, 2003, p. 8).

Social constructionists opine that language cannot be taken for granted as a "passive vehicle for our thoughts and emotions" as well as "attitudes, memories, and other cognitive events" (Burr and Dick, 2017, p. 59-80). The mainstream realist philosophical orientation, based on the "assumption that language is a straightforward expression of thought rather than a pre-condition of it" (Burr, 2003, p. 8) should be challenged and language should be "interrogated" through critical cogitation as a constructive, performative, action-oriented and sophisticatedly instrumentalised *pièce de résistance* and anchor of the reality it constructs. Language is never "transparent" as it has real consequences and implications (Burr, 2003, p. 48). "The power of language to bring about a change in our thinking is sometimes explicitly utilised by those seeking social change" (Burr, 2003, p. 50). Language furnishes its users the possibility to structure their experience of the outer world and inner selves or the person they are (identities, personalities, experiences, etc.), thus, the concepts that people use are not pre-existent or predate but rather fabricated by language (Burr, 2003, p. 48).

People draw on linguistic resources to construct their accounts of events, and therefore 'interpretative repertoires' are viewed by Wetherell and Potter (1988, p. 172 as cited in Burr, 2003, p. 59) as 'building blocks' which interactants avail of to construct 'versions of actions, cognitive processes and other phenomena'. Therefore language cannot be taken for granted as a means to unproblematically express the opinions, the ideations, the attitudes, intentions, etc., lying within the speakers (Potter and Wetherell as cited in Burr, 2003, p. 129). Restricted range of broadly discernible and culturally shared clusters of terms, descriptions and figures of speech are used in a specific stylistic and grammatical fashion in order to a) make evaluations; b) construct factual versions; and c) perform particular actions (Potter & Wetherell, 1988, p 172; 1995, p. 89 as cited in Burr, 2003, p. 59-60).

The focus must be shifted from "psychological centre of gravity' to "social realm" and the "linguistic space" in which both individual people as well as groups, classes or societies interact (Burr, 2003, p. 54). The problem is that even though Wetherell and Potter from their poststructuralist stance believe that language does not have 'fixed meanings upon which everyone agrees' (Burr, 2003, p. 54), they do pinpoint that such paradigm shift is not easy

Language is a realm of dissention, constant identity negotiation, struggle, and conflict in terms of power relations being acted out and contested and identities challenged (Burr, 2003, p. 54-55). Even though according to poststructuralist approach our experience of ourselves and our lives is subject to constant modification in pursuit of transformation (by constructing, maintaining or rejecting the identities on offer in a given situation (p. 58)), this stance does not imply that "change is easy, or that we can just talk our way out of damaging identities or oppressive social relations" as our speech is intrinsically linked to our deeds, "either as individuals or as groups (social practices) or from the way that society is organised and run (social structure)" (Burr, 2003, p. 56). Thus, once a new construct became socially entrenched, it will be very difficult to backpedal Burr (2003, p. 61).

People's use of interpretative repertoires and their efforts to construct events in a particular way my be conducted at a non-conscious, non-intentional level' (Burr, 2003, p. 61). Burr calls into question the 'machiavellian' nature and the degree of intentionality of our utterances, but views them as rather our tendency to do or say 'what seems appropriate or what comes naturally in that situation' (Burr, 2003, p. 61).

13.2. DECONSTRUCTIONIST APPROACH TO DISCOURSE ANALYSIS AGAINST THE BACKDROP OF SOCIAL PSYCHOLOGY (BURR'S MACRO APPROACH)

According to Burr (2003, p. 17-18), the concept of "deconstructionism", which was introduced by Jacques Derrida and upheld by Michel Foucault, lays stress on how ideologically instrumentalised structures of language construct our identities. Foucault avers that discourses present us with a particular vision of the world and the socially entrenched representations of concepts imply power relations and shape our stance on other people (Burr (2003, p. 17-18). Burr's macro approach is in line with Foucauldian poststructuralist work:

> In its most extreme form, this view renders people the hapless carriers of discourses who are also constructed by them in a rather deterministic fashion; our identities become multiple and

> changeable, distributed across the discourses that construct us. However, taking this approach brings to fore the issue of power, something which psychology has arguably neglected. Prevailing discourses are said to be constructed in the interests of the relatively powerful. (Burr, 2015, p. 224)

Burr (2003, p. 23) pinpoints that macro social constructionist approach highlights the ineffectual and dysfunctional nature of individual persons, either alone or collectively, to bring about change. This methodology gravitates towards the idea of the "death of the subject", whereby "the person can be conceptualised only as the outcome of discursive and societal structures" (Burr, 2003). Thus, "Whatever it is that we have become [...] is socially constructed and not part of some essential nature" and language is the cornerstone of this construction (Burr, 2003, p. 104).

Therefore, we need to reconsider our assumption of ourselves as the "authors" of our personality, opinions, choices, attitudes, skills, motivations, etc. because these concepts only exist and are manifested in and through discourse. But in the light of social constructionism what is important is what people identify us as and how they do it:

> The point is that it is you that is doing the identifying, and the identity you confer has more to do with your purposes that the nature of the thing itself. The same applies to the things that make up human identities, such as masculine/feminine, hetero/homosexual, sane/insane, black/white, working/middle class and so on – these may by seen as socially bestowed identities rather than essences of the person, and this is why the term identity is often found in social constructionist writing. (Burr, 2003, p. 106)

Thus, in the same way that the age, social stratum, social class, level of education, level of income, occupation, gender, ethnicity, sexual orientation, etc. produce the fabric of person's identity, the underlying type of skill/knowledge/expertise, immediate function value, societal function, degree and kind of specialisation/education, social, symbolic and economic value construct the fabric of profession.

> We are the end product, the combination, of the particular versions of these things that are available to us. [...] For each thread of our identity there is a limited number of discourses on offer out of which we might fashion ourselves. [...] Our identity therefore originates not from inside the person, but from the social realm, a realm where people swim in a sea of language and other signs, a sea that is invisible to us because it is the very medium of our existence as social beings. However, to say that identities are socially constructed through discourse does not mean to say that those identities are accidental. It is at this point that social constructionism can bring to bear a political analysis of the construction of personal identity. (Burr, 2003, 107-109)

Such fatalistic approach definitely stands up to the test of rational critique, because the non-randomised character of phrasings and wordings in the media clearly carries the stigma of politicization of connotations, overtones and undertones in our speech. Thus:

> Kitzinger's concluding remarks could seem to suggest that no matter how hard you try to break out of the discourses maintaining your relatively powerless position in the world, the whole discourse system closes in around you and you end up caught up in it again sooner or later. [...] The process of constructing and negotiating our own identities will therefore often be ridden with conflict, as we struggle to claim or resist the images available to us through discourse. (Burr, 2003, p. 110)

This "powerless position" despite all endeavours of discursive resistance may be manifested in medical discourse where all interactants without medical training will be addressed either as

patients or as non-medics, "positions which carry lesser rights to take decisions, make diagnoses, use medical terminology and so on" (Burr, 2003, p. 112). Therefore the positioning in everyday workplace interaction, which "acknowledges the active mode in which persons endeavour to locate themselves within particular discourses during social interaction" (Burr, 2003, p. 113) is so important for role fixation and crystallisation of tasks, but at the same time so problematic and difficult to accomplish.

> In any interchange between people, there is a constant monitoring of the 'definition of the situation' that each participant is struggling to bring off. Participants' understanding of 'what kind of interaction this is' will radically affect their perceptions of what subject positions are available to them and whether they wish to claim or resist those positions [...] Different constructions of an interaction can offer radically different subject positions, which in turn entail different sets of rights and obligations for the participants. [...] But we can recognise and develop an awareness of the potential implications of the discourses we adopt in our dealings with others. (Burr, 2003, pp. 114-115)

Once a professional "subject position" (Davies & Harré, in Burr, 2003, p. 119) has been taken up within a workplace discourse, emotional commitment on the part of the professional to the category of profession to which he/she becomes allocated and sees him/herself belonging to must be taken on. Such commitment to the professional subject positions we occupy within the current occupational stratification system entails compliance with its intrinsic system of rights and obligations as well as morals or rules of possible/impossible, right/appropriate and wrong/inappropriate (Burr, 2003). In other words, these subject positions "legislate for what 'that kind of person' may or may not reasonably do or say" (Burr, 2003, p. 124). Some subject positions are protean as they hinge upon constant negotiation within social interaction. Thus, human agency is extremely limited:

> We continue in the belief that human beings can change themselves and the world they live in through the force of their (apparently) independently developed and freely chosen beliefs and acts. We look around us and see the world changing, and imagine that human intention and action is at the root of it, but this is an illusion. There is a real danger that we can become paralysed by the view that individual people can really do nothing to change themselves or their world. (Burr, 2003, p. 124)

13.2.1. Ideologies

Ideology against the backdrop of SC may be defined as "the way in which meaning is mobilised in the social world in the interests of powerful groups" (Thompson, 1990, in Burr, 2003, p. 85) who use what Althusser terms 'ideological state apparatuses' thus referring "to the mechanisms by which people are manipulated and controlled by ideology" (Burr, 2003, p. 85).

It was Althusser's contention that "all of us live out the requirements of the prevailing ideologies while doing so under the illusion that we have freely chosen our way of life" (Burr, 2003, p. 120). Thus, for Althusser ideology embodies "the experience of being the authors of our own actions", when "we are simply the bearers of social structures, but experience ourselves as agents". In other words, human being can be portrayed as "puppets operated by structures they cannot see". This approach to fathoming out the positioning may be called "the death of the subject", as it relocates and re-casts the focus of interest from "intra-psychic domain" into societal level/domain (Burr, 2003, pp. 120-122).

This approach denotes the prevalence of dominant discourses which "maintain the positions of powerful groups" (Burr, 2003, p. 123). Therefore, changes in identity construction, positioning, negotiation and maintenance cannot be accomplished easily, because by challenging and resisting our personal, professional and social positions offered by these elites, we are also challenging their power relations (Burr, 2003, p. 123).

All "Narratives are subject to social sanctioning and negotiation. Similarly, in furnishing accounts of and justifying our actions" everyone is "subject to the same limitations". "In our attempts to represent ourselves in particular ways, we are dependent upon the willingness of others to allow us to paint a picture of their part in the action that suits our story" (Burr, 2003, p. 145). People's self-narratives may only have implications for their respective identities and bring off a publicly sanctioned version of themselves if these self-narratives are understood and shared by other social actors. Our identity accounts must be compatible with the accounts of other co-actors, only then will our activity gain social value, recognition and status.

Nevertheless, "even if we could change our subject position, it could only be up to an extent, because the elites "stress the choices that are available to the person in how they may take up or resist the positions on offer to them, and to this extent the person can be seen as a negotiator of their own identity" (Burr, 2003, p. 124).

> On an interpersonal level, we can work towards change firstly by becoming more aware of the positions we are being offered and that we offer to others in our interactions with them. We can then devise strategies for how unacceptable positions might be resisted and positions un alternative discourses taken up. This would involve deciding how to change one's response to particular conversational gambits, or when to remain silent (silence may well be a particularly useful way of resisting positions we do not want to accept). (Burr, 2003, p. 124)

Hence, the macro approach takes into account the values of dominant groups, who condition the ordinary people into compliance and into constructing, negotiating and positioning their personal and professional identities as befits the narrative of these "elites" (Freidson, 2001). The topic of ideology has also been addressed by some sociologists. According to in Freidson (2001, chapter 5, Ideologies section, §4) ideologies or elements of an ideology are important to anchor the discipline's status, justify "the privileged position of the institutions of an occupation in a political economy as well as the authority and status of its members".

The ideology of professionalism must "neutralize" the opposing ideologies which extenuate the control of work by the market (*consumerism*) and by bureaucracy (*managerialism*). *Persuasion* is the key feature of ideology.

> Persuasion is central and fundamental in all social systems. [...] [I]t is a ubiquitous form of social control and is of special importance in the analysis of politico-economic systems on three counts. In the form of ideological instruction and propaganda, persuasion is a major method of elite control of masses [...]. In the form of commercial advertising, it is a major instrument of corporate control of masses of consumers in market societies. In the form of mutual persuasion in "free" societies – that is, in the form of "free competition of ideas" – it is fundamental to liberal democracy. (Lindblom 1977, p. 13, as cited in Freidson, 2001, chapter 5, Ideologies section, § 3)

From the standpoint of the ideology of consumerism against the backdrop of the free market philosophy, the "individual consumers who cannot themselves perform the work that produces

the goods and services they desire nonetheless claim competence to choose those to perform work for them, determine what tasks they will perform, and judge the results. Contrary to the professional's claim that only the specialists who can do the work are able to evaluate and control it properly" (Freidson, 2001, Generalism and Spacialization, § 1).

According to Freidson (2001), the ideology of consumerism is grounded in *populist generalism* (emphasis in the original) based on liberal economics. This ideology challenges specialists' authority by remaking that "average people with ordinary human abilities are capable of learning and knowing all that is necessary in order to make economic and political choices that will serve their own best interest without specialists to choose on their behalf" (Freidson, 2001, Generalism and Spacialization, § 2).

Thus, "the neoliberal economic creed holds that the marketplace could be free of any constraint on consumer choice" and renders the customer always right. According to this philosophy specialised knowledge must serve rather than prescribe and superintend. Similarly to the ideology of consumerism, the doctrine of managerialism, based on *elite generalism*, "does not defer to the authority of specialized knowledge, instead claiming authority over it" in order to instruct, coordinate and monitor the consumers' choices as well as the work of specialists (Freidson, 2001, Generalism and Spacialization, § 3). Managerialism seeks to assume authority over the specialists and experts by virtue of "special kind of preparation for positions of leadership – an advanced but general formal education that equips them to direct or lead specialists, consumers and citizens" (Freidson, 2001, Generalism and Spacialization, § 3).

In light of the above mentioned statements, medical interpreting in private sphere is extremely susceptible to the effects of elite generalism, which "is embodied in the idea of versatility or generalized skills [...]". This causes interpreting to lose its social and practical value. Unfortunately, interpreting is an ideologically underprivileged discipline as it is viewed by the elites as impractical, unprofitable and "susceptible to displacement by workers with lesser training" (Freidson, 2001, Comparing the Consequences of Knowledge section, § 5)

> The most important handicaps to professionalism flow from the contingencies stemming from the particular tasks which the members of a discipline must perform in order to make a living. (Freidson, 2001, Comparing the Consequences of Knowledge section, § 1)

Elite generalism or managerialism attaches more importance to 'polyvalence' or general skills by viewing it as "a more important outcome" of the applicants' professional education than the "specialised curriculum" (Freidson, 2001, Eduction and Ideology section, § 6). The advocates of the doctrine of managerialism aver that it is the polyvalence that separated professional from technicians (Freidson, 2001).

The problem with both elite and populist generalism is that 'versatility' becomes frontiers-free interprofessional interoperability. As this chapter will seek to substantiate, a discipline without support for privilege, which fails to successfully battle custody of its value and struggles over clear jurisdictional boundaries with other disciplines, the public and the elite and whose members are uncapable of persuading the rest of social interactants that the desirable outcome can be achieved *only* through the professionals' specific expertise is going to be taken advantage of. Thus, with medical interpreting the goal is to hire multilingual staff whose versatility would encompass

flexibility in the assignment of tasks and profitable, cost-effective division of labour between interdisciplinary practitioners.

Thus, all social interactants involved in this situation (medical professionals, patients and interpreters) are subject to and contingent upon the 'disciplinary power' (Burr, 2003) whereby they are reluctant to produce change through resistance even though these elite professionals who occupy an authoritative position have power in society to set standards or norms to which the rest of us are expected to conform (Burr and Dick, 2017, p. 59-80). Professional medical interpreting could perfectly become one of these indispensable norms or standards, but owing to 'disciplinary power' social actors, whose willingness in the construction of our identity and support of our version of events we heavily hinge upon, opt to remain passive and compliant in the eyes of those who, figuratively speaking, sit behind the Panopticon.

Therefore, our situation has reached an impasse leading to a compromise on the part of interpreters in terms of accepting any terms and conditions of the contract. The interpreters practicing in private health sector in the study-relevant geographical area view themselves as secondary/ancillary workers in a host institution, since a hospital or any other medical centre is a "secondary institutional sphere" (Freidson, 2001). The institutional power in private institutions is much more arbitrary than the state sanctioned power, therefore medical interpreters both professional and layperson are subject to a stricter control and may be mandated by the interested parties to make decisions and carry out tasks that they received no professional training in.

These ideologies are based on two socially entrenched constructs. The first construct is a famous self-transplanting assumption that everybody can learn a foreign language in a short period of time. It is obvious that language learning has been socially constructed as a leisure or hobby activity taught at numerous language schools and academies around the world that adapt the teaching process to all age groups. This is something that clearly does not happen with law or medicine. The second construct is the lack of consideration towards the level of language proficiency necessary for proper communication. The construct of the actual professional knowledge of MIs is short on factuality as the society including state-officials and decision-makers has perpetuated another construct of this occupation by discursively constructing it as intellectually effortless, reduced to mere unselfconscious relaying of words cross-linguistically, which does not make a huge difference when compared to any translation software.

This construct goes in hand with the assumption that medical staff already does enough by trying to communicate in a foreign language and that the foreigners must learn the language of the host country as soon as possible (Niño Moral, 2008, p. 1068). Another premise that helps reify the former construct is the pragmatisation of English as *lingua franca* of the globalised world we live in. The internationalisation of this tongue has firmly entrenched itself in the interorganisational ecosystem dynamics, and now the fact that the doctors who have positioned themselves at the top of the hospital hierarchy allege to be able to speak English has a much greater tendency to be seen as a common sense and has a greater validity than medical interpreting service.

Apparently, every self-respecting private health centre in the Valencian Community seeks to hire medical professionals with the (alleged) knowledge of at least two or three foreign languages (among which English is an absolute must) (Niño Moral, 2008; Pascual & García, 2017; Valencian Institute of Infertility, Medicality International Medical Centre, Hospital Quirón, IMED

Valencia, *inter alia*). The aim is to get social validation through virtue signalling and to tick all the boxes in terms of services being provided by the centre. The third construct redefines, essentialises and socially crystallizes the concept of pseudo bilingualism and pseudo language proficiency (without distinguishing language knowledge form language notion) as an equivalent to professional interpretation. And this is happening because another socially entrenched construct of inextricable interrelatedness between higher education and immediate exclusionary meritocracy is being challenged, disputed and contested (if not directly dislodged). In the light of the foregoing:

> While many disciplines may claim to have that special type of professional knowledge and skill which is given official recognition, the particular substance or content of each and the institutional requirements for the performance of the tasks it claims as its own have critical bearing on its success in gaining the full political, economic, and social recognition and support necessary for establishing and consolidating professionalism. (Freidson, 2001, Bodies of knowledge section, § 2)

The disciplines of varied epistemological status such as history, literature, esoteric languages, philosophy, and musicology "must depend on the sufferance of elites to gain and maintain their official status in the labor force" (Freidson, 2001, The Contingencies of Knowledge section, § 4).

> By their very substance disciplines differ in the values they can claim, and that neither the general public nor elites nor the state are equally committed to all of them. The transcendent values of the core disciplines, Health, Justice, and Salvation, are of nearly universal attraction and can gain broad support for privilege, though the particular discipline which can claim custody of a value of course varies in time and place and is often in contention. Contention exists not only between disciplines struggling over jurisdiction, but also between disciplines and the public or an elite over the ideological claim that desirable goals can be realized only through the use of expertise. (Freidson, 2001, The Contingencies of Knowledge section, § 11)

Freidson's notion of institutional ethics (Freidson, 2001) encompasses all of the above mentioned constructs, thus, demonstrating that the issue of power is indeed present in the prevailing discourses constructed in the interests of the relatively powerful authority bearers, decision/policy-makers, resource-holders, grantors, etc. (supranational and national elites, employers) who have the opportunity to disseminate such discourses (Starr, 2013 in García-Beyaert, 2015, p. 53, El Economista, 2018). Freidson's "institutional ethics" is the perfect representation of how professional medical interpreters' willingness to abide by the practice ethics totally hinges upon the employers' 'ideology' or as he calls it 'economic, political, social and ideological circumstances' (Freidson, 2001, Institutional Ethics section, § 1). "While power relations are never fixed or invariable, those occupying more authoritative positions are able to set the standards and the norms to which the rest of us are expected to conform" Burr and Dick, 2017, p. 59-80).

It is worth noting that Freidson also foregrounds the salience of the vested interests of the state or "an influential elite" (2001, Trust and Ethics section, § 1). But the real problem is the state of dysconsciousness that the direct participants of medical interaction are in. Neither the patients, nor the medical staff, nor the interpreters are resisting or contesting the dominant and prevailing discourse perceived as common-sense. Everybody seems to be desensitised to the official ideology. As maintained by Burr:

> There is a real, material state of affairs [...] but that people do not recognise and challenge this reality because it is obscured by widely accepted ideas and beliefs. People are therefore said to be living in 'false consciousness' because their understanding of their position is distorted [...] human beings become potentially irrational creatures committed to a way of life which is not in their best interest. How is it possible for people to be self-deceived in this way, and what kind of psychology must we adopt in order to understand this self-deception? (Burr, 2003, p. 83)

Medical interpreting in the study-relevant area is a perfect example of this metamorphic nature (protean subject positions). During their university courses T&I students have been taught to take up subject positions which they cannot always maintain in their workplace. Even though they endeavour to intersubjectively negotiate these subject positions later in the workplace environment, the labour market demands and the occupational identities that have been allocated to them vary drastically from the identities they were told to take up by their university lecturers.

13.2.2. Discourse and power

Deconstructionists[103] envisage discourse as something 'beyond the immediate context in which language is used by' social interactants:

> Whereas discursive psychology seems to emphasise the freedom of the speaker to draw upon language as a cultural resource for his or her own ends, macro social constructionism [deconstructionism] emphasises the way that the forms of language available to us set limits upon, or at least strongly channel, not only what we can think and say, but also what we can do or what can be done to us. (Burr, 2003, p. 63-66)

Thus, the vantage point is the process of construction, the aim is to bring to the fore and to shed light on the process whereby the representations of someone or something are being brought into being. Deconstructionist or macro social constructionist analytic approach, also termed 'Foucauldian' (after Michel Foucault) is particularly suitable for those who seek to zoom in on the issues of identity, subjectivity, personal as well as social structure and change and power relations (Burr, 2003, p. 63). In other words, discourses 'form the objects of which they speak' (Foucault, 1972, p. 49 as cited in Burr, 2003, p. 64). As its taxonomy indicates, *macro* approach takes into account 'the discursive context' of the phrasing and wording:

> Words or sentences do not of themselves belong to any particular discourse, in fact the meaning of what we say rather depends upon the discursive context, the general conceptual framework in which our words are embedded. In this sense, a discourse can be thought of as a kind of frame of reference, a conceptual backcloth against which our utterances can be interpreted. (Burr, 2003, p. 66)

Moreover, both text and context of the discourse against the backdrop of the macro approach can be practically any form communication: oral or auditory material such as conversation or interview, written material in all shapes and forms (paper or digitalised texts of all genres),

> Visual images like magazine advertisements or films, or even [...] the meanings encoded in the clothes someone wears or the way they do their hair. In fact, anything that can be 'read' for meaning can be thought of as being a manifestation of one or more discourses and can be referred to as a 'text'. [...]

[103] Burr (2003, p. 63) refers to deconstructionism as macro social constructionism.

> Clothes and uniforms may suggest class position, status, gender, age or subculture and as such can be called texts. (Burr, 2033, p. 66)

Hence, discourse heavily impinges upon people's deeds, thoughts and speech (Burr, 2033, p. 65), it defines, determines, grants meaning to and produces the world around us and the way in which we experience that world, thus, engineering people's consciousness and behaviour patterns. These discourses "manage to control [...] society and its members efficiently and without force, through [...] 'disciplinary power'" (Burr, 2003, p. 69). The elites, the powers that be or as Burr calls them 'the present-day bearers of authority' dictate what normalcy is: '[w]ith the power to say what practices were permissible and which not inevitably came the idea of normality" (Burr, 2003, p. 70), thus, 'people came to monitor and control their own behaviour according to the prevailing standards of normality' (Burr, 2003, p. 72). It is key that we understand that discourses are continually imbricated into the texture and fabric of human society formatting our thoughts and disciplining and refining our behavioural patterns. As maintained by Burr, 'discourses are intimately tied to the structures and practices that are lived out in society from day to day, and it is in the interest of relatively powerful groups that some discourses and not others receive the stamp of truth' (2003, p. 76).

"If discourses regulate our knowledge of the world, our common understanding of things and events, and if these shared understandings inform our social practices then it becomes clear that there is an intimate relationship between discourse, knowledge and power" (Burr, 2003, p. 67). Hence, the statement that 'by gaining the knowledge offered by higher education, a person increases their access to good jobs, good pay and high status' (Burr, 2003) is in many cases extremely inconsistent. For Foucault 'knowledge then simply refers to the particular construction or version of a phenomenon that has received the stamp of truth' (p. 68) in the society in question, it is a 'particular common-sense view of the world prevailing in a culture' over a given period of time, which is inextricably linked with power. Thus, 'any version of an event brings with it the potential for social practices, for acting in one way rather than another, and for marginalising alternative ways of acting' (Burr, 2003).

> The power to act in particular ways, to claim resources, to control or be controlled depends upon the knowledges currently prevailing in a society. [...] To define the world or a person in such a way that allows you to do the things you want is to exercise power. When we define or represent something in a particular way we are producing a particular form of knowledge, which brings power with it. [...] Some constructions will have a greater tendency to be seen as common sense or more truthful than others [...] Given that there are always a number of discourses surrounding an event, each offering an alternative view, each bringing with it different possibilities for action, it follows that the dominant or prevailing discourse, or common sense, is continually subject to contestation and resistance. (Burr, 2003, p. 67)

"Discourses are intimately connected to institutional and social practices that have a profound effect on how we live our lives" (p. 75). In our modern western society we have a capitalist economy, whereby institutions such as education give shape and substance to the daily lives of each of us [...] These discursively constructed institutions "offer us positions and statuses: the capitalist economy makes us into 'workers', 'employers' or 'unemployed'. [...] The institution of education provides 'educated' and 'uneducated' people and so on" (p. 76). In the same way, discourses

differentiate between occupation/member of an occupation and profession/professional. Thus, the society becomes structured by social practices.

In the same vein, medical interpreting may be classified as an occupation that is not of major interest to military, civil, state or public affairs. In other words, the state and public disinterest may be explained by lack of profit and a major dependence of MI services in public sphere upon substantial capital investment, when it was reported that the universalisation of medical care by itself would result in 'unsustainable cost' for the country ("Gasto insostenible para la Sanidad pública", 2018). In light of these criteria it is unlikely that political endorsement would become a major source of support of medical interpreting in public sector. The employers in the private sector are also concerned with finding employees who would accept to be paid at the lowest possible cost. Employers in private sector would also evade hiring specialists in medical interpreting preferring layperson apprentices, whose training (mainly consisting in shadowing more experienced staff members) and task distribution they can control. Thus, the job title 'medical interpreter' es being assigned at will by the employers, thus generating a conflict between employers and faculties. Besides, most people, are not acquainted with the occupational title of interpreter, which would explain the persistent and pervasive usage of designations other than 'interpreter'. Nor is there a "distinct set of tasks", which the public associates medical interpreting with (Freidson, 2001, Comparing the Consequences of Knowledge section, § 4). The following remark made by Freidson regarding engineers may be applied to (medical) interpreters as it mirrors the current *status quo* of our occupation with great accuracy:

> The public does have a notion, stereotyped and overdramatized as it may be, of what lawyers, physicians, and teachers do, but engineers have only the most general identity, certainly none that could arouse public interest and support. Given the variety of their specializations, there is good reason for this vague image. Any effort engineers might make to gain special privilege, therefore, cannot count on mobilizing public sympathy; they must seek support solely from their employers or from the state. They also hold a weak position in the economy because they serve as disparate specialists in many different industries. (Freidson, 2001, Comparing the Consequences of Knowledge section, § 4-5)

According to Burr (2003, 2007, 2015), power relations is determined by the influence of 'dominant groups', also referred to as 'elites' by Freidson and other renowned sociologists (2016, 2001). Rudvin draws upon:

> Fairclough's distinction between "power behind discourse" and "power in discourse," respectively. For Fairclough, "power behind discourse" is the social order which exercises hidden power and governs how and how effectively the power-holders in the institution are able to police the shared conventions, how these are enforced and which sanctions are taken against the actors if they are infringed. The manifestation of such conventions would be for example the codification of standard languages and sociolects. (Rudvin, 2005, p. 161)

Rudvin pinpoints that compared to other modalities or branches of translational activity such as conference interpreting, power asymmetries in community interpreting are much more pronounced at the collective level (institutional: client vs. service provider, and socio-political: host country representative vs. migrant) than at the individual level (class, gender, ethnicity, individual political positioning) (2005).

13.3. DISCOURSE ANALYSIS AGAINST THE BACKDROP OF EDWARDS' AND POTTER'S DISCURSIVE PSYCHOLOGY (BURR'S MICRO APPROACH)

Having deconstrcucted the concepts of "social psychology" (Burr, 2015, p. 225), "social/discursive determinism" (Burr, 2015), "ideology" (Burr, 2003, 2015; Freidson, 2001), "false consciousness" (Burr, 2015, p. 225), and the relation between discourse and power (Burr, 2003, 2015; Freidson, 2001, Rudvin, 2005), it is worth noting that there is another approach to understanding the discourse and the discourse in social interaction. Burr (2015) refers to it as "micro approach". This approach to discourse analysis stems from the discipline of "discursive psychology" (Potter and Wetherell, 1987 as cited in Burr, 2015; Edwards and Potter, 1992 as cited in Burr, 2015, Potter and Wiggins, 2007), as one of the main mechanisms of qualitative research in psychology. Discursive psychology focuses on "the constructive work that people do in interactions in order to build accounts of themselves and events that are effective for them" through everyday, local "linguistic practices" and "spoken interactions", instead of the global "constructive power of prevailing discourses" (Burr, 2015, p. 224) evolving from the politicised ideologies. Given that we are talking about local discourse practices, participant accounts are conditioned by their "moment-to-moment needs" (Burr, 2015, p. 225). The main aim of this thesis and of the qualitative analysis carried out within the framework of this thesis is however not to simply syncretise the socially deterministic approach (or the macro approach) and individually agentic approach (or the micro approach), but to synthesise and cohere both approaches into a integrative analysis method. Burr (2015, p. 225) stated that these approaches must not be viewed as mutually exclusive or "incompatible". The attempt to harmonise these perspectives conducted to the concept of "positioning" proffered by Harré in 1999 (2015, p. 225): "Here, persons are simultaneously positioned by discourses (the macro approach) and draw on these to position themselves and others within specific interactions (the micro approach)" (Burr, 2015, p. 225).

Wiggins and Potter stated that discursive psychology is a qualitative discursive research method within psychology, according to which the "sense of agency" of different social interactants is manifested and displayed through the "business of interaction", identity positioning and role negotiation in particular local settings, be it institutional settings, such as workplaces, or everyday informal settings (2007, p. 73). Discursive psychology focuses more on naturalistic interaction[104] rather than open-ended interviews, which is why I applied this approach to the conversation analysis, while social psychology (macro approach) was used for the thematic analysis and multimodal critical discourse analysis.

Discursive psychology is based on the assumption that "the business of talk and text define[s] [...] the world [...] including mental states, perceptions, motivations, dispositions, thoughts, prejudices" in both the actors, the producers or recipients of events (Edwards and Potter, 2001, p. 1). It is a constructionist approach, whereby discourse is both "construct*ed* and construct*ive*" (Edwards & Potter, 2001, p. 5, italics in the original). According to this approach, action-oriented discourse creates and determines reality and cognition (pp. 5-6). Our "discourse practices"

[104] Naturalistic materials such as audio recordings of naturally occurring conversations have recently been declared more suitable for the discursive psychology research method than open-ended interviews (Wiggins & Potter, 2007, p. 78).

produce "versions of external reality [...] categorize and formulate the world [...] beliefs, values, emotions, and sicpositions" (Edwards & Potter, 2001).

> Because of this emphasis, shared with ethnomethodology and conversation analysis, on the situated, action- performative nature of talk, DP favours the analysis of records of natural interaction, or textual materials produced as part of life's activities (newspaper reports, medical records, written testimony, etc.), rather than using experiments, surveys and interviews to generate research data. (Edwards & Potter, 2001, p. 6)

According to this paradigm, discourse "is occasioned" or "embedded [...] in various kinds of mundane and institutional activity", whereby "identities" are being either "invoked and oriented to" by the participants, or "subverted and ignored" (Schegloff, 1997 in Edwards and Potter, 2001, p. 2). Discourse is also "rhetorical", as our words "are often designed to counter potential alternative, and to resist attempts (whether actual or potential) to disqualify them as false, partial or interested" (Edwards & Potter, 1992, in Edwards & Potter, 2001, p. 2).

> Analysis, therefore, takes into account the sequentially occasioned, situationally oriented, and rhetorically designed nature of discourse. DP's particular focus when approaching discourse in *institutional* settings is on how psychological matters are introduced, defined, and made relevant to the business of those settings. Psychological themes are generally pervasive in how such settings work, as they are in mundane talk, but they are sometimes also part of an institution's official normative goals or agenda, such as in educational and therapeutic settings, where how people think and feel are a central focus of concern. (Edwards & Potter, 2001, p. 2)

DP respecificies cognitions as constructs with action-oriented implications (Edwards & Potter, 2001, pp. 3-4).

13.4. BUCHOLTZ' AND HALL'S MECHANISMS OF DISCURSIVE IDENTITY CONSTRUCTION (SOCIAL PSYCHOLOGY MACRO APPROACH)

In the light of the micro approach the focus of interest is shifted from the "constructive power of prevailing discourses" to "the constructive work that people do in interactions in order to build accounts of themselves and events that are effective for them" (Burr, 2015, p. 225). The micro approach undergirds discursive psychology which studies situated language use in prosaic parlances occurring on every day basis. The interactants conduct linguistic practices throughout spoken interactions, thus positioning themselves by means of instrumentalised accounts. Potter and Wetherell's (1987 in Burr, 2015, p. 225) standpoint purports to explain that 'interactants' talk is occasioned by the moment-to-moment needs of each party in the conversation". According to the above mentioned authors such needs may include the need to justify one's actions, fashion identity, create good impression or attribute blame to somebody else but them (Potter & Wetherell's, 1987, in Burr, 2015). Consequently, Potter and Wetherell do not gravitate towards building scientific evidence on the basis of power relations where the elites pre-condition the masses (or 'hapless carriers of discourses') to construct their discourses according to the narrative, but rather view every one of us as active 'interactants', 'agentic individuals', or 'skilled social practitioners' able 'to monitor and comment upon their own activity' (Burr, 2003, p. 14). Gergen, as well as Harré and Secord strongly believed that people "are conscious social actors, capable of

controlling their performances and commenting intelligently upon them" (preface from Harré & Secord, 1972, as cited in Burr, 2003, p. 14).

> One danger here is that these two approaches threaten to recreate the mainstream division between the individual and society, with the macro approach being socially deterministic and the micro approach seemingly reinstating the agentic individual. However, the macro and micro approaches are not in themselves incompatible and some have been keen to explore how they might be synthesized. One such attempt is in the concept of 'positioning,' put forward by the philosopher of science Rom Harré (Harré and Van Langenhove, 1999). Here, persons are simultaneously positioned by discourses (the macro approach) and draw on these to position themselves and others within specific interactions (the micro approach). (Burr, 2015, p. 225)

In light of the above mentioned, the aim of this empirical chapter will be to combine the two major social constructionist stances –micro and macro social constructionist research approaches– in order to broaden the scope of this thesis. Macro social constructionism encompasses deconstructionism or Foucauldian social constructionism (critical realist analysis focusing on power relations and ideology which "underpins, generates and affords our ways of understanding and talking" about the reality), while micro approach encapsulates discursive psychology, which adopts a relativist stance and focuses on 'micro-processes of the manufacture of accounts in interaction' (Burr, 2003, p. 102). Burr pinpoints that the relativist view can be defined as a "bottom up" model whereby the reality that we know and experience is totally generated by language, whereas the critical-realist stance can be defined as a "top-down" perspective, which gravitates more towards perceiving reality as a knowledge genetrix and a matrix of the morphemes used to portray the world.

Both macro and micro approaches are extremely important for this thesis and none can be elided. In my opinion, macro approach is mirrored in the micro approach Constructivist approach according to Glasersfeld (1981 as mentioned in Burr, 2003, p. 19) advocates for "a Kantian distinction between an individualised phenomenal world and an unknowable real world". Radical constructivism upholders believe that "the 'real' world is [...] a different place for each of us", because each human being experiences and construes it in a different way (Burr, 2003, p. 19). A workplace reality is the perfect opportunity to investigate into how the macro approach which foregrounds ideological discourse instrumentalisation is mirrored in the institutional ethics and how identities are constructed and negotiated through micro constructivist approach. The 'individualised phenomenal world' will be represented by the professional medical interpreters' aspirations and attempts to adhere to practice ethics, whereas the workplace reality will represent the real world and the real market demands.

The ever increasing dichotomisation of the two identities of medical interpreters showcases a great polarisation of views regarding this occupation. The first construct corresponds to professional interpreters' self-perception, the second construct is being built by the political (domestic policy-makers as well as EU authority bearers), social (unrelated lay citizenry as well as service users) and economic (national and supranational resource holders) elites. The latter has for the time being a far greater tendency to be seen as common sense and more truthful construct than the former one. The latter is also dominant and prevailing discourse. It is continually subject to contestation and resistance, but not within the macro-contextual framework, but rather from

constructivist or micro social constructionist perspective. The construct built by the elites receives the stamp of truth without having to face the groundswell of professional medical interpreters' dissatisfaction. Given that this occupation is an emergent career path and yet another branch of a discipline strongly characterized by fragmentation, it is difficult for these professionals to compete on the macro-social-constructionist level. Translation and Interpreting field has many different sectors and each of them its own ramification. Conference interpreting (working with consecutive and simultaneous modalities) and public service interpreting (working with dialogue or liaison modality) constitute two major subdisciplines. But public service interpreting is fragmented into sworn, court, police and medical interpreting. Such professional fragmentation results in few common interests among the members of each stratum of this occupation, which makes it more difficult for them to resist.

Clarke's and Kredens' (2018) research paper on the discursive identity construction of the forensic linguistic expert constituted a major inspiration for and the brainchild of the present thesis. The idea of researching the intersubjective construction of the professional identity in the local interactional contexts is an absolute mainstay of this thesis as well as the fundamental piece of the jigsaw puzzle that needs to be put in its place in order to reach the realistic future orientation regarding the occupation in question. It is worth noting that the previous chapters of this thesis focused on international, EU, national and regional interactional contexts, whereby the current status quo of medical interpreters in different spheres could be assessed. However, a thorough examination of intersubjective identity construction of medical interpreters in local interactional context will allow for an utter comprehension of the very process of such construction and, most importantly, whether it is possible and, if so, how we as professional interpreters can influence it.

Clarke and Kredens were informed by the Bucholtz' and Hall's (2005) research on the sociocultural linguistic approach to the identity construction through discursive interaction.

According to Bucholtz and Hall (2005), linguistic research on identity has garnered interest of researches from a number of disciplines such as speech accommodation theory (Giles et al., 1991), social identity theory (Meyerhoff, 1996; Meyerhoff and Niedzielski, 1994; Tajfel and Turner, 1979), social psychology and theories of language ideology (Irvine and Gal, 2000; Silverstein, 1979), indexicality in linguistic anthropology (Ochs, 1992; Silverstein, 1976, 1985), theories of style (Eckert and Rickford, 2001; Mendoza-Denton, 2002), and models of identity in sociolinguistics (Le Page & Tabouret-Keller, 1985).

The disciplinary subfields that have been reported by the authors to have influenced their research the most are: sociolinguistics, linguistic anthropology, socially oriented forms of discourse analysis (such as conversation analysis and critical discourse analysis), and linguistically oriented social psychology (Bucholtz & Hall, 2005, p. 585).

Bucholtz and Hall put forward a framework for the analysis of identity, which they construe as a linguistic, social and cultural product of linguistic interaction, which "emerges and circulates in local discourse contexts of interaction", rather than a static "internal psychological phenomenon" or "a stable structure located primarily in the individual psyche or in fixed social categories" (Bucholtz & Hall, 2005, p. 586). According to the authors intersubjective discursive construction of identity occurs within local interactional contexts, whereby our multi-layered linguistic

choices[105] gain social meaning, and only an interdisciplinary approach can provide "the comprehensive toolkit" for analysing identity. The authors "propose five principles" that they deem "fundamental to the study of identity" (Bucholtz & Hall, 2005, p. 586).

13.4.1. The emergence principle

According to the first principle – the emergence principle – identity is a product that emerges from the specific conditions of linguistic interaction and is therefore a social and cultural phenomenon. It is reified, pragmatized, materialised through "dialogic linguistic performance" and thus "built, maintained and altered on social ground" (pp. 587-588). "Self-conception", self-image or self-identity denoting an *a-priori* self-awareness housed within an individual mind or internal mental state only become manifested and gain social meaning through discourse. The emergence principle is being upheld by a number of major disciplinary branches of sociocultural linguistics (description in more detail available in Bucholtz & Hall, 2005, p. 588):

- Ethnomethodological concept of 'doing' various kinds of identity (e.g. Fenstermaker and West, 2002; Garfinkel, 1967; West & Zimmerman, 1987)
- Conversation-analytic notion of identity as an interactionally relevant accomplishment (e.g. Antaki & Widdicombe, 1998; Aronsson, 1998; Auer, 1998; Kitzinger, n.d.; Moerman, 1993; Sidnell, 2003)
- Post- structuralist theory of performativity (Butler, 1990)
- Semiotic concepts of creative indexicality (Silverstein, 1979)
- Referee design (Bell, 1984)

> Despite fundamental differences among these approaches, all of them enable us to view identity not simply as a psychological mechanism of self-classification that is reflected in people's social behavior but rather as something that is constituted through social action, and especially through language. (Bucholtz & Hall, 2005, p. 588)

Bucholtz and Hall aver that it is easier to recognise that identity is indeed emergent "in cases where speakers' language use does not conform with the social category to which they are normatively assigned" (2005, p. 588). Nevertheless, "even the most predictable and non-innovative identities" are "only constituted as socially real through discourse, and especially interaction" in "immediate social context" and in accordance with "interactional demands" (p. 591). But discourse is always "ontologically prior" (pp. 588-591) to the existence of any identity, be it personal or professional. Each (professional) identity (especially the most established ones) has "essentialist preconceptions" and "ideologically expected mapping between language" (pp. 588-591) and occupational/professional status. Medical professionals, for example, will treat members of other occupations and discursively build their professional identities according to their professional hierarchical status. Drawing on my professional experience I know that doctors would treat nurses less condescendingly than reception staff or interpreters. In the same vein, doctors and

[105] Bucholtz and Hall explain that the linguistic choices that construct identity are not confined to "vowel quality, turn shape, code choice, or ideological structure", but rather operate "at multiple levels simultaneously" (2005, p. 586).

nurses would constantly use the term *translator* instead of *interpreter* despite being told by professional interpreters that it is incorrect. In numerous occasions I would find myself discursively contesting my professional identity by negotiating my professional positioning. Thus, my self-reference did not match the "ideological expectations" and "essentialist preconceptions" (pp. 588-591) of my co-workers. I was trying to "reject dominant social ideology" (pp. 588-591) regarding medical interpreting by producing "new forms of identity through language by disrupting naturalized associations between specific linguistic forms and specific social categories" (pp. 588-591).

13.4.2. The positionality principle

In accordance with the positionality principle, "identity emerges in discourse through the temporary roles and orientations assumed by participants such as evaluator, joke teller, or engaged listener" (Bucholtz & Hall, 2005, p. 591). These "temporary roles" are "interactional positions that social actors briefly occupy and then abandon as they respond to the contingencies of unfolding discourse" (Bucholtz & Hall, 2005). These roles or positions may be ideologically associated with "both large-scale and local categories of identity" (Bucholtz & Hall, 2005). Thus, the authors conclude that: "Identities encompass (a) macro-level demographic categories; (b) local, ethnographically specific cultural positions; and (c) temporary and interactionally specific stances and participant roles" (p. 592). All these positions or roles "typically occur simultaneously in a single interaction" (p. 593). Thus, the positionality principle foregrounds the multifaceted nature of imbricate role and position categories which culminate in the construction of identity.

13.4.3. The indexicality principle

The indexicality principle differs markedly from the above described emergence principle and positionality principle. Indexicality principle must be construed as a "mechanism" whereby identity is accomplished, negotiated, contested and maintained. It investigates how "linguistic forms", "linguistic means" or linguistic recourses are being instrumentalised in order to discursively "construct identity positions" (Bucholtz & Hall, 2005, p. 594):

> In its most basic sense, an index is a linguistic form that depends on the interactional context for its meaning, such as the first-person pronoun I (Silverstein, 1976). [...] In identity formation, indexicality relies heavily on ideological structures, for associations between language and identity are rooted in cultural beliefs and values – that is, ideologies – about the sorts of speakers who (can or should) produce particular sorts of language. Indexical processes occur at all levels of linguistic structure and use. (Bucholtz & Hall, 2005, p. 594)

The "indexical processes" include:

1) Overt (obvious and direct) mention of referential identity categories and labels into discourse. According to Bucholtz and Hall: "The circulation of such categories within ongoing discourse, their explicit or implicit juxtaposition with other categories, and the linguistic elaborations and qualifications they attract (predicates, modifiers, and so on) all provide important information about identity construction" (2005, p. 594). This can be easily seen when medical staff uses the terms *la traductora* [translator] in feminine

grammatical gender, la *chica rusa/holandesa/alemana* [the Russian/Dutch/German girl] (especially when the interpreter comes from this country, belongs to this culture or has the above mentioned citizenship), *alguien que me traduzca* [somebody who would translate for me], or the name of the person/interpreter in question to refer to them (instead of Dr. _____). This tells me three things: first, as maintained by Rudvin:

> For what concerns power in language specifically related to cross-cultural institutional dialogue, the underlying power-generating factor, I believe, is that the host language is considered to be the default language: *The interpreter has been called in for the client, not the service provider: the judge requires that the entirety of the interlocutor's utterances be interpreted to him/her or what the judge him/ herself selects as relevant* (this is at least frequently the practice in Italy), and not vice versa. *The non-native speaking client does not, in practice, have a legal right to understand the proceedings, but the judge needs the information s/he possesses to arrive at a verdict. The interpreter is called in to put the judge in a position to understand that information.* (Rudvin, 2005, p. 169)

The selected modes also speak volumes about the power tensions during consultations: I had to choose simultaneous chuchotage when there was more than one medical professional in the consultation in order for the patient to understand what was going and consecutive mode to translate *for* the doctor (This mode difference is described in Rudvin, 2005, p. 173). Thus, it is Rudvin's contention that "the interpreters often tend automatically to be "lumped" together with the client and subject to that same superior, condescending, hostile or patrician gaze reserved for most migrants in this country" (Rudvin, 2005, p. 171).

Second, these terms can be diagnostic of derogatory attitude towards medical interpreters, either because medical staff does not care to remember to call them interpreters, which denotes insulting condescendence, or because they claim that "tú no estás aquí para interpreter nada, sino para traducirme y ya está [you are here not to interpret, but to translate for me, and that's it]"[106]. This denotes fear on the part of physicians that a) medical interpreters will interpret medical results/data/information in a way a doctor does it b) that interpreters will force clinicians out of the spotlight.

Third, these terms denote ideological association with lower status of medical interpreters, their non-belonging to a prestigious occupational niche situated in the higher positions of professional stratification and their status of assistant, hostess, attendant, girl who helps with the language, girl who escorts patients and family members across the facility and its premises, etc. These terms go hand in hand with the visual text (see Denzin, 1995, p. 52, cited in Burr, 2003, p. 18) such as outfit and certain wardrobe accessories (high heels, scarf tied à la flight attendant) already discussed earlier, which also signals low status.

2) Implicatures and presuppositions regarding one's own or others' identity position are less direct than an overt mention and "require additional inferential work for interpretation" (Bucholtz & Hall, 2005, p. 595).

[106] This phrase is from my own professional experience.

3) Another micro indexical process is carried out through the display of evaluative, affective, assessing, positioning, and epistemic orientations, otherwise referred to as stance. According to Bucholtz and Hall: "John Du Bois (2002) characterizes stance as social action in the following terms: 'I evaluate something, and thereby position myself, and align [or disalign] with you'" (Bucholtz & Hall, 2005, p. 595). All the above mentioned terms denote "linguistic marking of a speaker's orientation to ongoing talk" (Bucholtz & Hall, 2005, p. 595). Thus, I shall seek to discover how my informants evaluate and assess professional language provision services in the study-relevant sphere and geographic region.
4) Through the use of linguistic structures and systems that are ideologically associated with specific personas and groups, the authors underline the intrinsic character of ideology in the macro process of formation of "indexical ties" or associations (Bucholtz & Hall, 2005). This process may either be bottom-up or top-down. In the case of medical professionals' evaluative, epistemic stances, positions or orientations towards the occupation of medical interpreting is in my opinion a top-down process of *indexical inversion* (Miyako Inoue, 2004, in Bucholtz & Hall, 2005, p. 596), whereby such "indexical associations can also be imposed from the top down by cultural authorities such as intellectuals or the media. Such an imposed indexical tie may create ideological expectations among speakers and hence affect linguistic practice" (Bucholtz & Hall, 2005). Thus:

> In addition to micro-level linguistic structures like stance markers and style features, entire linguistic systems such as languages and dialects may also be indexically tied to identity categories [...] In addition, work on language choice has also begun to appear in the emerging field of language and globalization. (Bucholtz & Hall, 2005, p. 597)

Accordingly, Bucholtz and Hall mention a number of contemporary studies carried out by Besnier (2004), Hall (2003) and Park (2004) among others on the massive impact and implications of the "large-scale social processes such as globalization" on the way identity is shaped in interaction (Bucholtz & Hall, 2005, p. 598). The authors cite Niko Besnier (2004) whose study showcases how a Tongan seller at a second-hand market in Tonga uses English rather than Tongan to communicate with a customer who chooses to stick with Tongan. "Besnier demonstrates that this language choice constructs the speakers as modern and cosmopolitan" (Bucholtz & Hall, 2005, p. 598). In the same way, as I shall seek to demonstrate in the upcoming sections, physicians choose to communicate with their patients in English in spite of having professional interpreters available during the encounter and in spite of the patients being non-English speaking. In the previous chapters of this thesis I described this phenomenon as *lingua franca* and dedicated a whole section to its discussion. To conclude the section on the indexical processes I believe it is worth reproducing the following excerpts from Bucholtz and Hall:

> Disparate indexical processes of labeling, implicature, stance taking, style marking, and code choice work to construct identities, both micro and macro, as well as those somewhere in between. By considering identity formation at multiple indexical levels rather than focusing on only one, we can assemble a much richer portrait of subjectivity and intersubjectivity as they are constituted in interaction. (2005, p. 598)

13.4.4. The relationality principle

The relationality principle views identity as a "relational phenomenon", which should not be parsed as an autonomous, isolated and detached psychological phenomenon because according to Bucholtz and Hall (2005, p. 598) it is an intersubjectively negotiated identity category that only acquires its social meaning when juxtaposed with other identity positions belonging to other social actors. Thus, a person becomes framed as somebody in relation to somebody else. In some cases the person whose identity is being intersubjectively constructed may find other social actors' descriptive accounts derogatory and opposite to one's own self-perception, self-image, introspection or self-esteem. It is my contention that the relationality principle is key to understanding how institutional ethics works and why medical interpreters' professional knowledge is associated with mechanical (Freidson, 2001), intellectually effortless activity reduced to unselfconscious cross-linguistic relaying by equating this "prevailing mechanistic view of language transferral" (Rudvin, 2005, p. 171) with translation machines/walking dictionaries. I shall seek to enucleate why this occupation is thought to be based on tacit unverbalisable (Freidson, 2001) skills only acquirable through work experience conditional on practical knowledge learnt situationally/on the job (by shadowing a "senior" interpreter). I shall also endeavour to analyse through the Bucholtz and Hall's relationality principle how medical interpreters' knowledge is being related to everyday knowledge through the processes of de-specialisation, exoterisation, demystification and oversimplification and equated with mere linguistic proficiency. Thus, Bucholtz and Hall identify three non-mutually-exclusive, often overlapping, complementary relation pairs: similarity/difference or adequation/distinction, genuineness/artifice or authentication/ denaturalization, and authority/delegitimacy also referred to as authorization and illegitimation (2005, p. 598).

1) *Adequation* (italics in the original) implies similitude, likeness and affinity between social groups, individuals, or in this case professionals or members of occupations:

> The term adequation emphasizes the fact that in order for groups or individuals to be positioned as alike, they need not – and in any case cannot – be identical, but must merely be understood as sufficiently similar for current interactional purposes. Thus, differences irrelevant or damaging to ongoing efforts to adequate two people or groups will be downplayed, and similarities viewed as salient to and supportive of the immediate project of identity work will be foregrounded. (Bucholtz & Hall, 2018, p. 599)

Through adequation we may see how during positioning processes the informants associate themselves with or through juxtaposition mechanism antagonise certain professional or occupational groups. People would normally use distinction principle to separate themselves from other identities. "Social differentiation is a highly visible process" whereby linguistic mechanisms used by social actors denote willingness to be viewed as different from another individual or group.

2) *Authentication* is a social process played out in discourse, which focuses on the discursive verification of identities and consequently rights that these identities grant their holders to do something. Thus, the realness or authentication serves to construct the interactional identity and to claim ownership over a certain *modus operandi* that belongs to this identity

that the interactant is claiming. It is worth stating that Bauman terms this process as *traditionalization* which I believe to be extremely useful in terms of professional identities as it "relies on a claimed historical tie to a venerated past" (as cited in Bucholtz and Hall, 2005, p. 602). Thus, if the doctors were to discursively construct their professional identity, they would turn to the fact that they are traditionally called professionals, unlike medical interpreters (social differentiation) they have tradition of collective action, status, prestige, recognition and traditional authority to do what they do.

> In denaturalization, by contrast, such claims to the inevitability or inherent rightness of identities is subverted. What is called attention to instead is the ways in which identity is crafted, fragmented, problematic, or false. Such aspects often emerge [...] in some displays of hybrid identity (e.g. Bucholtz, 1995; Jaffe, 2000; Woolard, 1998), but they may also appear whenever an identity violates ideological expectations (e.g. Barrett, 1999; Rampton, 1995). (Bucholtz & Hall, 2005, p. 602)

In this case, medical interpreting is being clearly denaturalised, so that its "inherent rightness" is "subverted", which implies that it is a problematic hybrid identity which "violates ideological expectations" (in terms of institutional ideology described by Freidson, 2001), especially when its members (professional interpreters) exercise task discretion by rejecting those tasks which should never fall within medical interpreters' remit. Thus, the authentication process of medical interpreters and their positioning is hindered as well, because they cannot claim ownership over their *modus operandi* that belongs to this identity because non-professional self-proclaimed outsiders have already authenticated themselves as eligible for the position of medical interpreter.

3) Both authorization and illegitimation constitute "institutional aspects of identity formation" (Bucholtz & Hall, 2005, p. 603).

> The first of these, authorization, involves the affirmation or imposition of an identity through structures of institutionalized power and ideology, whether local or translocal. The counterpart of authorization, illegitimation, addresses the ways in which identities are dismissed, censored, or simply ignored by these same structures. (Bucholtz & Hall, 2005, p. 603)

It is patent that in case of medical interpreting both domestic and pan-European structures of authority demonstrate through their interactional dynamics that they dismiss and ignore medical interpreting, turning it into a hybrid identity sought after by private centres as a way to enhance their market competitiveness and thereby attract international patients.

13.4.5. The partialness principle

This principle encompasses the fragmented nature of identity or fragmentary manifestations of identity construction:

> Any given construction of identity may be in part deliberate and intentional, in part habitual and hence often less than fully conscious, in part an outcome of interactional negotiation and contestation, in part an outcome of others' perceptions and representations, and in part an effect of larger ideological processes and material structures that may become relevant to interaction. It is therefore constantly shifting both as interaction unfolds and across discourse contexts. (Bucholtz & Hall, 2005, p. 606)

In all of the cases mentioned above identity "exceeds the individual self" and is "produced through contextually situated and ideologically informed configurations of self and other" (Bucholtz & Hall, 2005, p. 605). Both intentional and unselfconscious display of identity showcasing certain degree of autonomy or agency to accomplish social action depend on ideological constraints (Bucholtz & Hall, 2005). Agency may be exercised both individually (individualistic action) and intersubjectively (*distributed agency*, Hutchins, 1995 italics in the original, *joint activity* or *co-construction*, e.g. Eckert & McConnell-Ginet, 1992; C. Goodwin, 1995; M. Goodwin, 1990; Ochs & Capps, 2001, as cited in Bucholtz & Hall, 2005, p. 606, italics on the original). Bucholtz and Hall make an interesting point in stating that agency may be either "ascribed through the perceptions and representations of others" or "assigned through ideologies and social structures", but "even the most mundane of everyday conversations are impinged upon by ideological and material constructs that produce relations of power" (Bucholtz & Hall, p. 606-607). Therefore, in this chapter I shall seek to carry out both microanalysis of conversation and macroanalysis of ideological processes both compounding the construction of the professional identity of medical interpreters.

PART III. EMPIRICAL EVIDENCE

14. MATERIALS AND METHODS

14.1. IDENTIFICATION AND DIAGNOSIS OF THE PROBLEM

The problem that this thesis seeks to tackle is that MI is not recognised as a profession in the secondary institutional sphere in question. MIs have no professional autonomy, no social closure mechanisms such as credentialing or licensing, no clear division of labour, no task discretion, no monopoly. These de-professionalisation symptoms may be diagnostic of the severe under-recognition and undervaluation of the complexity of professional knowledge and skill underlying MI, as well as the fallacious construal of the typology of professional knowledge and skill underpinning this emergent occupation.

Advanced profile hybridisation and the expert/specialist knowledge democratisation and proletarianization pose a dilemma as to how MIs are supposed to professionalise when their expertise is being stripped away from them and deprived of its uniqueness, esoteric and mystical character, professional charisma, specialisation and inaccessibility.

Now that we have diagnosed the problem and what is causing it (Part I and Part II), it is necessary to determine how exactly all of these processes are occurring. In order to do this we all need to understand how others intersubjectively construct our professional identity. Therefore, the intersubjective identity construction through discourse against the backdrop of Social Constructionism (hereafter SC) must be carefully and multimethodologically scrutinised. The socially deterministic approach belonging to the Social Psychology (Burr, 2015) and the individual-agentic approach belonging to the Discourse Psychology (Burr, 2015), must be combined in order to find an antidote that would inhibit the further exacerbation of this occupational malaise.

Consequently, the 3rd part of this thesis will focus on the mechanisms of the professional identity construction by conducting three qualitative analyses (Conversation Analysis (CA), Multimodal Critical Discourse Analysis (MCDA) and Thematic Analysis (TA)), as well as a quantitative analysis to substantiate the results.

14.2. RESEARCH QUESTIONS

My point of departure for this thesis is that "any 'problem' does not have an 'objective existence' for the simple reason that" any occurrence or phenomenon considered a "problem" is "always [a] problem for someone", in that "one person's problem is another's solution" (Burr, 2003, p. 153). So the key question that this thesis aims to answer is whether what I consider to be a "problem" is also a problem for somebody else, or whether I am just problematizing certain aspects of my practice on the basis of a personal prejudices or convictions.

Thus, this thesis will seek to provide valuable and useful insights in four main areas: a) the difference between the language knowledge acquired as the means to improve employability, as the means to communicate at the amateur level, or as specialist/expert knowledge; b) language proficiency credentials; c) current market demands; and d) professionalisation plausibility.

The main research questions, which sought to explore and ferret out the social processes occurring in a very specific location and in a very particular context and leading to the current state of affairs are the following:

I. Why is MI in the private healthcare settings of the VC still either dismissed, dispensed with or delivered by laypeople if the patients who seek cross-border healthcare are willing to cover its costs and the excuse of limited public budget is no longer applicable?

II. Why is the dire need for quality language provision in the private clinics and hospitals not being addressed by professional graduates when the excuse of exotic languages of lesser diffusion is no longer applicable because the languages spoken by the users of these services are mainly European[107]?

III. Why has MI not been professionalized yet despite the fact that the higher education institutions in Spain have the cognitive authority over the codified, formalized and disciplinarized professional knowledge of MI since 1972[108]?

IV. Why were relatively low numbers of graduates being recruited by the private clinics and hospitals even though many of these facilities have signed educational cooperation agreements on extracurricular external work placements with a number of Spanish universities teaching translation and interpreting?

V. Why is nobody concerned with the fact that the patients' right to medical information enshrined in the Ley 16/2003 sec. 3, Ley 41/2002 art. 4 and Ley 10/2014 art. 50 is not being complied with, and subsequently, why the language issue is not being problematized or foregrounded in the EU and/or national legislative texts?

VI. Are there still chances to professionalize, if so, how can this process be accomplished and by whom? Do we owe it to ourselves to try?

14.3. METHODOLOGY

14.3.1. Qualitative analysis

All qualitative research methods focus on the image construction, action legitimization and justification of behavioural patterns. Subjective meanings may become intersubjectively valid, socially recognised, objectivized and widely accepted social reality (Hitzler & Eberle, 2004, p. 70), *ergo* an interdisciplinary and multi-method research was carried out in order to construct a scientifically valid and reasonably lucid description of a shared reality. In order to put the encountered and experienced phenomena into the language of science I decided to explore the paradigm of SC by implementing a series of qualitative discourse research techniques, which included Discursive Psychology applied to CA (otherwise known as micro approach) and Social Psychology (otherwise referred to as macro approach) applied to Thematic Analysis and Multimodal Critical Discourse Analysis.

[107] And taught at the national universities.
[108] Which is when the first Translation and Interpreting Degree was established at the Autonomous University of Barcelona.

The goal was to investigate the performative role of language in the construction and re-construction of MI's professional self-images through negotiation and positioning by combining two synthesizable and synergic ethnomethodological approaches (Harré & Van Langenhove, 1999, cited in Burr, 2015, p. 225). All data were viewed from the perspective of social positioning analysis, described in Bucholtz and Hall (2005). I have opted for "the greatest possible *openness* to the particular meanings and relevances of actors – an openness that is seen as being endangered by the prior formulation of hypotheses" (Meinefeld, 2004, p. 153-154).

> This perspective is *knowledge-sociological* in that it investigates how action subjects on the one hand (have to) locate and adapt themselves in an opposite and socialized way in the historically and socially developed routines and meanings of a particular field of action, and how, on the other hand, they (must) constantly re-interpret and thereby also invent themselves 'individually'. The new (that is, constituted in accordance with the relevances of the action subject) re-interpretations of socially pre-interpreted knowledge, for their part, are then (again as knowledge) fed back into the social action field (Berger & Luckmann, 1966; Soeffner, 1989). [...] [T]he behaviour of individuals is only considered to be understood if the interpreter is in a position both to put the observed behaviour into some relation with the frame of reference and is relevant to the particular type of action, and in this way also to demonstrate that it is meaningful. (Reichertz, 2004, p. 293)

According to Gee (2014) the conventionalised meanings crate a figured world (folk theory, sociocultural discourse model) stored in our minds (stories, ideas, images), books, media, etc. It is a "socially and culturally constructed realm of interpretation of the depictions of a simplified, unconscious and taken-for-granted world that captures what is taken to be typical or normal, which varies by context and by social and cultural group" (Gee, 2014, p. 89). We base what we take to be typical for our figured world on our experiences, but again, these experiences are guided, shaped and normed by the social and cultural groups to which we belong. Thus, there are three major simultaneously occurring processes that pilot the evolution of the professional identity construction:

- Conversation/interaction, whereby interpreters can either reject/ negotiate/ contest the imposed roles, or accept/embrace their new identities –"normative conformity" (Asch, 1951)– by denying their self-image and their pre-conceptions on functions repertoire and practice ethics and by yielding to the "group think mentality" (Asch, 1951). Conversation implies positioning during interaction. CA is the perfect way to understand identity negotiation.
- Figured worlds of the relevant social actors: their subjective intentions, the way they think, what they wish, how they seek to invite the listener to assume a particular identity (Gee, 2014, p. 21), how they assign meanings and construe interpreting-related aspects in their mind, how they "[implant] in thought and action unfair dismissive or derogatory assumptions about other people through prototypical and biased simulations of possible meanings or behavioural patterns" (Gee, 2014, pp. 89-90, 100). In some occasions going "on automatic pilot in regard to some things" allows us to be efficient as we end up "devoting more conscious thought to other things in a situation, text or conversation", however, such efficiency comes with the risk of "taking things for granted" (Gee, 2014, p. 100). Thought and ideation

verbalisation is the only way for us to fathom out the figured worlds. Thematic Analysis is in my opinion the most suitable method to grasp the whole process.

- Signs and sign values are key indicators of professional identity, and some signs or non-verbal texts operate at a less conscious level. These may include elaborate or plain paraphernalia ranging from orchestrated rituals to outfits (scrubs, high heels, etc.). An outfit can confer upon the owner certain status or group belonging. According to Gee, we design our identities "with clothes, gestures, bodies, environments, [...] technologies, objects, the social display of beliefs and values" (Gee, 2014, p. 24). Therefore, non-verbal language manifested through these signs and their respective values is important in terms of expanding our scope of research, and from my personal standpoint, MCDA is the best method to examine it.

Thus, I have conducted an emic action oriented research based on a biographically driven understanding of the subject area and its problem, which is the key indicator of reflexivity in research (see "phenomenological empiricism" in Hitzler and Eberle, 2004, p. 68 and "reflexivity" in Burr, 2003). This methodological approach implies:

> Identifying the actions of others as belonging to a particular meaning pattern available in the knowledge of the social group in question and subsuming these actions in this meaning pattern in the way in which and to the extent that it is familiar to the person understanding. (Meinefeld, 2004, p. 156)

This approach is based on "objective hermeneutics" (Oevermann, 1984), whereby researchers should be "competent members of the linguistic and interactive community being investigated" and be knowledgeable about the "external context", the "pragmatics of a type of interaction" in order to conduct a "full interpretation of the objective social data from all those who participated in an interaction, before any approach is made to the text to be interpreted" (Reichertz, 2004, pp. 290-292).

This thesis is a "confessional description" (Van Maanen, 1988, as cited in Matt, 2004, p. 328). This "textual presentation" is characterised by a "very personal style", whereby "the investigator is narrating form the field, with practical fieldwork experiences concerning access, experiences, feelings and, beyond that, how he or she was changed by the field" (Van Maanen, 1988, as cited in Matt, 2004, p. 328).

The analyses which I have conducted with a "premature analytical and theoretical permeation of the material" (Reichertz, 2004, p. 294) are not limited to a mere description of my observations, but they rather offer a "depiction of subjectively developed and intended meaning" (Reichertz, 2004, p. 294). This study focuses on utterance-token meaning, which stands for a context-specific situated meaning (Gee, 2014, pp. 80-94). Thus, for instance the phrase "organizar tratamiento [organise the treatment]" has an extremely vague meaning, but the situation that it was used in provides a very concrete and specific, meaning that can only be accessible and subject to interpretation once the researcher has discovered and fully comprehended the broad and immediate context (Gee, 2014). In order to interpret form-function correlation and convey the correct meaning of the language in context, the researcher needs to be fully familiarised with the

context. The data and the results of the analyses may not be universally generalisable, but they do however mirror a particular context-bound reality.

This investigation was designed to result in the "reflux" or "feed-back" (Gee, 2014) of science into the everyday life, thus contributing to a re-construction of the current catch-22 situation with MI as we know it today. I sincerely hope that the results of this thesis may actually end up capturing the attention of broader public (Gergen, 1973, in Flick, 2004, p. 92).

14.3.1.1.Micro approach (Discursive Psychology and conversation analysis)

Discursive psychology approach (referred by Burr as micro approach), as opposed to the macro approach, reinstates the idea of an "agentic individual" (Burr, 2015, p. 225) and investigates "the ways in which discourse is oriented to actions within settings, the way representations are constructed and oriented to action, and a general caution about explanations of conduct based in the cognition of individuals" (Wiggins & Potter, 2007, p. 74).

According to this relativist stance it is not the powers that be who finally and irrevocably construct a reality for us, but it is all of us who construct our reality and our identities in this reality through the discursively built accounts of ourselves. Thus, the relativist stance upholds the idea of a language generated reality, where normal people also play a role, even though they may not be the protagonists.

Consequently, the CA was carried out within the methodological framework of discursive psychology. CA focuses on "micro conversational structures" of "naturalistic interactions" (Burr, 2003, p. 163), it is a "naturalistic observational discipline that could deal with details of social action rigorously, empirically and formally" (Schegloff & Sacks, 1973, as cited Paltridge, 2012, p. 95).

Discursive psychology focuses on "larger meaning units" and studies the very "nature of interaction" (Burr, 2003, p. 163). Discursive psychology "is centred on questions about identity and subjectivity" and its "primary concern is about how people construct versions of themselves [...] how they present versions of themselves and events as factual and how they legitimate their actions" (Burr, 2003, p. 163).

14.3.1.2.Macro approach (social psychology, thematic analysis and multimodal critical discourse analysis)

Social psychology is a synonym for Foucauldian poststructuralism as it focuses on the idea of social determinism. This type of deconstructionism advocates for critical realism based on ideology (Burr, 2015; Freidson, 2001) and the power relations, which produce reality, knowledge and description of the world through the language. Foucauldian discourse analyses within the framework of social psychology may be conceived of as an extension of discursive psychology, which is not only interested in instances of language use, but also in material conditions and contextualising social structures (Burr, 2003, p. 170).

> Foucauldian discourse analysis aims to identify the discourses operating in a particular area of life and to examine the implications for subjectivity, practice and power relations that these have. The kinds of materials that may be used in a Foucauldian discourse analysis are virtually limitless; any text or artefact that carries meaning may be analysed. So, to the extent that such things as family

> photographs, choices of interior décor, hairstyles, road signs and written instructions on bottles of medicine carry meanings that may be read by people, they may be analysed. Typically, however, it is written texts, including transcripts of conversations or interviews that are used. (Burr, 2003, p. 170)

Burr subsumes "under the rubric of Foucauldian discourse analysis the range of approaches referred to as critical discourse analysis (CDA)", which purports to delve deeper into the interrelatedness between language and power and to expose and deprecate power inequalities spawned by ideology. Willing identifies six phases of critical discourse analysis (2001 as cited in Burr, 2003, p. 171):

1. Identification of discursive constructions which portray the subject of interest
2. Identification of the image that is being discursively created to portray the subject of interest
3. Analysis of the actual reality accomplished by/through these discursive constructions and investigation of the effects that these constructs have on the social interactants ("action orientation")
4. Investigation of how the subjects in question discursively negotiate their positionings
5. Identification of practical "possibilities for action made available by subject positions", which in the case of this research is vital because it seeks social change
6. Analysis of experiences, thoughts and feelings during the subject positioning ("subjectivity")

If most approaches in discourse analysis tend to depict the *status quo* of the issue being analysed, *critical* approaches are problem-oriented social and semiotic analyses seeking to expose and clarify the taken-for-granted assumptions in order to transform and thereby improve certain realities. These approaches seek to shed light on "how relations of power are established, reinforced and subverted by discourse participants and possibly contributing to the emancipatory efforts of marginalised groups" (personal communication of DeMarco, October, 2019).

There are four major types of critical approaches: social actor analysis, grounded theory, social positioning and TA. This thesis in particular will be focusing on TA taking into account social positioning analysis. The researchers who implement TA seek to identify themes or patterns across the data set that they have either canvassed themselves or have recourse to. These patterns will enable the researcher to see how the research-relevant phenomena are described and how this description is affecting social positioning.

MCDA is yet another socially deterministic approach subsumed under the discipline of Social Psychology. The concept of multimodality, which implies analysis of metaverbal signs and sign values (visual materials), is extremely important as it will possibly facilitate an explanation from yet another methodological perspective.

Multimodality is absolutely essential in terms of constructing, re-constructing and defining meanings, which are then subject to interpretative processes of the social interactants during social interaction. These social conventions are constructed by the images, meanings and experiences produced by the mass media, which manufactures an invisible "second-hand world we all live in" and perceive as natural (Denzin, 2004, p. 82). It is worth clarifying that Flick (2004, p.

89) highlights that perception must not be seen as a passive-receptive process of representation, but rather as an active constructive process of production. Thus, there may be an external reality but the meaning, perception and knowledge thereof are discursively constructed.

Denzin (1995, p. 52, in Burr, 2003, p. 18) and Hughes (1958, p. 90, 96, in Paterson, 2016, Becoming a Judge chapter, Ancillary Problems section, § 7) view these types of visual text materials as important visual signals carrying messages. Visual materials are perceived as particularly complex texts. MCDA studies the "backgrounding" or "automatization" of semiotics (Halliday, 1982), whereby these semiotics become "normal", "natural" and even "invisible" (Iedema, 2003, p. 40).

Thus, the way "we describe ourselves, other people and events has consequences for our action, either as individuals or as a society" (Burr 2015, p. 72), be it verbal or non-verbal description.

14.3.2. Quantitative analysis

Descriptive research design was used for my quantitative analysis. This type of quantitative research is intended to ensure thorough understanding of the phenomena –and the situations these phenomena unfold in–, by identifying social trends leading to these phenomena. This method goes hand in hand with the scope of this thesis, which is based on the Sociology of Professions and SC. Descriptive quantitative analysis is based on two major pillars: researcher's observation (just like in the case of reflexive TA that ineluctably bears the mark of the analyst) and the administration of surveys in order to measure the variables and stack them up against the results obtained through other investigation methods.

14.3.3. Methodological triangulation

In conclusion, this study is relying heavily on the data triangulation, which in Munday's terms is "a multimethodological perspective which aims at explaining a given phenomenon from several vantage points combining quantitative and qualitative methods" (2009, p. 237). Such data cross-fertilisation will allow for a greater reliability, trustworthiness, validity and transparency by refining and upgrading the mutually enriching results in order to obtain a clearer understanding of the phenomena in question. It will permit a more accurate depiction of the problem related to these phenomena (Alves & Gonçalves, 2003, pp. 3-24). My purpose was to collate, conflate and curate the canvassed data in a way that would allow us to see how the ideational content of my participants' accounts constructs a scientifically valid and reasonably lucid pattern of theorisation. The use of triangulation permits attainment of more robust results, which could more easily withstand the scrutiny of rational critique. Triangulation affords a much more sophisticated way of looking at the research questions, as such combination of approaches will help the investigator render a more reality-close assessment of the situation, but of course it will always remain a subjectively experienced reality. In the case of this project, triangulation will constitute a combination of different perspectives on the relevant phenomena coming from different sources (audio recorded conversations, interviews, documentaries) and my own observations and interpretative stance as the researcher. In my case, the researcher (myself) happens to be an inside observer or participant-observer, which implies profound understanding of the social and situational context,

its impact on individual patterns of behaviour and the way in which these behavioural patterns tailored by discourse construct this social context.

I shall focus on both the diversity and the quantity of data. This triangulation is set to combine multiple research methods and different data sources resulting in a convergence of relevant information. I have used a research tool consisting of the deployment of multiple methods of data collection, both quantitative and qualitative. With regard to quantitative analysis, a survey containing 54 questionnaires responded by 24 medical professionals, 8 patients and 22 MIs will be used to present a general overview... Four methodological tools were selected to comprise the qualitative analysis: CA (4 audio recordings), MCDA (visual materials from different sources) and TA (consisting of 62 open-ended interviews given by 6 interpreters, 7 patients, 3 nurses and 45 doctors), and they will be used to delve deeper into the research questions.

It is worth noting that in terms of the data source triangulation medical professionals, patients and interpreters from different medical centres were asked to participate in order to provide a confirmation of findings form different perspectives on the topic of interest. Such methodological synergy is expected to broaden the horizon of this thesis and expand the scope of the phenomena in question, as well as to provide evidence to substantiate the allegations presented in Part II. The use of the data source triangulation is intended to tackle informant parsimony, while the method triangulation is aimed to address research parochialism. The following diagram recaps the triangulation approaches that I am going to be using in this thesis:

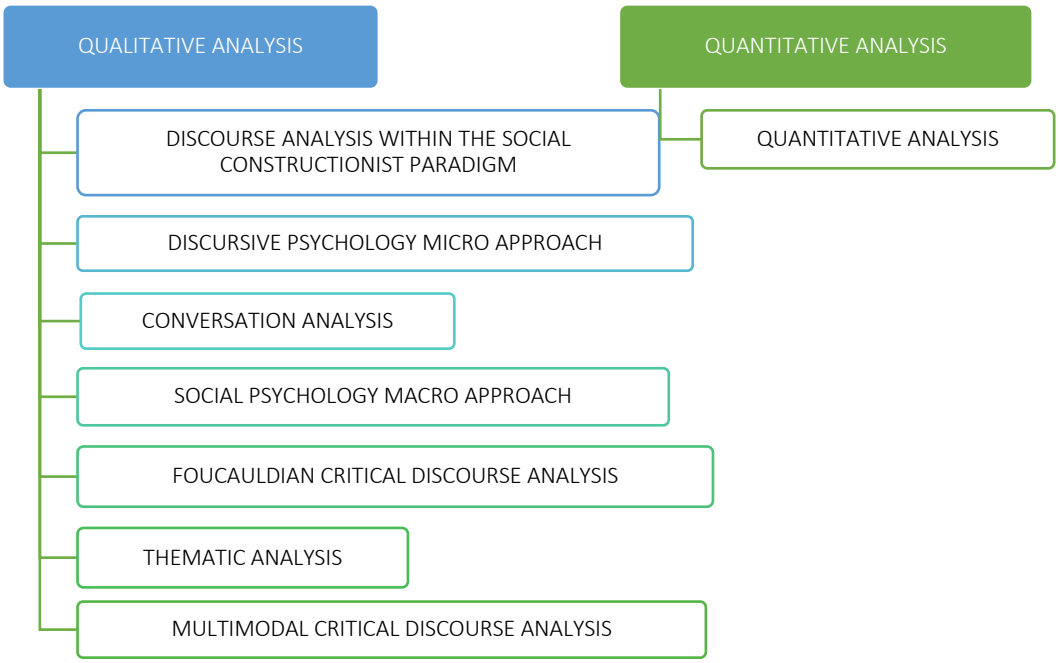


Figure 40. Triangulation approaches

The main research goal that this thesis pursues is the development of general knowledge of a particular subject so as to allow professionalisation of MI. I pursue theoretical generalisability of the obtained results, where the number of individuals participating or situations studied (quantitative analysis) is less decisive than the variability of the theoretical scope (qualitative data).

Triangulation is expected to be more informative than a large pool of data with only one method (quantitative analysis) used to break it down. I was not conducting a target selection of cases, therefore counter examples and case contrasts will also be addressed in addition to the case comparisons (Kelle & Kluge,1999, p. 40, in Flick, 2004, p. 150).

14.3.4. Subjectivity in discourse analysis

Objectivity, impartiality and unbiasedness constitute long-established and conventionalised criteria for orthodox research model in the field of science. Purportedly, the supposed and conjectural objectivity can guarantee truthfulness, factualism, reliability, soundness and trustworthiness of scientific research method, as well as signal its validity and thereby validate the researcher's representations and views of the world. The detachment of the experimenter or researcher from their humanity, sympathy, bias, prejudice, mindset, partiality and predilection in order to "reveal the objective nature of the phenomena" being investigated is seen as the only way to avoid bastardisation or contamination of research outcome "with leakage from their own personal involvement" (Burr, 2003, p. 151). A common belief held by the worldwide scientific community is that the researcher must uphold principle of neutrality by abandoning biased positioning and by thus turning themselves into selfless experts.

That being said, the very concept of SC challenges the criterion of objectivity by defying its very essence, because within social constructionist paradigm as framework of research "the 'objectivity-talk' of scientists becomes just part of the discourse of science through which a particular version, and vision, of human life is constructed" (Burr, 2003, p. 151). As maintained by Gilbert and Mulkay (1984 as cited in Burr, 2003, pp. 151-152) there are two diametrically opposite "interpretative repertoires". The empiricist repertoire encompasses "impersonal, data-driven nature of research", while contingent repertoire encapsulates "possible motives and biases" of the researcher. Needless to say, contingent repertoire is construed as "bad science" (Burr, 2003). However, SC –as a highly heretical doctrine– purports to rationalise the impracticability, implausibility and unreasonableness of objectivity by arguing that "each of us, of necessity, must encounter the world from some perspective or other [...] and the questions we come to ask about that world, our theories and hypotheses, must also of necessity arise from the assumptions that are embedded in our perspective" (Burr, 2003, p. 152). Therefore,

> No human being can step outside of their humanity and view the world from no position at all, which is what the idea of objectivity suggests, and this is just as true of scientists as of everyone else. The task of the researcher therefore becomes to acknowledge and even to work with their own intrinsic involvement in the research process and the part that this plays is the results that are produced. The researcher must view the research as necessarily a co-production between themselves and the people they are researching. For example, in an interview it can be readily seen how the research's own assumptions must inform what questions are asked and how, and that the interpreter as a human being cannot be seen as an inanimate writing pad or machine that records the interviewee's responses uncontaminated by human interaction. In addition, facts themselves can never be impartial. They are always the product of someone asking a particular question, and questions always derive from, albeit often implicit, assumptions about the world. (Burr, 2003, p. 152)

Burr also pinpoints that any "problem" does not have an "objective existence", for the simple reason that these problems are "always problems *for someone*" and "one person's problem is another's solution" (Burr, 2003, p. 153). And it is therefore that:

> Concern with the issues outlined above has led to new developments in research [...], as well as a preference for qualitative methods of enquiry since these are often ideal for gathering linguistic and textual data and are viewed as less likely to decontextualise the experience and accounts of respondents. The data are then often analysed using approaches that are referred to as 'discourse analysis'. (Burr, 2003, p. 149)

According to the principle of "reflexivity", both the investigator and the informants have equal status and therefore the discourse analysis has to mirror both the role of discourse analysts in the production of the obtained discourse being analysed as well as the role of the informants.

The type of qualitative investigation that I have conducted for this thesis is not only aimed at co-producing an accurate account of the *status quo* of MI in the study-relevant area, but also at trying to ferret out how a change for the better can be achieved. Thus, according to Burr, this research approach can be defined as "action research", "where the aim [...] is not just to study some existing state of affairs but to change them for the better, and where the values and political agenda motivating the research is therefore explicitly acknowledged" (Burr, 2003, p. 155). Thus, such research can be described as "potentially empowering", as it seeks to find "participant-led ways of improving specific problematic situations" (Burr, 2003).

According to traditional approaches in scientific research, for the research findings to be reliable, they must be "repeatable", and "validity is the requirement that the scientist's description of the world matches what is really there, independent of our ideas and talk about it" (Burr, 2003). However, research within the social constructionist framework:

> Is not about identifying objective facts or making truth claims. There can be no final description of the world, and reality may be inaccessible or inseparable from our discourse about it; all knowledge is provisional and contestable, and accounts are local and historically/culturally specific. (Burr, 2003, p. 158)

Moreover, Tiselius (2018) notes that many researchers who pursue research in interpreting are either former interpreters or active practitioners themselves (p. 748). Being referred to as *practi-searchers* by Gile (1995) and Pöchhacker (1995) they are thought to have "a deep pre-understanding of the field" (Tiselius, 2018, p. 748).

Furthermore, research into interpreting implies that the data is in numerous occasions canvassed from colleagues or peers as informants or subjects, because in the case of MI is Spain, where the occupation is practically inexistent and restricted to a small number of private facilities, the practi-searchers' access to data is extremely limited. Therefore, "the data may be granted only thanks to his or her collegial relationship with the research participants, as described for instance by Bendazzoli (2016) and Biagini (2016)" (Tiselius, 2018, p. 748). Thus,

> The researcher's position in research which involves collecting data from former or present colleagues may be delicate in terms of handling results which are less flattering for the participants. The delicate position between colleagues' trust and researcher's duties may challenge the ethical obligation to report findings truthfully. (Tiselius, 2018, p. 748)

Thus, due to the emic[109] approach of the researcher, the patent presence and manifestation of the interpreter's/researcher's voice in the investigation problematising different aspects of practice is ineluctable (Tiselius, 2018, p. 748).

In my case I was integrated in my object of study to an extent that now allows me to "provide readers with an insider's view of the topic" (Tiselius, 2018, p. 749). But Tiselius is raising concerns as to whether such "a deep background knowledge in a given area" and the researcher's "preconceived understandings of the area" may bring the reflexivity to a whole new level transforming it into a biographically driven understanding of the situation rather than an investigation into the situation.

The researchers working within the framework of SC can be said to be struggling to find proper benchmark that would allow them to justify, legitimate, validate and endorse the outcome of their research, because "at present there appear to be no criteria that are universally" applicable (Burr, 2003, p. 159). Nonetheless, according to Taylor (2001, cited in Burr, 2003, p. 159) by "showing that the analysis has been carried out systematically", by furnishing the reader with sound and robust argumentation of the outcome construal, by "providing in-depth information" regarding the sequence of analytic procedure, by "member checking"[110] and by falling back on "usefulness" and "fruitfulness" investigators may upgrade the rigour, trustworthiness and soundness of discourse analytical approach in research.

14.4. RESEARCH DESIGN

14.4.1. Canvassing the data

This "potentially empowering [...] action-research" (Burr, 2003) draws heavily on my personal and professional experiences, which contextualise the data extracted from the experience and accounts of my respondents. My observations are based on my "deep pre-understanding of the field" (Tiselius, 2018, p. 748), which I acquired through my values, history, bibliography and experience as both a child-ad-hoc interpreter for my parents and community and a professional graduate interpreter. This biographically driven preconceived understanding of the situation and my deep background knowledge in this area turned me into a "practi-searcher" (Gile, 1995, in Tiselius, 2018).

So, when I started to work as a MI, I noticed a series of tendencies, which I felt I would like to investigate in order to obtain a rationale for these occurrences. The following are the observations that led me to hypothesize and inquire into why this is happening, where all this is going, whether I/professional interpreters can do something about it, whether something needs to be done to tackle what I perceive as serious social problems and what could be done. The key question that this thesis aims to answer is whether what I consider to be a "problem" is also a problem for somebody else, or whether I am just problematizing certain aspects of my practice. This is exactly why the testimonies that have been confided to me comprise the *pièce de résistance* of my

[109] Emic perspective refers to research approach from within the field in question (Pike, 1967, in Tiselius, 2018, p. 749).

[110] According to Burr (2003, p. 159) "member checking" is a procedure whereby the researcher may ask for feedback from the research participants themselves.

work. They constitute a true fulcrum of the "behind-the-scenes" of the traditional triadic interaction, being taught at the university as liaison interpreting, as well as of the non-traditional dyadic interaction, which scientists rarely have an opportunity to peep into. My research aims at addressing the theoretical parsimony with regard to the interpreters' role outside the medical consultation, in that the majority of the existing papers only focus on the interaction during the encounter, thus contributing to "the prevalent ideology of conceptualizing interpreters as a role that only is meaningful in provider–patient interaction" (Hsieh, 2006, p. 936). The following were my initial observations, which inspired me to conduct this investigation and subsequently led to the completion of this research:

1. Extremely low numbers of graduate interpreters were being recruited by the private medical facilities, in spite of the educational cooperation agreements on extracurricular external academic placements between the Universities teaching T&I and private entities willing to collaborate annually.
2. Lack of recruitment and selection criteria. Apparently, procurement managers were guided by the overpromise-underdeliver principle both in the case of candidates applying for clinical and non-clinical positions, as well as in the case of the candidates applying for the position of MIs.
3. Undervaluation of interpreting skills, overestimation of unverifiable language skills. Purported knowledge of English, German, French and other languages became a prerequisite for application for all medical professionals (also reported by Niño Moral, 2008, p. 1066).
4. Precarious employment and working conditions. Severe underremuneration (also reported by Angelelli, 2015, p. 74) indicative of and compatible with underestimation of professional competencies, which dissents from the ISCO-08 and CNO-11 job classification.
5. Language provision was being marketed as a luxury, high-end, personalized and customized service available only for few, rather than a necessary tool provided for all non-Spanish speaking patients.
6. Lack of national and European regulations on language provision guaranteeing safety (also reported by Angelelli, 2015).
7. Hybridization of roles and profiles. Interoccupational encroachment due to overlapping jurisdictional boundaries and lack of clear delimitation of each person's tasks, duties and responsibilities.

Once I decided to pursue research in this direction, I contacted the commercial managers and hospital managers of a number of private medical centres located in the Valencian Community. Five private medical centres agreed to participate in the research. Every contract or agreement (see Appendix N) that I signed with a healthcare centre where my research was conducted contains an extensive confidentiality clause in compliance with the current data protection law (Ley Orgánica 3/2018).

Once my interview and questionnaire questions[111] were approved and cleared for being used (see Appendix O, P, Q, R, S, T, U for the questionnaire intended for medical professionals; Appendix V and W for the questionnaire intended for MIs, and Appendix X, Y for the questionnaire intended for patients), I was granted consent to conduct my research upon condition that I would not expose neither the details which could possibly compromise anonymity and disclose the identity of my informants, nor the medical facility I had the opportunity to undertake my research at, and that I would comply with the applicable legislation on personal data protection. In order for me not to be found in breach of the obligation of confidentiality, I agreed to the terms and conditions that the analysis released upon completion of my study would under no condition divulge or facilitate any data that would allow the reader(s) to identify either the participants or the centre in question. Each consent form contained relevant information on the nature of my research. It was clarified in all consent forms that my investigation was being carried out for the sake of academic research only. I also obtained an recorded? oral consent from my participants and informants before embarking on my project.

Thus, the apparently perfunctory but purposefully vague description of subjects is intended to guarantee complete anonymity. So before disseminating the transcriptions of the garnered recordings all "anonymity-sensitive words" have been "*bleeped* or otherwise obscured" (Du Bois, 2004). Thus, as a disclaimer I would like to state that the transcriptions of neither the interviews nor the consultation audio recordings contain any sensitive information that would allow the reader to identify any of the participants or informants of the study or the medical centres that the investigation has been conducted at.

Moreover, only the excerpts of recordings containing no identificatory information have been carefully singled out before they were curated for this thesis. All the dates, medication denominations, medication doses or dosages, treatment and procedure denominations, etc. preceded by a tilde symbol ~ are pseudographs whose purpose is to protect the privacy and preserve the anonymity of individuals involved. Thus, any resemblance to actual conditions that somebody might be suffering from, procedures or treatments that somebody might have undergone, medication somebody might be on, dosage, etc. is purely coincidental. My intention is not to make an exposé of the participants or medical centres who partook in this research, but to scrutinise the current situation by conveying the voices of my informants. Anonymity preserving data analysis is key to guarantee that the trust built up between my participants and myself is not abused or betrayed, but rather honoured:

> Participants trust researchers with information which may be private and personal or otherwise important for the individual. The decision of how this information is handled and analyzed often depends on the researcher's discretionary power. When this power is ill exercised, the decisions risk breaching the trust of the participant. By allowing the researcher to study and share this information, the individual participants trust the researcher not to spread that information and not to let any harm happen to them. The researcher cannot promise unfailing anonymity or complete secrecy. [...] This said, it must, of course, be absolutely clear to the participant that the researcher who promises anonymous treatment and publication of data will under no circumstances seek to share information that can be directly linked to the participant. (Tiselius, 2018, p. 751)

[111] For more details, please see the section on the "Description of the Method".

My intention is not "to privilege [my]self as the one who more correctly understands the truth about another's situation' (Alcoff, 2009, p. 134, cited in Tiselius, 2018, p. 750), but to look into the *status quo* of the occupation in question from an emic ethnographical perspective, to endeavour to fathom out the "symptoms" of de-professionalisation or stagnation of the process of professionalisation, and to attempt to find the rationale behind occurrences diagnostic of the profession's exoterisation and debasement in a hope to offer possible solutions. Whilst every effort has been made to ensure the accuracy of the information provided herein, as the author of this thesis I do not assume and hereby disclaim any liability to any party for any damage or disruption caused by the data garnered herein, which was gathered with official permit issued by the corresponding competent authorities.

Once all the agreements and consents have been duly negotiated and officialised, and once all the workers of the participant medical centres were advised of the purpose of my presence in the medical facilities and the nature of my research via an official email sent by managing directors, I started to approach the doctors, the nurses, the interpreters/patient care assistants, and the patients one by one explaining the scope and the aim of the research. The vast majority of the medical professionals (55 doctors and 18 nurses in total to be exact) found this research extremely interesting and almost all of them agreed to participate instantly. The patients were far more reluctant to participate, which is also understandable, in that their mood was far from cheerful and optimistic due to various reasons such as agitation, uneasiness, distress, physiological and psychological discomfort, and other characteristics of a pathological condition. Practically all the interpreters/translators/care assistants (27 in total) found this research "absolutely necessary" and the arguments in favour of conducting this study "compelling". Only 5 multilingual assistants (out of 32) confessed that they felt fearful and uncomfortable with sharing their point of view. After a person had expressed their desire to participate, I would normally ask them what data collection method they felt most comfortable with: questionnaire or interview, and after obtaining the answer I would either hand them the questionnaire or book an appointment for the interview. Before engaging in an interview my informants were advised that they were not obliged to answer a question if they did not feel comfortable or prepared to.

In respect of the naturally occurring medical encounters, the data collection was much more complicated. I was allowed to audio record 10 encounters in total, however 6 thereof contained extremely sensitive information that had to be edited out thus leaving the transcript almost empty. Therefore, only 4 audio recording were included into this study.

14.4.2. Description of the medical settings

In this section I shall proceed to limn the main characteristics of the medical settings where my research was conducted. First of all it should be pointed out that the clinical consultations which took place in the study-relevant geographical area and against the study-relevant demographical backdrop differ from traditional dyadic clinical communication. This is due to "sociotechnical" (exponentially advancing "computerisation" and "technologization of care") and "sociolinguistic" (market-driven globalisation) changes (Swinglehurst et al., 2014, p. 2).

Thus, interpreted consultations, which "lie beyond the 'dyad' by inclusion of additional people" will alter the traditional "configurations" in terms of "orderliness[112] [...] distribution of knowledge and expertise [...] power authority and social identities" during clinical consultation (Swinglehurst et al., 2014, p. 3). The authors cross-reference Davies (2012), who introduced the concept of "crowded consultation". In triadic interactional sequence, where interpreters are used, conventional roles and identities of the interactants are disturbed (Swinglehurst et al., 2014, p. 7).

Swinglehurst et al. also accuse interpreters of "constantly choosing the quantity and quality of information that is translated, thus creating a hybrid voice and assigning themselves an extra role as either 'doctor' or 'patient' with blurring of the usual boundaries between the two" (2014, pp. 7-8). The authors report that the patients' right to speak is always compromised, as interpreters would tend to prioritise doctors' right to speak over the patients' right to be heard, thus, leaving the patients "at the bottom of the hierarchy", and abusing their power to distribute speaking turns (Swinglehurst et al., 2014, p. 8). The authors also argue that: "even when the prototypical doctor–interpreter–patient sequence is followed, there remains considerable scope for misunderstanding, due to ambiguity over the interpreter's role and how the interpreting task is actually performed in practice" (Swinglehurst et al., 2014).

Thus, I pursued my research from 2014 to 2020 and I managed to canvass data from 5 different medical centres. All of them were private facilities located in the Valencian Community and geared towards medical tourism. The wide range of medical specialties is diagnostic of the complexity of interpreting in terms of conceptualisations and terminology, deontological issues and praxeological subtleties and sensitivities. The following are the most relevant specialties that one may encounter in these types of facilities: assisted reproduction treatments (genetics, embryology[113]), cardiology, hemodynamics and interventional cardiology, haematology and hemotherapy, internal medicine, general surgery, bariatric surgery, gastroenterology, medical oncology (radiotherapy and chemotherapy), oncological surgery, thoracic surgery, plastic surgery, aesthetic medicine, oral and maxillofacial, vascular and endovascular surgery, neurology, neurosurgery, traumatology, orthopaedic surgery, paediatrics, gynaecology and obstetrics, urology, dialysis, neurophysiology, allergology, pathological anatomy, anaesthesiology, dermatology, electrophysiology, endocrinology, microbiology, laboratory, otolaryngology, nuclear medicine, nephrology, pneumology, preventive medicine, ophthalmology, nutrition and dietetics, psychology, psychiatry, interventional radiology, podiatry, radiology and diagnostic radiology, rehabilitation and physiotherapy, rheumatology, Emergency Room (ER), Intensive Care Unit (ICU), and palliative care *inter alia*.

Each medical centre had different departments apart from around 50 medical specialties itemised above including 24/7 emergency room (accident and emergency or casualties department), admissions, around 20 intensive care units, diagnostic imaging, laboratory, ward (around 150

[112] Here Swinglehurst et al. are referring to the stages or phases that a clinical consultation is divided into according to Byrne and Long (1976) as well as Calgary-Cambridge (1996). Anamnesis, explanation and planning are believed to be three major stages in clinical counselling.

[113] Highly complex assisted reproduction techniques ranging from artificial insemination, in-vitro-fertilisation to reception of oocytes from partners or egg donation.

beds), around 5 operating theatres, dialysis unit, outpatient department. All medical centres work with in-house interpreters and employees of different nationalities and cultural backgrounds. The number of interpreters hired by each centre varies from 5 to 15.

In terms of the volume of foreign speaking patients, which the medical centres in question cater for, each medical facility provides different figures ranging from at least 20% up to over 80%. In terms of patient profile, these customers are:

- Affluent elderly population (expatriates) who seek foreign retirement as long-term residents in Spain
- International travellers who visit Spain out of the peak tourist season
    - Business tourists
    - Regular tourists
- Traditional high season travellers
- Those who intentionally seek to undergo a planned elective treatment which became the main purpose for their journey abroad
    - (Genuine) Medical tourists attracted by affordability of care, high quality standards & infrastructure, highly qualified medical professionals, no waiting lists, lax legislation in infertility treatments, optimal geographical and climatic conditions, rich cultural environment and gastronomy

Increased readiness to travel for healthcare, deployment of new technologies such as history taking software, (free) video conferencing software platforms including Zoom, Microsoft Teams, Go To Meeting, Skype, etc., which allow to conduct first or follow up consultations remotely, low-cost air travel and high disposable income are key factors in making medical tourism in the region thrive and burgeon.

In terms of language profiles I would like to emphasise: English, German, Dutch, Italian, French, Russian, Arabic and Scandinavian speaking patients. The patients can be divided into two groups: private patients [*paciente privado*] and holders of private medical insurance. All of the centres that I conducted my research at, are located in the Valencian Community region.

14.4.3. Materials

Once I decided to pursue research in this direction, I contacted the commercial managers and hospital managers of a number of private medical centres located in the VC. Five private medical centres agreed to participate in the research. Every contract or agreement (see Appendix N) that I signed with a healthcare centre where my research was conducted contains an extensive confidentiality clause in compliance with the current data protection law (Ley Orgánica 3/2018). Once my interview and questionnaire questions[114] were approved and cleared for being used, I was granted consent to conduct my research upon condition that I would not expose neither the details which could possibly compromise anonymity and disclose the identity of my informants,

[114] For more details, please see the section on the "Description of the Method".

nor the medical facility I had the opportunity to undertake my research at, and that I would comply with the applicable legislation on personal data protection.

The data corpus consists of five types of materials: 4 audio recordings of naturally occurring medical encounters with 11 participants in total; 62 in-person semi-structured audio recorded interviews granted by 46 doctors, 3 nurses, 7 patients and 6 interpreters; 53 written questionnaires responded by 24 medical professionals, 21 interpreter and 8 patients; 1 documentary television programme broadcast on Spanish national television, and 2 photographs of outfits. The total number of participants amounts to 126 people.

In respect of the naturally occurring medical encounters, the data collection was very complicated. I was allowed to audio record 10 encounters in total, however 6 thereof contained extremely sensitive information that had to be edited out thus leaving the transcript almost empty. Therefore, only 4 approximately 15-minute-long audio recordings were included into this study almost in their entirety, except for the sensitive data. The encounters were audio recorded with a pre-installed iOS App on an iPhone 6s. Four doctors, 6 patients and 1 interpreter participated in the encounters. They all granted non-recorded oral consent. The recordings' names were encoded and stored on the hard drive of my personal computer and on a memory card. The recording were manually transcribed using Arial Unicode MS font for the layout, which provides the widest range of options for using special symbols such as characters capable of writing any of the languages of the world in their traditional standard orthography (Du Bois, 2005). I translated all the materials into English from Spanish, German, French, Russian and Ukrainian.

The visual materials were constituted by a series of images or screenshots retrievable from a documentary television program *Tener o no tener hijos – Tratamientos fertilidad* (Comando Actualidad, 2016) released in Spain on the national television broadcaster, as well as photographs of outfits, which belong to me and which I had in my custody all along. Comando Actualidad is a Spanish television programme that brings to public attention, foregrounds and sheds light on current social dilemmas and salient social phenomena occurring across the country. These problems or issues are related to very specific social and historical events unpacked from different perspectives. Each episode lasts for about 60 minutes and is broadcast on Tuesdays (23:00-00:00h) and Saturdays (09:55-10:30h). I extracted and transcribed the most relevant excerpts manually to avoid the unnecessary level of detail offered by transcription software. I translated all relevant extracts from Spanish into English. I took several screenshots and included them into the data corpus in order to facilitate understanding.

The photographs feature an interpreter in her uniform, as well as a patient's family member and a doctor. All participants gave their non-recorded oral consent to appear on the photographs. The facial features of all participants were touched up in Microsoft Word in order to conceal their main characteristics and thus make them unrecognisable. I took the photographs with an iPad for the purpose of research.

The data corpus[115] used for the TA is comprised of the interviews with medical professionals, interpreters and patients, affording data source triangulation. The interviews were audio recorded with a pre-installed iOS App on an iPhone 6s. All participants granted non-recorded oral consent

[115] Data *corpus* "refers to all data collected for a particular research project" (Braun & Clarke, 2006, section 1).

before each interview. The recordings' names were encoded and stored on the hard drive of my personal computer and on a memory card. As for the transcription I chose intelligent verbatim transcription, which is intended to deliver a concise and readable text. All materials intended for the TA were transcribed manually, as the utilisation of a transcription software would only lead to unnecessary level of detail.

This method allows for the transcriber to have leeway to edit out parts of speech, which challenge immediate comprehension. Thus, sometimes grammatical restructuring, correction of grammatical errors, removal of distracting, redundant, repeated sentences, removal of irrelevant noise (coughing, throat clearing, laughter, phone ringing, door slamming, etc.), removal of non-verbal communication as well as verbal pauses, distracting fillers, repetitions (including stuttering and stammering), editing out of irrelevant off-topic content and off-the-cuff remarks as well as non-standardised language, correction of spelling and inclusion of facilitative punctuation are an absolute priority to ensure correct interpretation of meaning and conveyance of message. All transcribed elements were translated from Spanish, French, German, Russian and Ukrainian into English. Each excerpt is followed by a brief profiling of the participant.

The resulting TA data corpus encompassed unconventionalised, extralinguistic non-ceremonially marked but still institutionally influenced data extracts and data items. In an attempt to canvass informants' associative reactions and interpretations I chose to conduct "focused interviews" (Hopf, 2004, p. 205). I have focused on a particular social situation that my participants reported to have been participating in on daily basis in order "to maximize the scope of the topics and to give interviewees an opportunity to invoke points of view that had not been anticipated" (Hopf, 2004, p. 205). This approach allows to widen the "spectrum of problems addressed in the interview" (Hopf, 2004, p. 205). The case study of MI has a "longitudinal perspective within a temporally limited framework", which is common in ethnographical (participant-observation) studies "by virtue of the researcher's extended participation in the field of study" (Flick, 2004, p. 148), and a retrospective focus, as it was influenced by biographical elements. Given that the field being investigated is new, theoretical constructs and concepts are underdeveloped.

The interviews may be classified as semi-structured, lasting between 10-60 minutes, evolving in tête-à-tête conversations, conducted in person, containing mainly open-ended questions and follow up exploratory questions, sometimes conducted in a noisy venue and in a tense environment of tight time constraints. main interview questions were preformulated, the follow up questions were flexible, spontaneous and improvised, resembling a discussion with my informants. The main interview questions constituted the following:

1. What is a MI?
2. Is there a need for MIs in the Spanish medical facilities of these characteristics?
3. What qualifies a person to practice as a MI, what makes a person eligible for the exercise of this profession?
4. Should formal education be a sin qua non prerequisite for practice?
5. If so, what type of formal education?

It is worth noting that almost all transcribed material is displayed in the *Results and Discussion* chapter for two reasons. First, because these excerpts reflect the rationale behind each overarching

theme and sub-theme better than any explanation that I could furnish the reader with. Second, because my aim was to let the informants speak and express themselves in order to understand their train of thoughts and the ideations and rationales behind their attitudes and behaviours, and displaying these truly priceless contributions was extremely necessary. Out of circa 50 pages of transcriptions and 50 pages of translations, approximately 25 are on display in the *Results and Discussion* section.

Upon carrying out a thorough analysis of the current situation in the field, I phrased a series of questions, which were specifically designed to elicit insights via interviews that would allow me to rationalise certain syllogisms trending among the relevant social actors as well as their argumentations. I classified the questions in three groups: those aimed to be replied by the medical professionals, those aimed to be answered by interpreters, and those addressed to patients. I shall display the examples of the questionnaires I used for my survey in the Appendix section (please check Appendix O, P, Q, R, S, T, U, V, W, X and Y). Please, check Appendix O, P, Q, R, S, T, U for the questionnaire intended for medical professionals; Appendix V and W for the questionnaire intended for MIs, and Appendix X, Y for the questionnaire intended for patients. The first questionnaire was addressed to the medical group and was constituted by 25 questions, the second was addressed to the interpreters' group and consisted of 8 questions, and the third one was addressed to patients and contained 11 questions.

Upon completing the formulation of the questionnaires, I printed them out and handed the paper version thereof to all those willing to participate. These questionnaires ended up being answered by 24 medical professionals (9 physicians and 15 nurses), 21 interpreters and 8 patients (amounting to 53 people in total). These surveys constitute physical evidence of a research.

The research was conducted from 2015 to 2020 in 5 different medical centres located in the Valencian Community and geared towards medical tourism. These surveys were geared towards those participants who refused to be interviewed and/or audio-recorded. All of these surveys were canvassed anonymously, just as it was previously agreed with the hospital administration.

Given that I am not going to include all the transcriptions of my interviews and the questionnaires in the Appendix section, as these will take up a lot of space (approximately 300 pages in total), I included all the relevant excerpts into the chapter on "Results and Discussion".

14.4.4. Subjects

The total number of people, who agreed to contribute to this project, amounts to 126 in total. The project involved the participation of 59 doctors, 18 nurses, 21 patients and 28 interpreters, the majority of whom were officially referred to as administrative assistants and unofficially as medical/patient assistants. The data was canvassed from 5 private hospitals located in the VC region. The participants were categorized and arranged in three different groups:

1. Those who agreed to have their interaction during medical encounter audio recorded (4 encounters featuring 1 interpreter, 4 different doctors and 6 patients)
2. Those who agreed to be interviewed and audio recorded (62 interviews featuring 46 doctors, 3 nurses, 7 patients and 6 interpreters)

3. Those who agreed to fill out the corresponding questionnaire (53 responses featuring 9 doctors, 15 nurses, 8 patients and 21 interpreters)

In order to honour each person's willingness to participate, I respected each person's decision to choose one data collection method or the other in accordance with their personal preferences and confidentiality concerns. The data obtained from the first group of participants were subject to the conversation analysis, the evidence collected from the second group of informants was used for thematic analysis, and the information facilitated by the third group constituted the basis for the quantitative analysis. The qualitative analyses (CA and TA) were audio recorded, transcribes and translated into English from Spanish, German, French, Russian and Ukrainian. The quantitative analysis was administered in Spanish, English, German, French and Russian, and the findings thereof were translated into English. The additional details of each population group that participated in each type of analysis are presented below.

14.4.4.1. Conversation analysis subjects

I was present at the consultations and I was given oral permission to record before I started to document the encouter. The doctor from the first recoding is male, over 10 years of professional experience, works with multilingual staff on daily basis. The doctor from the second recording is male, over 25 years of professional experience, also works with interpreters on daily basis. The doctors from the third and fourth recording are also males, over 35 years of professional experience, also work with interpreters on daily basis. Their mother tongue is Spanish. The interpreter in all four recordings is a female, 25-year-old graduate interpreter, she had 3 years of professional experience in the field at the time and worked full-time. Four patients and two family members were present during these encounters, however, I am not allowed to reveal any information about them or their respective treatments.

14.4.4.2. Thematic analysis subjects

As for the participants, it is worth clarifying that 46 doctors, 3 nurses, 7 patients and 6 interpreters, –amounting to 62 persons in total–, were interviewed for the TA. The age bracket of the participants is from 27 to 68. Detailed information on each of the participants, more specifically their gender, department, mother tongue and years of professional experience was facilitated in the parenthesis right next to the number that was assigned to each participant. In the case of interpreters, it was also specified whether they are professional graduate interpreters or layperson interpreters. These interviews were canvassed in five different medical centres all located in the study-relevant geographic area. All medical professionals used to work with interpreters on daily basis as the percentage of foreign patients in some of these medical facilities reached up to 80%[116] back in 2015-2019.

[116] More information can be found here: https://www.clinicabenidorm.com/nl/about-us

14.4.4.3.Quantitative analysis subjects

The questionnaires were responded by 24 medical workers (9 doctors and 15 nurses), 8 patients and 21 MIs, who may have been officially classified as administrative assistants, and who may self-identify as international or personal medical assistants, however all of whom have been initially hired to act as interpreters, as it was revealed by Participant nº 6: "nos contrataron para traducir no para todo lo que hacemos [we were hired to translate, not to do everything we do]". The age bracket of medical professionals ranges from 24 to 65 years, and their professional experience in the same or similar positions ranged from 1 to 36 years. The age bracket of the patients ranges from 53 to 84 years, 4 patients were German-speaking, 2 patients spoke Russian, 1 patient speak English and 1 patient had French as their mother tongue. Questionnaires were also filled in by 22 female interpreters from 5 different private clinics/hospitals, age bracket of 27 to 53 years, professional experience as translator or interpreter in the medical field ranges from 1 year to 15 years (10 people indicated 1 year, 7 people between 4 and 10 years, and 5 people indicated 12, 13, 13 14 and 15 years of professional experience respectively).

14.4.5. Method description and data selection procedure

The method was specifically designed according to the characteristics of the setting and the population. It was adapted to the preferences and desiderata of the participants. Each participant only participated in one data collection technique. This was done because some participants expressed reluctance to have their voice audio recorded, others expressed disinclination to bear their testimony in writing thus revealing their identity through the handwriting, while other potential participants refused to have their interaction audio recorded during medical encounter due to highly sensitive information being discussed. Different participants had different reasons not to participate (sensitive data, confidentiality issues, fear of losing their job, etc.) or to participate only by sharing their feelings, experiences and thoughts in the way they felt most comfortable with.

Therefore, every potential/prospective participant was offered different data collection method to choose from, and every informant decided to choose only one method on the basis of their personal preferences. After a person had expressed their desire to participate, I would normally ask them what data collection method they felt most comfortable with: questionnaire, interview, or consultation recording, and after obtaining the answer I would either hand them the questionnaire or book an appointment for the interview/consultation. Before engaging in an interview my informants were advised that they were not obliged to answer a question if they did not feel comfortable or prepared to.

This was the only way to obtain information. The presentation of the obtained information follows an organisational pattern of presenting the information starting with very concrete situations (exploring the individual-agentic approach through discourse psychology) and moving towards more generalisable opinion on these situations (adopting deterministic approach by applying social psychology). A more detailed description of each the type of analysis applicable to each type of participant is presented below.

14.4.5.1.Conversation analysis

The main aim of the CA was to examine the effectiveness of communication of the non-native language speakers, their linguistic competence, their communication skills in a foreign language and the discursive psychology of the MIs' intersubjective identity construction through the structure of interaction, turn-taking and sequence organisationation, epistemological facets (reference, intertextuality, mutual knowledge) and lexical choice. Special attention was attributed to the institutionality of the interaction, how the institutional ethics permeates the interaction, the orderliness of talk, and the architecture of an unconventional encounter due to multilingualism. It is absolutely essential to clarify that I moved from observation to hypothesis (and not the other way round) because CA is not done for the purpose of hypothesis testing. I followed Sacks reasoning by considered (and sometimes re-considering) "whatever can be found in any particular conversation we happen to have our hands on, subjecting it to investigation in any direction that can be produced from it" (Sacks, 1984, p. 27, cited in Richards, 2015), in that "nothing can be ruled out as random, insignificant, or irrelevant" (Atkinson and Heritage, 1984, cited in Richards, 2015).

As agreed, all the word units laden with any sensitive information that may trigger off further inspection have been altered or modified. Thus, the real names of the participants used in the following transcripts in speaker attribution labels as well as in utterances of the discourse participants have been replaced by hypernyms instead of pseudonyms such as doctor and patient, whereas the names of patients, the names of doctors, the types of treatments, the trade names of medication, etc. were all exchanged for pseudographs which according to Du Bois et al. (1991, 1992, 1993) are notations in which a sensitive indicator of identity (person's name, address, cell phone, etc.) has been modified to preserve anonymity. A pseudograph (tilde ~ in my case) cannot be used to replace a speaker label, but only to indicate the place where the word was actually uttered on the actual recording (Du Bois, 2006).

Conventional orthography was used throughout the whole transcribed data set. I employed literal transcription transcribing all sounds into the written text without recurring to phonetic transcription. The literal transcription includes grammatical errors, pronunciation mistakes, original (mis)spelling, unfinished and repeated word units. I adhered to the true verbatim style transcribing every word unit on the recording as it is/as it sounds. True verbatim style[117] (also called strict verbatim or verbatim) has been employed throughout a set of excerpts destined for CA in order to draw attention to the extent of the multifacetedness of the interpreters' role outside the consultation and to measure the extent of figurativeness of the term "assistant".

I chose to use true verbatim fashion because it allows to study the manner in which something is being said, both capturing not only the meaningful utterances but also meaningless filler speech as well as meta-verbal indicators of ideological implications attitude, showcasing what has apparently already become a routine predisposition to delegate their duties as doctors to interpreters, which proves to be a rather idiosyncratic approach to MI. Reinforcement of tail slots, non-lexical tokens, interjections and laughter, and emotions were all included into the transcription and

[117] For more information on different transcription styles, please visit the following web page: https://www.opal-transcriptionservices.com/transcript-example

analysis. Neither letter repetition, nor vocal spelling to imitate dialectal or casual pronunciation were used in the transcription.

I did this purposefully so that the reader can get a grasp on the participants' linguistic proficiency and their idiolects in English. Although the transcription categories have remained unaltered and valid, the transcription symbol conventions employed to indicate basic transcription categories have undergone several revisions and I have used the most recent updated discourse transcription conventions (Du Bois, 2004, Du Bois, 2005) and DT2 (Comparison of Transcription Symbols, 23-Jun 2006, see Appendix Z). I have drawn strongly on Du Bois' "Representing Discourse" (2006), where basic symbols for discourse transcription are displayed. I used Arial Unicode MS font for the layout of my transcriptions, which provides the widest range of options for using special symbols such as characters capable of writing any of the languages of the world in their traditional standard orthography (Du Bois, 2004).

No glossing will be needed, because I am not investigating the linguistic morphology of word units or the syntactic morphology of the language, I am seeking to look at the meaning of the whole discourse, more precisely, I am seeking to instrumentalise the discourse and to view it as a tool of workplace reality and identity construction, rather than a simple grammatic structure. The main focus will lie on the salience of the implications and most importantly the impact that this discourse is actually exerting upon the workplace reality within this very specific context of private health care and medical tourism. Thus, an accurate idiomatic translation is more fit for purpose than the glossing. Nevertheless, I did use grammatical category labels in the gloss of some specific utterances when I translated this utterance from Spanish to English. No transcription software was used. All translations are mine.

For this analysis I have drawn on Sacks et al. (1974, 1978), Heritage (1984a), Levinson (1983), Atkinson and Drew (1979), Schegloff and Sacks (1973), Schegloff et al. (1977), Atkinson and Heritage (1984).

14.4.5.2.Multimodal critical discourse analysis

The concept of multimodality, which implies analysis of meta-verbal signs and sign values, is extremely important as it will possibly facilitate an explanation from yet another methodological perspective. This documentary is of paramount importance for this thesis as it displays the extent of profile hybridisation against the backdrop of the current market demands in this sphere very well. In ties in with the rest of the analyses conducted for this thesis. This documentary belong to the factual, expository and issue-oriented genre, with regard to the generic stage it has introduction, set of arguments, facts and procedures, and a conclusion (Iedema, 2001, in Paltridge, 2012, p. 177-181). After having watched this documentary very carefully several times, I selected all the frames, shots and scenes that was particularly interested in and then I proceeded to do a literal transcription of the most relevant dialogues. I translated the transcription into English. Then I conducted a multimodal discourse analysis in accordance with the guidelines of Iedema (2001) presented in "Multimodality in film and television genres" (Paltridge, 2012, p. 177-181). Simultaneously, a comparison was being made between the information presented in the documentary and the images and photographs that I had in my custody.

Denzin (1995, p. 52, cited in Burr, 2003, p. 18) and Hughes (1958, p. 90, 96, as cited in Paterson, 2016, Becoming a Judge chapter, Ancillary Problems section, § 7) view these types of visual text materials as important visual signals carrying messages. Visual materials may be perceived as particularly complex texts, even though in this case these visual texts have not been previously or intentionally orchestrated or prepared but rather depict spontaneous behaviour and role of interpreters during medical consultations.

However, MCDA literacy is still going to be needed to achieve a complete comfortable grasp of the concepts being involved. "The backgrounding or 'automatization' (Halliday, 1982) of [...] semiotics, to the point where they appear so normal and natural as to become 'invisible'" (Iedema, 2003, p. 40) is an important notion to take into account. I would like to sum up with the deconstructionists holding the view "that how we describe ourselves, other people and events has consequences for our action, either as individuals or as a society" (Burr 2015, p. 72), however such description does not necessarily need to be always verbal.

According to Kress (2010) and van Leeuwen (2005) multimodal DA "aims to describe the socially situated semiotic resources that we draw on for communication" (in Paltridge, 2012, p. 170). All texts, be it "printed, visual, oral or auditory" (Denzin, 1995) imply complex interpretative and interactional processes, which shape and construct the meanings. Each means or tool of communication (verbal language including accent, intonation, voice quality, choice of vocabulary, text structure, text texture as well as non-verbal language ranging from gestures, gaze, posture, outfit to music, light, colour, images) "conveys information value" according to its "affordances" (Gibson, 1977 in Paltridge, 2012, p. 171).

> This meaning potential (van Leeuwen (2005a)) of the particular mode is 'shaped by how mode has been used, what it has been repeatedly used to mean and do, and the social conventions that informs its use in context'. (Jewitt 2009a, p. 24, in Paltridge, 2012, p. 171)

Thus, I shall focus on the data that in my opinion stands out the most in terms of contribution to the construction of socially accepted meanings. I shall follow the parameters of the multimodal analysis in film and television genres provided by Iedema (2001 in Paltridge, 2012, p. 177). In his article on visual communication "Multimodality, resemiotization: extending the analysis of discourse as multi-semiotic practice" (2003), Iedema is interested in the "*transformative* dynamics of socially situated meaning-making processes" that "require an additional and alternative analytical point of view" (2003, p. 30). "This alternative view favours the social-processual logic which governs how material meanings mutually transform one another (Douglas,1994), and is referred to here as resemiotization" (Iedema, 2003, p. 30). Following Denzin's reasoning and ideation regarding the definition of a text, it is clear that this visual material is essential to deepen our understanding of the situation. "The meaning of a text is always indeterminate, open/ended and interactional" (Denzin, 1995, p. 52 in Burr, 2003, p. 18).

14.4.5.3. Thematic analysis

I will base the application of TA to my data set upon the guidelines provided by Braun and Clarke (2006). In their paper *Using TA in psychology* (2006) they provide an exhaustive explanation of the value, functionality and efficiency of this method in psychology research. However,

TA may be used in and beyond the realm of psychology. I drew on these instructions in order to dissect the intersubjective professional identity construction through social positioning and role negotiation in a more "deliberate and rigorous way" (Braun & Clarke, 2006, abstract). This method is considered to be comprised under the CDA (Critical Discourse Analysis), which in turn is subsumed under Foucauldian discourse analysis. This type of data set screening is intended to identify themes or patterns "in relation to different epistemological and ontological positions" (Braun & Clarke, 2006). It is worth reminding that TA is a socially deterministic approach within the realm of Social Psychology.

I have curated the following diagram drawing on Hutchby & Wooffitt, 1998; Smith & Osborn, 2003; Glaser, 1992; Strauss & Corbin, 1998; Burman & Parker, 1993; Potter & Wetherell, 1987; Willig, 2003; Murray, 2003; Riessman, 1993; Aronson, 1994; Roulston, 2001; Antaki et al., 2002, cited in Braun & Clarke, 2006, § 1-4):

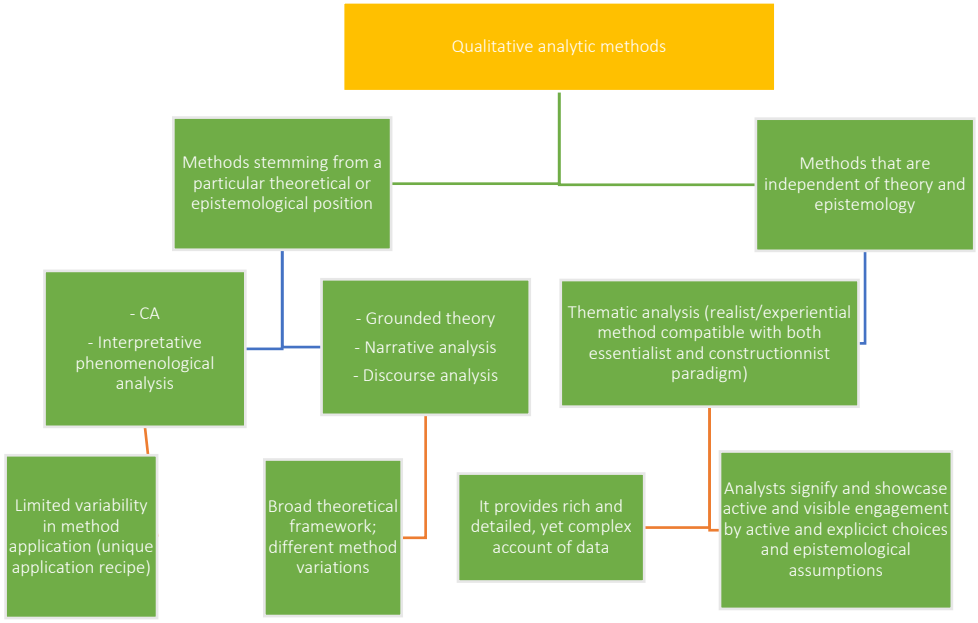


Figure 41. Qualitative analytic methods

This ontological diagram maps out some of the key characteristics of TA as well as its categorisation within the domain of qualitative analysis. The hallmark of TA is its flexibility across the epistemological and ontological spectrum as it can be used within critical realist, constructionism and contextualist paradigm. Thus:

> Thematic analysis is not wed to any pre-existing theoretical framework, and so it can be used within different theoretical frameworks (although not all), and can be used to do different things within them. Thematic analysis can be an essentialist or realist method, which reports experiences, meanings and the reality of participants, or it can be a constructionist method, which examines the ways in which events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society. (Braun & Clarke, 2006, What is thematic analysis section, § 10)

For this thesis I shall be using TA within a social constructionist epistemology, whereby patterns are viewed as social constructs. TA from constructionist perspective theorises socio-cultural contexts as well as structural conditions that enable the individual accounts (Braun & Clarke, 2006, Epistemology: essentialist vs constructionist TA section, § 2).

In this case I will focus on the latent themes (which can be identified at interpretative level). TA "at the latent level goes beyond the semantic content of the data" (Braun & Clarke, 2006, Semantic or latent themes section, § 1-2) in that its aim is to detect and disclose "underlying ideas, assumptions and conceptualisations – and ideologies – that are theorised as shaping or informing the semantic content of the data" (Braun & Clarke, 2006). A latent TA undergoes a thorough interpretative process carried out by the analyst. The result thereof is not a mere description of the state of play, but a theorised socio-psychological dissection of constructs from a constructionism paradigm, which is also compatible with psycho-analytic modes of interpretation. Therefore, my role was not that of a passive observant, but rather that of an active analyst.

Active researcher engagement in identification examination, classification, collation, codification, organisationation and reporting of themes or patterns denotes strong reliance on subjectivity. The themes are neither randomly discovered, nor emerge by chance. The patterns do not "reside" in the data waiting to be found or discovered: "if themes 'reside' anywhere, they reside in our heads from our thinking about our data and creating links as we understand them" (Ely et al., 1997, p. 205-206, in Braun & Clarke, 2006, What is thematic analysis? section, § 3-4).

Thus, the authors urge researchers and analysts to finally concede and acknowledge that they have their own theoretical positions in relation to the research being conducted: "we do not subscribe to a naïve realist view of qualitative research where the researcher can simply 'give voice'[...] to their participants", because even the very intention to give the participants or informants the opportunity to become vocal about the subject of interest and verbalise their opinions on it "involves carving out unacknowledged pieces of narrative evidence that we select, edit, and deploy to border our arguments" (Fine, 2002, in Braun & Clarke, 2006, What is thematic analysis? section, § 4-5). Therefore, after perusing numerous works on different analytical frameworks I have chosen a theoretical framework. The advocates of the theoretic approach in TA argue that "engagement with the literature can enhance your analysis by sensitising you to more subtle features of the data" (Tuckett, 2005, cited in Braun & Clarke, 2006, Doing thematic analysis: step-by-step guide, § 2).

In order to conduct the TA I followed the guidelines suggested by Braun and Clarke (2006): TA must by no means be construed as a "*lineal* process where you simply move from one phase to the next", but rather a "*recursive* process, where you move back and forth as needed, throughout the phases" (Braun and Clarke, 2006, Doing thematic analysis: step-by-step guide, § 3, italics in the original).

1. The first step of the TA consisted in producing a clean verbatim transcription of the data corpus. No transcription software was used to transcribe the data. As I proceeded with the transcription process I studied the canvassed data by actively and repeatedly listening, writing and reading the utterances of my participants. Transcription is construed as "a key phase of data analysis within interpretative qualitative methodology" (Bird, 2005, p. 227, in Braun & Clarke, 2006, p. 88), and recognised

as an interpretative act, where meanings are created, rather than simply a mechanical one of putting spoken sounds on paper (Lapadat & Lindsay, 1999). Afterwards, I translated the transcribed data corpus into English.

2. In the second phase I started to identify the recurrent codes, which are key to "organising [...] data into meaningful groups" (Tuckett, 2005, in Braun & Clarke, 2006, p. 88) in order to form broader "units of analysis" or themes. This process is "a deliberate and self-consciously artful creation by the researcher and must be constructed to persuade the reader of the plausibility of an argument" (Foster & Parker, 1995, p. 204, in Braun & Clarke, 2006, p. 95). I coded all data extracts, then I collated the data extracts together under their respective umbrella code. In order for the context not to be lost I kept the surrounding data. In TA individual excerpts or data items can be coded in "as many 'themes' as they fit into" (Foster & Parker, 1995, p. 204, in Braun & Clarke, 2006, p. 95).
3. Also, "no data set is without contradiction, and a satisfactory thematic 'map' [...] – an overall conceptualization of the data patterns, and relationships between them – does not have to smooth out or ignore the tensions and inconsistencies within and across data items" (Braun & Clarke, 2006, p. 89).
4. Once the data was coded and collated, all relevant excerpts that combined with one another were subsumed under an overarching theme. An initial thematic map was created to represent different levels of themes (overarching themes and sub-themes subsumed under the overarching themes). At the end of this phase I had "a collection of candidate themes, and sub-themes" as well as all extracts of corresponding data (Braun & Clarke, 2006).
5. The fourth phase implies "refinement" of the candidate themes. According to Patton (1990 as cited in Braun & Clarke, 2006, p. 91) all themes should manifest "*internal homogeneity* and *external heterogeneity*" (italics in the original). In other words, "data within themes should cohere together meaningfully, while there should be clear and identifiable distinctions between themes" (Patton, 1990, cited in Braun & Clarke, 2006, p. 91). A candidate thematic map was created.
6. The fifth phase consists of defining, naming and refining themes. As maintained by Braun and Clarke (2006, p. 92): "the 'essence' of what each theme is about (as well as the themes overall) and determining what aspect of the data each theme captures" is key to organising the themes into "a coherent and internally consistent account, with accompanying narrative". Each individual "story" of every theme fits into the general underlying storyline or diegesis, which mirrors both the factual reality as well as our own reality, the one we are trying to convey by discursive construction. The themes and their respective sub-themes do not overlap, but rather form a coherent and cohesive narrative, where the sub-themes give "structure to a particularly large and complex theme", thus "demonstrating the hierarchy of meaning within the data" (Braun & Clarke, 2006, p. 92).

7. The sixth phase encapsulates the final analysis as well as the final write-up. The final report contains the overarching themes, the sub-themes, the thematic map, all corresponding excerpts (in the original language and in English) and the final remarks.

It is worth mentioning that TA has been recently used in academic research on MI by Gao (2022) to study the "array of demands" encountered by the accredited and professional MIs practicing in New Zealand, as well as the "responses they employ" when dealing with such challenges.

14.4.5.4. Quantitative analysis

Three different questionnaires were administered to medical professionals (it contained 25 questions, see Appendix O,P, Q, R, S, T, U), interpreters (comprised by 8 questions, see Appendix V, W) and patients (formed by 11 questions, see Appendix X,Y). These questionnaires were answered by 24 medical professionals (9 physicians and 15 nurses), 21 interpreters and 8 patients over the course of 5 years (from 2015 to 2020). The participants were practitioners at 5 different private facilities located in the VC and geared towards medical tourism. These surveys were administered to those participants who refused to be interviewed and/or audio-recorded. All of these surveys were canvassed anonymously, just as it was previously agreed with the hospital administration.

14.5. Limitations

The current *status quo* of MIs is being approached from two different but interrelated perspectives: sociology and psychology. I combined two different theories or approaches (sociology of professions enriched by the sociology of knowledge and social constructionist discursive analysis). I used three different methods of data collection: qualitative in-depth individual interviews, naturalistically occurring medical consultation interaction, and quantitative questionnaires. Different data sources including different participants' personal and professional accounts were used to gain scientific value. I have also used other scientific sources of knowledge such as neurophysiology, neuroscience, neurolinguistics and even genetics to prove my point. And although all of the above mentioned research efforts were employed to enhance data richness, its scientific validity, approval and acceptability, I am aware of the limitations of this thesis.

For instance, the lack of clear scientific "conceptual tools" constitutes the rationale for criticism of CDA and other critical approaches (Burr, 2003, p. 171). CDA relies heavily on the "analyst's interpretation" (Cameron, 2001, in DeMarco, 2019, Personal communication), and often it is believed that instead of a "pure description" the analyst engages into action, which in itself is subjectivism at work" (Jäger & Zimmermann, 2010, in DeMarco, 2019). Braun and Clarke argue that:

> [...] thematic analysis currently has no particular kudos as an analytic method – this, we argue, stems from the very fact that it is poorly demarcated and claimed, yet widely used. This means that thematic analysis is frequently, or appears to be, what is simply carried out by someone without the knowledge or skills to perform a supposedly more sophisticated – certainly more kudos-bearing – 'branded' form of analysis like grounded theory, IPA or DA. (Braun & Clarke, 2006, p. 97)

However, for Jäger the pure description of a state of affairs is impossible, as decisions favouring specific interpretation must also be made in the description. Researchers therefore always act politically, as they are permanently entangled in discourses that shape their knowledge and practices (Jäger & Zimmermann, 2010, p. 144, in Maier, 2017, p. 21). Thus, a contingent and subjective CDA can still have highly problem diagnostic accuracy when done correctly (Gilbert & Mulkay, 1984, in Burr, 2003, pp. 151-152.). The analyst must choose a method that would tackle their research question(s) in the most appropriate way, rather than "fall victim to 'methodolatry'" by being more committed to a certain method than to one's own research interest (Holloway & Todres, 2003, cited in Braun & Clarke, 2006, p. 97).

Another limitation is the reluctance to participate on the part of medical professionals, patients and interpreters. Such reluctance hindered a more extensive and comprehensive data corpus and data set collection.

Last but not least, my educational background in T&I and my scientific inexperience in the application of the above described methods mainly used in psychology and forensic linguistics, amongst other disciplines, also constitute a concern.

15. RESULTS AND DISCUSSION

15.1. QUALITATIVE DATA ANALYSIS

15.1.1. Conversation analysis and discursive psychology

This CA is conducted within the framework of the Discursive psychology paradigm (Edwards & Potter, 2001; Burr, 2015; Burr, 2003). The idea of garnering the data that would allow me to peep into whether an interpreter indeed plays a significant, determining and decisive role outside the consultation by becoming quasi-medical personnel, stems from the idea of professional instrumentalisation of interpreters to an extent of their extreme over-involvement in the process of treatment. I strongly believe that the assistance outside the consultation is an anchor point that must not be glossed over, but must be subject to thorough scrutiny, as it might be perceived as beneficial interoperability.

The following are the aims that this CA is pursuing:

- To determine the actual role of interpreters within the consultation
- To delve deeper into why the interpretation service is not used even when available during the consultation
- To ferret out why the interpreters are requested to perform tasks which they are not qualified to perform
- To ferret out why some doctors are adamant about using English as lingua franca, even when neither the patients nor the doctors themselves display a good command thereof

The extent of the multifacetedness of this role is very complex and controversial. I consider that the garnered data provides the target audience of this thesis with an insight into how the interpreter transitions from expendable linguistic tool to decisive medical figure taken up after walking out the doctor's office door.

The doctors were adamant about using English as lingua franca, even when neither the patients nor the doctors themselves displayed a good command thereof. This double role inversion constitutes the major vantage point of this thesis. Both phenomena set forth above bear on one another.

It is worth noting that such multiconsequential interoperability by means of over-involvement in the patients' diagnosis and treatment is not meant to be perceived an overgeneralisation. However, the patterns of this "business of talk" (Edwards & Potter, 2001) showcase that the excerpts curated for this section are not just isolated cases either, which the researcher just accidentally happened to witness. Moreover, these are socially, interprofessionally and interpersonally engineered identities, which have already been reported to exist (Hsieh, 2010, cited in Hsieh & Kramer, 2012).

15.1.1.1.Results

Four medical encounters were recorded for the purpose of conducting CA presented below. One interpreter, 4 different doctors and 6 different patients (4 patients and 2 family members) participated in these encounters. The doctor from the first recoding is male, over 10 years of professional experience, works with multilingual staff on daily basis. The doctor from the second recording is also male, over 25 years of professional experience, also works with interpreters on daily basis. The doctors from the third and fourth recording are also males, over 35 years of professional experience, also work with interpreters on daily basis. Their mother tongue is Spanish. The interpreter in all four recordings is a female, 25-year-old graduate interpreter, she had 3 years of professional experience in the field at the time and worked full-time. Four patients and two family members were present during these encounters, however, I am not allowed to reveal any information about them or their respective treatments. The following excerpts belong to the transcriptions of four audio recordings made in a number of private clinics located in the Valencian Community.

Audio recording 1

DOCTOR; ┤ °uhh we will explain you° ### the medication umm we will give you also an appointment ### ┤ [TCU[118] speaker allows a lapse]

PATIENT; ┘ ### ((PATIENT AND ACCOMPANYING PERSON TALKING WITH EACH OTHER IN A VERY LOW PITCH IN A FOREIGN LANGUAGE)) I started from the 8th 11th remember? ### ((PATIENT AND ACCOMPANYING PERSON TALKING WITH EACH OTHER IN A VERY LOW PITCH IN A FOREIGN LANGUAGE)) ### #i'm taking #2,25 but I didn't take the other injection, only only: ~lidocaine [Turn Yielding Cue, the speaker selects next speaker –the doctor– at TRP119]

DOCTOR; And you didn't #pick the: the ~hydrocortisone [TRP]

PATIENT; ┘ err doctor said ### use it [TCU] [dispreferred response: speaker designs his turn to elicit a particular response, but the response was unpredicted, so he repeats the question]

Doctor; Uhh ok ummm (4.9) you ummm (0.2) didn't pick the ~hydrocortisone? [Adjacency pairs failure]

PATIENT; I have it we have it we have it but we did not use it she did not use it because #the #doctor #did #not #tell #her to use it that's #this the the reason and the last time that she used this one that was the last name ((POSSIBLY SHOWING PRESCRIPTION OR INSTRUCTIONS OF ADMINISTRATION OF THAT MEDICATION)) [TRP] [Adjacency pair: repair]

DOCTOR; OK don't worry <L2=SPANISH> entonces hoy le vamos a dar ~lidocaina ~4 horas antes de ~la ~hidrocortisona [By switching from English into Spanish, the doctor manifests a turn denying cue and selects next speaker – the interpreter at TRP, who is now obliged to hold the floor] [Adjacency pair failure: the doctor leaves the patient and their family members out of the conversation]

so today she'll take ~lidocaine 4 hours before taking ~hidrocortisone[120]

((EVEN THOUGH THE DOCTOR COULD HAVE EXPLAINED HOW TO TAKE THE MEDICATION IN ENGLISH, THE DOCTOR ADDRESSES THE INSTRUCTIONS OF MEDICATION ADMINISTRATION TO THE INTERPRETER SWITCHING FROM ENGLISH TO SPANISH EXPECTING THE INTERPRETER TO EXPLAIN AND/OR SCHEDULE THE MEDICATION ADMINISRTATION))

[118] TCU - Turn Constructional Unit.
[119] TRP - Transition Relevance Place.
[120] Here the patient is being rather spoken about, than spoken to.

INTERP; (Hx) (THROAT CLEANING) he said that you have to take ~lidocaine today ~4 hours before you injec-= [the interpreter self-selects to speak to the patient, but finds herself interrupted by the doctor who yet again chooses to communicate in Spanish] [Unpredicted reaction of the doctor, dispreferred response]

DOCTOR; <L2=SPANISH> =<F> sí pero ahora se lo das</F> ⌋cuando ⌋salga [TCU, the doctor allows a lapse, yet the interpreter self-selects to justify previous intervention] [Unpredicted reaction of the doctor, dispreferred response]

yes but now them it give-2SG. IMP when walks-3SG SBJV out

yes, but you'll give it to ~her once ~she has walked outside ((the physician's office))

((THE INSTRUCTIONS ARE BEING REFERRED TO BY THE PRONOUN "IT"))

INTERP; <L2=SPANISH> <F>sí sí </F> o sea pero para que sepan de lo que estamos hablando[121] [The interpreter self-selects to justify previous intervention]

Yes, I mean but [I'm interpreting] so that they know what we are talking about

I'll give you everything written down ok? ### [TRP] [Unpredicted reaction of the doctor, dispreferred response]

((ASSUMING THE RESPONSIBILITY OF PROVIDING THE FINALISED INSTRUCTIONS TO THE PATIENTS OUTSIDE THE CONSULTATION))

PATIENT; So we are going to use what now? Which medicine? ### ((THE PATIENT EXPECTS THE DOCTOR TO GIVE THEM THE INSTRUCTIONS REGARDING THEIR MEDICATION)) [TRP]

Doctor; Yes, now we will explain [the: ..] [Turn Denying Cue, the doctor allows a lapse]

((AVOIDING THE QUESTION)) [Unpredicted and dispreferred response; negative adjacency pair, whereby the doctor negates the response to the patient's inquiry]

PATIENT; [OK] [preferred response]

DOCTOR; the .. new medi[cation ..]

PATIENT; [ok]

((THE DOCTOR IS EXPECTING THE INTERPRETER TO EXIT THE CONSULTATION AND EXPLAIN TO THE PATIENTS IN DETAIL HOW TO PROCEED WITH MEDICATION ADMINISTARTION OUTSIDE THE CONSULTATION))

((INTERPRETER FINALISES THE DETAILS ON THE MEDICATION ADMINISTRATION WITH THE DOCTOR IN A LOWERED VOICE TONE, WHICH MAKES IT PRETTY MUCH INAUDIBLE ON THE RECORDING AND EXITS THE CONSULTATION ALONG WITH THE PATIENTS))

INTERP; Ok so you can come with me and I will explain what medication you will have to take and when ok? [The interpreter selects the patient as the next speaker at TRP,] [preferred response/reaction]

PATIENT; ok and then we wait for the report ### we will take medication today [however, the patient dismissed the interpreter and selects the doctor to respond]

INTERP; exactly [Turn Denying Cue, even though the doctor has been selected to reply, the interpreter has no other choice as to self-select and answer the question, as the doctor has previously given her the instruction not to bother him with further questions, but to deliver instructions outside the consultation]

PATIENT; and tomorrow [again seeking doctors explanation/approval, TRP]

INTERP; exactly but tomorrow these are not going to be injections I will explain-= [yet again self-selecting at TRP]

PATIENT; =### ((SPEAKING IN ~HUNGARIAN WITH THE FAMILY MEMBER))

[121] "It is often better to say that speakers and writers are bidding to get a certain socially significant identity (or set of them) recognized by listeners/readers" (Gee, 2014, p. 25). In this case this bid definitely fails. The interpreter tried to invite or bring about negotiation or contestation from the listener. "It is about recognition of "kinds of people" in performances in context" (Gee, 2014, p. 25).

ACCOMPANYING PERSON;What about the blood test? [the patient is selecting the doctor at TRP and the doctor is obliged to reply]

DOCTOR; I I I will see the blood test in in hour in one hour [TCU, allows a lapse] [dispreferred response]

PATIENT; ok and after you see it [the patient is selecting the doctor at TRP and the doctor is obliged to reply]

DOCTOR; Yes no it uhh if uhh everything is ok I: uhh: (3,4).. will not: uhh call you ok if we have a problem I will call you [the patient is selecting the doctor at TRP and the doctor is obliged to reply] [preferred response]

PATIENT; Ok perfect no problem [TCU] [preferred response]

Audio recording 2

PATIENT; Wann bekomme ich die Ergebnisse? Wer muss das alles schreiben für die Ergebnisse und so?

INTERP; ¿Cuándo tendrá el resultado y quién se lo envía?

DOCTOR; Esto uhh I will contact you as soon as we have the results err before the ~treatment we will prepare that for you [TRP, the Spanish-speaking doctor chooses to communicate in English even though the German-speaking patient is not English-proficient]

PATIENT; Ja

Yes

INTERP; [Wir werden alles für Sie vorbereiten Sobald wir ihr Ergebnis bekommen haben, nehmen wir mit Ihnen Kontakt auf]

we will prepare everything for you. We will contact you as soon as we have received your results

DOCTOR; [we will go on with the same treatment] but if there is an infection I will deal it with a treatment by phone in order to be treated [TCU, the speaker allows a lapse]

[…] ((ANONYMITY-SENSITIVE INFORMATION HAS BEEN OMMITTED))

((THE PATIENT PROCEEDS TO TALK TO THEIR PARTNER IN GERMAN))

PATIENT; ┤Am besten mit dir kurz telefonieren. ┤Kannst du jetzt ihm während des Gesprächs sagen, ┤gib ihm deine Nummer

HUSBAND; If you phone today to me me she ask me it's may be better if it's possible for you to contact me

INTERP; If you want we could afterwards register[122] your telephone number at the reception desk

DOCTOR; This is the phone for me to call

PATIENT; Falls etwas mit dieser Schleimhaut is-=

If there is something wrong with the mucous membrane-

HUSBAND; =<F>dann wird es dir gesagt</F> gracias, muchas gracias

then you will be told thank you, thank you very much

DOCTOR; So ~Emma will arrange now everything, [the doctor selects the patient at TRP] <L2=SPANISH> arré-glale todos los papeles de la medicación y luego ya arreglamos ### [the doctor simultaneously selects the interpreter at TPR] ((CONDESCENDING, ARROGANT, DEMEANING))

arrange-2SG-IMP all ~her paperwork regarding medication and then we arrange ###

INTERP; vale, perfecto, ¿qué le explico, el medicamento ###?

alright, perfect, what do you want me to explain to her, the medication?

[122] All personal details –including the patient's contact details such as the telephone number–, must be introduced into the electronic health record.

DOCTOR; <L2=SPANISH> <F> ↿ no, ↿ todo </F> o sea, quiero decir, n@o, que le arregles el proceso para que se identifique ya estando #los requerimientos los los consentimientos hechos y de allí ya vamos adelante ((CONDESCENDING, ARROGANT))

No, [I want you to do] everything I mean, [you have to] arrange the process so that ~the patient can be identified once the requirements have been fulfilled and the the informed consents [filled in] and from there we'll go ahead [with the treatment] [TRP] [dispreferred and unpredicted response]

INTERP; ⌋ vale###

alright

PATIENT; Letzte Frage weil ich ~Schilddrüse Probleme habe ich nehme auch ~Eltiroxin ist es auch wichtig für die ganze–

One last question since I'm suffering from a thyroid gland problem I'm also taking ~Eltiroxin, is that important for the whole–

INTERP; se está tomando el ~Eutirox porque: por el problema con el tiroides, ~hipotiroidismo

~the patient is taking the ~Eutirox due to a problem with the thyroid gland, hypothyroidism [TRP]

DOCTOR; it will be important for you to repeat the analysis ~T3 ~T4 and ~TSH before the next ~procedure [the doctor holds the floor, still choosing to communicate in English and selects the patient at TRP]

PATIENT; wie viel muss das sein ich habe-

how much should it be? I have-

INTERP; ja, genau, er hat gesagt bevor sie noch eine ~Behandlung haben ja? Vor der nächste ~Behandlung sollen sie eine Blutabnahme durchführen mit der Werte T3 T4 TSH [the interpreter self-selects to intervene to rest assured that the patient understands when[123] they should proceed with the thyroid function tests]

Yes, exactly, he said before you undergo yet another treatment yes? before the next treatment you must have a blood test to check T3 T4 TSH values [adjacency pairs failure, the question of the patient was dismissed by the interpreter, thus leading to unpredicted dispreferred answer]

DOCTOR; In one month from now repeat these analysis and let us know ((“US” IS REFERRING TO THE INTERPRETER OR THE INTERNATIONAL MEDICAL ASSISSTANT TEAM WHO IS BEING LEFT WITH THE RESPONSIBILITY TO ARRANGE THE TREAMENT))

INTERP; in einem Monat von diesem Tag an so ungefähr machen Sie diese Blutabnahme und geben Sie uns das Ergebnis davon durch oder rufen Sie uns an ((BY SAYING “UNS” THE INTERPRETER IS REFERRING TO THE INTERNATIONAL MEDICAL ASSISSTANT TEAM, WHICH AS INDICATED BY THE DOCTOR ABOVE WILL BE IN CHARGE OF ARRANGING THE WHOLE PROCESS))

Do this blood test in one month from now on approximately and send us the results or call us

Audio recording 3

DOCTOR; Now the ~nurse review the ~cannula to view what happened with the ~cannula […] ((I AM OMITTING ALL SENSITIVE INFORMATION)) [gap]

NURSE; Everything is fine doctor

[…] ((SENSITIVE AND IDENTITY REVEALING MATERIAL HAS BEEN LEFT OUT))

DOCTOR; Ok [good ~procedure] very good because [no pain no bleeding very good]

[no bleeding] very very #good now

PATIENT; [yeah yeah] [no no no no thank you]

[Ok thank you thank you yes]

[123] At what point of the treatment.

NURSE; go back a little bit=

PATIENT; =yeah

((BACKGROUND NOISE OF JANGLING MEDICAL INSTRUMENTS AND OF THE DOOR BEING OPENED AND CLOSED))

DOCTOR; Ok (4.9) #where do you #leave #live to Valencia?

PATIENT; #Sunday=

DOCTOR; [=Sunday? Very] good ok

PATIENT; [### ⌋ rest #til ⌋ tomorrow]

DOCTOR; ok today### [ok tomorrow] don't don- [worry] ### normal [life ok?]

PATIENT; [yes] [yes] [yeah]

<😌> thanks a lot doctor </😌>

DOCTOR; ready?@@@@@@

((BACKGROUND NOISE OF JANGLING MEDICAL INSTRUMENTS AND OF THE DOOR BEING OPENED AND CLOSED))

PATIENT; Thanks a lot thank you very [much]

DOCTOR; [yeah]

<L2=SPANISH> ⌊ le das entonces los datos a ~ella, ⌋ los:..

⌊ so will you give ~the patient the information, ⌋ the~ART. M. PL:..

[the doctor selects the interpreter by addressing her in Spanish, whereby the interpreter is obliged to speak, not others]

INTERPRETER; todo aquí

everything's here

DOCTOR; todo está [aquí]?

is everything here?

INTERPRETER; [todo] aquí

Everything's here

DOCTOR; copia your instrunction ok the same medicament and the proof is ~2 ~months[124]

INTERP; yes on the ~25 of ~May

PATIENT; thank you very much@@

((INTERPRETER PROVIDING MEDICAL INSTRUCTIONS DURING THE FOLLOWING 2 m. DUE TO IDENTIFICATION SENSITITVE INFORMATION THE TRANSCRIPTION THEREOF WILL NOT PROVIDED HEREIN))

Audio recording 4

DOCTOR; [...]The tissue of embryo is this, you can see the embryo, this is the *external membrane*[125], *peripheral cells, placenta*, the proper embryo... Your bladder how is <X a little or more X>?

PATIENT; More than the half

DOCTOR; Pain o no pain?

[124] All details such as idiolectal colouring and slips of the tongue have been preserved to demonstrate poor command of English language, which this doctor is trying to use as *lingua franca*.

[125] Please note the abundancy of Latinisms also referred to as terms in Latin in the doctor's discourse.

PATIENT; I'm good, my bottom, is it OK?

DOCTOR; <🙂No se preocupe🙂>... [dispreferred and unpredicted response in Spanish indicating that the patient's question remains unanswered] I put the *speculum*, <P very, very, very, very good P> relax... No pain? Now I clean and rinse the *mucus* and the *cervix* of the white *phlegm*... [...] You can see the *uterus*, bladder urine [sic], *cervical channel*, *endometrial cavity* near to the *fundus*... [...] Now clean the *mucus* of the *cervix* and rinse... <X Now I proof the.. proof X> Pain o no pain?

PATIENT; No pain

DOCTOR; [...] you can see the white shine / tʃaɪn /? [...] Now I <X view to review X> what happen with catheter, <X empty o no empty X>. Go back! [...] OK today tomorrow don't worry, OK, normal life... Les das los datos [the doctor selects the interpreter by addressing her in authoritative tone in Spanish] OK, instrunction / ɪn'strʌnk.ʃɒn / Ok, you're the same medicament / mədɪ'k.ʌ.mənt / and the prove in ~2 days

15.1.1.2. Discussion

A. *Professional MI's positioning challenged by imposed identity by institutional authorities*

All the conversational excerpts displayed above demonstrate that social actors in this particular context attempt to produce situational appropriateness, effectiveness and action coordination by uttering and interpreting the utterances of other social actors (Bergmann, 2004, pp. 296-297). The social interactants produce a "meaningful social order", a "social reality" which "real-izes" or materialises itself in everyday practice action, which in its turn constitutes an ever ongoing production of meaning attributions and interpretations (Bergmann, 2004). A reality is created where the interpreters who may be willing to position themselves as the actual interpreters and negotiate their role (see recording 1 and 2) end up matching their utterances to the context, thus demonstrating their context-sensitivity and creating this Garfinkel's "lived orderliness" (Bergmann, 2004, p. 297).

In terms of Bucholtz's and Hall's emergence principle (2005, p. 585), we can clearly see how MI's professional identity is totally a linguistic, social and cultural product of linguistic interaction. This final identity product "emerges [...] in local discourse contexts of interaction" (Bucholtz & Hall, 2005). The first audio recording clearly showcases that the identity as an "internal psychological phenomenon" or "a stable structure located primarily in the individual psyche or in fixed social categories" (Bucholtz & Hall, 2005, p. 586) does not really matter if it is not socially recognised. Please re-read carefully the following excerpt:

INTERP; (Hx) (THROAT CLEANING) he said that you have to take ~lidocaine today ~4 hours before you injec-= [the interpreter self-selects to speak to the patient, but finds herself interrupted by the doctor who yet again chooses to communicate in Spanish] [Unpredicted reaction of the doctor, dispreferred response]

DOCTOR; <L2=SPANISH> =<F> sí pero ahora se lo das</F> ⌋cuando ⌋salga [TCU, the doctor allows a lapse, yet the interpreter self-selects to justify previous intervention] [Unpredicted reaction of the doctor, dispreferred response]
yes but now them it give-2SG. IMP when walks-3SG SBJV out
yes, but you'll give it to ~her once ~she has walked outside ((the physician's office))

Please note that in this extract the doctor raises his voice, he basically yells at the interpreter, he is clearly irritated that she is wasting his valuable time by doing something she is expected to do afterwards: "=<F> sí pero ahora se lo das</F>". The interpreter's *a priori* self-conception, professional self-image and self-awareness mirrored in her behaviour is being constructed by the

interpreter, but it cannot be maintained as it gets contested, challenged and altered in the most suitable way by the doctor through a social action which is enacted, produced and enabled through language. Thus, it is not the interpreter's intentions or self-classification housed within her individual mind or in the internal mental state that matter, but the social meaning and social reality thereof achieved through dialogic interaction.

The manifestation of the interpreter's self-image gets instantly challenged, contested and altered by the doctor through this dialogic interactional discourse. The attempt to build her professional identity clearly fails as it is questioned and altered on social grounds. Its social meaning is different form the personal meaning that the interpreter gave her identity. Her self-image cannot be materialised, pragmatised and real-ized through dialogic linguistic performance, thus changing the socially accepted and assimilated meaning, as this meaning has already been deeply entrenched, fossilised and crystallised in/across the social and interprofessional conscience. The professional interpreter fails in the negotiation of her role and identity. She knows how to position herself, but fails to do so due to two major factors that absolutely need to be factored in this analysis: the doctor's authority and the secondary institutional sphere (medical facility).

The relevance of this finding increases when we realise that it is a qualified graduate interpreter we are talking about. Obviously, an underqualified and incompetent interpreter would not know how to position herself, as the fact that she lacks formal university education to attest to her knowledge could result in her feeling out of place and not being able to exercise her professional discretion and the task discretion properly and accurately. However, I am not sure about non-qualified amateurs having the "impostor syndrome" in its most traditional form (term coined by Imes & Clance, 1978).

In the case of MI in private centres of the VC one should distinguish and conceptualise the impostor syndrom in two different ways: the impostor phenomenon in professional interpreters and the impostor experience in non-professional layperson interpreters.

I would characterise the former in the following way:

- Professional interpreters are definitely a marginalised socio-professional group in the study-relevant geographical area.
- Therefore, the notion of the impostor syndrome may translate into a feeling that they ended up being hired and offered this role and positiondespite the fact that their occupation does not enjoy socio-professional prestige or social value. They may be haunted by the thought that this is a decent position that not all T&I graduates achieve, and therefore they must be grateful for what they have.
- They may feel as impostors and intriders because they practice in a "secondary institutional sphere" (Freidson, 2001), surrounded by practitioners belonging to the most established and privileged profession in the world, who naturally are at the very top of the professional and institutional hierarchy, and who are the authority.
- Professional interpreters may tend to think that they have no rights to express their opinions or advice on how to work with interpreters as a hospital is not their "primary institutional sphere" (Freidson, 2001).

- Due to the fact that the doctors are convinced that they can manage in English and choose to conduct the encounters with their patients in this language, they view medical interpreters as intruders who steal their limelight.
- Professional interpreters may fear to interfere by re-negotiating their role and re-positioning themselves because they see that nobody cares about their professional competencies, as they are viewed as mere dogsbodies with languages.
- Professional MI do have the right to practice and they may have the feeling that they belong in this sphere, but they may feel anxious to push the negotiation of their professional identity further for they fear to lose their job.
- Professional MIs may experience the urge to question certain behavioural patterns of other professionals and they may feel they need to negotiate their position in the professional interaction, but due to the impostor syndrome they feel their kind comments will be viewed by the secondary institutional sphere authorities as impertinent, gratuitous and uncalled-for.

The non-professional amateurs, on the contrary:

- Cannot be referred to as a marginalised socio-professional group, in that they are being hired even without any credentials and even preferred over professional MIs due to their alleged bilingualism.
- Some of them might feel like impostors because they know they do not deserve to work as MIs as they are actually occupying somebody's natural position, but the majority of layperson interpreters have the entitlement mentality as they do not realise that they have no right to practice because they are occupying another professional's niche.
- Layperson interpreters feel lucky that they found a job, they feel grateful and embrace all the tasks that have been entrusted to them. They feel honoured to be viewed as medical assistants. They perceive this role as a prestigious position and as a promotion.

The fact that physicians routinely work with unqualified interpreters may be related to how the physician treats the interpreter, and the poor interactive dynamic in the communicative encounter. The physician neither knows what a professional interpreter is, nor knows how to work with a professional interpreter, nor is interested in learning how to work with interpreters.

Unlike professional interpreters, amateurs do not feel the need to take a stand, or to negotiate their professionalism, they simply do what they are told without questioning anything or contradicting anyone. This is a huge advantage, as these private clinics and hospitals are not exactly looking to work with professionals in the field of translation and interpreting, but rather expect the employees to be their dogsbodies, who would never have the urge or the courage to renegotiate their professional identities as they are not even professionals in the first place. There is a huge difference in the perception of the same role (of medical/patient assistant): professional MIs perceive it as a role for dogsbody, whereas the layperson interpreters view it as a promotion and an honourable assistance and apprenticeship.

B. Power imbalance in the secondary institutional sphere

This is where power imbalance, professional hierarchy and authority inherent to this secondary institutional sphere and the reinforcement of the stereotypes, prejudices and inequalities come into play. As we have seen in Part I and Part II of this thesis, the profession of MI has not been recognised as such, and this along with the ideology of the doctors' superiority and deification explains why the interpreter's attempt to position herself as an important decision-maker and a professional who complies with the corresponding code of ethics[126] has eventuated in the interpreter's endeavour being a complete failure. The very fact that the doctor arrogates to himself the power to raise the voice and yell at the interpreter in an extremely inappropriate manner, in front of the patients and for no reason whatsoever just emphasises the salience of all-permeating institutional ethics and institutional rituals in stifling all endeavour to challenge these rituals. Such undialogized stance, attitude and tone highlight the importance to take into account that the sphere of activity of the MI does not allow him/her to change or even slightly influence the established social meaning and order.

C. *The hegemony of English*

The English language hegemony obviously helps in ousting, ostracising and alienating interpreters from their own domain of competence, competency and expertise. The interpreter wanted to claim ownership over this task and legitimise jurisdiction over this expertise, but unfortunately the social meaning of the concepts of "interpreter", "language", "fluent speaker" and "language proficiency", as well as the interpreters' role and identity do not allow them to reify their self-image. We must not forget the fact the doctors seek to "show off" their knowledge of English, because in Spain in certain circles those who do not speak English are looked down upon, which is yet another aggravating factor.

Medical encounter may not have such a ceremonial, conventional or prescriptive discourse as that used in the courtroom for instance, but it is still an institutionally marked, preordained and specific discourse. It is important to note that English is used in these encounters as the primary, diplomatic and vehicular language. In spite of the fact that none of the patients are neither native English speakers, nor proficient in this language the doctor insists in using English as a *lingua franca*. This according to Besnier (2004, in Bucholtz and Hall, 2005, pp. 590-600) views entire linguistic systems as salient ideological ramifications. As in the example provided in Besnier (2004) the market seller still uses English even though the buyer keeps using Tongan, thus trying to fall into the identity category of modern and cosmopolitan.

In our case English language is also indexically tied to an identity category. The language choice in this case plays an essential role in categorising the doctor's professional identity as internationalised, internationally experienced, sophisticated, fashionable, reaching out to each and every patient despite language barrier, keeping abreast of the latest cutting edge technologies in the sector as most of the medical advances nowadays are published in English (Navarro for IntraMed, 2010). Self-rated language proficiency can definitely improve doctors' employability, as they are "competing [...] and struggling to improve their status by new acquisitions", such as self-

[126] Interpreters will select the language and mode of interpretation that most accurately conveys the content and spirit of the messages of their clients (IMIA, 2006).

assessed language proficiency, "or the relinquishment of less attractive properties" (Hughes as cited in Dingwall, 2016, Introduction section, § 10-12). These "less attractive properties" include in our case the duty to provide the patient with thorough medical information concerning medication administration, procedures they have been advised to undergo, informed consents, and the like.

In the same vein, the implicatures and presuppositions used in indexicality may be subtle, but very telling. It does not require much additional inferential pondering to get the correct interpretation of the pronoun "we" used by the physician, because at the end of each extract it is the interpreter who proceeds to provide further details on the procedures. It is my contention that by saying "we" the doctor wants to include himself physically in this a posteriori explanation, so that it does not sound as atypical, unorthodox, unexpected or absurd.

D. Plurilingual factotum with medical responsibilities

The following excerpt, belonging to the second audio recording, showcases that neither the professional category being assigned to the MI –which, as I have already mentioned in the previous chapters, is that of "auxiliar administrativo [administrative assistant]"–, nor the 1000 -1200 € salary (roughly according to Angelelli, 2015, pp. 73-74; Varela, 2019) correspond to the volume and the complexity of assignments that this administration assistant is expected to fulfil:

INTERP; vale, perfecto, ¿qué le explico, el medicamento ###?

alright, perfect, what do you want me to explain to her, the medication?

DOCTOR; <L2=SPANISH> <F> ↿ no, ↿ todo </F> o sea, quiero decir, n@o, que le arregles el proceso para que se identifique ya estando #los requerimientos los los consentimientos hechos y de allí ya vamos adelante ((CONDESCENDING AND ARROGANT))

No, [I want you to do] everything I mean, [you have to] arrange the process so that ~the patient can be identified once the requirements have been fulfilled and the the informed consents [filled in] and from there we'll go ahead [with the treatment] [TRP] [dispreferred and unpredicted response]

The very fact that the language professional is present at the encounter only and exclusively to "explain medication", procedures or bureaucratic details thereof, informed consents, etc., even though doctors in all four recordings proved to struggle greatly with some basic English grammar and lexicon (esp. rec. N°3), indicates that interpreters have not been hired on the basis of their interpreting skills or for their interpreting competencies. Interpreters have not been recruited to enable and facilitate communication using their interpreting and mediation skills, which is something that is definitely needed, but to use their self-declared bilingual language skills to carry out routinised, repetitive and more time-consuming part of the encounter. The doctor gives basic treatment directives and guidelines in Spanish so that the interpreter can proceed to explain, arrange and organise this treatment.

It is evident that in all four recordings the patients end up leaving the consultation without knowing what to do. Thus, the knowledge underlying the whole process of interpreting is being debased and dismissed as unnecessary, when it is in fact very necessary. Proper interpreting service is essential to guarantee patients' statutory right and entitlement to medical information enshrined in Spanish legislation. This knowledge is de-mystified and de-specialised. Consequently, according to relationality principle (Bucholtz & Hall, 2005) professional identity cannot be viewed as an autonomous and isolated psychological phenomenon, but as an intersubjectively

negotiated or enforced relational phenomenon, whereby a professional is framed as somebody a) in accordance with the identity category being allocated and assigned to them b) always in relation to somebody else, for instance another professional.

The doctor uses an overt mention of the interpreter's name ("So, Emma will arrange everything [...]"), then proceeds to alternate languages and switches to Spanish to address the interpreter in an authoritative tone and imperative mood: "arréglale los papeles". This indicates that there is a clear ideological "process of indexical inversion" (Inoue, 2004, in Bucholtz & Hall, 2005, p. 596), whereby "indexical associations" are "imposed from the top down" in this case by professional and institutional authorities, although this can also be done by "cultural authorities, intellectuals or the media" (Bucholtz & Hall, 2005). This "imposed indexical tie creates ideological expectation among speakers" (Bucholtz & Hall, 2005). In this case the doctor expects the professional interpreter to take on the role of a subordinate, inferior dogbody. If we focus on "phonology" and "language choice" (Bucholtz & Hall, 2005) as the linguistic form in question, we will see that English language is associated with prestige and self-sufficiency of the doctor, and Spanish is used to give internal institutional orders. The authoritative tone underscores the doctor's association of the identity of professional MI with a dogbody identity. Thus, there is a clear "semiotic link between the linguistic form and social meaning". The doctor "disaligns" (Bucholtz & Hall, 2005) his identity with that of interpreter and positions his professional identity as superior in juxtaposition to the socio-professional category of MI.

E. False fluency

This third excerpt just corroborates that the concept of "false fluency" (Cox & Lázaro, p. 40) has not acquired a social meaning yet in the study-relevant region. The doctor tries to communicate, but their command of the English language as well as their articulateness, eloquence, oratory and fluency of this language leave much to be desired. But the interpreter, who was present all the time, did not dare to correct the doctor, and unlike in the previous extracts, she embraced the fact that she needs to explain the information to the patient after the procedure has been completed. Thus, if in the previous two cases the interpreter tried to negotiate her professional identity and to position herself as a language professional, in this third case she just came to embrace the social meaning of her job, role and professional identity. She may have idealised her professional identity, but she cannot materialise it as the same undialogised tone is mirrored in all four excerpts:

DOCTOR; [yeah]
<L2=SPANISH> ↓ le das entonces los datos a ~ella, ↓ los:..
↓ so will you give ~the patient the information, ↓ the~ART. M. PL:..
[the doctor selects the interpreter by addressing her in Spanish, whereby the interpreter is obliged to speak, not others]
INTERPRETER; todo aquí
everything's here

The fourth recording is also a clear demonstration of the notion of "false fluency" (introduced by Cox & Lázaro, 2016, p. 40) not being interiorised by the relevant social actors in the study-relevant geographical context. The transcription of the fourth recording is quite self-explanatory.

The profuse and overflowing use of Latinisms otherwise referred to as terms with etymologically Latin stems, abundant linguistic errors (including first language interference, pronunciation, grammar, vocabulary, lexicon choice, etc.), automatised use and repetition of routinary phrases that have been committed to memory, excessive use of "okay" as both acquiescence adverb and interjection are all showcasing poor language command. Apart from all the linguistic errors ("Your bladder how is a little or more?"; "the prove"; "bladder urine"; "I proof the proof"; "view to review", etc.) the patient's question remained unanswered because the doctor answered it in Spanish, although he showed a (reassuring?) smile. As we have already seen in the previous recordings, the doctor also addresses the interpreter –who was, by the way, present during the entirety of the encounter– in Spanish in an authoritative tone, using the second person singular, when the doctors would normally require to be addressed formally and respectfully by the utilisation of the tonic grammatical pronoun "Usted" in the third person, which implies a deferential detachment, politeness and formality.

F. Conclusion

The professional identity of many interpreters in the study-relevant geographical area have emerged from the very specific conditions of linguistic interaction or "dialogic linguistic performance [...] built, maintained and altered on social ground" (Bucholtz & Hall, 2005, pp. 587-588). In my opinion, these extracts demonstrate how the "psychological mechanism of self-classification" mirrored in social behaviour has no importance if it has not been discursively constructed (Bucholtz & Hall, 2005). The doctors' language use in all four cases has shown that they do not conform with the social category to which interpreters are normatively assigned.

MIs in their turn also displayed their nonconformance with the category of assistant undertaking medical tasks, but given the fact that this social interaction is taking place in a secondary institutional sphere (Freidson, 2001), where doctors are at the top of the hierarchy pyramid, and given that they have been employed by a private facility to do that they are asked to do they need to yield these interactional demands. Also, due to the institutional sphere and ethics, doctors may treat interpreters condescendingly (as displayed in recording Nº 1 and 2). Due to the "dominant social ideology" interpreters have been even devoid of their designation and are now being called "translators" unofficially and "administration assistants" officially.

Now this specific linguistic form has acquired a naturalised association with this specific social category, and in my opinion it is going to be very difficult to change this interconnection unless this occupation becomes fully professionalised. According to the positionality principle –described in Bucholtz and Hall (2005, p. 591)–, this new hybrid identity has emerged "in discourse through the temporary roles and orientations assumed by participants". Thus, according to the personal communications of several interpreters, who did not consent to be audio recorded, at the beginning of their careers, which started approximately 20 years ago, they were not asked to carry out medical tasks, but due to the fact that they went assimilating and embracing their (at that time temporarily!) roles of co-diagnosticians and co-therapists, these roles went from "local categories of identity" to "large-scale categories of identity", thus having metamorphosed form "temporary and interactionally specific stances and participant roles" to "macro-level" (Bucholtz & Hall, 2005) professional category.

With respect to the partialness principle, I would like to highlight the "fragmented nature" of the construction of identity: on the one hand the agency used by the interpreter to negotiate her tasks and role is exercised in individualistic action, but it gains meaning and carries implications only when this individualistic action is intersubjectively acceptable and co-constructed. In these cases interpreter's agency clashes with the doctors agency, which was "assigned through ideologies and social structures" (Bucholtz & Hall, 2005). These ideologies and social structures grant doctors the freedom to treat other professionals from their primary institutional sphere as subordinates. These processes may be conscious and intentional as well as subconscious and habitual, but it is usually the mélange of negotiation, perceptions of others and ideology.

I believe that presenting excerpts from my own harvest (collected in Valencia in 2015-2019) along with the excerpts from a documentary (shot in Madrid in 2016) supports the assumption that the phenomena taking place in all of the excerpts, if not 100% generalisable, are still (in the process of becoming?) a commonplace reality and a procedural convention across the country. In this case my research produced a "factual result" (Bergmann, 2004, p. 298), because these are not just a couple of isolated "irretrievable past social events" (Bergmann, 2004, p. 299) being reconstructed for the purpose of this study, but a self-evident, normalised practice happening on daily basis in an conventionalised, prescriptive and "institutionally marked form of communication" (Bergmann, 2004, p. 298). But even though it is still a preordained discourse as opposed to other trivial "extrainstitutional type of communication" (Bergmann, 2004, p. 298), a medical setting is not as "ceremonially marked" and is not as "canonical" and orthodox in character as a court hearing or a religious service (Bergmann, 2004, p. 298).

And we can see that there are serious irregularities and deviations from the conventional way to conduct medical consultation. Without any "stimulus" from the researcher or "experimentally induced behaviour" to elicit desired results, we see how interactants in their more or less natural habitat "cooperate to achieve in a fixed time and place intersubjectively determined constructions of reality" (Bergmann, 2004, p. 299). By reading the unpurged raw material of these excerpts one may witness a "local production of a social order" (Bergmann, 2004, p. 299). The transcripts denote social and institutional hierarchy and tendency to listen to the doctor manifested through scarce overlaps, rare latched utterances and manifold response tokens. In recording 1 the positioning struggle between the doctor and the interpreter is clearly visible. The doctor was conducting the consultation in English with patients whose native tongue in not English. The doctor was visibly struggling to understand whether the patient managed to buy the required medication at the pharmacy, but still he chose to use English as lingua franca throughout the consultation.

The fact that doctors practicing in Spain can conduct their consultations in English whenever they choose to on the basis of their high self-reported level of English language proficiency is of course one of the major problems that underpin the conundrum of hybrid profiles in the study-relevant area. Diamond et al. decried the dearth of studies on the relationship or the correlation between self-rated and self-reported and tested language proficiency among medical professionals. The authors contend that:

> No prior studies have attempted to assess clinicians at all levels of the non–English-language proficiency spectrum. Structured, validated tools are used less commonly outside of research. Written proficiency tests may not successfully assess oral communication ability. Bilingual staff assessment

> interviews are also used, but generally without a validated tool. [...] [tests] most evaluated interpreting skills, not direct patient-clinician interactions. [...] Health care organizations could use the adapted ILR to screen clinicians who wish to use their non–English-language skills with patients. Those at the lower end should always use professional interpreters. Those at the higher end may be able to use their own non–English-language skills without proficiency testing. Both groups should document their use of interpreters or their own skills in the patients' records. (Diamond et al., 2014, p. 437)

The doctor could have himself explained the medication administration in English, but instead he chose to indicate the type of medication in Spanish addressing the interpreter as a medical co-worker or a fellow practitioner.

The crux of the matter is that he "instrumentalises" and empowers the interpreter to operate as a nurse, as his "extension" or "duplication" (Hsieh, 2010, cited in Hsieh & Kramer, 2012, p. 158 assuming his duties, role and function) once they have exited the consultation. He enacts the interpreter's identity as a fellow practitioner, but by starting to convey the message in English for the patients, the interpreter is negotiating her identity and positions herself as a professional interpreter, however she gets interrupted abruptly by the doctor who is almost yelling at her (=<F> sí pero ahora se lo das</F> ↓cuando ↓salga [yes, but you'll give it to ˜her once ˜she has walked outside ((the physician's office))]).

By doing this the doctor wields his authority, his goal is to compel respect and compliance. This utterance demonstrated that even though on first examination the doctor seemed to address and position the interpreter as a fellow practitioner (so as to have her providing the medication instructions outside the consultation), he actually views her as a subordinate personnel, a secretary, a nurse or an auxiliary nurse. Even though the audio recording does not furnish the opportunity to examine the paralinguistics (eye contact, nodding, facial expressions, etc.), some transcription symbols still allow to signal prosodic elements such as the tone and the intonation of the utterance, in this case the loud tone undergirds the authoritative character of the doctors request.

Same sequence of utterances and events can be observed in the second recording. The doctor used English as lingua franca throughout the consultation, then addresses the interpreter in Spanish (So ˜Emma will arrange now everything arréglale todos los papeles de la medicación) positioning her as his medical assistant, auxiliary nurse, nurse, etc. The interpreter accepts the doctor's view of who he wants her to be and the way in which he seeks to position her by his design. The interpreter made an attempt to contest this imposed hybrid identity (vale, perfecto, ¿qué le explico, el medicamento ###? [alright, perfect, what do you want me to explain to her, the medication?]), but she ended up accepting this innovated or newly gained professional identity, which was being both construed and constructed at the same time.

The interpreter was left with no choice but to comply and agree upon the new label of multilingual assisstant who does multitasking (que le arregles el proceso para que se identifique ya estando #los requerimientos los los consentimientos hechos y de allí ya vamos adelante [[you have to] arrange the process so that ˜the patient can be identified once the requirements have been fulfilled and the the informed consents [filled in] and from there we'll go ahead [with the treatment]]). The third recording follows the same pattern. If the English language command of the two previous doctors was limited, we can see that the third doctor struggles to even formulate the most basic (in terms of grammar and lexicon) sentences. Still he also choses to conduct the

consultation in English and rely on the interpreter to further work with the patient after the consultation is over.

These data indicate that interpreter's role and professional identity has been hybridised to form new breeds of auxiliary staff and new breeds of hospital assistants. I believe that such hybridisations of profiles and professional identities has been an academically neglected area in the field of technical translation and interpreting. Hsieh in her seminal work *Interpreters as co-diagnosticians: Overlapping roles and services between providers and interpreters* (2006) and Hsieh and Kramer (2012) in their paper *MIs as tools: Dangers and challenges in the utilitarian approach to interpreters' roles and functions* have addressed the gap in knowledge regarding the instrumentalisation of MIs for purposes other than interpreting or meta-interpreting, but it is my contention that multi-purposefulness of interpreters/multilinguals is not a very well documented occurrence in the context of medical tourism in Spain. Other authors (Lleó & Torroba, 2014) do address the market demands in interpreting against the backdrop of medical tourism, but they neglect to delve deeper into potential socio-psychological rationale of such socio-professional processes. The two major phenomena that I would like to unpack are:

- The fact that the interpreters have been present during the above examined encounters, but they never got the chance to actually interpret because all four doctors were sure that using English as *lingua franca* would be the optimal solution. As shown in the transcription, the physicians' self-assessment of their linguistic skills is overestimated and hyperinflated, but they are in their primary institutional sphere and therefore the interpreter needs to comply with the institutional ethics of their secondary institutional sphere if they want to preserve their job. Moreover, as showcased in the second audio recording, by persisting with English as *lingua franca* despite inability to convey his message properly, the male doctor a) marginalises his German-speaking patient and excludes her from the conversation; b) disregards her linguistic needs; c) disenfranchises and decapabilises the patient by overturning patient power and right to decide and strengthening paternalistic approach to healthcare; d) acts as information gatekeeper; e) dismisses and disrespects the interpreter and her role; f) triggers irritable behaviour of the husband who abruptly interrupts his wife dismissing her questions; g) challenges fiduciary duty and morality as well as civic professionalism as he show himself oblivious to the patient's welfare.
- The dichotomy between two major components of the MIs' professional identity: the interpreters' professional image (during the consultation) and the tasks they are expected to carry out (outside the consultation). In consideration of the foregoing, interpreters can be yelled at by the doctor, brought into disrepute by the doctor, patient or family member, tolerated rather than welcome, professionally invisible as they have to squeeze themselves into a corner, often marginalised by bilingual family member, lacking appropriate infrastructure within he facility and the premises thereof (computer, place to sit down and lean the arms and the notebook on, etc.). Under different circumstances/in different contexts, however, interpreters may end up replacing the doctor when explaining the course of procedure or the informed consent. The position and the location of the interactants on the following picture is quite self-evident. On

the first image we see the interpreter, who has assumed the role of a doctor and is explaining the procedure to the patients in a dyadic communication (00:07:42). This is the purest form of profile hybridization, where the interpreter is seen replacing the physician during the a number of essential stages of the medical encounter: pre-consultation part, anamnesis, discussion, decision-making and even action planning. This is why the doctor in recording nº2 explicitly stated: "=<F> sí pero ahora se lo das</F> ⌊cuando ⌊salga [yes, but you will give it to her once she is outside/when the consultation is over]", referring to the post-consultation counselling. Apparently, interpreters who work in these contexts have to re-invent their professional self and broaden, hone and display a different set of skills encompassing clinical competences, which should in principle be attributed to the doctor: active listener, good communicator, conscientious, vigilant, skilful in building therapeutic rapport, empathetic, inherently curious, never condescending or arrogant willing to help navigate the healthcare system, good bedside manner, etc. I was struck by the very fact that it was the interpreter who has been assigned the task of working with the RTVE Comando Actualidad film crew and answering a number of questions about the price of the treatment, pregnancy rate in this particular case, embryo transfer preparation guidelines including medication intake, etc. On the second image, however, it is shown that the interpreter is now facilitating communication rather than conducting communication. Please notice the difference between the first image and the second: on the first screenshot the interpreter, who was performing the role of a doctor, had a desk, a chair, an office and a computer at her disposal; on the second screenshot, the interpreter is standing near the ultrasound machine, observing the images, listening carefully to the doctor's utterances, who is now the centre of attention, and interpreting.

Figure 42. Interpreters and dyadic communication. Image extracted form RTVE Comando Actualidad

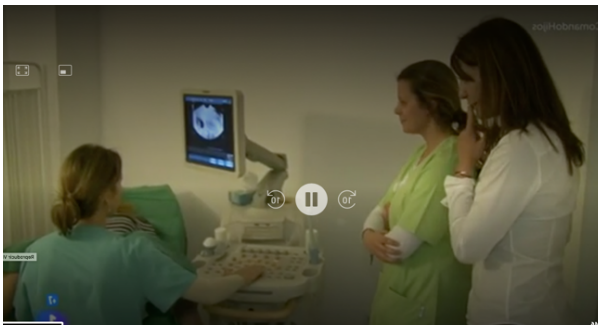


Figure 43. Interpreters and triadic communication. Image extracted from RTVE Comando Actualidad (2016)

15.1.2. Multimodal critical discourse analysis and social psychology

The Multimodal Critical Discourse Analysis is a socially deterministic approach subsumed under the discipline of Social Psychology. The concept of multimodality, which implies analysis of metaverbal signs and sign values (visual materials), is extremely important as it will possibly facilitate an explanation of the phenomena in question from yet another methodological perspective.

Denzin (1995, p. 52, in Burr, 2003, p. 18) and Hughes (1958, p. 90, 96, in Paterson, 2016, Becoming a Judge chapter, Ancillary Problems section, § 7) view these types of visual text materials as important visual signals carrying messages. Visual materials may be perceived as particularly complex texts, even though in this case these visual texts have not been previously or intentionally orchestrated or prepared, but rather depict spontaneous behaviour and role of interpreters during medical encounters. I shall be focusing on the "the backgrounding or 'automatization' (Halliday, 1982) of [...] semiotics, to the point where they appear so normal and natural as to become 'invisible'" (Iedema, 2003, p. 40).

I have retrieved the video materials from the documentary television program – *Tener o no tener hijos – Tratamientos fertilidad* (Comando Actualidad, 2016). This documentary programme was broadcast on national television in Spain in 2016, and it covered the fertility treatments being carried out in Spain within the context of medical tourism. It featured patients from Germany and France undergoing a series of procedures in a fertility clinic. This documentary programme televised the process that patients would normally go through during their holiday in Spain in order to pursue pregnancy. The term "all-inclusive holidays" acquires a new meaning in this case, in that it includes the pregnancy the patients were longing for.

Apart from the MCDA, this section will also include an introductory analysis of the study-relevant dialogue excerpts extracted from the documentary, which may shed light on and complement the situations displayed in the audio recordings used the Conversation Analysis. Although the medical centre in my case study might not necessarily pertain to the same classification, typology or categorization as the clinic featured in the documentary, it does display very well the role and identity of the interpreters who work there both inside and outside the consultation, and interestingly these conduct patterns and duties coincide in both cases. I shall start this section with the transcription of the most relevant segments of the video, whereafter the multimodal analysis will ensue.

In this first extract the multilingual worker is identified and classified as a "contact person in charge of guiding the patients", she is viewed and interviewed as somebody who is knowledgeable up to a certain extent and well versed in the field of IVF. She certainly possessed specific expert knowledge and the knowledge of the case.

<T=00:54:10>

JOURNALIST;	Eres la encargada de conducir, de estar en contacto con los extranjeros que vienen de vacaciones aunque buscan en este viaje el gran sueño ser padres cierto? You are the person in charge of guiding [the potential patients] of keeping in touch with the foreigners who are holidaying although during this trip they seek to fulfill the big dream of becoming parents, right?
INTERPRETER;	(H)bueno@, sí@

	Well, yes
JOURNALIST;	Cuánto les supone a ellos llegar hasta aquí para hacer este tratamiento o sea cuánto les cuesta?
	How much does it take to reach this stage of treatment, I mean how much does it cost?
INTERPRETER;	bueno un tratamiento de recepción ovocitaria cuesta normalmente 6.300€ y cada caso es un poco distinto porque cada pareja a lo mejor tiene más técnicas extras, unos casos distintos que necesitan un apoyo más especial
	Well an oocytes reception [egg donation] treatment costs normally £6.300 and each case is a little bit different because probably each couple needs more extra techniques to be applied, [there may be] different cases where a more special support is required
JOURNALIST;	Esta es la primera visita el primer contacto ¿no? cara a cara
	This is the first visit the first contact, right? Face-to-face
INTERPRETER;	No eso no es la primera cara los pacientes ya han venido aquí en la clínica porque han tenido que dejar una muestra el día de la punción de la donante la ley en Alemania no les permite un tratamiento que hacen aquí que es la recepción ovocitaria pero
	No this is not the first face [visit], the patients have already been here in the clinic because they had to provide a sample on the day of the donor's egg retrieval. According to German legislation it is strictly forbidden to carry out the treatment that they are undergoing here [with us] which is the reception of oocytes
JOURNALIST;	donación de un óvulo
	Egg donation
INTERPRETER;	Exactamente
	Exactly
JOURNALIST;	no se permite allí?
	Is it not allowed there?
INTERPRETER;	no en Alemania no es permitido absolutamente no entonces cuando ellos se han informado un poco en Europa en general en cuáles países se puede hacer fue España lo más atractivo
	No, it is absolutely forbidden in Germany. So after seeking information about what European countries they could travel to in order to get this treatment done, Spain turned out to be the most appealing to them.

Judging from the fact that the clinic administration lets this interpreter be the protagonist of the first 15 minutes of the documentary, one can surmise that the private clinic seems to recognise her role and her professional identity, even though she does not speak proficient Spanish. In spite of producing an error-ridden discourse in Spanish (including grammatical, lexical, syntactic, etc. mistakes patent in the original version in Spanish), her professional function as Spanish interpreter is still acknowledged. The English translation does not mirror these inaccuracies since the function of the translation was to facilitate understanding and not to make it more difficult. The following extract showcases that this profile must have been institutionalised due to the fact that the grantors of the service must have construed such hybridisation as "beneficial" in terms of time-saving. This theoretic speculation finds its substantiation in the following extract:

<T=00:55:20>

Next scene shifts to an office where the German-speaking person, who has a duty of care to these patients, in other words, she is the one in charge of guiding the patients throughout the

process, is giving the instructions for the embryo transfer without any doctor or other medical worker being present at the consultation.

<T=00:55:24>

INTERPRETER; Also Sie wissen ja am Donnerstag findet der Transfer statt

So you know already that the transfer will take place on Thursday

JOURNALIST; Me imagino que estás dando las pautas pertinentes para que en dos días ella venga preparada, relajada para esa transferencia de óvulos.

I presume that you are providing the patients with the relevant guidelines so that she comes prepared and relaxed for the oocyte transfer which is due in two days

INTERPRETER; Las indicaciones que tiene que tener en cuenta de su medicación y que tiene que tener un poco la vejiga llena para que es más fácil hacer #la #transferencia

[These are] instructions that [the patient] has to take into account regarding her medication and [the procedure requires her] to have a moderately full bladder in order to make it easier [for the doctor] to carry out the transfer

JOURNALIST; Ah, sí Imagino que hasta llegar hasta aquí han hecho una singladura importante. Habrán intentado más medios

Right, I presume that they must have had a long journey before they have reached this point. They must have tried other means

INTERPRETER; Saben que tienen la edad que tienen y que en su edad ya el reloj realmente ya se ha ido para ofrecer sus propios ovocitos. Entonces fue una decisión muy concreta, sabiendo que si quiere embarazarse que tiene que ir el camino por la recepción ovocitaria.

They are aware that they have certain age and when it comes to this age time is up and the patient can no longer offer her oocytes. So they made this very concrete decision knowing that if she's determined to become pregnant she must go for Reception of Oocytes

JOURNALIST; Ah o sea este es el primer intento, ¿no? ¿Qué edad tenéis si se puede saber?

So this is their first attempt, right? May we ask how old are you?

INTERPRETER; Dürfen wir fragen wie alt Sie sind?

May we ask how old are you?

PATIENT Nº 1; Ja, ja klar, ich bin 46

Sure, I'm 46

INTERPRETER; Yo tengo 46 años

I'm 46

PATIENT Nº 2; Ich bin 45

I'm 45

INTERPRETER; Yo tengo 45

I'm 45

JOURNALIST; ¿Se sabe cuántos embriones #se le van a implantar?

Do we already know how many embryos is she going to get implanted?

PATIENT Nº2; zwei

Two

INTERPRETER; Sí se han decidido a transferir dos embriones que va a tener una mejor tasa de embarazo. La clínica solamente transfiere dos embriones porque el riesgo sería muy grande de que realmente tres embriones se podrían implantar pero solamente de lado de la ley en España se permite transferir hasta tres

Yes the decision was made to transfer two embryos which allows for a better pregnancy rate. The clinic would normally transfer only up to two embryos because otherwise the multiple pregnancy risk would increase since actually all three embryos may end up implanting even though Spanish legislation allows to transfer up to three embryos

JOURNALIST; Y la tasa de éxito que ellos también se preguntarán de cuánto es?

And, as they must be wondering as well, what is the success rate?

INTERPRETER; Sí con dos buenos blastocistos podemos alcanzar hasta 70%

Yes with two good blastocysts we can reach up to 70%

<T=00:56:50>

The contact person in charge of guiding the patients through the treatment provides an explanation on the case and even a prognosis for success in this case. Apparently, this is rutinary task, that may be too time-consuming and repetitive for the doctors. Thus, they "relinquish" the "less attractive properties" of their work by allocating them to this newly emergent figure (Hughes as cited in Dingwall, 2016, Introduction section, § 10-12). The ability to undertake these clinical tasks adds "immediate functional value" for this position (Freidson, 2001, section 7, subsection The Contingencies of Knowledge, § 4). This hybrid identity is therefore being "invoked" by the employers as market demands are "oriented" towards polyvalence, while the traditional construct of "interpreter" is being rather "subverted" and "ignored" (Schegloff, 1997 as cited in Edwards and Potter, 2001, p. 2).

Next scene shifts to the corridor. The German-speaking person who is in charge of the patients reports to the doctor about the arrival of the patients whose transfer is due to take place on that day.

<T=01:02:29>

JOURNALIST; Y cuántas coordinadoras tenéis soléis trabajar en la clínica?

So how many coordinators are there in this clinic?

INTERPRETER; Somos nueve coordinadoras

It is nine of us

JOURNALIST; Nueve coordinadoras, seis idiomas. ¿Y los más demandados? O sea cuál es la nacionanlidad que más viene aquí?

Nine coordinators, six languages. ¿and the most requested ones? I mean people belonging to which nationality come here the most?

DOCTOR; Actualmente el mayor volumen es de Francia, pero tenemos bastante volumen también de Alemania, Italia y de Inglaterra

The largest amount of patients comes from France, but a considerable number of patients also comes from Germany, Italy and England.

<T=01:02:49>

So, nine coordinators combine their bilingual language knowledge and skills with certain dose of medical expertise (types of treatments, success rates in specific cases, instructions for certain procedures, etc.). Obviously, the acquisition of medical knowledge, even if it is done by the in-situ shadowing, means esoterisation and mystification of expertise. This leads to the establishment of the professional charisma similar to that of medical professionals (due to shared

knowledge), and all the factors set forth above translate into the occupational recognition in a very concrete institution. However, in this case this recognition occurs only due to the vested interests of both the grantors (administrative assistants' fees are lower than doctors' fees) and the receivers (doctors who instead of wasting their time building rapport are carrying out more profit-making procedures). Subsequently, this type of recognition does not necessarily translate into a higher status, prestige, remuneration and perks.

The following MCDA has been conducted within this context. The MCDA affords yet another perspective from which the current situation can be deconstructed. The opening sequence [00:00:36] of the documentary starts with a call centre agent answering the incoming phone call in French. This foregrounds the transcendence of the phenomenon of reproductive tourism in Spain, the salience of cross-linguistic communication in this particular business sector and the importance of having employees who would bridge the gap between the clinic and the customer. This call centre agent epitomises one of the newly emerged hybrid profiles: customer service manager/ information desk manager/ receptionist/ secretary plus self-reported/self-rated bilingual/ multilingual person/ professional translator/interpreter (Translation and Interpreting graduate). The uniform that the French-speaking agent wears resembles a uniform worn by the hotel employees[127].

Figure 44. Uniform example 1

Figure 45. Uniform example 2

[127] For more information about uniform typology worldwide, please check this article: https://en.wikipedia.org/wiki/Uniform

The shot is close, but I do not think that it has a strategic meaning in this particular context. Her use of foreign language, manner, gestures (smile) and the background music performed by an Argentinian ska[128] band[129] certainly has hotel-like vacation vibes, it is relaxing and inviting. In the very first sequence [00:00:00 – 00:00:35] the listener is introduced to the fact that Spain is a world leader in reproductive tourism, which has two major components: pregnancy (dream to become parents) and vacation (wellness, relax). So the message is basically 'dreams to become parents come true while having a wonderful time on holiday'. The next sequence features a young woman wearing green scrubs (theatre blues). She opens the door and greets the patients in German. This outfit differs greatly from the attire worn by the young woman in the second sequence. Even though both are allegedly bilinguals, polyglots or fluent users of foreign languages, they have different identities, roles, outfits, positions and prominence throughout the episode. Obviously the scrubs or the theatre blue instantly and without even knowing who this person is transmits the important, more sophisticated and certainly much more imposing bearing. The first young woman is perceived as a hotel or office worker, administration and bureaucracy being her main fields of activity, whereas the second lady was instantly perceived as a medical worker, a nurse for example (although, the coordinator's scrubs has a slightly different shade of green when compared to the scrubs worn by the doctor).

A clear analogy can be drawn in my opinion between the office worker appearance, a hotel manager or receptionist and a flight attendatnd, stewardesses or hostesses ("azafata") described by Angelelli (2015) and Ortega-Herráez and Blasco-Mayor (2018, pp. 189-190), who decry the absurdity of some tasks that the hostesses were told to undertake: "the placement and removal of DVDs, delivery of free press, [...] watering the plants, calling ambulances, delivering medical material or heating feeding bottles". I know –drawing on my own professional experience– that sometimes (if not always) the secondary tasks may include the following assignments: escorting patients and family members across the facility and its premises; providing the admitted patients on the ward with some extra blankets and extra pillows, as well as with newspapers, magazines, books, remote controls, etc., finding the TV channel that the patient wants to watch; commenting and discussing the news in the press; sight translating menus for each patient individually and informing the kitchen of the patients' culinary choices and preferences as well as food allergies; switching on and off the air conditioning regulating the optimal temperature; putting patients' personal belongings into the safe; and acting as a quasi-psychologist comforting and counselling patients and their families *inter alia*. If we pause to ponder and reflect on these tasks we will notice that the typology of these tasks are extremely similar to the career profile and the role of a flight attendant in terms of ensuring comfort of the patients in the same way as a flight attendant would ensure comfort of airline passengers.

It is worth noting that the workplaces are also extremely different: an information desk or a call centre for example, denotes lower specialisation as it is more about being a good looking smiling person, who carries out basic administrative tasks, whereas a separate medical office is like a "holy of holies" where patients confide their most personal concerns with the doctor.

[128] Originated in Jamaica, this music genre combines Afro-Caribbean rhythmic elements, American jazz and blues. For more information, please visit: https://en.wikipedia.org/wiki/Ska

[129] Full article on this band is available here: https://en.wikipedia.org/wiki/Los_Fabulosos_Cadillacs

It is worth noting that linguistic expertise required for a call centre position is more limited than the expertise required for the position of "coordinator"; and it is absolutely clear when we observe the socially and professionally situated identities of both employees reflected through the use of a foreign language, particularly their accents and their ethnic background and/or nationality. I believe an observative listener can notice that the lady answering the phone in French has an accent in this language, which is a clear indicator of the fact that she may not be a French native speaker, whereas the lady greeting the patients –the one in charge of liaising between the patient and the clinic, coordinating the treatment process and providing guidelines– has a typical German accent in Spanish, which clearly indicates her German origin. According to Moreno Muñoz (2002, pp. 212-122), the correct pronunciation of some of the Spanish diphthongs (e.g. [ei], [ey] and [eu]) poses problems for German speakers because graphically they are the same as some German diphthongs and the learner suffers a clear interference which in the case of some diphthongs is difficult to eliminate. This is clearly audible in [00:01:10]. In [00:01:36] we can hear how the coordinator says "los pacientes ya han venido aquí *en* la clínica", which means that this person has retrieved the wrong preposition, because "a la clínica" would have been the correct option. Last but not least, the German-speaking coordinator said "para que es más fácil hacer la transferencia", when a native Spanish speaker would have used the subjunctive mood: "para que sea más fácil" [00:02:24].

This clearly demonstrates that bilingualism or being a native speaker of the foreign language in question is valued more than the mere foreign language proficiency. In the following sequences [00:00:51-00:05:05] the viewer can witness the versatility of the role of the coordinator. First of all, viewers must be struck by the fact that the bilingual coordinator is being interviewed about questions that have absolutely no relation to language, translation or interpreting difficulties or challenges, bilingualism in contemporary medical field against the backdrop of medical or reproductive tourism, the salience of quality translation and interpreting in this area, etc. Instead, the bilingual coordinator who has presumably been hired to bridge linguistic and cultural gaps between customer/patient and company/medical centre is being inquired about topics outside her remit, field of competence or area of expertise. It has caught my attention that it has never been made clear what education the coordinator has actually pursued that has led to her current position in this clinic. Nevertheless, she was answering interviewer's questions concerning the cost of the treatment (egg donation 6.300 €) and legal issues with this particular treatment in Germany (egg donation in this country in outlawed and criminalised). Then the coordinator suggests guidelines for the embryo transfer (medication instructions and full urinary bladder[130]). The coordinator explained that egg donation is the only solution is this case as the patient can no longer produce her own oocytes due to her age. According to her prognosis a double embryo transfer with two good quality blastocysts may signify up to 70% pregnancy success rate. She concludes

[130] These pre-embryo-transfer guidelines may include going through the informed consents, making sure that the patient was not exposed to viruses whose sequelae lead to congenital brain abnormalities (foetal microcephaly or neuropathologies) such as Zika virus, instructing the patient to come with full urinating bladder in order to facilitate ultrasound visualisation, reviewing the medication (for example metronidazole pessaries), coordinating the time of the transfer with the time of patients' arrival in the country of treatment (Spain in this case), and clarifying the number of embryos that are going to be transferred (SET or DET).

by saying that multiple embryo transfer is not recommended as it may result in multiple pregnancy risk.

All this explanation shows that, apart from being quite familiarised with this particular case, the coordinator most likely does this routine on daily basis, it has become a commonplace occurrence which she has embraced. Please note that there were basically two major segments [00:00:40-00:05:05 and 00:08:43-00:14:50] dedicated solely to talking to the coordinator (that is over 10 min. out of 15 min. or 2/3 of the whole video). During this time the presenter was not discussing language or culture issues with the coordinator, but rather issues concerning national and German legislation, budget and reproductive medicine (all outside her competence and remit). Curiously enough the members of television crew such as story editor, screenwriter, writer, head writer, television producer, researcher or director decided to interview a person with a vague role description and unknown education instead of professionals in the field such as doctors, medical staff, public authorities and officials, politicians, clinic administration, parliamentarians, specialists in moral, ethics and religion, policy-makers, law-makers and other individuals competent in statutory regulations and more specifically Ley 14/2006.

In the segment between 00:05:03-00:08:24 the presenter interviews the biologists from the laboratory, who show her the biobank of that particular clinic, but it is interesting how the shadowing of two coordinators replaces the opinions, explanations and clarifications of other specialists. This can only mean that the programme crew want to emphasize the importance of the figure of the coordinator.

In the segment starting at 00:03:50 the presenter highlights that coordinators, who are in charge of staying in touch with the patients, liaise with them and guide them, also provide information, advice and service regarding hotels, gastronomy, leisure and entertainment, transport to the airport after the embryo transfer. This would constitute yet another facet of their role and the only one that corresponds to the category that these workers are given by some clinics – administrative assistants.

The next relevant sequence starts at 00:08:40 where the coordinator informs the doctor that German patients have arrived for their procedure. It is worth mentioning that the presenter addresses the coordinator by her name –Irene–, and the physician by the title –dr.–, and the surname –Gómez de Segura–. This, of course, denotes and showcases how important and transcendent the status and the prestige of a profession really are. It is worth noting that Irene (the German-speaking person) does not self-identify, she does not comment on her role or professional identity. It is the presenter who defines Irene's professional identity, who tried to give a definition of who she is and what she does. At first [00:00:50] the presenter says "Irene, eres la encargada de conducir, de estar en contacto con los extranjeros que [...] buscan el gran sueño de ser padres, ¿cierto?". The word "¿cierto? [right?]" appended to the declarative statement instantly turns it into a question, which means that the presenter wants to understand who Irene really is and what her professional role is. She wants Irene to co-construct her own professional identity, to define it. But Irene is either not sure of whether this is what she really is, or she knows that being "the person in charge of guiding, staying in touch with foreign patients" is just an approximation or just a partial description of what she really is and what she does. It is clear from her answer: "Bueno, sí [Well, yes]" and they cut right after she said that, and after she could have potentially

said something else which was edited out. The viewer does not see her facial expression, but the "well, yes" utterance was vocalised with a laugh pulse, which also denotes approximation rather than accurate representation of reality. In the segment starting at 00:08:43 the presenter now calls Irene "coordinadora [coordinator]" and her head nodding, neck and upper torso inclination, intonation, smile and direct eye contact with Irene sounds as if the presenter was searching for Irene's approval to call her like that, or as if they had previously agreed in this term.

In the same sequence, the coordinator ends up adding information to the doctor's answer on the most common nationalities visiting the clinic by noting that China has become a major Asian sending country in terms of reproductive tourists, as many Chinese citizens are pursuing parenthood yet again after the famous one-child-policy in China has been revoked in 2015. In this scene the coordinator acts as an information source once again.

In the sequence that starts at 00:11:00 the coordinator takes on the role of interpreter during the embryo transfer. It is extremely difficult to determine whether the interpreter was actually interpreting or talking in that there were many edited cuts and I know from my own professional experience that I was asked and expected to provide the patients with a detailed explanation of the routinised procedures. Thus, I had to explain everything that the physician was doing without him/her saying a word.

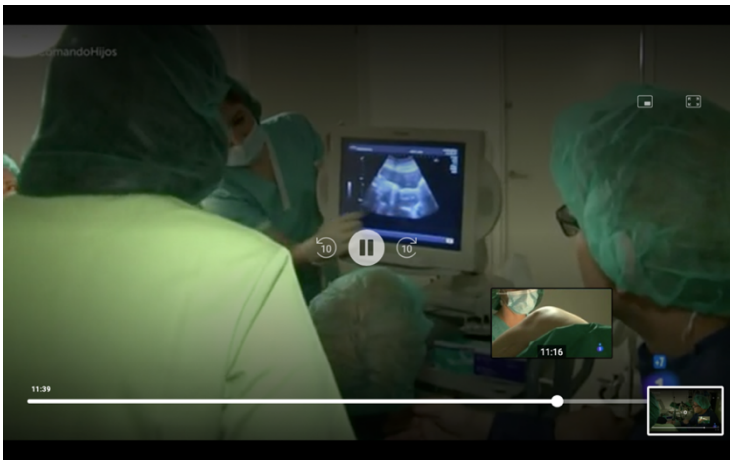


Figure 46. Interpreter's role during the embryotransfer

Figure 47. Interpreter's role during echography

In the next sequence we can see a very interesting image that reveals the third role of the coordinator: hospital orderly/assistant nurse. The role of an orderly falls under the category of unlicensed assistive personnel (UAP) or (personal) care workers in health services. By way of a reminder I would like to highlight that Castillo and Taibi have also mentioned that sometimes medical workers are not cognisant of the occupational boundaries, the limits of the competency and competence of medical interpreters and they ask them for/to help: "The doctor asks the sister and the interpreter to help the patient undress, and the interpreter is forced to explain to the doctor that this is not her job" (Castillo & Taibi, 2005, p. 111, my translation). Some medical interpreters working in the field of reproductive tourism however, argue that:

> Como en todas las profesiones, la experiencia sirve para encontrar la flexibilidad adaptada a las situaciones reales de la profesión. Descubrimos que no todo lo aprendido podía aplicarse íntegramente y que esto no era incorrecto, que la interpretación en este ámbito tiene una dosis de humanidad, intimidad y cercanía necesarias para una comunicación adecuada.
>
> As in all professions, experience helps us find flexibility adapted to the real situations of the profession. We discovered that not everything we learnt could be applied in its entirety and that there is nothing wrong with it, that interpreting in this field has a dose of humanity, intimacy and closeness necessary to ensure proper communication. (Lleó & Torroba, 2014, p. 259)

In the scene [00:12:10-00:12:25] the coordinator is seen pushing the stretcher with the patient, who is lying down after the transfer.

Figure 48. Interpreter is seen pushing the stretcher 1

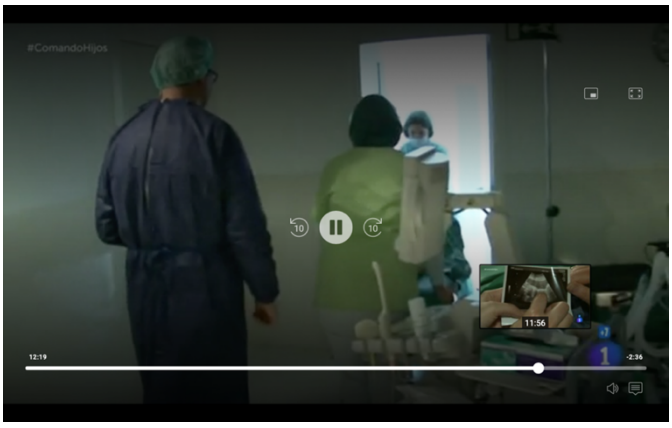


Figure 49. Interpreter is seen pushing the stretcher 2

This multimodal analysis showcases how spoken and visual texts are used to position people in the social action. As maintained by Halliday (in Iedema, 2003, p. 31) semiotics must be scrutinised in terms of socially meaningful tensions and oppositions manifested through socially oriented forms of linguistic, visual, audial and special analyses (p. 32).

> Halliday's work enabled the analysis of 'language as social semiotic' to go beyond applying syntactic criteria to structures 'above the sentence'. On the basis of the metafunction hypothesis, the stratification hypothesis, the text-context hook-up, and the focus on whole social processes as texts rather than on isolated sentences, analytical methods were devised which did justice to texts' socially meaningful role. At the same time, and taking its cue from the ideology critique of Critical Linguistics, texts' features could be systematically linked to those of their social and institutional contexts, as well as to the politics, the 'ideologies', or the worldviews that informed and shaped those contexts. (Iedema, 2003, p. 31)

As explained by Iedema, the term "multimodality" was launched to foreground the salience of taking into consideration semiotics expressed through alternative forms of texts such as images, music, gestures, etc. One therefore must not be strictly limited to the discourse analysis of the language in use, but also learn to rely on other forms of communication. The author argues that the ubiquity of sound, image, film, TV, computer, and the internet (and now also the internet of things and the internet of bodies) is underpinning "the multi-semiotic complexity of the representations we produce and see around us" (Iedema, 2003, p. 33). Thus, the language in isolation may no longer be the optimal choice for exhaustive analysis, because "a multimodal appreciation of meaning making", –apart from "de-centring" language favoured meaning-making–, focuses on complex social and cultural discourse practices by "re-visiting [...] roles allocated to language, image, page layout, document design, and so on" (Iedema, 2003, p. 33). "In talk, we mobilize language as sounded speech, and we further 'mean' through gestures, posture, facial expression, and other embodied resources such as physical distance, stance, movement or stasis" (Iedema, 2003, p. 39), but the non-verbal information is also crucial in understanding the "origin and the dynamics of emergence of a construct" as well as the multi-semiotic complexity of such construct or practice (pp. 33-34). During the multimodal analysis we must take onto account the term "resemiotization" coined by Iedema (pp. 33-34). Such resemiotization is contextualised against the backdrop of social practices, social rules, resource availability and moral habitats (Iedema, 2003, p. 40).

This term studies "how we are able to create meaning", "how our meaning-making unfolds", how meaning-making "shifts from context to context, from practice or practice, from one stage of a practice to the next" (Iedema, 2003). Given that it is a process, "historicization", "historicizing" or contemporarisation of certain phenomena, their contextualisation is essential in fathoming out how did a concept/construct/representation come to signify, mean or be viewed as a common sense or commonplace practice, a taken for granted and a normalised reality. How did the practice and professional identity of a person, who was supposedly hired to bridge the linguistic and cultural gap has now come to be viewed as an orderly, a nurse or an auxiliary nurse? How did the practice of interpreting come to be complemented with the practice of pushing the stretcher or explaining medication and providing medical guidelines?

In order to apply the reasoning underpinning resemiotisation we need to start by the contextualisation of the phenomena described above. Thus, as it was reported in the Spanish television programme Comando Actualidad (2016) at the very beginning of the programme, a certain demographic, touristic, social, legal and medical phenomenon has started to emerge in Spanish territory. The presenter was very clear in her introduction: "Vacaciones en España con embarazo incluido. Crece el número de pacientes extranjeros que vienen a nuestro país a realizarse tratamientos de fertilidad [Holidays in Spain with pregnancy included. The number of foreign patients coming to our country for fertility treatments is growing]". As maintained by Iedema, any meaning needs to be "historicized" and "contextualised" in order to understand the process of meaning-making. Thus, within the context of an ordinary process, the hospital administration would hire an interpreter, who would come to the consultations to enable communication between two or more parties, who do not share the same language. Nevertheless, in the specific context of reproductive tourism –an emerging phenomenon–, apparently there is an increasing demand for in-house interpreters. But due to globalisation and increase in professional mobility spurred by Directive 2005/36/EC on the Recognition of professional qualifications (Directive 2005/36/EC) "many countries are reliant on foreign health care professionals to replenish their workforce" (Footman et al., 2014, p. 4). Also, English is considered a *lingua franca* and many doctors choose to communicate in English even though their struggle – as it can be seen in my conversation analysis– is quite obvious.

Thus, it is totally up to the (generally overestimating) self-assessment criteria of self-reported and self-rated "fluent" clinicians whether they choose English or their native language. In many cases they opt for English for a number of reasons (anxiety of losing limelight, prominence, praise or attention of the patient, mistrust towards the professionality of the interpreter or claimed competence and competency of the bilingual coordinator, to name a few), and this leads to the language facilitator becoming unnecessary during the consultation. The internationalisation of English as international auxiliary language, the transnationalisation of markets, globalisation, brain-drain or professional mobility, migration-related demographic changes are major factors leading to people being willing to communicate in English with medical tourists, foreign residents and conventional tourists. This results in professional re-training and in distortion of what used to be a conventionalised, traditional concept of interpreter.

Unwilling to face contract termination, both professional interpreters and non-professional bilingual personnel end up accepting the time-saving and most importantly cost-saving initiatives of the management. These initiatives include the expansion of the range of tasks, which under "normal circumstances" and in the case of more professionalised branches of translation and interpreting (such as conference interpreting) would have never been allocated to medical interpreting. It is my contention that one of the major factors underpinning the phenomenon of reprofiling is the repurposed use of interpreter as multilingual medical and administrative personnel, which yields substantial savings in time and cost-efficiency. I have examined the salary grid presented in the collective agreement[131] and it is quite self-explanatory. Administrative assistant,

[131] BOPV nº 38 Boletín Oficial de la Provincia de Valencia, 2016, *Convenio de la Sanidad privada de la provincia de Valencia para los años 2013 a 2016*: https://www.uv.es/cliniques/transparencia/CONVENIO%20SANIDAD%20.pdf

which is the job category normally assigned to medical interpreters in the employment contract[132], falls within the "intermediate level technician" category. Premised on the definition and role description of "administrative assistant" (workers who, without initiative or responsibility, are engaged in the auxiliary services in the administration department), the salary of workers belonging to this occupational category amounts to 1.155 € per month, whilst according to a report issued by Medscape (Varela, 2019) on the salaries earned by physicians practicing in Spain, the average gross annual salary in 2016 constituted 53.000 €, which makes 4.417 € per month.

Both categories were taken into consideration when elaborating the report: those practitioners working in public healthcare institutions as well as those who perform their duties in private medical facilities. In the VC the figure amounts to 54.000 € in case of specialists and drops to 51.000 € in case of primary care physicians. Thus, taking these figures into account, we may say that a doctor may probably earn around 25€ per hour, while an administrative assistant would probably make 6,50€ per hour. It is therefore that oral requests to help with tasks that professional interpreters/ bilingual personnel lack training and competence for has translated into a written and official change of social and professional category. The newly allocated category of "administrative assistant" leads to the reconstruction of the academic construct of "medical interpreter", which was constructed at the university, because a workplace construct of "medical interpreter" has just started to emerge with clinics such as Hospital Clínica Benidorm not so long ago:

> HCB began [...] at the time of Benidorm's tourist expansion, providing a service to the first tourists in the area. The needs were not those of a normal hospital; the team had to attend to patients of different nationalities and this was done. Thirty years later, HCB is a private hospital with 400 employees of all nationalities from the EU, Russia, the Middle East and South America. Today, HCB serves 80% of foreign patients: mostly European residents on the Costa Blanca and is gradually becoming one of the reference centres for Health Tourism patients. (HCB, 2016)

While some clinics are committed to preserving the academic construct of "medical interpreter" in terms of duties, tasks and responsibilities, other medical centres are betting on changing this social and professional category to "administrative assistant" with no professional or jurisdictional boundaries or limitations. The status also changes. And, given that no statutory regulations have been put in place to regulate this newly emergent occupational category, the meaning of the professional identity of medical interpreters has been constructed and crystallised according to the interpretative and interactional processes as well as construal of people outside the profession whose only aim is time and cost-saving. By the way, the presenter highlighted that apart from being a medical facility, a clinic, it was also a business, a company [00:03:50]. By taking a closer look at the job advertisement displayed and analysed in the previous chapters of this thesis, we can see that this distorted and re-contextualised meaning of the construct has already become entrenched into the social consciousness. Now it is not only normal, but also trendy and fashionable to hire bilingual or even self-reported polyglots or multilinguals for a wide variety of tasks. And this is how an academic reality is being re-constructed.

[132] Please check the section on the ISCO-08 and CON-11 official classification of occupations.

According to Mehan (1993, cited in Iedema, 2003, p. 41), "as the construction of reality unfolds, original statements 'become divorced from the social interaction that created them'". Each step in in this re-construction (ritualisation, institutionalisation, naturalisation, normalisation of some factors, such as use of English as *lingua franca*) "reconfigures" and recontextualises the original construct. These shifts from context to context are governed and regulated by the socio-demographic as well as historical rules and practices. In Spain, for example, public service interpreting or medical interpreting is inexistent, and it is not uncommon to see doctors communicating in English. This along with the lack of legal sequelae is precisely what allows for multifunctional, hyper versatile, endlessly resourceful personnel embracing multitasking. The meaning-making process underpins material realizations of situated, local talk or request, which translate into durable, formalised and ritualised forms of interaction. This shift from hiring a conventional medical interpreter to recruiting amateur bilingual staff open to any assignments is called intersemiotic shift or, as Iedema (2003) calls it, resemiotization. So, the meaning-making constitutes the social construction of reality, and the "resemiotization" of these meanings behind the constructs is not based only on a textual representation (discursive structured meaning), but on social co-construction (practice, material affordance). Unlike thematic and conversation analyses it is not only the discursive representation that counts, but also material and historicised dimensions of such representation, in other words, real social, historical, cultural structures and circumstances. Thus, this documentary itself, according to Iedema, comes about as a semiotic construct that puts together deliberations of the filmmakers. The problem that I see with these natural processes is that this "restructuring derives from different expertise and literacies, and resemiotization opens up different modalities of human experience" (Iedema, 2003, p. 48). This means that the professional identity of the medical interpreter is being constantly co- and re-constructed as well as resemiotised and rematerialized by the people who do not belong to this profession, so they adapt it to their needs and not the needs of all end users and professionals themselves.

G. *Analysis of Photographs*

This section will look at two photographs that I took, which may help us better understand the MCDA presented above. The uniform worn by the interpreters, public relations, mediators, assistants, etc. in some private facilities in the study-relevant areas is similar to the uniform worn by cabin crew. Please see the example below.

Figure 50. Uniform example 3

It is worth noting that the people responsible for approving this uniform for medical interpreters were absolutely unfamiliar with the occupation. They were unaware of the main tools that the interpreter uses to do their job: the telephone, whereby medical professionals can contact the interpreter and inform them that their presence is required, the notepad or at least a jotter absolutely indispensable for the note taking technique, and of course a pen to take notes with. There were no pockets on any of the uniforms that would allow to comfortably carry all these instruments.

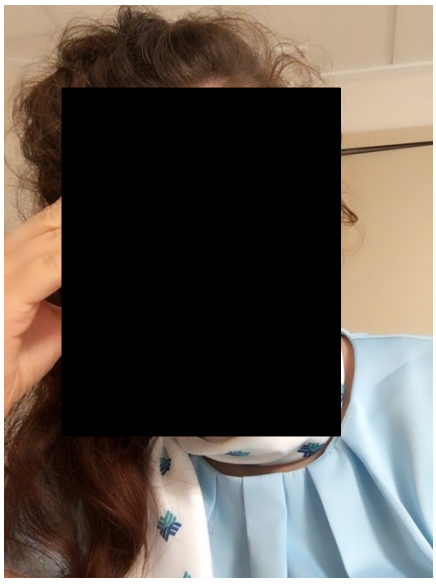


Figure 51. Uniform example 4

It was also required to wear high heeled shoes, a scarf with the corporate logo, a skirt, an appropriate hairstyle and makeup. It should be noted that in one of the private clinics of Costa Blanca even a *compulsory* make-up tutorial was organised geared towards interpreters and

reception staff[133]. One may contend that such outfit and appearance may mislead many patients and co-workers into believing that medical interpreters were just receptionists, assistants, and auxiliary staff whose main purpose was to help with minor, trivial, administrative or bureaucratic issues.

15.1.3. Thematic analysis and social psychology

The following is the final report of the TA. Before I start with the results and discussion, I would like to make a brief opening remark on the source of inspiration for my gravitation towards this method. Clarke and Kredens' paper "'I consider myself to be a service provider': Discursive identity construction of the forensic linguistic expert" was the major motivation, inspiration and influence for this thesis. Similarly to medical interpreting, forensic linguistics is an emerging occupation which "is still *in statu nascendi*, and/or it is an auxiliary, 'satellite' profession" (Clarke & Kredens, 2018, Conclusions section, § 2).

Therefore, a research project into how the professional identity of the forensic linguist expert is discursively and intersubjectively constructed combining TA and social constructionist paradigm may shed light on how this same methodology may be applied to professional medical interpreters. Following this methodology Gavlovych and Blasco-Mayor (2000, pp. 55-59) have conducted a pilot study on a very limited number of participants using TA. Thus a parallel could be drawn between forensic linguistics and medical interpreting as both share the "well-established status as an academic discipline", but are yet to attract academic interest to "the applied dimension of the field" (Clarke & Kredens, 2018, Introduction section, § 1).

Similarly to forensic linguistics, medical interpreting in the VC region has been neither "formally recognised as a profession", nor "statutorily regulated, meaning that pretty much anyone claiming expertise can act as an expert witness in cases where language-related evidence is involved" (Clarke & Kredens, 2018). In view of the fact that both occupations share the same problem, similar research methods may be implemented to reason it out. The TA within the social psychology approach was intentionally designed to complement the MCDA, and the CA against the backdrop of the discursive psychology perspective, as well as to enrich methodological cross-pollination and synergy.

In order to connect all discursive threads that would bear out the theories formulated in the second part of this thesis, I shall now proceed to present the results and discussion of the TA, whereby I shall humbly strive to relay to the reader my interpretation of the recurrent locutionary patterns found throughout my data corpus and based on latent and abeyant value assumptions entrenched and reinforced by covert ideologies.

As it was already revealed in the previous chapters, TA is a problem-oriented research approach used to foreground the semiotic dimensions of power which contribute to the marginalisation or emancipation of certain (professional) groups of people through the discourse of the involved social actors. Social as well as professional injustice, ostracism, abuse, etc. may be partially explained by applying a TA to the discourse that instigates such behaviours (Braun & Clarke, 2006, 2014; Clarke et al. 2019; Flick, 2014; Potter & Wetherell, 1987 *inter alia*).

[133] Datum extracted from my own personal experience.

Each encounter among a number of subjects in the physical realm creates a canvass for the identity construction, the word choice –which is rarely neutral or arbitraty– is the tool and the words per se are the paint, which portrays and depicts people's realities and their identities in these realities.

Hence, TA is the tool, which allows the researcher to look beneath the surface of the word choice of the study-relevant social interactants. Such socio-diagnostic analysis seeks to uncover speakers' ambivalent motives, motivation, attitude, intentions, vested interests and claims, and to demystify the abeyant facet of discursive practices. The dialectic relationship between the social structure (underpinned by social conscience, conventionalised social order, institutionally marked social behaviours, etc.) and social positioning by means of speech is extremely important for this thesis, as the meaning-making process relies on this interconnection. By means of a detailed textual analysis, interpretation and textual deconstruction I tried to track underlying ideologies and unpack ideological presuppositions, as well as explicate relevant biases relating them to the sociology of professions and the theory of professional knowledge discussed in Part II of this thesis.

By demystifying the latent facet of the discourse (socially and institutionally marked power relations being negotiated and performed), I tried to detect problematic functions of discursive practices (Wrbouschek, 2009) in order to possibly offer a prospective analysis by developing and formulating a practical (feasible) alternative (Wrbouschek, 2009).

The identities are materialised, reified, realised, pragmatized, negotiated, maintained, legitimised, altered, etc. "on social ground" and upon gaining "social meaning" through "dialogic performance", whereby these identities emerge ("emergency principle"), are being positioned ("positionality principle"), are being indexed ("indexicality principle"), are being assessed and classified as similar or different from other identities ("relationality principle") (Bucholtz & Hall, 2005). The conventionalised identity expectations or the social and occupational category that a person is ascribed to is extremely difficult to alter (Bucholtz & Hall, 2005).

Thus, the psychological mechanism of self-identification and self-reflection through discourse and behaviour can only be truly enacted, constructed, maintained, contested, altered or legitimised through social action and language underlying such action (Bucholtz & Hall, 2005). In the case of professional identity it is not only the country, region, culture, politics, ideology, ethnicities, demographics, but also the institutional rituals that permeate every aspect of the professional identity formation.

By way of a reminder, note that 46 doctors, 3 nurses, 7 patients and 6 interpreters, –amounting to 62 persons in total–, were interviewed for the TA. The age bracket of the participants is from 27 to 68. Detailed information on each of the participants, more specifically their gender, department, mother tongue and years of professional experience was facilitated in the parenthesis right next to the number that was assigned to each participant. In the case of interpreters, it was also specified whether they are professional graduate interpreters or layperson interpreters. These interviews were canvassed in five different private medical centres located in the study-relevant geographic area. All 62 participants expressed their preference to participate in the interviews, rather than fill out the quantitative questionnaires or have their medical encounters audio recorded. All interviews were audio recorded using an iPhone, transcribed, translated and analysed

thematically. All data were canvassed during the period from 2014 to 2018. The previous chapter contains details on the process of data collection, the subjects and the analysis.

15.1.3.1.THEME 1: Lack of consensus regarding the typology of knowledge and education that medical interpreters-to-be should pursue

A. Part I: Alternatives to formal education

Although there have been some monotonous and stereotypical regurgitations regarding this topic, some thrusts denote a number of truly diverse ideas or subthemes, which in the end all undergird the main theme, which is the limited awareness and understanding of the knowledge underlying medical interpreting and the education that one must pursue to deliver quality service. Through this theme we can see that the general support from the key social actors is weakened by general scepticism, indifference or ignorance. Therefore, MI as we know it, is becoming an "empty shell" as the risk of being "ultimately usurped by another more popular discipline" (e. g. philology) or by "schismatic movements which may fragment or dissolve the original" occupation (e.g. medical/patient assistant) gradually increases (Freidson, 2001, The Contingencies of Knowledge section, § 2). In short, the very essence of this theme can be described in one sentence "With or without training, but she has to be professional" (Participant nº 5).

1. Subtheme 1

Experience and on-the-job training as an alternative to formal education

Doctors

This subtheme explores how some participants contend that the knowledge underlying medical interpreting may be subsumed under an on-the-job training, which consists of the memorisation of medical verbiage, terminology and understanding of medical concepts. Participant nº 30 (male doctor, Department of Surgery, 15 years of professional experience) argues that it is the experience that allows for "correct" interpretation:

> Yo creo que *vosotras sois unas intérpretes expertas eficaces*, lógicamente *de recién llegadas si no tenéis experiencia en el ámbito sanitario os encontráis con alguna dificultad* para interpretar determinadas cosas o frases que dicen los médicos, *pero con el tiempo adquirís una práctica que lógicamente os pone en disposición de interpretar correctamente lo que el médico quiere decir*
>
> I believe that *you are effective expert interpreters*, logically, as newcomers, if you do not have experience in the health field you will find it difficult to interpret certain things or phrases that doctors say, but *with time you acquire a hands-on experience that logically puts you in a position to interpret correctly what the doctor means*

Considering that the overwhelming proportion of the interpreters which participants were interoperating with are lay person interpreters, the fact that this surgeon refers to these dilettanti as "expert" is quite unconventional and noteworthy. This participant confers on the non-professional amateurs, –and he knows that they are unqualified–, the status and qualification of "experts", which is an interesting word choice in terms of identity construction. It is worth noting that "in specific fields, the definition of expert is well established by consensus and therefore it is

not always necessary for individuals to have a professional or academic qualification for them to be accepted as an expert" (Wikipedia, 2022).

An example thereof may be occupation with mechanical specialisation, tacit and unverbalisable skills, as well as extensive experience (e.g. shepherd). In the rest of the cases "expert" denotes extensive competence underpinned by specialised knowledge, skill, technique, ability, specialised discretionary judgement based on intricate formalised abstract concepts, careful reasoning, experience, and finally yet importantly, informed, rational and sensible decision-making. Thus, experience is the only facet of "expertise" which can be acquired through practice, the rest of the facets are only accessible through official training, formal education and research, and credentials that would attest to all the above mentioned. Credentials play a key role in the official and legal public recognition of an expert or expertise. Such recognition denotes reliability upon and trustworthiness of the experts' opinions, which in turn indicate professional authority and status. By zooming in on the experience alone, the participant has completely elided the boundaries between a real expert and an amateur. Thus, the thrust of this theme is that no formal education is needed to become an interpreter, because "over time [interpreters] gain practice that logically puts [them] in a position to interpret correctly what the doctor means". The question arises as to how would this or any other doctor know that the interpreter –be it professional university degree holders or unqualified layperson–, interpreters correctly what the doctors means if they do not understand the language. Consequently, this excerpt confirms that some doctors are convinced that tacit savvy (unverbalizable skills acquired through experience) is the bedrock of medical interpreting and no formal or working knowledge is required to practice. In the same vein, informant nº 25 (male doctor, ICU, 17 years of experience) also contends that: "una formación se puede adquirir por carrera universitaria o por experiencia [Skill or job training may be acquired either by university degree or by experience]".

Interpreters

Participant nº 38 (Female *amateur* interpreter, International Department, 2 months of professional experience) also considers that the process of interpreting is based on the tacit savvy acquired through on-the-job training and professional experience. When I asked her about the training I obtained the following answer:

> Depende, yo yo creo que es importante aprender lenguas y que esto ayuda mucho en las profesión, pero si a veces la persona puede vivir en otros países y aprender otros lenguajes sin haber hecho un curso antes. Yo creo que con un buen dominio de linguas [sic] ya es suficiente. Bueno es importante saber los términos técnicos que se usan en las profesiones.
>
> It depends, I think it is important to learn languages and that this helps a lot in the profession but sometimes a person can live in other countries and learn other languages without having done a course before. I think that a good command of languages is enough. Well, it is [also] important to know the technical terms that are used in the professions.

This self-proclaimed interpreter reduces the knowledge and skill underlying medical interpreting to mere "learning" of the languages, thus naturalising the process of language learning as something you do visiting other countries, oversimplifying it and universalising this ability. She

does not elucidate on what exactly does she mean by "a good command of languages", but she avers that she learned English "en el colegio [in school]", and then she goes on to say "*creo* que puedo entender una conversación y *creo que podría* hablar inglés con unos pacientes… el problema son los términos técnicos [*I think I can understand a conversation and I think I could speak English with patients…* the problem is the technical terms]" (my emphasis). After hearing this I posed a follow-up question as to whether she thought a specific training on how to interpret would be necessary or appropriate and she replied: "*No yo creo que no [No, I don't think so]*" as an interpreter "es una persona que interpreta algo en una lingua [sic] y la traduce para otra. […] is a person who interprets something in one language and translates it into another". This lay person interpreter advocates for the basic terminology training provided by the medical facility and concludes that all that an aspirant needs is experience:

> Yo creo que es importante que el lugar donde donde exige un intérprete si el interprete no tiene la formación médica necesaria o debería formarte no un poco por lo menos ya básica […] no como el médico […] yo creo que el básico debería ser ofrecido y yo creo que con la experiencia ya día a día se puede ir consiguiendo.
>
> if the interpreter does not have the necessary medical training he/she should be trained at least a little bit, at least [the] basics right? […] not like a doctor […] [but] basic training should be offered and I think that with experience, day by day, it can be achieved.

Informant nº 34 (female lay person interpreter, 2 months of professional experience as interpreter on daily basis and indefinite period of time of sporadic, piecemeal interpretations) also believes that experience is an alternative and an equivalent to a university degree:

> Desconozco las normas (códigos éticos y deontológicos) estoy totalmente de acuerdo que si tienes una formación lo haces todo mucho más te sientes mucho más segura lo haces todo tal vez de una forma más fluida pero sí que tengo que decir que la seguridad me la está dando la experiencia día tras día estoy aprendiendo algo nuevo me estoy formando yo también personalmente y la seguridad me la estoy ganando yo con el esfuerzo del trabajo sí que es efectivamente pienso por supuesto que una formación te da esa seguridad que a lo mejor te falta al principio de trabajar en un ámbito de traducción pero sí que es verdad que el formarse uno mismo y la experiencia del trabajo pues te da esa seguridad que tal vez ya con los estudios ya los tendría, ¿no?
>
> I am not familiarised with the ethical standards and deontological guidelines. I totally agree that if you have training you'll […] feel much more confident and perhaps do your work in a smoother way, but I have to say that I am gaining self-assurance through daily experience, each day I learn something new, each day I pursue personal development and I gain self-assurance through the efforts that I make by carrying out my work, yes, I do think that education gives you that assertiveness that you might lack at the beginning of the working process in the field of translation, but it is true though that the pursuance of self-education and work experience gives you that self-reliance that perhaps you would already have had you accomplished your studies, right?

Informant nº 34 goes on to elaborate on her acquisition of the hands-on experience in the following way:

> Llevo ahora mismo *2 meses y 2 semanas* trabajando [aquí] y la verdad que sí, *al principio me pareció abrumador porque eran muchos términos médicos* que yo obviamente al no haber estudiado nada de medicina ni en

> relación con la medicina me chocaba bastante al [sic] entenderlo[134] pero una vez que uno estudia un poquito más sobre el tema y *se forma* pues es un trabajo muy interesante porque ayudas al paciente por lo menos sientes que estás ayudando al paciente te sientes muy satisfecha después de cada traducción es muy personal el trabajo por eso también me gusta y es muy interesante.
>
> I have been working [here] *for 2 months and 2 weeks now and the truth is that at the beginning it seemed overwhelming because there were many medical terms that obviously, without having studied medicine or anything related to medicine, I found quite shocking to understand [she found quite shocking how difficult it was for to understand the meaning of the utterance],* but once you study a little more about the subject and *get trained,* it is a very interesting job because *you help the patient, at least you feel that you are helping the patient*, you feel very satisfied after each translation, it is a very personal work, so I also like it and it is very interesting.

The utterance displayed above showcases how an alleged bilingual with limited Spanish proficiency justifies and normalises her lack of competence. Thus, she claims that in the beginning she experienced a tremendous difficulty in understanding the interlocutors, but after having "studied a little bit" and after having "got trained" she feels she is now able to "help" the patients. Of course she is referring to a hands-on experience, an on the job training consisting in shadowing the seniors, which in her case lasted for 2 and a half months. To recapitulate, this informant is convinced that any type of bilingualism in conjunction with the superficial[135] familiarisation with medical terms constitute an appropriate knowledge base for interpreting, activity which this participant misconstrues as a good deed, an act of kindness/generosity or a favour to help vulnerable people rather than a job you are paid to do well. The term "help" is very ambiguous in this sense, especially taking into account the fact that there are medical facilities in Spain where medical interpreting is provided by volunteers who have managed to institutionalise their practice (please check the case of the Asociación de Intérpretes Voluntarios para Enfermos from Costa del Sol, described in Funes, 2015; Aguilar, 2012).

Last but not least, informant nº 37 (female graduate interpreter, 21 years of professional experience as medical interpreter) takes the concept of "experience" further and confesses that instead of facilitating her exercise of discretion, *Phronēsis* and sunesis[136] taking into account the uniqueness of each situation, her work experience resulted in her becoming an information gatekeeper and provider proxy:

> Pero realmente llega un momento en que muchas cosas ya las sabes porque las has ido aprendiendo con la experiencia y puedes explicarlas *sin tener que molestar o acudir o interrumpir a un médico, cosa que no se debe hacer, pero siempre te lo piden*
>
> *But there really comes a time when you end up knowing a lot of things because you've learned them through experience and you can explain them without having to bother or approach or interrupt a doctor, which is something that you should avoid doing, but that is [precisely] what you are always asked or required to do.*

[134] I believe that here my informant meant "me costaba entenderlos [it was difficult for me to understand medical terms]".
[135] Mostly because of its extremely short duration.
[136] Sunesis, –just like phronēsis–, is an Aristotelian concept described in Book VI of the Nicomachean Ethics, which depicts the notion of comprehension and other-regarding considerations. The notion of ethical discernment may be absolutely key in determining whether the willing transgression of professional ethical guidance, potentially resulting in the breach of the *primum non nocere* principle, could have been avoided had the interpreter been a professional delivering their service in compliance with the relevant code of ethics.

All the extracts presented above clearly indicate that these participants view medical interpreting as a craft, and the knowledge that underpins this occupation as practical working knowledge refined throughout the course of work. In other words, these participants are convinced that medical interpreters-to-be could and actually should undergo a craft-type training rather than professional formally codified and intellectualised training.

2. Subtheme 2

Bilingualism as an alternative to formal education

Doctors

Informant nº 35 (female doctor, Department of Gynaecology, 7 years of professional experience) argues that native-like or bilingual language competence is the bedrock of medical interpreting and that educational knowledge is deficient and unnecessary.

El simple hecho de haber estudiado traducción si realmente no dominas el idioma no es suficiente [...] prácticamente sería mejor que fuese personal nativo, [...] los pacientes de alguna manera agradecen que haya gente realmente que pertenece a su país, porque sienten una cercanía, sienten una confianza que con una persona extranjera no siempre sienten. Si es a través de la carrera fenomenal, y si no, porque haya vivido en otro país y porque haya estado fuera el tiempo suficiente como para ser bilingüe, sobretodo asegurarme un nivel lingüístico muy muy alto más que el grado de formación que haya cursado. Para mí es más importante el nivel lingüístico [que la formación], porque [...] se aprende inglés o [...] alemán de una manera puramente digamos no sé pues establecer unas clases en el contexto de una clase [...] reglado por unos programas o por unos exámenes. Creo que eso no aporta suficiente. *[...] muchas veces haber estado estudiando alemán 2 años no es suficiente ni para conocer la cultura ni para dominar el idioma*, por eso priorizo el nivel lingüístico y prefiero que sea una persona nativa alemana [...] Nosotros cuando hacemos contratación del personal hacemos prueba de idioma [...] porque tener un C1 de inglés o de francés no quiere decir que la persona domine el idioma, ni la cultura, quiere decir que has estudiado, te has preparado un examen y lo has aprobado y todo el mundo sabe [riéndose] cómo se hacen los tests de idiomas. Puedes tener un C1 y no tener ni idea de la cultura ni dominar el idioma como para ser traductor. [...] Creo necesario exigir unas competencias en el idioma. Y eso, cuando al final tienes personal nativo lo tienes claro porque mejor que esas personas obviamente no habla nadie. Sin embargo [los graduados en] traducción e interpretación no siempre tienen buen nivel en dos o tres idiomas, sino más bien en inglés. Y allí es donde veo un poquito quizás el déficit. [...] yo he estudiado idiomas yo sé qué es hacer una clase de idiomas [...] en una carrera hacer una lengua C como	The simple fact of having studied translation if you don't really master the language is not enough [...] it would practically be better if it was native staff, [...] patients are grateful that there are people who really belong to their country, because they feel a closeness, they feel a confidence that they don't always feel with a foreign person. If [one became bilingual] is through a degree, great, and if [one became bilingual] by having lived in another country and by having stayed abroad long enough to be bilingual then so be it. It is all about ensuring a very, very high language proficiency level rather than the level of training one has completed. For me, the language proficiency level is more important [than the education], because [...] [when] you learn English or [...] German in a way that is purely, I don't know, to establish classes in the context of a classroom [...] regulated by syllabuses or exams. I don't think that's enough. [...] *[O]ften having been studying German for 2 years is not enough either to know the culture or to master the language*, that's why I prioritise the language proficiency level and I prefer a native German speaker [...] When we recruit staff we do a language test [...] *because having a C1 in English or French does not mean that the person masters the language or the culture, it means that you have studied, you have prepared for an exam and you have passed it and everyone knows@@ how language tests are done. You can have a C1 and have no idea of the culture or mastery of the language to be a translator.* [...] I think it is [absolutely] necessary to demand language skills. And that, when you end up having native staff, it becomes clear to you that nobody speaks [a language] better than those people, obviously. However, [graduates in] translation and interpreting don't always have a good command of two or three languages, but rather [only] in English. And that's where I see perhaps a little bit of a deficit. [...] *I [myself] have studied languages, and I know what it means to take a language class [...] in a*

decís y adquirir un nivel que es lo que se suele pedir en la carrera de B2 si no me equivoco para mí no es suficiente para trabajar [irónico] como traductor en ese idioma. [...] nosotros necesitamos personal que hable varios idiomas [...] necesitamos que también tenga un C1 o un C2 en francés, en alemán, en italiano, en ruso, en cualquier orto idioma porque esta misma persona cuantos más idiomas tengas más capaz es de resolver ella sola o de ser autosuficiente en un puesto de trabajo. [...] es muy fácil o suele ser muy fácil coger a una persona por ejemplo alemana, que ya tenga un alemán nativo y que encima tenga un C1 o un C2 en inglés, por lo tanto estoy matando dos pájaros de un tiro, vale?	*university degree course, taking a language C course as you call it and acquiring a B2 level, which is what is usually required by the university degree, if I am not mistaken, as for me it is not enough to work [ironic] as a translator in that language.* [...] we need people who speak several languages [...] we need people who also have a C1 or a C2 in French, in German, in Italian, in Russian, in any other language because the more languages you have, the more capable this person is of working on their own or of being self-sufficient in a job. [...] it is very easy or it is usually very easy to take a German person for example, who already has a native German and on top of that has a C1 or a C2 in English, so I'm killing two birds with one stone, right?

However, informant nº 35 accuses the T&I faculties of Spain of neglecting the linkage between education and practice. It may be implied that the faculty members may be acquainted with the comfort of armchairs of their ivory towers better than with the current workplace realities and the actual market demands in this field. Therefore, this informant is convinced that the term "T&I graduate" is not a synonym of "language proficient person who delivers high quality services". This participant inveighs against the national Translation and Interpreting faculties by alleging that universities certify as competent even those graduates who do not meet demonstrable language needs and demands in the field of medical interpreting.

Thus, at first glance it may seem as though these statements render the contribution of the national Translation and Interpreting faculties to the occupation demonstrably non-utilitarian. Faculty members are basically accused of pursuing new knowledge without having to gain a living by dealing with the practical, everyday problems posed by lay consumers. The fact that amateur bilinguals are preferred over graduates may signify that in spite of institutionalised means of developing new knowledge and skill, this occupation still remains extremely vulnerable to the loss of their jurisdictions and exclusionary shelters. This obviously means that lay consumers (especially employers) seek to exercise absolute control over the professional identity of medical interpreters in order to create new hybrid profile that would suit their vested interests. One of such vested interests may be the obtention of cheaper services. It would seem as if full-time faculties of Translation and Interpreting in Spain lack resources to control the labour market. They do not institutionalise the cognitive authority of the profession by rooting it in the authority of higher education, because its authority in this field of practice is not being recognised by some relevant social interactants. In short, some social actors are convinced, or pretend to be convinced for their own gain, that faculties simply fail to meet consumer demands and their curricula fail to equip students "to perform the particular tasks required by employers after matriculation" (Freidson, 2001, Professional Privilege in the Future section, § 6).

This participant does not associate the knowledge underlying medical interpreting as based on abstract concepts, highly esoteric procedures and techniques. By stating that the knowledge and skill taught at the university is insulated from the knowledge needed to satisfy everyday demands of consumers in this work setting, this participant seeks to hire people, who would adapt to the requirements of this specific marketplace. This work setting has very particular

contingencies, which definitely have a bearing on what work must be done (task allocation) as well as dictating and limiting how it can be done. Thus, this participant does not take into consideration the standards of work performance stipulated in the correspondent international codes of ethics, but rather gravitates towards improvisations that must adapt to the confusion and impurity of practical affairs at all costs, even by breaching the *primum-non-nocere* tenet and by acting at the expense of the service receivers.

According to Freidson "many practitioners are likely to resent the intellectual authority of the faculty [...] because it advances more stringent [...] standards for practice than most are able or even willing to meet in light of settled habit and the demands of practice" (Freidson, 2001, The Control of Knowledge section, § 6-7). Upon entering labour market, the contingencies of practice temper the graduates' use of formal knowledge, which will eventually lead to "developing" one's own "pragmatic methods of coping" and coming to terms with the workplace reality and adapting to it (Freidson, 2001, Comparing the Consequences of Knowledge section, § 15-18). Therefore, many graduate interpreters give in as a result of peer pressure. All the aforementioned factors may end up resulting in some of the humanistic disciplines (community translation and interpreting definitely falling into this category) failure to demonstrate a "clear vocational value", which may mean that these disciplines "may not survive at all, and those that do will be pressed" to meet market demands (Freidson, 2001, Comparing the Consequences of Knowledge section, § 15-18).

However, all this ideation misconstrued as perception may be interpreted as deception, because this informant does not know what type of knowledge and skill actually underpins medical interpreting. A university faculty simply cannot purport to teach a language in 4 years, because it may take *up to* 30 years to fully master a foreign language as indicated by Hartshorne, Tenenbaum and Pinker (2018). The Translation and Interpreting faculty is concerned with teaching techniques and skills that will allow alumni to translate and interpret, not teaching languages. The minimum level of proficiency achieved at the university is intended to facilitate the students' stay abroad for the purpose of extending, deepening or enriching their linguistic abilities or to enable their additional language training aimed to further nurture, cultivate and upgrade their language competency (Oster, 2008, Desarrollo de Competencias section, § 2). Thus, the graduates will be able to apply their skills, techniques and knowledge only provided that they have already achieved a native-like level of foreign language proficiency.

From this extract it is clear that the members of our occupation did not normatively determine what exactly constitutes a problem fit for and in need of the expert intervention of the members of this occupation. The knowledge base as well as its public acceptance should have been determined by the professional interests of the members of this occupation, which clearly did not happen because some relevant social actors (such as my informant) still believe that self-reported native-like language proficiency and bilingualism constitute the knowledge needed for interpretation. The following statement "sobretodo asegurarme un nivel lingüístico muy muy alto más que el grado de formación que haya cursado [It is all about ensuring a very, very high language proficiency level rather than the level of training one has completed]" renders professional university education "insufficient", deficient and unnecessary.

This doctor is correct in her assumption that all candidates must successfully complete a series of verification tests before their onboarding, just like in the case of any other important profession. For this doctor it is vital to hire somebody with exceptional foreign language skills, and the university education or the university diploma does not guarantee exceptional linguistic skills in foreign languages. As it was revealed in the previous chapters, according to some studies the prcess of learning a foreign language can be as long as 30 years (Hartshorne, Tenenbaum and Pinker, 2018).

As members of our occupation, we failed to protect and preserve the mystique and the complexity of our occupation. This leads to the fact that professional over-education (T&I undergraduate degree, MA degree, postgraduate degrees, etc.) does not fulfil the aim of professional respectability and limitation of the access to the profession. The real problem is that this employer is dismissing T&I education as useless in favour of language proficiency, but she isnt considering philology graduates either. Why? Because it is just an excuse, a justification as to why they are not employing graduates, which is of course due to economic reasons. Thus, instead of requiring university attestation and selecting the best candidates with successful degree completion and exceptional foreign language skills –just like it happens with the rest of professions–, the employers in this case create a perfect excuse by saying that the graduates are linguistically incompetent and, therefore, bilinguals without university education are the only reasonable option.

Thus, being bilingual already guarantees access without having acquired formal knowledge and skill to actually interpret in an efficient manner. This informant does not associate education qualification with occupational performance, in fact this doctor has clarified that she does not believe that the existing formal education may be considered the guarantee or the demonstration of expert knowledge as it is "insufficient". This informant decries the lack of linkage between education and practice. The transmission of knowledge is replaced by the natural acquisition of knowledge, thus not only demystifying, but directly challenging and debunking the existing education provision.

Participant nº 36 may have been neither as explicit about the concept of "bilingualism" as participant nº 35, nor as critical of the currently available formal education as participant nº 35, but still he opined that medical interpreter is:

> Persona con una capacidad y un conocimiento adecuado de uno o de varios idiomas, que le permite expresarse con fluidez en los mismos y nos facilita la comunicación a nosotros [los médicos] con el paciente.
>
> [A person with certain abilities and an appropriate knowledge of one or several languages that would allow them to express themselves fluently in these languages and that would allow them to facilitate our communication with patients].

This informant does not mention the term "bilingual", but expressions such as "adequate language knowledge", "fluency" and "a person with an ability" imply that he may be referring to both a person who has acquired such "language knowledge" and "fluency" via formal university education or a person with certain (innate) ability or talent, such as bilingualism or polyglotism. Also, it is worth noting that the informant does not specify what the term "adequate knowledge" actually entails. Is he referring to native-like knowledge, advanced knowledge, bilingual

knowledge or full professional knowledge? This was one of the follow up questions, however, the answers differed from participant to participant. The majority indicated that they referred to native-like and/or bilingual language knowledge. And, most importantly, what kind of accreditation attesting to the possession of such knowledge must the candidate or incumbent need to present in order to be selected for the position? The lack of clear answers to these questions can signify that this informant ignores the importance of episteme (scientific knowledge) and techne (practical skill) being delivered through paideia (education), which enables quality professional praxis based on discretion.

The theme of control over professional identity of medical interpreters is also quite evident. By seeking to usurp the control over the construction of hybrid occupational identities, the lay service consumers breach one of the most important tenets of international codes of ethics of translators and interpreters (The Australian Institute of Interpreters and Translators, 2012; EULITA; European Association for Legal Interpreters and Translators, 2013): neutrality and double allegiance. The fact that this doctor says: "knowledge [...] that would allow them to facilitate our communication with patients", means that the interpreter is called in to put the doctor –the main representative of an institutional authority–, in a position to understand certain information in order to be able to do their job (Rudvin, 2005, p. 169 also spoke about it). Also, and as we have already seen in my conversation analysis, the doctor would often require that the interpreter deliver only what the doctor him/herself selects as relevant (as mentioned in Rudvin, 2005, p. 169). Thus, the institutional ethics and ritualities totally regulate institutional relations governed by the asymmetry among experts from different professional strata, hindering implementation of practice ethics of medical interpreters. Such asymmetry is also conditioned by the monetary interdependence between the interpreter and the private medical facility that hires this interpreter. Thus, the interpreter is working for a private clinic and therefore must fulfil their contract requirements. As I shall purport to demonstrate through the further analysis of the recurrent latent themes, this willingness and tendency to hire bilinguals with "adequate knowledge of one or several foreign languages" may be due to the fact that the employers seek to mould and shape the figure of medical interpreter into a hybrid identity that will embrace all the demands and requirements of the employer/labour market heedless of the existing codes of ethics, codes of conduct, interoccupational jurisdictional boundaries and guidelines inculcated by the university education.

Participant nº 48 (male doctor, oncology department, over 35 years of professional experience) also highlights the salience of being highly proficient in those foreign languages in which the interpreter claims to be able to operate:

> El punto fundamental aunque incluso el médico sea capaz de hablar otra lengua con propiedad [...] que pueda decir bien los términos clínicos o médicos, pero la lengua lleva aparejada una cultura y una manera de pensar y no siempre la información que pasas aunque la hayas pasado correctamente consigue el objetivo de informar en lo que tú quieres. [...] En ese sentido los intérpretes son fundamentales gente que maneja muy bien las lenguas no manejan las lenguas que las manejan manejan los conceptos de las lenguas esa es la diferencia entre alguien que hable una lengua y alguien que estudia una lengua [...] el problema es que los idiomas tienen retículas que a veces coinciden conceptualmente de uno a otro por ejemplo las lenguas latinas tienden a tener los mismos conceptos pero

> las no latinas los tienen diferentes y eso es lo que es muy importante conocer a la hora de pasar información.
>
> [The fundamental point is that even if a doctor is able to speak another language properly [...] they can articulate clinical or medical terms correctly, but language brings with it a culture and a way of thinking and the information you pass on, even if you have passed it on correctly, does not always achieve the objective of informing in the way you want it to. [...] In this sense, interpreters are fundamental, people who know languages very well, it is not about them knowing the languages per se, which they do, but rather about grasping the concepts of the languages, that's the difference between someone who speaks a language and someone who studies a language [...] the problem is that languages have grids or frameworks that sometimes overlap with one another conceptually, for example Latin languages tend to have the same concepts but non-Latin languages have different concepts and that is what is very important to know when it comes to passing on information].

Of course, this statement does not rule out the necessity of university education, which is the overarching theme here, on the contrary, it highlights the salience of learning/studying the language in a general sense, but always with reference to the mother tongue and other foreign languages that the interpreter may be operating in.

Participant nº 49 (male doctor, Internal Medicine Department, 30 years of professional experience) has declared that:

> *Una formación universitaria especializada no es necesaria en la traducción al nivel en el que nosotros trabajamos. La mayor parte de los intérpretes que se usan aquí no conocen bien los* idiomas; sin embargo, hacen su labor bien [...] es usted una trabajadora de la lengua del idioma el idioma que es específico de los animales llamados seres humanos *los seres humanos son capaces de comunicarse entre ellos mediante el habla sin tener ninguna carrera específica* que desarrolle el tema del habla [...] Pero qué duda cabe que por supuesto que es muy importante y muy útil y deseable el disponer de un intérprete profesional: [el] entendimiento con el paciente es mucho más fácil se le pueden explicar las cosas desde luego con mucha más claridad el paciente las va entender mejor eso por supuesto
>
> *A specialised university education is not necessary for translation at the level at which we work. Most of the interpreters used here do not know languages well; however, they do their job well* [...] you are a language worker, the language that is specific to animals called human beings, *human beings are able to communicate with each other through speech without having any specific degree* that develops the subject of speech. But there is no doubt that it is of course very important and very useful and desirable to have a professional interpreter: [the] understanding with the patient is much easier, things can be explained much more clearly and of course the patient will understand everything much better.

Here we see naturalisation of interpreting and an example of deployment of natural interpreters. This doctor in particular views translation, sight translation or liaison interpreting as a natural process, which every bilingual does unselfconsciously, mechanically and automatically. As already stated, this medical professional along with other few doctors, who I had the opportunity to interview for this study, claims that it would be unnatural and iconoclastic to allocate interpreting, translation and language usage exclusively to Translation and Interpreting graduates, because language cannot be parochially viewed as expert knowledge or as a mystique science which is withheld from the general public and accessible only to the initiated ones. Language is something inherent to human beings, so everybody can start to learn languages from any age as opposed to law or medicine. Interpreting and translation are construed and have been socially embedded as effortless activities, just like speaking in foreign languages. Consequently, no license is required to use one's linguistic skills and therefore many unqualified applicants take up the

position of interpreter. The construal of interpreting as a natural activity obviously debunks the whole theory of professional knowledge, and resonates with an ideology spread across many countries. Such standpoint may contribute greatly to the overestimation of linguistic capital as a major employability asset and to the devaluation of official university education. It is interesting how this participant assumes that the *soi-disant* interpreters do their job well when their supervisors or administrative authority are co-workers belonging to other professions or occupations. What criteria are being used to determine whether the alleged bilingual staff is proficient or not? This question remains unanswered.

After stating that "it is very useful and desirable to have a professional interpreter", the informant went on to compare medical interpreters with air-conditioning technicians:

> Es igual que si tengo que ir a arreglar un aire acondicionado pues mejor que sea un especialista que sepa de que va el aire acondicionado, la superficie, calorías, frigorías que hay que poner que no un aficionado que le guste que probablemente controla pero no es lo mismo, qué duda cabe.
>
> That would be like me trying to have somebody fix my air conditioner. It would be better for it to be a specialist on the matter who is on top of things like the surface area, BTU or watts, joules, etc., rather than an amateur who despite being fond of it and probably despite being able to handle the situation would not be able to deliver the service in the same way. There is no doubt about it.

This participant is clearly trying to explain that even though there is a clear difference between an "expert" and an "amateur", the current clinic administration might have already adopted the ideology of the naturalisation of interpreting, whereby this activity is seeing as a spontaneously, unselfconsciously, natural, automatically occurring phenomenon, intrinsic to every self-declared bilingual or self-proclaimed proficient user. Due to this cliché-ridden demystification and deproblematisation of patients' linguistic needs (and therefore failure to honour these patients' needs) the management and the doctors are lead to believe that a specialised university education is not something indispensable or imperative in order to deliver translations at the level at which we work here [in a medical facility]. As most of the interpreters deployed in these private healthcare facilities do not know the languages –which they operate with– well, however, they do their job well:

> *Hay que reconocer desde luego que hay poco, poco futuro para los profesionales de la interpretación en el ámbito sanitario.* ¿Por qué? Básicamente *porque no está valorado esta figura por los directivos actuales de la sanidad* y aún así siendo penoso de la *sanidad especializada en el turismo médico* como es nuestro caso.
>
> *It must be recognised that there is little, little future for interpreting professionals in the healthcare sector*. Why is that? Basically *because this figure is not valued by the current managers of the health sector*, which is a shame taking into account that we are talking about *a health sector specialised in medical tourism.*

In the final part of the interview hospital management is revealed to be totally uninterested in providing quality care in that they a) are convinced that interpreting is a natural ability every bilingual intrinsically possess, and b) in that they ignore the existence of professional interpreters thus, not only settling for subpar services, but embracing every substandard alternative.

As stated by Participant nº 14 (male doctor, ICU, 24 years of professional experience), the only requirement he would lay down for the candidates is that they must display command of both of their working languages, which should be manifested in the familiarity with the nuances

and customary verbalisms of these languages: "los intérpretes deben conocer los dos idiomas con matices y expresiones habituales".

All of the aforementioned is yet another argument in favour of my theory that neither the state, nor society, nor service users recognise that the knowledge underpinning medical interpreting goes far beyond the alleged intrinsic ability to interpret that all bilinguals have. This lack of recognition of professional knowledge results in the lack of recognition of the profession and of its immediate functional value leading to de-professionalisation y desprecio. The interviews in this subtheme demonstrate that the institutional ethics play a major role in the development or decline of an occupation. In this case it is clearly a niche agenesis within the professional stratification system through exoterisation, oversimplification, naturalisation and de-mystification.

According to the relationality principle (Bucholtz & Hall, 2005) some social actors advocate for adequation, which implies similitude and likeness between professional interpreters and amateurs. Both groups are positioned as alike (although not identical) or "sufficiently similar for current interactional purposes" (Bucholtz & Hall, 2018, p. 599). As explained by Bucholtz and Hall, "differences irrelevant or damaging to ongoing efforts to adequate two people or groups will be downplayed, and similarities viewed as salient to and supportive of the immediate project of identity work will be foregrounded" (Bucholtz & Hall, 2018). By using linguistic mechanisms this particular social actor juxtaposes expert interpreters with amateurs. He recognises that their occupational identities are different, the quality of the service being delivered is different, the body of knowledge is different and yet due to the socially accepted ideology of the validity of the so-called natural interpreting/interpreters the relevant social actors fail to perceive these differences as the key factor in guaranteeing quality medical care and the right to information in healthcare settings (which every patient is entitled to according to national and international legislation).

It is through the social authentication (or realness) process that the non-experts are granted a right to claim ownership over the *modus operandi* that should have been reserved only for the professional identities of university graduates in T&I. Thus, MI specialists find themselves obliged to seek imposition of an exclusionary eligibility for the exercise of profession since the amateurs enjoy the possibility of a barrier-free access to the occupation.

To conclude, I would like to share another interesting excerpt belonging to Participant nº 60 (male doctor, Paediatrics Department, over 40 years of professional experience), who assumes that no education is necessary to "clearly and reliably convey" the message as long as the interpreter "understand[s] the meaning of the question" and "in certain circumstances" the interpreter knows the "meaning of some words". The following is the extract that I believe is worth deconstructing:

> Que sea un intérprete con mucha formación o no bueno básicamente pienso que [...] un intérprete es que sea una persona que transmita de forma clara y fidedigna [...] lo que yo quiero manifestar pero también es posible que el intérprete también tenga que tener ciertas destrezas de saber entender cuál es el sentido de la pregunta [...] hacia el paciente. [...]Se supone que el médico ya tiene la formación y que el en determinadas circunstancias el intérprete también debe de tener información sobre algunos aspectos o significados de algunas palabras sobre todo porque los médicos tenemos la mala costumbre de hablar en términos médicos.

> *Whether it is an interpreter with a lot of training or not well* basically I think that [...] an interpreter is a *person who clearly and reliably conveys* [...] what I want to express but it is also possible that the interpreter also has to have certain skills to be able to *understand the meaning of the question* [...] to the patient. [...] Supposedly, the doctor already has the [necessary] training and *in certain circumstances the interpreter should also have information about some aspects or meanings of some words*, especially because we doctors have a bad habit of speaking in medical terms.

We see how the medical interpreter's identity is being intersubjectively enforced by relational phenomenon, whereby an identity –in this case a professional identity–, is being tailored and framed in relation to the other social interactants' identities. Please note how the doctor classifies interpreters' qualifications as different from the doctors' qualifications. During this positioning process this respondent antagonises the occupational group of medical interpreters through juxtaposition, and uses the distinction principle to separate himself and his colleagues from the medical interpreters' identity.

Thus, this doctor juxtaposes two different typologies of knowledge: the knowledge attained through formal university education, and the "information about the meaning of some words". The former denotes sophistication, prestige and status, whereas the latter denotes naïve ignorance and inexperience in phronesis. In this case, this "relational phenomenon", through which medical interpreters' identity category gains its social meaning, implies that no previous education or training is needed for the interpreters to exercise their discretionary judgement, which may imply that their (professional?) activity does not entail discretionary judgement inherent to the complexity of the task. This means that this respondent views interpreting as a simple, intellectually effortless, mechanical activity. He reduces this activity to a mere parroting or relaying words from one language to another, where only "in certain circumstances the interpreter should also have information about [...] the meanings of some words". This, of course, bodes de-professionalisation as formal, vocational, disciplinarised knowledge (purely academic Episteme) and working knowledge (Techne or vocational competencies) are deemed unessential for the exercise of discretion. By implying that *Phronēsis*, –essential in achieving collective good through ethical and competent praxis/practice of profession–, is unnecessary, this participant dooms this occupation to pervasive and perpetual professional impasse.

3. Subtheme 3

Polyglotism as an alternative to formal education

Doctors

Participant nº 35 (see subtheme Nº 2) clearly indicates that in her medical facility alleged polyglots are favoured over language proficient graduates. This showcases how this participant associates alleged polyglotism with professionalism and self-sufficiency. The more languages a person allegedly masters, the less people the employer will need to hire in order to cover the demand, which is a cost-effective mechanism.

Participant nº 36 also follows the same ideation:

In this case we see how a doctor implies that medical interpreters should have knowledge of and skills in "several languages".

Participant nº 49 (male doctor, Internal Medicine Department, 30 years of professional experience) also believess that:

> Es muy importante y muy útil y deseable el disponer de un intérprete profesional que domine una dos tres cuatro x lenguas [...] [el] entendimiento con el paciente es mucho más fácil.
>
> It is very important and very useful and desirable to have a professional interpreter who is fluent in one, two, three, four, whatever languages [...] [the] understanding with the patient is much easier.

And participant nº 60 (male doctor, Paediatrics Department, over 40 years of professional experience) can also be subsumed under the coterie of medical professionals who concur with one another that quantity is cognate with quality. This participant does mention though that it is important that medical interpreters display similar competence in all languages they claim to be proficient in:

> Yo creo que sí, un intérprete es mejor si habla 8 idiomas que si habla 3 pues yo lo que pienso es que bueno cuanto más hable mejor para el intérprete lo importante es que [...] su trabajo su función sea completo en todas las lenguas que intente utilizar no o sea que no haya que haya un desequilibrio entre ciertos idiomas que domina mejor otros que no lo domine tan bien.
>
> [I think that an interpreters who speaks 8 languages is better than the one that speaks 3, the more languages they speak the better for them. It is important that [...] their work and function be complete in all the languages they try to use, so that there is no imbalance between certain languages that they speak better and other languages that they do not speak so well].

Participant nº 31 (male surgeon, Laparoscopic and Colorectal Surgery Department, 35 years of professional experience) implies that interpreters-to-be study several languages at the university, which resonates with the theme of polyglotism. Although this participant states very clearly that polyglotism or multilingualism is not an alternative to formal education in Translation and Interpreting, he still views this education as plurilingual philology with an emphasis on medical terminology:

> Bueno si [la educación] es universitaria – mejor, pero si cuando tu estudias alemán, inglés o ruso en la universidad te dan un inglés especializado bien si no a lo mejor tienes que complementarlo luego posteriormente, eso es muy probable porque a mí cuando me enseñaron inglés, que tampoco es una maravilla el inglés que a mí me enseñaron, ahora sí lo enseñan mejor, pues tuve que por mi cuenta leerme libros de inglés médico.
>
> It is better if the candidate has university education, but when you study German, English or Russian at the university they should teach you specialised English, [German, Russian, etc.], because if they don't – perhaps you will have to complement it later. That's very likely, because the English that I was taught was not good enough, [hopefully] now they teach it better, and so I had to read medical English books on my own.

These extracts may be considered as diagnostic of a widespread consideration that "interpreter" is basically a synonym of "polyglot", which is of course completely erroneous, in that it denotes prevalence of quantity over quality. This excerpt, as well as this subtheme should also foreground the fact that many times a person's alleged multilingual abilities are overestimated and exaggerated, be it by the self-proclaimed polyglot themselves or be it by those who surround them. This obviously occurs out of ignorance regarding the complexity of the language learning

processes, as it was already discussed in the previous chapters of this thesis. This statement does not necessarily imply, but rather suggests the possibility that the rationale behind such ideation might be the fact that this doctor may have been working with people who might have noticeably exaggerated, inflated or overestimated their linguistic skills. It can also be the case of a popular notion very extended in some countries (Certainly in Spain), regions or cultures that the expression "to know/speak a language" automatically implies native-like proficiency in that foreign language. They might have done so un(self)consciously, unintentionally, without having ever been aware of what an actual language command entails.

4. Subtheme 4

Philology as an alternative to formal education

Doctors

Participant nº 36 (male doctor, Gynaecology department, 23 years of professional experience) raises an extremely important topic, which I have not addressed in this thesis yet, but which in my opinion merits our attention and is worth discussing: professional encroachment on the part of philologists:

> Pues desconozco exactamente cuál es la formación que tienen [los intérpretes y los traductores], pero sí que si una *filología* de la lengua que habla el paciente o interpretación como tal creo que podría ser mucho más fidedigno y mucho más exacto esa traducción o esa interpretación que realicen que si simplemente tienen un conocimiento más superficial de la lengua, sobretodo a nivel especializado probablemente un mayor interés.
>
> Well, I don't know exactly what training they [the interpreters and translators] have, but if they have a philology of the language spoken by the patient or interpretation as such, I believe that the translation or interpretation they carry out could be much more faithful and much more accurate than if they simply have a more superficial knowledge of the language, above all at a specialised level.

This extract poses some truly challenging questions, which may be subject to heated debates. In Spanish society, philology is considered a science that studies cultures as they manifest themselves in their language and literature, mainly through written texts (Diccionario de la Real Academia Española, 2022). But is philology considered to be a profession? The web page belonging to the Philology Faculty of the Complutense University of Madrid, there is a list of career opportunities and employment prospects of the philology graduates. Due to its extensive repertoire and the irrelevance of some of these professional options and possibilities, I am going to touch on the most salient ones and only those which conflict with Translation and Interpreting. Thus, this list includes the following job opportunities, activities, and potential fields of practice: text analysis and interpretation, discourse analysis and interpretation, cultural consultancy, language consultancy, international communication, linguistic correction, liaison interpreting, international relations, sociolinguistics, subtitling, specialised translation, community translation, literary translation, website translation, freelance translation and interpretation, sight translation, courts of law, tourism *inter alia*. This expertise overlaps or has imbrications between philology and public service interpreting and it perfectly exemplifies those cases where interoccupational jurisdictional

boundaries as well as task and expertise ownership of two different candidates to professionalisation or established occupations compete for access into the workplace and struggle to improve their status by usurpation of competencies, skills and professional knowledge. In this case philologists oust translators and interpreters from a potential occupational niche[137].

Thus, if we revisit the relationality principle described in Bucholtz and Hall (2018, p. 599), we will see that in this case adequation/distinction relation pair can be applied. Both philologists and liaison interpreters are "understood as sufficiently similar for current interactional purposes" (Bucholtz and Hall, 2018, p. 599). The differences between two profiles are downplayed as irrelevant. Through adequation we may see how during positioning processes my informant has associated liaison or dialogue (also known as public service or community) interpreters with another completely different occupational group. The information on career opportunities and employment prospects of the philology graduates found on the Universidad Computense de Madrid web site definitely undergirds such association. Therefore, the crux of the matter is that medical interpreting is much less established that other branches of interpreting such as conference interpreting, and possibly even less established that philology, although I am not going to zoom in on the topic of the professionalisation of philology in this thesis. To conclude, it is worth noting that the following chapter (focusing on quantitative data) will contain information and discussion on the educational background of the medical interpreters who currently practice in the study relevant area.

5. Subtheme 5

Personal traits as an alternative to formal education

Even though this subtheme may not be the most recurrent or the most salient, it still merits our attention as some participants have explicitly stated that personal traits are more important than the formal university education in the case of medical interpreting.

For instance, Participant nº 11 (male doctor, Endocrinology Department, over 10 years of professional experience) is convinced that "amabilidad [kindness]" is the only thing apart from bilingual, quasi-bilingual or proficient language skills that medical interpreters must have. Participant nº 21 (female doctor, ICU department, over 15 years of professional experience) contends that: "determinadas características humanas y un saber estar [Certain humane characteristics as well as a savoir-faire/savoir-être is needed]". Participant nº 23 (male doctor, Department of Internal Medicine) argues that: "La forma de ser de la persona es más importante que la formación [The person's way of being/personality/individuality is more important than the training]". Participant nº 15 (female doctor, ICU, 13 years of professional experience) claims that empathy is absolutely essential for medical interpreting, while Participant nº 35 (female doctor, Department of Gynaecology, 7 years of professional experience) does not believe that: "por el hecho de ser traductora vayas a tener una mejor actitud que otra persona que no necesariamente es traductora. Y eso va asociado a la capacidad y a la responsabilidad de la persona [I don't think that just because you are a [graduate] translator you are going to have a better attitude than someone who

[137] Please check https://filologia.ucm.es/salidas-profesionales-y-empleo

is not necessarily a [graduate] translator. And that is associated with the person's ability and responsibility]".

B. Part II: Typology of formal education

Juxtaposition of ill-defined and underrecognised translation and interpreting education versus a clearly expressed need for medical specialization

1. Subtheme 6

Ill-defined and underrecognised translation and interpreting education

Nurses

Even though I would usually start with the doctors, this time I shall start the analysis of this subtheme by quoting a nurse, whose remark in my opinion summarises the essence of an "opaque definition" and the spirit of this subtheme. Thus, when inquired about whether she thought education was necessary and if yes what type of education she believed the interpreters-to-be should pursue to succeed as professionals in the field, she responded by saying:

> Es muy importante que tengan una formación adecuada no solamente en cuanto a la traducción e interpretación sino algo que va más allá [...] tiene que saber pues mucho más vocabulario mucho, interpretar no solamente traducir sino interpretar que es diferente.
>
> *It is very important that they have an adequate training not only in terms of translation and interpreting but something that goes beyond that* [...]. they have to know much more vocabulary, much more, [they need to know how to] interpret, *not only translate but also interpret, which is different* (Female nurse, over 20 years of professional experience)

I am pretty confident that she probably meant a degree in T&I and a specialisation in health science that would allow interpreters to navigate through the system and master medical jargon. However, she never explicitated on what "an adequate training" actually signifies, and what exactly she was referring to when she said "something that goes beyond that". By saying "not only translate but also interpret, which is different", the informant implies that translation is an automatic action without thought, whereas interpreting is giving meaning, a more complex cognitive activity. Was she referring to the difference in difficulty between translation and interpreting in terms of not having that much time to ponder when interpreting, or was she saying that medical interpreters were not to translate words o terms, but rather to fathom out complex medical concepts when relaying them to the patients. Again, I believe that this excerpt is a clear example of a very loose and vague definition. It's a perfect example of the confusion in society about our task. A very common affair, I am afraid.

Doctors

A number of participants suggested that there should be a regularised: "formación y acreditación del intérprete [training and accreditation of the interpreter]" (Participant nº 22, male doctor, ICU, 9 years of professional experience), however, even the open-ended exploratory

follow-up questions designed to elicit insights on the nature of such education, training, and credentials failed to deliver a clear answer, which is attributable to, compatible with and diagnostic of the fact that some participants do not link the lack of credentials conferred by the formal university education to a compromised quality. Thus, in this section I shall try to fathom out the factors that informants view as key in qualifying the aspirant as interpreter. As the title of the overarching theme indicates, there is a patent lack of consistency or consensus regarding the type of knowledge and education that medical interpreters-to-be should pursue, and this subsection will not be an exception in demonstrating this. As maintained by my participant nº 26 (male intensivist, ICU, over 15 years of professional experience): "*Es necesaria la formación, pero yo no sé quién da esa formación. En algunos otros países hay centros donde acreditan a personas para la traducción sanitaria, pero aquí en España yo creo que no lo hay* [Training is necessary, but I don't know who provides that training. In some other countries there are centres whereby people are accredited for medical translation, but here in Spain I don't think similar centres exist]". Participant nº 36 contemplates the possibility that the rationale behind the recruitment of layperson self-reported interpreters may be the dearth of highly-qualified professionals: "Con tu perfil hay poca gente Nina que tenga cualificación yo creo que hay poca gente a lo mejor el tema es que a lo mejor no es fácil de llegar a encontrar. [There are few people with your profile, Nina, who are qualified, I think there are few people, maybe the thing is that it is not easy to find them]". He goes on to reveal that he does not know what professional or personal qualities an interpreter should possess, or what education an interpreter-to-be should pursue, but there is one thing he is quite confident of: foreign language proficiency alone is not enough to work as interpreter:

> No solamente un conocimiento del idioma, debe ser capaz de empatizar con el paciente, debe ser capaz de tener una capacidad de trabajo, tiene que tener una serie de características y no solamente vale con saber la lengua.
>
> [It is] not only a knowledge of the language, [interpreters] must be able to empathise with the patient, they must be able to have certain working capacity, they must have a series of characteristics and it is not enough to only know the language.

Thus, the main pillars of the professional knowledge according to this gynaecologist are: language proficiency, (natural?) ability to empathise, and ability to deal with certain workplace requirements, such as the capacity to deal with pressure or increased workload.

Participant nº 36 construes formal education as a way to improve performance of medical interpreters, but he is unaware of whether all of the graduates will be able to showcase the same level of qualification and competence, thus implying that formal university education may be an important adjuvant element, but he contends that a university attestation may not be the ultimate guarantee of skill and proficiency. His statement is also suggestive of the fact that universities may not be viewed as the producers and reproducers of all knowledge (Atkinson, 2016) underlying this occupation. It is absolutely clear that a person cannot come to master a foreign tongue in four years, which is the duration of Translation and Interpreting Degree in Spain, this is why my informant states: "If, apart from knowing several languages, they have adequate training [...]". As it was clarified by Oster, according to Kiraly's socio-constructivist approach (2000) the acquisition of "the foreign language as a prior step to teaching translation itself" (Kiraly, 2000, p. 34 in Oster,

2008, El enfoque constructivista, § 1). Hence, my informant believes that the process of becoming a medical interpreter is subject to a concatenation of factors and determinants that are not limited to the completion of the corresponding university degree:

> *Si aparte de conocer varios idiomas tiene una formación adecuada lo hará de una forma más rigurosa y más exacta* con lo cual colaborará y contribuirá mejor a la adecuación de esa traducción y la satisfacción del paciente y del médico. *Pero no sé si en todos los casos es posible tener ese grado de cualificación, que sí que sería deseable por otra parte.*
>
> If, apart from knowing several languages, they have adequate training, they will do it in a more rigorous and accurate way, which will help and contribute better to the adequacy of the translation and the satisfaction of the patient and the doctor. *But I don't know if it is possible to have this level of qualification in all cases, which would be desirable.*

Participant nº 39 (male doctor, Emergency Department, 16 years of professional experience) advocates for education, be it an official state-controlled university degree or another type of conventional or unconventional education –which he does not specify–, in order to ensure that this individual is a well-rounded and generally knowledgeable person with certain unspecified "language skills" and "specialisation in languages":

> La atención médica implica *un nivel determinado de habilidades lingüísticas* y de *nivel cultural* de la persona en general con lo que sería necesario una *persona con una formación universitaria* o *de otro grado* y ideal si además tiene alguna *especialidad en lenguas y experiencia en medio hospitalario.*
>
> [Medical care implies *a certain level of language skills and cultural level* in general [...], which means that *a person with a university degree or other education is needed*, ideally a person with a *specialisation in languages and experience in the hospital environment*].

The lack of specificity regarding education whereby a "specialisation in languages" is achieved is diagnostic of lack of consistency or consensus regarding the type of knowledge and education that medical interpreters-to-be should pursue. Thus, the participant recognises the salience of intellectual nature and comprehensive knowledgeability of medical interpreters, which is already a very important step towards professionalisation. It is worth noting that this participant was the only one to explicitly mention the intellectual virtues in relation with language skills and basic medical notions.

This orientation in ideation and reasoning denotes recognition of the typology of professional knowledge underpinning medical interpreting, which is grounded in discretionary specialisation as opposed to mechanic/unselfconscious specialisation, formal knowledge ("a person with a university degree or other education is needed") as opposed to tacit skill, specialised knowledge ("ideally a person with a specialisation in languages") as opposed to everyday knowledge, and working knowledge (diagnostic, prescriptive and practical) as opposed to merely practical knowledge. However, he clearly showcases lack of awareness regarding the type of education that interpreters-to-be ought to pursue.

2. Subtheme 7

Imperativeness of medical specialization

Nurses

I shall start this subsection by quoting a nurse practitioner, Participant nº 50 (male nurse practitioner, over 30 years of professional experience), who advocates for a hybrid profile and hybrid formal education, where medical knowledge merges with linguistic skills:

> Yo creo que es preferible que sea una persona que tenga una formación en ciencias de la salud es preferible a lo mejor no es indispensable pero si que es bueno pues porque así los pacientes se enteran mucho mejor de lo que nosotros les estamos informando [...] si tenéis conocimientos médicos o conocimientos sobre problemas de salud ellos lo van a entender mejor yo creo que sí que sería deseable por lo menos un curso específico [...] un curso de la duración del tiempo que fuera para preparase en temas de salud.
>
> I think it is *preferable that it be a person who has an educational background in health sciences*. It is preferable, perhaps it is not essential, but it would be a good thing, in that the patient would end up being much better advised of whatever we are trying to inform them about [...] *If you have medical knowledge or knowledge about health problems, the patients will be able to grasp [the information] better*, I think it would be desirable to have at least *a specific course [...] a course of whatever length it may take to prepare them in health issues.*

Doctors

Participant nº 52 (male German-speaking doctor, Internal Medicine department,15 years of professional experience) indicates that "a good education" is needed not only in languages, but also in medicine:

> Creo que es importante que traductores tienen una buena educación no solamente de la lenguas que tienen que traducir también de la del tema que tienen que traducir porque la tema de medicina es algo especial y tienen que traducir con varias especialidades de la traumatología, cirugía, hasta medicina interna hematología oncología mucho más con con diferentes exigencias por eso una formación es muy importante [...] también porque el médico quiere preguntar al paciente algunas preguntas muy especiales para recibir información y si el traductor no entiende la el sentido[138] de la pregunta [...] manera si es una traducción mala podemos perder muchas informaciones importantes para el tratamiento del paciente y eso puede ser un desastre [...] porque a veces el paciente dice una palabra una frase al lado sin darle mucha importancia pero para el médico es la una información muy importante no podemos perder ninguna información para poder tratar al paciente adecuadamente y de buena calidad por eso claro la traducción debe ser profesional [...] Claro, es más como [que] solamente una traducción porque las traductores necesitan también conocimientos del tema de que hablan y claro eso es difícil porque vosotras entenderéis a muchas especialidades y tenéis que saber de todo para hacer una traducción muy buena.
>
> I think *it is very important for translators to have a good education not only in the languages* they have to translate from and into, *but also in the subject that they have to translate*, because *medicine is a very special discipline*, and they have to translate *different specialities ranging from orthopaedic traumatology, surgery, to internal medicine, haematology, oncology, and many more with different requirements*, that's why the *education is very important*. [A]lso

[138] The Spanish noun "sentido" in this case denotes both: the "meaning" or "significance" as well as "orientation" or "direction" of the question that the doctor is posing in order to elicit a very specific answer, reaction or insight.

> because the doctor wants to ask the patient some very specific questions in order to receive [certain] information and *if the translator does not understand the line of inquiry, we can lose a lot of crucial information [and] if it [results in] a deficient translation we can lose a lot of essential information [that may end up affecting] the treatment of the patient, which can be a disaster, because sometimes the patient may casually mention a word, a sentence without making it sound overly important or without putting special emphasis on it, but for the doctor this information may be essential to prescribe an appropriate treatment* and, thus, *offer high quality medical service*, so of course, *the translation must be professional. Of course, it is more than just a translation because [in this case] the translators also need [to have] knowledge of the subject they are talking about and of course that is difficult because [they need to] fathom out many specialities* and *[they] have to know everything* in order to produce a very good translation.

Participant nº 52 positions medical interpreters on a similar level to medical professionals. He highlights similitude, likeness and affinity between two professional groups (health care providers and interpreters) by extending the characteristic traits of the medical profession (specialisation, esoterisation, mystification and multidisciplinarity) to medical interpreters. By using the adequation mechanism of the relationality principle, this participant advocates for a reproduction and burgeoning of medical knowledge in the translation and interpreting sphere. This signifies that this informant categorises medical interpreters as medical manpower or medical professionals, because "[they] have to know everything" about "the subject that they have to translate". Their education must not be limited to language proficiency, and their specialisation must not be confined to medical terminology from the multiple medical specialties. Medical interpreters must rather fathom out the *modi operandi* belonging to each specialty they are working with. By stating that: "if the translator does not understand the line of inquiry, we can lose a lot of crucial information", this doctor expects interpreters to be able to identify different patterns of doctors' ideations, understand the rationale behind the efforts to elicit certain specific information and comprehend that under no condition should an interpreter undertake the initiative to adulterate the rendition in any way or form, because even the slightest omission of an apparently insignificant utterance may prove to be crippling. Judging from the following extract I dare speculate that such insistence on interpreting everything without leaving out, editing out or omitting any information from the discourse may be based on past experiences with non-professional interpreters:

> Yo recuerdo bien de mi trabajo en Alemania había [...] por ejemplo en mi clínica había un plan de lenguas de traductores no siempre de traductores de verdad pero de personal enfermeras, médicos, otros otro personal de la clínica con los conocimientos de las lingüísticas y si necesitas traducción algo en español algo en inglés algo en otro idioma pudiste ver quién en la clínica hablaba el idioma y quién pueda ayudarte eso estuvo un poco ventajoso porque claro este gente tenían también conocimiento médicos [...] y solamente en casas raras [casos raros] hemos también pedido traductores de fuera para venir en el hospital para traducir.

> I remember well from my work in Germany there was [...] for example in my clinic there was a language plan of translators, not always of real translators, but of staff nurses, doctors, other clinic staff with the knowledge of the linguistics and if you needed translation, something in Spanish, something in English, something in another language, you could see who in the clinic spoke the language and who could help you. That was a bit advantageous because of course these people had also medical knowledge [...]. and only in rare cases we have also asked for external translators to come to the hospital to translate.

By stating that what medical interpreters do "is more than just a translation" as "[they need to] fathom out many specialities and [they] have to know everything" he introduces medical interpreters into the cosmology of the medical profession. Yet another participant differentiates

between translation and interpreting, thinking that the former is merely an automatic robot-like activity done unselfconsciously and effortlessly, whereas the latter is viewed as s complex cognitive activity. This is a very common mistake rooted in the expression "to interpret a text" (biblical, philosophical, literary, etc.), which requires previous knowledge of the topic.

The expansion of the interpreters' body of knowledge into medical expertise may be interpreted by some medical professionals as an upgrade to a more sophisticated and more scientific competence. Such ideation may result in two bifurcating outcomes. The first outcome is the emergence of a hybrid profile, whereby the interpreter becomes an "extension" or "duplication" of the clinician (Hsieh, 2010) and ends up embracing the role and the functions of the physician. There is a risk that officially they would fall into the category of administrative assistants, but they would be expected and required to undertake medical tasks. Such profile hybridisation would signify that medical interpreters would become subordinate support staff, whose professionalisation efforts and bargain for more autonomy and status will fail to come to fruition. This knowledge and understanding of medical *modi operandi* (and the taken-for-granted language proficiency) may be abused and they will end up becoming doctors' "helpers", whose claims for recognition may be viewed as an assault on the doctors' traditional territory (Johnson, 2016, Doctors and the Sociology of Medicine section, § 5). We will see some cases of hybrid profiles in the upcoming sections and also in the analysis of the second overarching theme. The second outcome is the one this participant is referring to: professionalisation. By stating that "education is very important [...]" because the "translation must be professional" this participant clearly advocates for professionalisation and recognition of the complexity of translation and interpreting in this "very special" field.

The evidence educed form the interview with Participant nº 48 (male radiation oncologist, MD-PhD, Oncology department, over 35 years of professional experience) indicates how difficult it is to interpret in the medical field:

Y luego los intérpretes tienen inexcusablemente que tener una formación específica de lo que están hablando porque si no es casi imposible pasar el concepto. O sea no es que tenga que ser como un médico si estamos hablando de medicina pero sí que tienen que conocer los conceptos y cómo se mueven los médicos creo que si no no hay una buena traducción. La traducción sin conocer el concepto ya la hago yo paso el dato y ya está pero efectivamente yo creo que eso es o lo hace Google que también hace traducciones pero no yo creo que el intérprete tiene que conocer muy bien su herramienta se le supone la lengua que está traduciendo el concepto es esencial el concepto equivalente ¿no? no exactamente la palabra equivalente y luego la formación específica porque todas las profesiones tienen lenguajes muy particulares pero el griego más, o sea el griego, el médico más, digo el griego porque habla mucho con conceptos griegos y es muy especial porque luego además a la hora de pasar tú tienes dos formas de hacer tienes al médico sajón que cuenta las cosas usted tiene sólo 30% de posibilidades de salir vivo le duele es normal tome aspirina me sigue doliendo lo siento eso es una enfermedad que tienden a ser muy	Thus, *it is absolutely imperative that interpreters complete a specific training in the discipline or subject area they are practicing in*, since otherwise it is almost impossible to get the concept across. In other words, *they don't have to be like a doctor if we are talking about medicine*, but they do have to *grasp the concepts* and *understand how doctors work*, otherwise I don't think there is [a chance of delivering] a good translation. Produce a translation without having grasped the concept –I can do it myself, I can convey the piece of information and that's it, I think that's pretty much what Google does, Google also produces translations, but no, I think the *interpreter has to know his tool very well, that is the language they are translating from and into, the concept is essential, the equivalent of that concept, right? it's not exactly the translation of the word, but of the concept.* And then in terms of specific training, all professions have *very particular jargons*, but *medicine is literally loaded with Greek terminology and concepts* [...] *medicine is also a very unique profession*, in that you have two different ways of conveying information: you have the Saxon physician model, who delivers information like that: you have only 30%

objetivos y fríos. Los médicos latinos y mediterráneos tenemos tendencia a intentar arropar más a los pacientes quizá por nuestro concepto de familia pero a su vez eso puede oscurecer los conceptos y que los pacientes acaben entendiendo que le ha dicho que le voy a curar no es lo mismo curar que cuidar y bueno pues eso el intérprete yo creo que es muy importante porque tiene que conocer la profesión, tiene que conocer el idioma y idealmente tiene que conocer al médico. En Anderson había intérpretes de departamentos y de unidades funcionales entonces personas que estaban traduciendo mama no traducían sistema nervioso central por ejemplo, no es porque no lo pudieran traducir sino porque se impregnaban de lo que es el ambiente la problemática de los pacientes con un cáncer especial [...]	chance of surviving, it hurts, it is normal, take aspirin, it still hurts, I am sorry, that is a disease. [That way to convey a message] tends to be very objective and cold. As Latin and Mediterranean doctors, we have a tendency to try to cosset/rally around/ mollycoddle our patients, perhaps because of our concept of family, but at the same time this can obscure the concepts and the patients may end up (mis)understanding that you have told them that you are going to cure them and "cure" is not the same as "care" and, well, the interpreter I think is very important because *they have to know the process/the way to proceed, they have to know the language and, ideally, they have to know the doctor [be familiar with how a particular doctor works].* At Anderson[139] there were interpreters from departments and functional units, so people who were translating breast cancer did not translate central nervous system, for example, not because they could not translate it, but because they were [too] impregnated with the environment and the problems of patients with a special cancer [...].

By carefully perusing this excerpt, and by collating it with the rest of the extracts from my data corpus, I managed to glean a number of patterns, which complement the subtheme of imperativeness of medical education. Such tendency signals the necessity to highlight the esoteric nature of medicine manifested in terminology stemming from Greek. By saying "they don't have to be like a doctor", this participant claims an exclusionary ownership over a certain *modus operandi* inaccessible for those uninitiated and and exlusive to the professional identity of the doctors. By "authenticating" medicine as "a very unique profession", he is traditionalising (Bucholtz & Hall, 2005, p. 602) this ideal typical historic profession by relying on a claimed historical tie to a venerated past (Bucholtz & Hall, 2005, p. 602) and on the professional charisma in general medical practice[140] (Horobin, 2016). By suggesting that "ideally" medical interpreters "have to know the doctor and how each doctor works", this informant assumes that medical interpreters need to adjust their professional performance to each doctor. Even though no hybrid identity is being constructed, key features of medical interpreters' identity such as double allegiance, neutrality, objectivity, etc. are still being denaturalised. Please note that this subtheme demonstrates how none of the participants has ever mentioned the need to learn how to work with interpreters, but how all of them highlighted the need for the interpreters to know how doctors work. This fact showcases the lack of professional respect towards this occupation and the professional dominance, imperialism and elitism of medical profession. In this intersubjective construction of the medical interpreters' professional identity, the importance of their performance is recognised only because they work directly with the doctors. I do not think that it is done through adequation (or by highlighting the similitude between two professional groups), in that by foregrounding the need for esoterisation of interpreters (terminology, etymology stemming from Greek) the

[139] University of Texas MD Anderson Cancer Center, Houston, USA.

[140] For more information on the correlation between professional mystery and charisma in medical practice, please read "Professional Mystery: The Maintenance of Charisma in General Medical Practice" by Gordon Horobin, 1983 in Dingwall & Lewis, 2014).

participant only highlights the mystique that medicine is surrounded by. He does not position medical interpreters as alike (adequation), but he rather "disaligns" with them and evaluates this occupation as subordinate by a clear imposition of subordinate, ancillary, instrumentalised extension of the doctor. The ideology of medical imperialism and professional charisma as well as mystique burgeons and proliferates within hospital walls, since we are talking about doctors' primary institutional sphere. In this case, the key external player's (García-Beyaert, 2015, p. 46) stance, manifested through micro indexical processes such as evaluation, assessment or positioning of doctors as users and receivers of the service, denotes subordination. This excerpt is a demonstration of this speaker's linguistic marking of his ideological orientation:

> El intérprete hace una labor como la mamá con lo niños en las familias clásicas mediterráneas de las cuales yo provengo. El padre es la persona autoritaria, enérgica sobre las que recaía la responsabilidad de alimentar la familia y defender la familia, y eso era lo importante. Normalmente estaba trabajando, estaba fuera, venía cansado y a veces no contactaba con los niños. ¿Qué hacen las madres en esos casos? Le cuentan a sus hijos lo bueno que es su padre y lo que les quiere su padre. Entonces el hijo aunque el padre no esté sonriendo interpreta que sí y aprende a interpretar los gestos de cariño del padre. Eso es lo que hace un intérprete.
>
> The interpreter's job is similar to that of a mother in a classic Mediterranean family [...].The father is an authoritarian, energetic person who is responsible for feeding the family and defending the family, which used to be the most important thing. Usually he would work outside his home, he would return tired and sometimes he would not interact with the children much... What do mothers do in such cases? They tell their children how good their father is and how much their father loves them. Then the child, even if the father is not smiling, interprets that he actually is, and learns to interpret the father's gestures of affection. That is what an interpreter does (Participant nº 48, male radiation oncologist, MD-PhD, Oncology department, over 35 years of professional experience).

The intrinsic character of ideology in the macro process of formation of "indexical ties" or associations (Bucholtz & Hall, 2005, p. 596) is manifested through the use of linguistic structures and systems that are ideologically associated with specific persons and groups. This process may either be bottom-up or top-down. In the case of medical professionals' evaluative, epistemic stances, positions or orientations towards the occupation of medical interpreting is a top-down process of *indexical inversion* (Miyako Inoue, 2004, in Bucholtz & Hall, 2005, p. 596), whereby such "indexical associations can also be imposed from the top down by cultural authorities such as intellectuals or the media. Such an imposed indexical tie may create ideological expectations among speakers and hence affect linguistic practice" (Bucholtz & Hall, 2005). In this excerpt we see how an indexical association is being imposed on medical interpreters from the top down by an authoritative figure of the doctor. This imposed indexical tie creates ideological expectations, where the medical interpreter is expected to become a motherly figure. My participant overtly states that his view of doctor-interpreter-patient encounter should resemble the model of a traditional Mediterranean family, a patriarchal family, where the *pater familias* –hence the doctor–, makes decisions concerning all members of his family. Such paternalistic authority and stance may completely overshadow the mother's –hence the interpreter's– yearning and eagerness for exclusive cognitive and regulative authority. The secondary institutional sphere may only exacerbate the situation and paralyse the interpreters' determination and desideratum to professionalise. The division marked by the gender roles gains social meaning in this context as well, in that

100% of all interpreters, who work in the healthcare facilities where this research was conducted were all female. Thus, the needs of the father/doctor are being prioritised, while the needs of interpreters, such as recognition, autonomy and authority are being obscured, neglected and dismissed. The imposition of an subordinate motherly identity through structures of institutionalised power and ideology is done deliberately and intentionally according to the partialness principle of identity construction. It is worthwhile noting that despite a quite lengthy and prolix discourse about the medical interpreters' specialisation, this participant did not clarify whether the aspirants need to receive a formal education to become translators and interpreters, and what type of education would that be. Also, by suggesting that the interpreter should specialise on a specific branch within a medical specialty instead of operating across the facility and premises, Participant nº 48 is "aligning" medical interpreters with auxiliary nurses through micro indexical processes (Bucholtz & Hall, 2005, p. 595).

Other participants also uphold this view of the medical interpreter as a subordinate and auxiliary figure, for instance Participant nº 4 believes that being a good interpreter in this field implies "discreción y saber adoptar posición de segundo plano [it takes discretion and knowing how to take a back seat to the doctor]".

In the same vein, Participant nº 54 (male ophthalmologist, Ophthalmology Institute, 25 years of professional experience) is also highlighting the need for instrumentalisation of medical interpreters, the importance of the institutional ethics in the secondary institutional sphere and the institutional rituals:

> Para transmitir a nuestros pacientes la información correcta y adecuada y la información veraz para que el paciente sea capaz de entenderla es imprescindible contar con un intérprete que pueda transmitir esta información un intérprete no cualquiera un intérprete experto en materia sanitaria para que sepa qué es lo que quiere el médico transmitir al paciente y saber qué es lo que el paciente quiere transmitir al médico porque en este caso el intérprete es la voz del médico es pensamiento del médico es la herramienta de trabajo indispensable en nuestra tarea diaria sobretodo en pacientes que hay que realizarles alguna intervención quirúrgica o sobretodo en los familiares cuando el paciente acude de una forma o de otra a urgencias con el estrés que conlleva todo esto. Yo pienso que tiene que ser intérprete sub especializado donde pueden realmente realizar su tarea con el médico y con el personal de enfermería a la perfección para que no quede ninguna duda al paciente o del paciente al médico en este caso y que sea una transmisión de información totalmente veraz y eficaz. Yo estoy absolutamente de acuerdo en que tiene que ser una formación universitaria e incluso una rama sub especializada insisto en ella es una rama sub especializada lo mismo que cualquier traducción simultánea pero en el mundo de la sanidad es muy importante y es imprescindible tener un personal muy preparado.
>
> In order to transmit to our patients *the correct and adequate information and truthful information* so that the patient is able to understand it, *it is essential to have an interpreter who can transmit this information, not just any interpreter, but an interpreter who is an expert in health matters so that he/she knows [exactly] what the doctor wants to transmit to the patient and what the patient wants to transmit to the doctor*, because in this case *the interpreter is the doctor's voice, he/she is the doctor's thoughts*. It is an *indispensable working tool in our*[141] *daily work*, especially for patients who have to undergo surgery or, for relatives when the patient in rushed into emergency room [...] with all the *stress* that that entails. I think that *it has to be a sub specialised interpreter where they can really perform their task with the doctor and with the nursing staff flawlessly* [...] so that there is *no doubt* [...] that it is a *totally truthful and effective transmission of information.* I absolutely agree that *it has to be a university training*

[141] "Our" meaning doctor's tool.

> *and even a sub specialised branch*, I insist that it is a sub specialised branch, the same as any simultaneous translation, but in the world of health it is very important and *it is essential to have a very well prepared staff*.

This respondent clearly challenges and debunks some "essentialist preconceptions" and "ideological expectations" (Bucholtz & Hall, 2005, p. 588-591), and instead of treating interpreters condescendingly by naturalising and popularising their body of professional knowledge (Participant nº 49, for example), Respondent nº 54 "rejects dominant social ideology" (Bucholtz & Hall, 2005) and "disrupts naturalised associations between specific linguistic forms and specific social categories", for example, socially accepted synonymy between "interpreter" and "bilingual", "interpreting" and "speaking languages", "interpreting" and "knowing medical words", etc. In accordance with the positionality principle, he views medical interpreters as a macro-level demographic, social and professional category. Participant nº 49 negotiates medical interpreters' professional identity by deploying micro indexical mechanisms, such as evaluative, affective, assessing, positioning, and epistemic orientations. He aligns with medical interpreters by saying that medical interpreters must be "experts in health matters", "doctor's voice, [...] doctor's thoughts", "indispensable working tool", who "can [...] perform their task with the doctor and nursing staff". By using the top-down process of indexical inversion, this respondent imposes an indexical association of medical interpreter with the doctor, thus considering this "indispensable working tool" as a part of the medical team, capable of X-raying verbal and metaverbal texts, inferring and relaying meaning as if they were doctors themselves. Thus, by using terms such as "perfect", "flawless" and "efficient", this doctor signals the importance of quality in interpreting, recognises and explicitly foregrounds the difference between an expert interpreter and an amateur interpreter. He openly (overtly) categorises and labels graduate or professional medical interpreters as experts, which is absolutely key for professionalisation. Once the knowledge and competency underlying an occupation have been recognised as expert competence, the recognition of this occupation will be easier to achieve. Also, this specialist explicitly juxtaposes amateur self-proclaimed interpreters with trained expert interpreters allocating them to different social categories and separating their identities. In this excerpt this medical professional dilates on the knowledge and skill that a medical interpreter should have acquired before being eligible to practice. This knowledge goes beyond a mere command of medical terminology and language proficiency. He highlights that medical interpreters must provide an accurate, adequate and truthful information in a way that would enable the patient to understand the thrust correctly. He positions the expert interpreter as a professional through the indexical process of overt mention of referential identity.

According to this participant, only the complete assimilation of highly specialised knowledge and skill, conceptualisation and complete interiorisation of specialised knowledge and skill and introjection of medical *modus operandi* and the continuous updating thereof by means of constant training in a specific field of specialisation will allow the interpreter to transfer not only the lexical shell of the specialised term, but also its essence in a way that the patient fathoms out the concept (as well as its salience, connotations, denotations, implications and the speakers' intentions). The doctor foregrounds the discretionary specialisation grounded in abstract concepts and theories requiring specialised university education and training, just like in the case of any other ideal-typical profession. The higher the degree and kind of specialisation, the easier it would be to

"establish [interpreters'] social, symbolic, and economic value and justify the degree of privilege and trust to which they are entitled" (Freidson, 2001, section 7, subsection The Contingencies of Knowledge, § 1-3). Taking into account the prestige and the salience of the secondary institutional sphere of practice (medicine), a belief of inaccessibility, mystique, complexity of training, a belief that [this knowledge] cannot be standardised [or] rationalised may help gain recognition on local, national and international level. Thus, by believing that the technical expertise of his occupation is so specialised that it cannot be reappropriated by lay agents, my informant deems non-professional interpreting unsuitable and totally unacceptable.

Moreover, Participant nº 54 also touches upon the concept of professional trust, he aligns his professional identity with that of medical interpreter by means of sharing the phenomenon of heroic intervention with the members of this occupation. By stating that: medical interpreting "is an indispensable working tool in our daily work" especially "especially for patients who have to undergo surgery or, for relatives when the patient in rushed into emergency room [...] with all the *stress* that that entails", in other words, in most stressful situations, this informant expresses the theme of trust and its interconnection with professional mystique and charisma very explicitly and clearly. The phenomenon or the myth of heroic intervention consists of a "sense of power", "heroic myth" (Horobin, in Dingwall & Lewis, 2016, Chapter 4 Professional Mystery: The Maintenance of Charisma in General Practice, § 4-7), where a doctor is viewed as a saviour due to the mystique and charisma of the medical profession. Trust in a profession and in the professional may reduce stress levels and calm the patient down, which is extremely important in this particular field of practice, and thus, what this ophthalmologist says is that "very well prepared" specifically trained interpreters experts in health matters may also have this power of being perceived as heroes or saviours in certain situations of dire need or acute stress. This is how a doctor (Dr Scott) interviewed by Horobin describes this phenomenon and how he experiences it:

> Now I suppose this is just appealing to my sense of power or something, *being able to walk in and take charge and in a minute or two they've settled down and they're not panicking because you've arrived* and all their burdens are on your shoulders and *they don't have to worry any more because the doctor's there*... By this *I don't mean that I can cure the patient, but that I can cope with the situation*. Most doctors merely alleviate suffering, whether physical or mental, and it's being able to do that ... *we alleviate by technical skill (or) by presence or personality*... [...] But what is peculiar to the doctor is that the successful action, the save, is seen to be brought about through the use of the *esoteric skills for which he trained* and which, by and large, remain untested and unused. *In practice, the policeman, the nurse and the ambulance driver probably perform more life-saving actions, but they perform them through skills anyone can learn. They lack mystery*. On the less dramatic level, we can see in Dr Scott's account the more usual performance of mystery - the acceptance of responsibility by mere presence. *However sceptical we may be of the claims of medicine and its practitioners, we do*, as Kosa said, *place our faith in them when we cannot cope by ourselves.* (Horobin, in Dingwall & Lewis, 2016, Chapter 4 Professional Mystery: The Maintenance of Charisma in General Practice, § 4-7, my italics)

In the same vein, Participant nº 55 (male doctor, Neurology Department, 5 years of professional experience) also recognises that only an "exquisit" training can guarantee quality:

> Aunque les hablemos [a los *pacientes*] en términos no *médicos precisan entender bien los conceptos y precisan entender bien la información sobretodo cuando es información delicada* [...] *hacer esto y hacerlo bien es complicado* desde luego, ¿no? Porque la terminología médica es muy muy amplia, incluso hay algunos lenguajes que tienen un doble uso de la terminología, ¿no? Porque me viene a la cabeza el alemán [en] el que utilizan por ejemplo latinismos pero que después tienen sus propias palabras concretas para esas

> enfermedades [...] *está claro que la persona que se dedique a esto precisa pues una formación a veces incluso* exquisita para poder hacerlo bien posiblemente *no vale solamente con una persona que simplemente hable el idioma sino porque tiene que tener una formación especial* en este sentido.
>
> Even if we use non-medical terms to communicate with the patients, they need to understand the concepts well and they need to understand the information [being given] well, especially when it comes to sensitive information [...] of course, it is complicated to do it, and to do it well, right? Because medical terminology is very, very broad, there are even some languages that have a double use of terminology, right? German comes to mind where, for example, they use Latinisms but then they have their own specific words for these diseases [...] it is clear that the person who works in this field requires training that sometimes needs to be exquisite in order to do it well, possibly a person who simply speaks the language will not do, because special training is required.

It is my contention that this excerpt is based on the indexicality principle, whereby my informant challenges the already deeply embedded ideological structure (based on the belief that whoever self-assesses as capable of interpreting is eligible to act as such) by saying: "It is clear that the person who is dedicated to this job requires training, sometimes even exquisite training, in order to be able to do it well, possibly a person who simply speaks the language will not do, because special training is required". This statement is definitely a major indicator of professional recognition. The doctor goes on to say: "patients need to understand concepts well and they need to understand the information [being given] well, especially when it comes to sensitive information" and it is quite "complicated". The salience of this statement and its contribution to professionalisation lies in the words "well" and "complicated". So, the interpreter requires an "exquisite training" in order to be able to do his/her job well, in that this job is complicated. By stating that it is "complicated" the doctor recognises that it requires "exquisite" education and training, which means that this occupation entails highly specialised and complex knowledge foundation. Consequently, by highlighting the difference between simply doing it and doing it well, the doctor foregrounds the salience of guaranteeing and signalling the quality. This respondent evaluates the complexity of knowledge underlying medical interpreting, which is a micro indexical process, and thereby positions himself aligning with the concept of professional interpreter, whose occupational status and prestige he deems similar to his own profession. Thus, he attributes to the occupation of medical interpreter the characteristics of a profession, recognising that only a person with "exquisite" expertise can claim ownership over tasks of this nature and complexity.

Participant nº 35 (female doctor, Department of Gynaecology, 7 years of professional experience) avows that:

> Yo no pretendo que sean médicos de la noche a la mañana, pero hay conceptos muy básicos de la biología muy básica que son erróneos, porque hay muchos mitos y creo que el personal que trabaja en una clínica como asistencia médica tiene que ser capaz de saber la realidad de la biología y no dejarse llevar por los mitos porque si no es muy difícil tranquilizar a los paciente sobre determinadas cuestiones... un mínimo de conocimientos básicos de la fisiología humana hay que tener. Esa formación lo ideal sería que fuese externa, o sea, obviamente en el grado de traducción e interpretación tiene que haber una rama que sea médico-sanitaria
>
> *I don't expect [interpreters] to be doctors overnight*, but there are very basic concepts of very basic biology that are erroneous, because there are many myths and I think that *the staff working in a clinic as medical assistance must be able to know the reality of biology* and not get carried away by myths because otherwise it is very difficult *to reassure patients* on certain issues... *a minimum of basic knowledge of human physiology is necessary.*

> This training should ideally be external, in other words, obviously in the Degree in Translation and Interpreting there must be a medical/healthcare branch.

In this excerpt my informant acknowledges the complexity of the medical field as the "primary institutional sphere" (Freidson, 2001) and highlights the salience of being well-versed in such a prestigious field through the discursive mechanisms of authentication and traditionalisation subsumed under the relationality principle (Bucholtz & Hall, 2005, p. 598). By allocating assignments such as "basic knowledge of human physiology [...] to reassure patients on certain issues", this participant discursively authenticates the professional identity of interpreters, which (d)evolved into the bilingual "staff working in a clinic as medical assistance" by granting them certain rights to do something such as "reassure the patient", to explain to the patient certain medical issues with only "a minimum of basic knowledge of human physiology", develop a relationship with the patient outside the consultation, assume a doctors' responsibility of giving medical information without being a specialist in this field. Unlike in the previous excerpts, where "the interpreters have to know everything" as the "translation must be professional" (Participant nº 52), where the interpreters is expected to "explain what the doctor says employing simple wording" (Participant nº 7), or where the interpreter was granted the right to alter medical discourse on a whim in order to determinologise it or "modulate" it (Participnat nº 30), this participant goes much further by expecting "the staff working in a clinic as medical assistance" to reassure the patients of something they barely fathom themselves. Thus, such authentication came to signify profile hybridisation.

Participant nº 47 (female doctor, Accident and Emergency Department, 10 years of professional experience) believes that formal education in the case of medical interpreting must not be limited to undergraduate degree, but must include a Master's Degree in medical translation and interpreting:

> Creo que sí deberían de tener una formación porque me imagino que, como todo, [uno] tiene que aprender técnicas sería importante en este trabajo aquí en un hospital tener un máster que conozcan ciertos términos médicos para que a la hora de traducir sea mucho más fácil.

> I think they should have training because I suppose that, just like in the case of any other occupation, one has to learn techniques. In this job, here in the hospital it would be important to have a master's degree, that would allow them to learn certain medical terms, so that when it comes to translating it would be much easier.

This extract in my opinion demonstrates how medical interpreters' professional identity is intersubjectively negotiated and how it acquires a social meaning when it is juxtaposed with other identity positions belonging to other social actors. We see how my informant compares medical interpreting with other occupations, seeing it as an occupation instead of a natural, innate, effortless, mechanical, unselfconscious, automatic activity/ability.

This participant acknowledges the difficulty of medical interpreting and the complexity of its underlying knowledge and skill. This statement marks a turning point in a situation where experience and savvy were long thought to have been an equivalent to university education. Thus, the participant acknowledges that this type of knowledge is not mechanical, tacit or everyday knowledge (natural translator), but rather discretionary, formal, specialised and academic.

Therefore, according to this extract, only the knowledge and skill acquired through a Master's degree may purportedly guarantee that the interpreter has attained adequate working knowledge (diagnostic, prescriptive and practical) necessary for quality service delivery.

Even though Participant nº 24 (male doctor, Cardiology Department, 18 years of professional experience) does not mention formal university education in Translation and Interpreting, he clearly advocates for certain medical training, which would allow the interpreters to "conocer pruebas diagnósticas, captar conceptos y dominar la terminología [be familiarised with diagnostic tests, grasp concepts and master terminology]".

Participant nº 51 (male doctor, Nuclear Medicine Department, 20 years of professional experience) avows that:

> Creo que para esto se necesitaría una persona que tuviera una formación universitaria en traducción y a parte de esa formación universitaria tendría que tener una base de conocimientos médicos ya que va a utilizar terminología médica y además de esos conocimientos médicos también debería de conocer un poco pues diferentes técnicas exploratorias en qué consisten ya que el médico al explicar al paciente las técnicas pues cuando el intérprete las traduce no sabe realmente si lo que está traduciendo el intérprete es justo lo que él está intentando informar al a esta persona, con lo cual no serviría una persona original del país, aunque su lengua materna fuera la lengua del paciente sino que necesitaría tener una serie de conocimientos.

> I think that *this [job] would require a person with a university degree in translation* and, in addition to this university degree, they would need to have a *basic medical knowledge*, as they are going to use medical terminology and, in addition to this medical knowledge, *they would also need to have some knowledge about different exploratory techniques*, because when the doctor explains the techniques to the patient, and when the interpreter translates these exploratory techniques, the doctor doesn't really know whether the translation is accurate. *This means that even a native speaker of the patient's language would not be suitable, in that prior expertise is required* [for this job].

By foregrounding the necessity of including medical knowledge into the university curriculum of the alumni, and thus broadening the formal body of their specialised knowledge, he recognises that quality service delivery is contingent on a formal body of specialised knowledge, which is based on abstract concepts and theories incorporated into specific university curricula. Participant nº 53 (male cardiologist, 18 years of professional experience) has shared with me the exact same opinion:

> Es importantísimo que haya un traductor presente en el hospital y además a ser posible con formación universitaria puesto que la traducción se necesita de una formación académica implícita, también en términos médicos, muy importante [...] es decir cualquiera no puede ser traductor aunque sea bilingüe.

> It is very important that there is a translator present in the hospital and, moreover, if possible *with a university education*, since *translation requires an implicit academic training*, also in medical terms, which is very important [...] in other words, *not just anyone can be a translator, even if they are bilingual.*

Participant nº 33 (female, dermatologist, 7 years of professional experience) advocates for formal university education with a specialisation in medical interpreting prior to the recruitment:

> Creo que los intérpretes sí que deberían tener una *formación universitaria* y creo que deberían antes de venir aquí *formarse un poco en el ámbito de la sanidad.*

> I think that interpreters should have a *university education* and I think that before coming [to work] here *they should have some training in the field of health*.

Participant nº 19 (male doctor, ICU, 14 years of professional experience) specifies that medical interpreters must have: "*conocimiento superficial* de los conceptos de la medicina [*superficial knowledge* of medical concepts]".

It is worth noting that Participant nº 36 has explicitly stated that in-house onboarding may be necessary for each type of facility where interpreters are recruited:

> Yo creo que la manera más práctica y probablemente más rápida [sería que] se consiga una formación interna en cada entorno más que una formación más general [porque] probablemente habrá que volver a formar a los intérpretes, al menos cuando lleguen a cada centro en concreto.
>
> I think the most practical and probably quickest way [would be] to get in-house training in each setting rather than more general training [because] interpreters will probably have to be retrained, at least when they arrive at each individual centre.

This excerpt highlights the unestablished character of our occupation, and the necessity to adapt to each facility's institutional ethics.

The excerpts conflated in this subtheme may possibly indicate that interpreters with an under- or even postgraduate degree in T&I or MI who were offered a student placement or who actually practice in a healthcare setting are not prepared for the demands of their role, since in some cases the educators themselves may not have the health literacy or the necessary medical knowledge required to teach properly. Then the question arises as to who is eligible to teach the aspirants to MI positions? Do the universities need to attract medical specialists as lecturers or guest lecturers? Is there a real need for cross-fertilised medico-linguistic degrees? This may be food for thought for future research.

3. Subtheme 8 Medical terminology as the most esoteric part of medical interpreters' knowledge

Participant nº 56 (female neurologist, Neurology and Neurosurgery Departments, 8 years of professional experience) states that:

> Y luego respecto al tema de la preparación evidentemente en medicina hay términos que son muy específicos y que aunque a veces tú a la familia se lo trasladas en un lenguaje que se pueda comprender el hecho de no tener que estar explicándole continuamente a alguien y de que sepas que esa persona además entiende perfectamente lo que le estás diciendo me parece que conocer los términos médicos y saber interpretarlos es muy muy necesario con lo cual creo que debe ser gente específicamente preparada.
>
> And then on the subject of training, obviously, in medicine there are terms that are very specific, and although sometimes you can convey these terms to the family in a language that they can understand, the fact that you don't have to be constantly explaining these terms to someone and the fact that you know that this person also understands perfectly what you are saying [is important]. It is very, very necessary for the interpreters-to-be to know medical terms and to know how to interpret them, which is why I believe that these people should be specifically trained [for this purpose].

This excerpt demonstrates that terminology is yet again considered to be the most important part of preparation, education and training that the interpreters-to-be should undergo. However, this excerpt harbours two important vantage points that I believe are worth mentioning.

The first occurrence implies that the doctor may need to explain a term or a concept to the interpreter. Sometimes the patient and/or their family members are not simply somewhat acquainted with the ailment in question, but rather fully familiarised with it and may have conducted an extensive research on their illness and/or visited many specialists in their homeland and overseas and thus, possess advanced understanding and appreciation of their current situation as well as their future prospects. In these cases, inexperienced graduates, who hurt for specialised education in medical interpreting, as well as unqualified bilinguals, who may lack basic healthcare literacy and, sometimes, even general erudition, may require an extra explanation on the part of the doctor or a previous familiarisation with the most complicated cases and time for preparation and assimilation of the major concepts. The problem in this case is the time that the already overburdened and overloaded doctor must dedicate to enlighten the interpreter, as well as the time that the patient may possibly be running out of.

The second point is that many doctors expect that interpreters would adapt their discourse so that it suits the erudition and education level, as well as cultural conventions of the patients and their families. Such adaptation may imply substitution of complex termini belonging to medical jargon or highly specialised sophisticated profession-related verbiage for common parlance and plain, simple, understandable language. Interpreters are sometimes expected to deliver an interlingual as well as intralingual rendition of discourse, which would include a re-expression of the utterances (from more specialised to less specialised). Such adaptation may include synthesis of information, terminological simplification (otherwise known as determinologization of complex medical terms), paraphrasis, use of synonyms, common sense explanations of difficult concepts, explication, personalisation of the language being used by expanding relevant information and by making key meanings explicit, by adjusting tenor or register to achieve more customised information, by simplification of syntax and lexis, as well as by substitution, omissions and additions. Such re-expression in a more comprehensive way implies double work, extra cognitive effort, absolute command of medical terminology and all related medical concepts and notions. Even though such cronified practices became institutional rituals permeating practice ethics of medical interpreters, the question as to whether such discourse alteration is a) necessary, b) bilaterally beneficial, c) ethical, d) acceptable, e) safe and f) morally imperative still remains unanswered. The need for adaptation is still a hotly debated issue, which gets constantly dichotomised, polarised and rebutted by the supporters and opponents of intercultural mediation as the new hybrid profession.

In the same vein, Participant nº 30, (male doctor, Department of Surgery, 15 years of professional experience) also contends that medical training should be completed beforehand, as by the time interpreters start working in the medical field they will have already familiarised themselves with a considerable proportion of medical terms:

> Pues lógicamente si previamente hay una preparación médica todavía mejora la valía de los intérpretes porque ya vienen con muchas palabras conocidas y lógicamente saben incluso modular las cosas que queremos decir [los médicos]. Indudablemente sería de un valor añadido importante.

> Well, logically, if there is medical training beforehand, the interpreters' value is even higher because they come here already *equipped with many familiar words* and logically they *even know how to modulate what we [doctors] want to say*. Medical training would undoubtedly be of significant added value.

It is worth noting that "modulation" of the physicians' discourse may come to signify its "adaptation", which may range from determinologisation or explanation to co-diagnosis or information gatekeeping, whereby the interpreter becomes provider proxy. Participant nº 8 (male doctor, Department of Clinical Immunology and Allergology, 16 years of professional experience) thinks of such discourse modulation as an "[ability to explain what the doctor says employing simple wording] saber explicar lo que dice el médico con un lenguaje sencillo", whereas Participant nº 9 (female doctor, Psychiatry Department, 8 years of professional experience) appreciates interpreters' "[ability to summarize] capacidad de resumen".

However, layperson interpreters, who may very well be bilinguals or language proficient users, are not familiarised with specific interpreting techniques, which would prevent them from producing superlative renditions. As I have already determined in the previous chapters of this thesis, the art and science of interpreting imply knowledge of certain interpreting techniques, compliance with the interoccupational jurisdictional boundaries, correct exercise of discretionary judgement based on moral and ethical commitments, and of course, *phronesis*, or the skill to make wise decisions and pragmatise all professional knowledge in unique context-dependent situations safeguarding the integrity of professional praxis. Hence, there is a risk that lay person interpreters may take such discourse "modulation" and the encouragement to practice such adaptation too far, as they are simply lack the knowledge of what "interpreting" actually means.

I have a perfect example of how a non-professional interpreter construes such "modulation". Participant nº 34 (female lay person interpreter, administrative assistant, 2 months of professional experience as interpreter on daily basis and indefinite period of time of sporadic, piecemeal interpretations), views the concept of "adaptation" and the role that the lack of formal knowledge and education plays in her professional performance in the following way:

> Estás totalmente expuesta al riesgo de equivocarte entonces tienes que estar muy segura claro que yo he tenido situaciones que *al no haber estudiado nada de medicina he tenido algunos momentos de confusión algunos momentos de estar no muy segura de lo que tenía que traducir* pero al hablarlo con el médico pues enseguida me lo ha resuelto y *de una forma humana se lo he intentado comunicar al paciente ya que el paciente tampoco entiende mucho de términos médicos.*

> You [as an interpreter] are totally exposed to the risk of making a mistake, so you have to be very sure [...] because I have had *situations [in which] I have had some moments of confusion [due to the fact that I haven't] studied medicine at all.* [These were] moments of *not being very sure of what I had to translate*, but when I spoke to the doctor, he immediately resolved my doubts and *I tried to communicate it to the patient and in a humane way [in lay terms], since the patient does not understand much about medical terms either.*

This informant purports to be able to adapt medical discourse by determinologising it, thus carrying out an inter-linguistic interpretation as well as intra-linguistic adjustments. The question is how can a bilingual lay person without any education in medicine or translation/interpreting do that without having even understood the discourse in the first place and without even knowing what to interpret? It is also interesting how she assumes that the patient would not have understood the discourse had it not been determinologised. It is worth noting that a person "with

no specific education" purports to have carried out: "verbal and written translations", which indicates that she is not even familiar with the basic T&I terminology.

Participant nº 31 (male surgeon, Laparoscopic and Colorectal Surgery Department, 35 years of professional experience) also highlights the importance of being acquainted with the specific terminology in the language the interpreter purports to operate in.

Participant nº 27 (female doctor, ICU unit, 14 years of professional experience) clarifies that: "*una especialización sanitaria*, puede ser *una asignatura* que te *profundice en palabras médico-técnicas* [medical specialisation may be materialised in the form of a subject/discipline that focuses on medical and technical words more in depth]".

Participant nº 57 (female dermatologist, Dermatology department, 10 years of professional experience) also highlights the importance of healthcare phraseology:

> Es necesaria una formación para los intérpretes no solo en el idioma [...] sino también una formación en el lenguaje sanitario porque sino sería imposible poder comunicarnos con ellos.
>
> Interpreters need to be trained not only in the language in which they speak, but also in the language of health care, otherwise it would be impossible to communicate with them.

The reflexions educed form the interview with Participant nº 46 (female doctor, Accident and Emergency Department, 28 years of professional experience) also endorse the idea of the salience of medical terminology and of the interpreter's literacy in and comfortable navigation through this specific verbiage:

> Y en cuanto a la formación por supuesto necesaria porque se manejan muchísimos términos médicos muchos términos muy específicos que sin una formación adecuada no podríamos llegar a un buen entendimiento en la historia clínica.
>
> And as far as training is concerned, it is certainly necessary because we operate with so many medical terms, so much highly specific terminology, that without a proper training [of the interpreter] we would not be able to reach a good understanding in the medical record.

Participant nº 44 (male surgeon, Trauma and Orthopaedic Surgery Department, 25 years of professional experience in the field) also upholds the idea of medical literacy achieved through a not-too-specialised medical training included into the Translation and Interpreting Degree curriculum, which would allow graduates to expand the scope of their performance in this field.

> Me parece importante además que tengan una formación extra [...] médica [...] es conveniente [...]. Yo creo que sería mejor con una formación universitaria, no vas a pedir que sean médicos las personas que vengan [...] pero sí terminología, términos anatómicos, términos fisiológicos y de patología, claro que sí. Yo creo que es una cosa que vendría bien en una licenciatura para traducción.
>
> I think it is *also important that they have an extra training* [...] *medical training* [...] it would be convenient [...]. I think it would be better with *a university education, you're not going to ask people to be doctors [...] but terminology, anatomical terms, physiological and pathological terms* are of course of importance. I think *this is something that would be a good thing in a translation degree*.

Participant nº 20 (male doctor, Accident and Emergency Department, 16 years of professional experience) argues that: "Cualidades humanas no son tan necesarias como el conocimiento de la terminología y además pueden acarrear sus dificultades [Human qualities are not as necessary as

being acquainted with medical terminology, besides the use of human qualities can also be fraught with difficulties]".

Thus, we went gradually from full professional competence including:

- professional translation and interpreting
- knowledge of medicine (biology, physiology, anatomy, pathology, etc.)
- ability to fathom out medicine by grasping its concepts
- familiarity with and comfortable navigation through the institutional rituals, which denotes salience of this particular institutional sphere (please see Participants nº 52, 48, 4, 54, 55, 35, 47, 24, 51, 53, 19, 33)

through to mere knowledge of medical terms (please see Participants nº 56, 30, 34, 31, 27, 57, 46, 44, 20).

Please note how in the last interviews, subsumed under Subtheme nº 8 Medical terminology as the most esoteric part of medical interpreters' knowledge, the emphasis no longer lays on the salience of understanding the intricate ideation patterns throughout the line of inquiry, the insightful and sophisticated discernment and discretion in performing interpreting, thorough knowledge of medical concepts and healthcare literacy, or Aesculapian reasoning in terms of paying close attention to apparently insignificant remarks made by the patient, etc. In the extracts encompassed in the Subtheme nº 8, the emphasis lays on a) vocabulary otherwise referred to as medical terminology; and b) adaptation or "modulation" of medical discourse, a topic, which will be addressed separately in the upcoming overarching theme.

Nurses

Participant nº 45 (nurse in the paediatrics department, 5 years of professional experience) also emphasises how important it is that the incumbents be familiar with the corresponding terminology in relation with pain variations and intensity, different pathologies, etc.

> En lo referente a la formación es muy importante que el intérprete que vaya a trabajar en la sanidad ayudando a médicos, enfermeras, a cualquier profesional de la salud debería formarse en [...] el aspecto de los términos sanitarios para saber más o menos de qué va un poco cada enfermedad o por lo menos saber traducir exactamente el nombre de esa enfermedad o de esa patología o todo lo que tenga que ver pues [con el] dolor y pienso que esa es la formación específica que deberían de tener independientemente del idioma que hablen.
>
> As far as training is concerned, I think it is very important that *the interpreter who is going to work in the health sector helping doctors, nurses or any other health professionals should be trained in health(related) terminology*, in order to know more or less what each illness is about, or at least know how to translate exactly the name of that illness or pathology or everything that has to do with pain, and I think that *this is the specific training they should have regardless of the language they speak.*

Before I proceed with part III, I would like to briefly recapitulate on the main points of part I and part II. As we have seen in the foregoing, some "external players" (as García-Beyaert, 2015 calls them) do not deem professional graduate interpreters to be the best qualified experts and the only viable option to do this job. Thus, episteme (formalised scientific knowledge), techne

(practical skills) and paideia (formal education) grounded in the genetic and neurophysiological predispository factors which afford them an actual capability to act as interpreters and exercise our professional praxis through discretionary specialisation are being ignored. Unverbalisable tacit savvy as well as other alternatives are believed to be sufficient to successfully address all possible contingencies not stipulated in the formal corpus of codified technique. There is clearly a gap between the university curriculum and a real workplace, but amateurish improvisation must be replaced by the exercise of discretion anchored by practice ethics. Such de-mystification and deprivation of professional charisma by denying the need to study in order to successfully implement discretionary specialisation in highly sensitive professional environments demarcated by the belt of restrictions regulated by the code of ethics may come to signify de-professionalisation and profile hybridisation, which will be discussed in the upcoming sections. Other alternatives such as polyglotism grounded in certain language abilities embedded and nested in a person's brain must be disassociated from a successful deployment of diagnostic, prescriptive and practical knowledge in the professional praxis enacted through ethical righteousness (exercise of Aristotelian *Phronēsis* and sunesis). We need to focus on the recognition of specialised knowledge underlying medical interpreting, otherwise the usurpation of our expertise by other occupiers shall become our nemesis.

C. *Part III: Well-defined necessity of formal university education*

1. Subtheme 9: University education as the key to professionalism

Patients

It is my intention to demonstrate through this subtheme that all of the patients whom I had the opportunity to interview for this thesis seem to agree that language provision through professional medical interpreting is absolutely crucial. They all associate this occupation with other more established professions through adequation mechanisms and disassociate layperson interpreters from professional university degree holders through juxtaposition and distinction principle. Thus, we may say that these respondents create social differentiation between two groups: professional university degree holders and amateurs. For instance, Participant n° 28 (63-year-old female Russian speaking patient), argues that quality university education[142] is absolutely mandatory in order to guarantee quality service:

> чем лучше и качественнее образование у этого переводчика тем качественнее его работа. Имея образование он лучше ориентируется в медицинских терминах и лучше объясняет и тем более что человек имеющий образование более коммуникабелен в общении с пациентами и поэтому с ним всегда на много легче общаться конечно приоритет за теми у кого образование [...] [Я] считаю что наличие образования это обязательный фактор, клиника достаточно серьёзная и конечно в такой клинике должны работать и качественный переводчик как тоже достаточно грамотный и эрудированный способный войти в контакт и с больными людьми.

[142] It should be clarified that even though this participant says "образование [education]", she is actually referring to and implying university or higher education (высшее образование).

> The better and the higher quality is the education [of the interpreter], the better and the higher standard will be the service being delivered. The education allows to better navigate medical terminology and to provide a better explanation especially since the person with an education has better communicative skills and is more gregarious and sociable when working with patients, which makes the communication easier. Of course, those with an education have priority. [...] [I] believe that education is a must, this clinic is quite serious and, of course, such a clinic should have qualified interpreters who are also quite knowledgeable, erudite and able to develop excellent rapport with ailing patients.

It is very interesting how this participant highlights the multidisciplinary nature of interpreting by positing that medical interpreters must be polymaths really in order to do their job well. Same ideation can be observed in the following excerpt belonging to Participant nº 29 (65-year-old male Russian speaking patient):

> Переводчик должен быть на профессиональном уровне, подготовленный, не просто вот так чтобы с улицы взяли который знает немножко чуть чуть испанский язык а должен быть именно с образованием, подготовленный чтобы владеть медицинскими терминами и так сказать вот всеми вопросами внутри данного учреждения. Непременно образование должно быть высшее потому что просто курсы перевода здесь это очень мало и крайне не достаточно.
>
> *An interpreter must operate on a professional level, he/she must be proficient, not just lay people off the street who know Spanish only a little, but it must rather be a person with a university education*[143], qualified, a person who masters medical terminology and navigates the system of this particular institution. It is imperative that you have a university degree because just a translation course in this case would be extremely negligible and insufficient (Participant nº 29, my translation).

Participant nº 32 (43-year-old female Russian speaking patient) highlights the far-reaching adverse consequences and grave implications which may ensue a deficient rendition:

> Нет, однозначно человек владеющий несколькими языками на бытовом уровне для того чтобы общаться в том или ином государстве этого совершенно не достаточно для того чтобы работать в клинике с пациентами с врачами переводя очень сложные парой термины названия лекарственных препаратов, объясняя состояние больного так чтобы правильно донести до доктора это крайне важно от этого зависит процесс лечения процесс выздоровления и когда человек находится в клинике его жизнь, его здоровье являются приоритетными и если будет не профессиональным переводчик то может пострадать в конечном итоге из-за неправильного перевода неверного понимания друг друга между пациентом и врачом может пострадать здоровье и привести к самым плачевным результатам. Однозначно переводчик должен быть высокопрофессиональным имеющим специальное образование а не просто владеющим разными языками.
>
> No, a person who *speaks several languages at the level of everyday life*, or *at the level that allows them to communicate or to interact with the native citizens of one country or another is definitely not sufficient*. [It is not enough] for it to be regarded as an appropriate competency to work in a clinic with patients and doctors interpreting very complex terms and names of pharmaceutical products, explaining the patient's condition so that the doctor can understand it correctly, [etc.] *The whole treatment-recovery process is contingent on the [correctness of the renditions]. When a patient finds themselves admitted to a hospital, their life and health condition are an absolute*

[143] In this context Russian term "education" implies state-controlled university education, be it undergraduate degree or postgraduate degree, just like in the case of Participant nº 28.

priority and [therefore] if the interpreter is not a professional144, the patient may be harmed in the long run because of a misinterpretation or misunderstanding between the patient and the doctor. [Such communication deficiencies] may harm patient's health state and lead to the direst and most crippling consequences. The interpreter must definitely be highly qualified, [have undergone] specialised training, [and] not just [any person] who claims to master different languages.

Participant nº 43 (61-year-old male Ukrainian speaking patient) foregrounds the necessity for both undergraduate and postgraduate education by explicitly alluding to a Master's Degree in T&I. He explicitly states that this education must be in translation and interpreting, and a university diploma must definitely be one of the ultimate credentials when recruiting employees.

Має бути перекладач дипломований який володіє двома трьома мовами. Перекладач має закінчити університет, з факультетом перекладача усного і письмового перекладу і плюс хоча б одну магістратуру для покращення рівня знань.

This *must be a certified interpreter* who speaks two or three languages. *An interpreter must graduate from a university, from a Translation and Interpreting faculty*, plus *they must have at least one master's degree* to improve their knowledge.

Participant nº 41 (61-year-old female Ukrainian speaking patient) subsumes medical interpreting under the umbrella term of "profession", thus aligning the members of this occupation with the members of more established professions. Thus, this respondent highlights the similarity between the socio-professional groups of medical interpreters, doctors and nurses, framing the former as professionals in relation to other professionals. Medical interpreters are positioned as alike or "sufficiently similar for current interactional purposes" (Bucholtz and Hall, 2018, p. 599). While medical interpreters are associated with nurses and doctors, the social identity of amateur bilinguals is being separated from that of graduate interpreters through distinction principle. The juxtaposition between interpreters and doctors, and interpreters and amateur proficient users spurs "social differentiation" (Bucholtz and Hall, 2018, p. 599), whereby interpreters are subsumed under the same occupational classification as doctors, whilst outsiders are viewed as different. This view fully matches the professional interpreters' self-perception and upgrades their professional category, that for-the-time-being matches that of the lower-status personnel who aspires to the rewards, status and prestige of doctors. This informant views medical interpreting as a new or emergent paramedical occupation, which proliferates due to globalisation and internationalisation processes.

Ну я вважаю що в будь якій професії повинен працювати професіонал: як і лікар, як і медсестра, як і в іншій сфері так і перекладач повинен бути професійний, з вищою освітою. Бо є вищі навчальні заклади які їх навчають, є така освіта, є така спеціальність. Професіонал [...] краще вміє свою роботу виконувати ніж людина яка просто може розмовляти на мовах.

Well, I believe that like in the case of any other profession professionals should be in charge: like in the case of doctors, nurses, or any other occupational field, interpreters should [also] be professionals, with a higher education. There exist higher educational institutions that train these people, there

[144] Meaning the expert or specialist.

> exists such university degree and there also exists such professional career, therefore, a professional will be better qualified to do this job than a person who can simply speak languages.

Participant nº 42 (72-yer-old German speaking female patient) also insists on a comprehensive education encompassing translation, interpreting and medicine:

> Also ich bin der Meinung dass die Dolmetscher gerade in diesen Regionen besonders gut ausgebildet sein sollten. Ein akademisches Studium wäre das sicherlich angebracht wenn die Menschen die dort mit sehr vielen Sprachproblemen auch hinkommen und im Spital wissen möchten was mit ihren Angehörigen oder mit ihnen selbst passiert dass die das so genau wie mögliche und am besten in ihren eigenen Sprache erfahren wollen [...] Also für mich ist sehr wichtig dass die Dolmetscher so gut wie möglich ausgebildet sind aber klare weise in Hinblick auf das medizinische Dolmetschen und das wird sicher nur in einem akademischen Studium möglich sein und ich kann aus eigene Erfahrung berichten dass ich in dieser Klinik die Möglichkeit hatte eine medizinisch und akademisch ausgebildete Dolmetscherin bei der Arbeit zu sehen und eine Dame die nicht ausgebildet war und dass der Unterschied zwischen den beiden Werte gravierend war denn das was der Arzt mitzuteilen hatte konnte von der akademisch ausgebildeten Dame viel viel besser für mich aufbereitet werden als von der anderen Dame die mit dem medizinischen nicht so viel Studienmassig auf dem Bot hatte.

> I am of the opinion that *the interpreters in these areas should be particularly well trained. An academic degree would certainly be appropriate* as the people who go to this hospital experience a lot of language problems and they want to know what is happening to their relatives or to themselves as precisely as possible and preferably in their own language [...] So for me it is very *important that the interpreters are trained as thoroughly as possible, but clearly with focus on medical interpreting*, and that certainly will only be possible in an academic degree. I can testify from my own experience that in this *clinic I had the opportunity to observe both a medically and academically trained interpreter as well as a lady who did not undergo such training operate at their workplace, and that the difference between the two interpretations was quite substantial, because the academically trained lady was able to convey to me what the doctor had to say in a much more accurate manner as opposed to the other lady, who did not have so much knowledge in the field of medicine.*

Participant nº 58 (71-year-old male German speaking patient) shares his experience with the non-professional medical interpreter and advocates for formalised university education:

> Also mir ist gestern im Krankenhaus ein großes Problem im Bereich der Dolmetscherei passiert und zwar war die Simultanübersetzung sicherlich sehr schlecht und ich hatte ### Eindruck dass der Arzt sehr sehr viele Fragen zu mir hatte aber ich hatte nicht das Gefühl dass das die Dolmetscherin die sagen wollte, sondern hat die Dolmetscherin nur gesagt Sie kommen jetzt im erste Stock Ambulanz und kriegen eine Blutübertragung. Ende der Durchsage. [...] Das war alles. [Ein Studium] Abschluss wäre schön. Viel besser. Ja, ja professionell.

> So, yesterday I have experienced a major problem in the area of interpreting of this hospital, namely the simultaneous translation was definitely very poor, and I had the impression that the doctor had many questions for me, however I did not have the feeling that the interpreter wanted to verbalise those questions, instead the interpreter had just said that I was going to be brought to the first floor out-patient area and that I was going to get a blood transfusion. End of the message. [...] That was all. A degree would be nice. Much better. It would be professional.

In spite of the dearth of participants belonging to this category, the salience of this subtheme lies in their unanimity on the issue of education and professionality. There is an absolutely clear ideation pattern, which has a latent rationale behind it. In order to understand why all of the interviewed patients unanimously recognise the importance of professionality in medical interpreting as opposed to the doctors and nurses, who seek alternatives to formal university education

in this discipline, we need to understand that their stances on this issue are totally different. If we apply McCormick's ideation regarding Medicine to medical interpreting, we will see the huge difference in both perspectives:

> Professions are distinguished from trades by the length of training, the depth of special knowledge and by codes of behaviour. Medicine is different from most other professions not by virtue of the length of training (which is extremely long), or the depth of knowledge but *by its code of behaviour and by its concern with people, rather than buildings, structure or accounts. This involvement with people is shared with priests, nurses, teachers, social workers and to some extent with lawyers. It is not characteristic of architects, actuaries, accountants and engineers.* (McCormick 1979, p.13 as cited in Horobin, 2016, The Meaning of Profession section, § 4)

Thus, from the medical workers' standpoint, deficient interpreting can only and exclusively impact or affect their professional reputation, whereas from the patients' perspective an error-ridden rendition can have serious implications and repercussions on their health, life quality, and life in general. That explains why all patients insisted so much on professional interpreting, because they know that their well-being and life quality are at stake and a mediocre rendition may signify a point of no return in terms of health or life damage, whereas doctors only risk temporarily tarnishing their reputation, status and/or prestige.

15.1.3.2. Theme 2: The Impact of Market Demands on the Hybridisation of Profiles

This part will be dedicated to gleaning insights from doctors as to whether they are willing to usurp unlicenced activities of medical interpreters by virtue of bilingualism, (alleged) language proficiency or utilisation of English as a "wild card" ("comodín" Angelelli, 2015, p. 61) or *lingua franca*.

Before I start to deconstruct the excerpts that I have collated to showcase that I did not find clear indications of generalised and ubiquitous role usurpation on the part of doctors, I would like to elaborate on the reason why I believe eliciting insights on this topic was important. The conversation analysis definitely kindled my interest in this topic, as all of the doctors on my recordings chose to communicate in English despite egregious underperformance and despite the availability of professional medical interpreters in the consultation. Additionally, I noticed an exponentially increasing trend among different private facilities to hire so-called people with languages, also reported by Niño Moral back in 2008. It is worth noting that I have already addressed the topic of (allegedly) bilingual or (reportedly) foreign-language-proficient medical professionals being sought after by major medical facilities located in the geographical area of interest. In the chapter on "Medical staff doubling up as interpreters in the private healthcare sector", I have already demonstrated that numerous private facilities in this study relevant region advertise on their websites the availability of multilingual medical professionals. Footman addresses the issue of professional mobility based on the mutual recognition of qualifications obtained in each Member State, which spurs the employment of doctors and nurses with increased employability and capitalisation on foreign language skills, because due to globalisation and medical tourism knowledge of languages became a real asset in this field. The cross-border migration of professionals was enabled by the "mutual recognition of various qualifications for medical professionals, including physicians, dentists, pharmacists, nurses and midwives" (Footman et al., 2014, p.

9) supported by the EU Directive on the recognition of Professional Qualifications issued in 2005 (EU Directive 2005/36/EC, 2005), which deems that all EU medical professionals "meet the same professional standards" (Footman et al. 2014, p. 29).

However, bilingual medical professionals do not constitute any problem for our professionalisation. The real acute dilemma that our occupation confronts is the fact that, due to lack of licencing, any averment from any doctor or nurse who alleges to be proficient in a foreign language without being bilingual is accepted at face value without the benefit of the doubt. The employers and the patients just take their word for it. The medical workers who are allowed to conduct encounters in foreign languages without credentials and whose word is taken for it perfectly epitomise the professional leniency bias. Participant nº 37 (female graduate interpreter, 21 years of professional experience as medical interpreter) confirmed that many doctors identify as proficient users, but in reality the "proficiency" of those medical workers who facilitate a role as interpreters is nothing else than stereotypical capitalisation on, hyperbolisation and overestimation of their foreign language abilities.

> Esa cita la apuntas en tu agenda para poder atender al cliente a *no ser que el médico hable el idioma, y estamos hablando de hablar un idioma no de inventarte tu idioma porque hay muchos médicos que desgraciadamente creen que hablan mucho idioma y luego no es así. [...] hay médicos que [...] todo lo que hablan parece lo mismo, parece un chicle en la boca que se mueve, no es un idioma... ¿Le ha pasado que después de la consulta el paciente no se ha enterado de nada y tras salir por la puerta le pide que usted se lo vuelva a explicar todo de nuevo? por supuesto. [...] evidentemente lo tienes que hacer de una manera que no se note demasiado, así que le dices al cliente: vámonos a tomar un café y te lo vuelvo a explicar porque si no no hay manera.*
>
> You write that appointment down in your diary to be able to attend to the client *unless the doctor speaks the language, and we are talking about speaking a language not inventing your own language because there are many doctors who unfortunately think they speak a language very well and then it turns out not to be the case. [...] there are doctors that [...] everything they say sounds the same, it sounds like a piece of chewing gum in their mouth that moves, it is not a language...* Has it ever happened to you that after the consultation the patient did not understand anything and after walking out of the door they ask you to explain everything all over again? of course. [...] obviously you have to do it in a way that is not too obvious, so you say to the client: let's go for a coffee and I'll explain it again because otherwise it is impossible.

Now, these doctors may not be intentionally seeking to dislodge medical interpreters form their inchoate niche or to do virtue signalling, but they certainly impose a "knowledge mandate" anchored to the epistemological foundation of their discipline, whereby the knowledge supremacy of certain types of professions is being extolled, while mediocrity and subjugation is being imposed on other more disadvantaged occupations in terms of knowledge and skills.

In this light, the scientific grounding of knowledge and skill employed in medicine has traditionally endowed this discipline with "cognitive authority" (Halliday, 1987, pp. 28-55 in Freidson, 2001) and therefore these doctors extend their cognitive and professional authority to another professional jurisdiction, to the expertise belonging to other occupation. In this process the "lock of tasks", which should naturally fall within MI's remit has now been "redeveloped" by its new "occupiers" –doctors–, who "[compete] for access and struggle to improve their status by new acquisitions" and by the "relinquishment of less attractive properties" (explanation of medication, explanation of IC, organisation of treatment, etc.) (Dingwall, 2016, Introduction section, § 10-11). In this case the occupiers are more "prestigious and powerful" than MIs (Dingwall, 2016). We are all "caught up in a constant evolutionary process" governed by the constantly changing

demands both form the clients (the patients who seek to be treated by cross-border doctors, who preferably speak their language) and from the private clinics' "internal attempts to influence the market" by making it more appealing and competitive (Dingwall, 2016).

D. Part I. Debunking doctors' generalised profile hybridisation via bilingualism, self-rated proficiency or utilisation of English as lingua franca

As opposed to the data presented in the Conversation analysis section, all interviewees responded that linguistic self-sufficiency in doctors is a relatively rare phenomenon, thus rendering the hybridisation attempts unavailing unless the doctor is bilingual. The fact that some doctors capitalise on their language skills does not necessarily imply that all of them are willing to usurp medical interpreters' expertise.

1. Subtheme 10: The doctors who capitalise on their foreign language skills still recognise the need for medical interpreters

Doctors

Participant nº 39 (male doctor, Emergency Department, 16 years of professional experience) confirms that certain private facilities indeed display a marked tendency to hire medical professionals, who allegedly know/speak languages. These specialists may be bilingual residents, expatriates who returned to Spain, doctors who have resided abroad for a period of time and therefore are acquainted with the target language, cross-border migrant medical professionals practicing under the protection of the Directive 2005/36/EC, or other medical professionals who claim foreign language proficiency. This type of professional encroachment and/or impingement is characterised by the fact that medical interpreters are not called upon on account of their language command, qualifications and competence or on account of their interpreting competency, which would guarantee higher quality of communication, but rather on account of their extensive exotic language repertoire.

> *Muchos de nuestros médicos saben idiomas*, pero la diversidad de los idiomas [...] hace imprescindible en muchas ocasiones el trabajo de un intérprete con nosotros. La actividad médica se basa en la comunicación médico-paciente y si no se logra no se puede hacer medicina.
>
> *Many of our doctors know languages*, but the diversity of languages [...] makes the work of an interpreter indispensable on many occasions. Medical activity is based on doctor-patient rapport, and if such rapport cannot not achieved, medicine cannot be practiced.

Participant nº 31 (male surgeon, Laparoscopic and Colorectal Surgery Department, 35 years of professional experience) implies that the ubiquitous internationalisation of English has come to signify that all incoming patients, especially arriving from Holland, Belgium or Germany must be proficient English users. Moreover, this respondent goes on to explain that: "I speak English but not too well, so sometimes we can reach a mutual understanding [...] but many times [...] older patients don't understand my English well". This statement suggests that in spite of being aware of his poor command of this language, my informant still acknowledged having used English as lingua franca to communicate.

Thus, many doctors would prefer to conduct their consultation in English, even though they struggle to communicate and even though there are professional medical interpreters ready to help. An interpreter would thus be called on only in the case of exotic languages such as Russian, for example.

> Sí, yo creo que es imprescindible las intérpretes en un hospital, puesto que aquí vienen pacientes de muchos países no solamente ingleses, holandeses, rusos, belgas, alemanes que se les puede hablar en inglés, pero, por ejemplo, rusos es más complicado, entonces sí que necesitamos que sean intérpretes rusos, alemanes, que también *hay alemanes que no saben inglés [...] y a veces como es mi caso que hablo inglés pero no demasiado bien así que a veces sí que me entiendo con ellos, pero muchas veces necesito intérprete* para que el paciente se entere *sobre todo pacientes mayores que para mí ellos no entienden bien mi inglés* pues necesitan intérprete.
>
> Yes, I think that interpreters are essential in a hospital, because *patients come here from many countries, not only English, Dutch, Russian, Belgian, German, who can be spoken to in English*, but, for example, Russians are more complicated, so we do need Russian and German interpreters, because *there are also Germans who do not know English.* [...] And sometimes, as in my case, *I speak English but not too well, so sometimes we can reach a mutual understanding, but many times I need an interpreter* so that the patient can understand, *especially older patients who, as for me, don't understand my English well*, so they need an interpreter.

However, despite acknowledging that he may have conducted encounters in English in a number of occasions, this informant has stated very clearly that his linguistic skills cannot replace professional interpreters' skills:

> Necesito intérprete para todo, para inglés, para holandés, para alemán, para ruso necesito que el paciente se entere bien de lo que le he hecho, de la intervención que le he hecho, de cómo va evolucionando, entonces es fundamental, o sea *yo con mi inglés desde luego no me puedo defender absolutamente bien y veo como yo hay muchos muchos médicos que no dominan perfectamente el inglés entonces es imprescindible que la intérprete esté presente cuando yo estoy hablando con él en el postoperatorio, en la intervención.*
>
> I need an interpreter for everything, for English, for Dutch, for German, for Russian, I need the patient to fully understand what I have performed on him/her, the operation I have performed on him/her, how he/she is evolving, so [interpreting] is fundamental, I mean, *with my English I am unable to communicate well enough and I see that there are many many doctors who do not speak English perfectly, so it is essential that the interpreter be present when I am talking to [the patient]* in the post-operative period or during the surgery.

At the end of the interview Participant nº 31 avows that medical interpreter "es una profesión fundamental [is a fundamental profession]", which indicates recognition and classification of this activity as "profession".

Participant nº 53 (male cardiologist, 18 years of professional experience) also mentions that doctors may be acquainted with one or two languages, but he does not specify to what extent may these doctors be qualified to conduct encounters and how verifiable their alleged language command is. However, he believes that it is yet again the extensive (exotic?) language repertoire what differentiates interpreters from doctors. Thus, he implies that a doctor can master or speak one or two languages whereas an interpreter can communicate in multiple languages and thus cover the needs of a higher number of patients. This is clear reference to polyglotism as the major characteristic of translation and interpreting. Please note that in spite of averring that there work multilingual doctors in the hospital, medical interpreters are still "es importantísimo sino por decirlo de alguna manera obligatorio el tener traductores [crucial if not mandatoty]".

> Bueno yo creo que en un hospital con tanta afluencia de pacientes extranjeros es importantísimo sino por decirlo de alguna manera obligatorio el tener traductores puesto que *nosotros los médicos podemos conocer pues una lengua como mucho dos lenguas pero no por supuesto todas las que se presentan aquí y lenguas además extranjeras difíciles* entonces es mandatorio.
>
> Well, I think that in a hospital with so many foreign patients it is critically important, if not mandatory, to have translators, because *we doctors may have knowledge of one language, maximum two languages, but of course not all the languages that are spoken here, difficult foreign languages*, so it is mandatory.

Participant nº 54 (male ophthalmologist, Ophthalmology Institute, 25 years of professional experience) recognises that:

> Muchos de los médicos hablamos el inglés a parte del español y tampoco lo hablamos muy bien el inglés exactamente [...] resumiendo la pregunta pienso que la interpretación en el mundo sanitario cada día es más imprescindible
>
> Apart from Spanish many doctors speak English, but we don't quite speak English very well either [...] to sum up the question, I think that interpreting in the healthcare world is becoming increasingly indispensable.

Please note that this statement is an implicature and a presupposition regarding his own and other colleagues' identity position. This participant contends that the English language skills that he attributes to his colleagues and himself cannot qualify them as fluent or proficient users, which would in theory unable them to become "*occupiers competing for access* and struggling to improve their status by new acquisitions or the relinquishment of less attractive properties" (Hughes in Dingwall, 2016, Introduction section, § 10-12). Also, in accordance with the relationality principle his stance consists in "disaligning" himself with (Bucholtz & Hall, 2005, p. 595) and disassociating himself and other medical professionals from professional interpreters.

Participant nº 44 (male surgeon, Trauma and Orthopaedic Surgery Department, 25 years of professional experience in the field) also believes that an interpreter is needed even if the doctor purportedly "speaks languages":

> Aunque puedas hablar idiomas como en mi caso hablo inglés y francés algo peor pero me entiendo con ellos y incluso en esos idiomas sería bueno tener un intérprete pero por supuesto en otros idiomas creo que el hablar en el idioma del paciente permite una mayor confianza del paciente y un mejor trabajo para nosotros por supuesto
>
> Even if you can speak languages like in my case –I speak English and French a bit worse but I understand them–, even when using those languages it would be good to have an interpreter but of course in other languages I think that speaking in the patient's language allows for greater trust of the patient [towards the doctor or centre] and an easier workflow for us, of course.

This excerpt constitutes a perfect example of an overrated language proficiency and a totally misconstrued idea of communication. First, we need to determine what the phrase "speak languages" mean, because as it has been demonstrated in the previous chapters of this thesis it happens to be an extremely difficult task, in that this statement is almost always subjected to a personal interpretation of one's own language abilities instead of being undergirded and attested by a formal certificate. Hence, when it comes to language command, both co-workers and patients just take each other's word for it.

It is also extremely interesting how this doctor owns up to having conducted consultations in French even though he concedes and avows that he speaks French worse than English (without us even knowing how well he actually "knows" English). More specifically, despite his poor and substandard language command he believes that "[we can still understand each other and communicate with one another]", and therefore he assumes that muddling through or doing quasi veterinary medicine is fully acceptable and safe. The phrase "I speak French a bit worse but we understand each other" is an antithesis of "I speak English and French".

Therefore, the question should never be whether somebody considers that they (can) speak a language (encouraging self-avowed naïve and pollyannaish, as well as excessively self-confident speakers to use a language despite acknowledgement of limited working proficiency), but rather how the alleged proficiency was measured and what credentials of such proficiency can ensure that no veterinary medicine is being unsafely practiced on human patients. However, the problem is that neither the physicians, nor the procurement management, nor the officials in charge of guaranteeing optimal care (show themselves willing to) comprehend the crippling effects and the far-reaching implications that miscommunication in this specific field may bring forth. Therefore, the lack of recognition of the complexity of knowledge underlying successful cross-linguistic and cross-cultural communication is the main rationale behind the impasse of this occupation's professionalisation.

Participant nº 56 (female neurologist, Neurology and Neurosurgery Departments, 8 years of professional experience) states the following:

> Me parece que en cualquier ámbito comunicarte con el paciente en su lengua es esencial. Como *evidentemente los médicos no todos pero la mayoría hablamos inglés* es verdad que *para una urgencia sí puedes hablar inglés pero me parece que no es recomendable dar una información médica que a veces repercute en una decisión relevante en un idioma que el paciente pues no es su lengua materna y que muchas veces se puede malinterpretar*. Entonces yo creo que es interesante y [...] a lo mejor hay veces que es totalmente necesario.
>
> I believe that communicating with the patient in their mother tongue is essential in any field. *As obviously not all the doctors but most of us speak English, it is true that for an emergency you can speak English but it seems to me that it is not advisable to give medical information that sometimes affects a relevant decision in a language that is not the patient's mother tongue and that can often be misinterpreted.* So I think it is interesting and [...] maybe sometimes it is absolutely necessary.

It is interesting that my informant uses the adverb "obviously" to state that the majority of doctors "speak English". English being used as *lingua franca* is an often-referred-to phenomenon in the study-relevant area. However, according to Ribes (specialist in interventional radiology, co-author of the sixth book in the 'Springer Medical English' collection at the headquarters of the Organización Médica Colegial, 2009):

> In general, [Spanish doctors] do not speak English. 90% are not able to tell a foreigner their e-mail address and only 5% are able to make a phone call outside Spain. Our doctors are afraid to express themselves in English at international congresses for fear of being asked follow up questions [...] in Spain, senior doctors, in general, do not speak English [...] Curiously, medical English is very easy for Spanish and French people, as 50% of the terminology is Greco-Latin and therefore well understood. However, we have trouble pronouncing everything that is easy to read, such as "edema" [oedema], for example. With the advantage of having a Romance language, we waste it to the extent that a

> Japanese person can match our level in five years. In general, the language level in the rest of Europe is better than ours (Ribes, 2009, my translation).

> Apenas el 19% de los que dicen hablar

According to the El Barómetro del CIS (EFE, 2016), less than 19% of those Spaniards who claim to speak English or French are able to actually hold an informal conversation on everyday topics without any difficulty (2014). This newspaper article explains that: "among those who claim to speak a language, only 26.5% (English) and 30.7% (French) feel able to shop, ask for directions or order something in a bar or restaurant without any difficulty. If it is a matter of informal conversation, the proportion is just under 19% in both cases" (EFE, 2016).

Lion et al. (2012) issued an extremely insightful study on the "Impact of Language Proficiency Testing on Provider Use of Spanish for Clinical Care", whereby they argued that: "we previously reported that a *substantial number of residents inaccurately assess their Spanish skills when compared with objective testing* " (Lion et al., 2012, p. 84). They explained that: "in this study, of 18 residents who reported themselves to be proficient or fluent, 33% tested at a "not proficient" level, and 78% tested at a "not highly proficient" level" (pp. 84-86).

> As has been found in other studies of physician self-assessment,[145] *less skilled providers were more likely to overestimate their proficiency and report an inappropriately high degree of comfort in complex scenarios*, whereas more skilled but not fully fluent providers tended to rate their comfort in such scenarios more conservatively relative to their actual skill. (Lion et al., 2012, p. 85)

However, the most disquieting part of the findings is that: "*self-assessment rarely changed, even when inconsistent with objective testing results* [...] testing did not change nonproficient residents' comfort using Spanish in complex or medicolegal scenarios" (Lion et al., 2012, p. 84). Thus, "*those who believed themselves proficient before testing continued to trust their abilities, regardless of test results*". Therefore, "*many providers reporting clinical Spanish use did so despite self-reported lack of proficiency*" (Lion et al., 2012, p. 84). The authors indicated that:

> Without clear guidelines and incentives, busy providers are unlikely to adopt behavior that is seen as time-consuming or unnecessary, even in the face of objective feedback. [...] We found no change in resident comfort in medically complicated and potentially legal scenarios, even among those testing as non-proficient. This is concerning given the potential for increased patient harm and physician liability should mis-communications occur. (Lion et al., 2012, pp. 84-86)

The authors also clarified that these results were fully consistent with the: "previous reports that paediatric residents at all levels of Spanish proficiency, including those self-identifying as nonproficient, provide care directly to limited English proficiency (LEP) families without professional interpretation, even when hospital policies require interpreter use[146](Lion et al., 2012, pp. 84-86).

Diamond et al. (2014, p. 437) have also suggested that the accuracy of the self-assessment of non–English-language proficiency by clinicians compared with an oral proficiency interview is not always accurate:

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[145] For more information see Davis et al (2006) and Colthart et al. (2008).

[146] For more information, please see: Yawman et al (2006); Diamond et al. (2009) and Burbano et al. (2003).

> Twenty-three clinicians (34.3%) underestimated their skill [...], and 5 clinicians (7.5%) overestimated their skill [...] Clinicians who self-assessed their non–English- language proficiency as "fair" or "poor" and those who reported "excellent" seem to be more accurate than those reporting they were in the middle of the proficiency scale. [...] Kaiser Permanente found that only 86% of physicians who self-reported as "fluent" passed the CCLA, but the study was limited to physicians at this high self-reported level. (Diamond et al., 2014, pp. 436-437)

Diamond et al. (2014, p. 437) bring to our attention the fact that "structured, validated tools [of official language assessment] are used less commonly outside of research", which leads me to the question what scientific data was my informant relying on when she averred that "obviously not all but the majority [of doctors] speaks English". As previous research displayed in the section on conversational analysis showcases, many persons, including physicians, may display an inclination to self-report as fluent or proficient English user, when such statement cannot be further from the (objective?) truth. Some people who self-rate in such a manner end up displaying a rather poor command (please see Conversation analysis section above). Therefore, as I found no scientific and robust data that would render this statement convincing, accurate or valid it is my contention that it may be a generally accepted fallacy.

Participant nº 48 (male radiation oncologist, MD-PhD, Oncology department, over 35 years of professional experience) believes that there is a difference between a doctor who speaks a language and an interpreter, and here is why:

> El punto fundamental aunque incluso el médico sea capaz de hablar otra lengua con propiedad [...] que pueda decir bien los términos clínicos o médicos, pero la lengua lleva aparejada una cultura y una manera de pensar y no siempre la información que pasas aunque la hayas pasado correctamente consigue el objetivo de informar en lo que tú quieres. En ese sentido los intérpretes son fundamentales gente que maneja muy bien las lenguas no manejan las lenguas que las manejan los conceptos de las lenguas esa es la diferencia entre alguien que hable una lengua y alguien que estudia una lengua me refiero tú puedes el inglés por ejemplo que se dicen cosas y se pronuncian distinto pues se escribe Estambul pero se pronuncia Constantinopla pero el problema no es ese el problema es que los idiomas tienen retículas que a veces coinciden conceptualmente de uno a otro por ejemplo las lenguas latinas tienden a tener los mismos conceptos pero las no latinas los tienen diferentes y eso es lo que es muy importante conocer a la hora de pasar información. Con lo cual creo que cuando hablamos con personas de culturas y lenguas diferentes el que haya un intérprete es esencial por lo menos en la primera consulta en la que vas a contar las cosas serias en las otras a lo mejor es suficiente si más o menos se enteran pero la primera es muy importante.

> The fundamental point is that even if a doctor is able to speak another language properly [...] they can articulate clinical or medical terms correctly, but language brings with it a culture and a way of thinking and the information you pass on, even if you have passed it on correctly, does not always achieve the objective of informing in the way you want it to. In this sense, interpreters are fundamental, people who know languages very well, it is not about them knowing the languages per se, which they do, but rather about grasping the concepts of the languages, that's the difference between someone who speaks a language and someone who studies a language [...] the problem is that languages have grids or frameworks that sometimes overlap with one another conceptually, for example Latin languages tend to have the same concepts but non-Latin languages have different concepts and that is what is very important to know when it comes to passing on information. So I think that when we talk to people from different cultures and languages, having an interpreter is essential, at least in the first consultation when you are going to talk about serious things, in the following consultations it may be enough if they more or less understand, but the first one is very important.

This medical professional juxtaposes two typologies of knowledge, that of an interpreter and that of a language proficient doctor, whereby he challenges the efficiency of the deployment of a foreign-language-proficient doctor as a replacement for professional and highly specialised medical interpreter. Thus, this informant challenges the idea of using English as *lingua franca* or any other language instead of seeking help from a professional interpreter. The excerpt: "even if a doctor is able to speak another language properly [...]" is absolutely crucial for this whole thesis, since the knowledge of an expert in medical interpreting is being given preference, prevalence, priority and precedence vis-à-vis the inexpert language knowledge of a doctor. Please note how we are still talking about the knowledge of a language and never about the knowledge and skill underpinning the profess of interpreting *per se*. However, even the sole cognisance of the difference between expert language knowledge and non-expert language knowledge may already be considered an important step forward towards professional recognition. This doctor has remarked that the expert language knowledge just doesn't stack up against the inexpert language knowledge, thus rendering the use of English as *lingua franca* insufficient. My informant conceives of a language as an abstract communication system based on axiomatic theoretic scaffolding, whereby its users convey concepts built on their culture and mindset. Therefore, mere knowledge about linguistic facts (correlation between syntax, morphology, semantics, lexis, grammar, phonetics, pragmatics) may not guarantee successful conveyance of "what you want to inform about", especially taking into account that we are dealing with highly sensitive information concerning people's integrity, health, life and death. Thus, the thrust, the intention and the spirit of the message may be easily misunderstood by non-experts and provoke and unexpected, unanticipated, negative and even damaging reaction to the message. My informant highlights the difference between learning a language, speaking a language and mastering a language.

Participant nº 51 (male doctor, Nuclear Medicine Department, 20 years of professional experience) has clarified that the utilization of English as *lingua franca* in patients who are not native speakers of English is inappropriate and unacceptable:

> Bueno yo creo que *la figura del traductor o intérprete es imprescindible* en un servicio hospitalario y sobre todo en un servicio como el nuestro en un hospital como el nuestro donde atendemos a mucha gente extranjera *creo que siempre se debería de atender al paciente en su idioma original.*
>
> Well, I believe that *the figure of the translator or interpreter is essential* in a hospital service and especially in a service like ours, in a hospital like ours where we attend to many foreign people, *I believe that patients should always be attended to in their original language.*

Participant nº 55 (male doctor, Neurology Department, 5 years of professional experience) concurs with the opinion of the previous informant in providing assistance to foreign patients in their native language: "El que se les atienda en su propio lenguaje lo considero fundamental [I consider it fundamental that they are attended to in their own language]".

Participant nº 57 (female dermatologist, Dermatology department, 10 years of professional experience) fully supports the idea expressed above by her colleagues:

> Bueno por supuesto que es necesario sino sería imposible comunicarlos con un montón de pacientes y más en esta zona que la gran cantidad de población no habla nuestro idioma o sea es que sería

> imposible comunicarnos con ellos y entonces no tiene sentido poder atenderlos y entonces lo utilizamos mucho [el servicio de interpretación] es necesario
>
> Well, *of course [interpreting] is necessary*, otherwise it would be impossible to communicate with a lot of patients, especially in this area where a large part of the population does not speak our language, so *it would be impossible to communicate with them and it makes no sense to attend to them [without interpreters], so we use it [the interpreting service] a lot.*

The word "impossible" merits our attention and must not be obviated. This elevates the status of medical interpreters. This doctor views medical interpreters as the cornerstone of the medical practice in multilingual environments.

Participant nº 47 (female doctor, Accident and Emergency Department, 10 years of professional experience) also argued against the deployment of English as lingua franca: "creo que lo importante también es que se le hable al paciente en su idioma natal porque nos entiende mejor podemos explicarle de una manera más fácil [I think it is also important to speak to the patient in their native tongue, because they understand us better and we can explain [things] more easily]".

By way of conclusion, all 58 participants who I have interviewed for the purpose of this TA (without including interpreters) clearly verbalised the need for medical interpreters. Some patients and doctors portray this activity as "fundamental" for "it is very important to have a complete information in order to administer a proper treatment" (Participant nº 30). Some patients argue that "without an interpreter, it would be impossible to communicate with the doctor and understand what to do next" (Participant nº 29). Other patients dismiss and rule out the possibility of using English as *lingual franca:* "given that I do not speak any language other than Russian, which is my mother tongue, interpreting services were crucial to me" (Participant nº 32). Participant nº 39 averred that interpreting "is indispensable in most cases" due to the "diversity of nationalities". "[On the basis of] my 28 years of experience working in the emergency department of this hospital, [I can say that] the presence of a translator is essential" (Participant nº 45). As maintained by Participant nº 61: "[Interpreting] is an important function, more than anything else, because communication is the most important thing between the doctor and the patient, so establishing precise and accurate verbal communication, that is, with the clear objective that both the doctor and the patient have a clear understanding of what each one wants to express is very important".

Other doctors do not highlight the imperativeness, the salience or the mandatory character of medical interpreting, but rather foreground its role as a co-adjuvant factor in communication, a factor that facilitates the performance of medicine in multilingual environments. Instead of "fundamental", "necessary", "important" or "crucial" Participant nº 46 uses verbs and adjectives denoting less intensity of meaning: "[this service] *helps* us as doctors to streamline patient care and to perform a *better* examination". The verb "help" and the comparative adjective "better" imply that interpreters facilitate or improve the performance of medical professionals instead of enabling it. Participant nº 59 (female nurse coordinator, The Nursing Department, 16 years of professional experience) also believes that "[interpreting] facilitates our work a lot, in some occasions our work even depends on their availability". Thus, medical interpreting can be seen as either a salient underpinning or a scaffolding for medical performance or an adjuvant expendable service,

which may sometimes be perceived as gratuitous (especially when somebody else claims language proficiency, expertise and interpretation task ownership) or non-essential luxurious accessory comparable with free wifi, TV, cafeteria, etc.

Be that as it may, I would like to reiterate that none of the participants believes that non-bilingual but allegedly foreign language proficient doctors can replace medical interpreters. As opposed to the data presented in the Conversation analysis section, all of my interviewees responded that full linguistic self-sufficiency in doctors is a relatively rare phenomenon, thus rendering the hybridisation attempts in the main service receivers unavailing unless the doctor is bilingual.

E. Part II: The embracing of the hybridisation through usurpation of medical expertise on the part of interpreters

How far can such co-adjuvancy go? Hsieh (2006, 2010; Hsieh & Kramer, 2012) has already reported on the medical interpreters' role as co-diagnostician inside the consultation, but what about co-diagnostician *and* co-therapist role outside the medical encounter? As we have seen in the previous subtheme, all the informants showcased reluctance to rely on their own foreign language skills and to use English as *lingua franca*, thus rendering medical interpreting important if not essential. By exploring this overarching theme I shall seek to give a glimpse into 1) the assignments that are being actually undertaken by the interpreters and 2) the assignments that the interpreters and the doctors believe should come under the purview of medical interpreters. In other words, in this overarching theme I shall juxtapose the workplace reality with the participants' desiderata.

1. Subtheme 11: Medical interpreters' spectrum of functions. Analysis of the current workplace reality

In this subtheme I am going to discuss the extent to which medical interpreting can be instrumentalised to satisfy the needs of the "receivers" and the "grantors" of this service (García-Beyaert, 2015, p. 46). The main question that we should be asking ourselves when deconstructing this subtheme should be whether the acquisition of the "guilty knowledge" –whereby medical interpreters become practically co-"experts on disease" (Dingwall, 2016, Introduction section, § 13)–, as well as the "involvement" or "concern with people" rather than inanimate objects will allow interpreters to gain recognition, prestige and the status of a "profession". Participant nº 49 (male doctor, Internal Medicine Department, 30 years of professional experience) acknowledges that medical interpreters cannot remain "objective" or neutral, as they become members of the medical team, but what role do they play in this team? Why even in spite of sharing the mystery and the charisma of the medical workers interpreters are still not recognised professionally? Participant nº 49 affords the following insight:

> En cualquier ámbito –pero más en el médico–, el intérprete pasa a ser un instrumento del jefe ––del médico–, que soy yo. Como un bolígrafo como una radiografía como una ecografía pues tengo otra herramienta que es el intérprete que hace de intermediario entre el paciente y el médico y que por tanto pasa a conocer cosas de carácter subjetivo de carácter íntimo del paciente y el paciente va a reconocer al intérprete como esa herramienta del médico.

> In any field - but even more so in the medical field - the interpreter becomes an instrument of the boss - the doctor - who is me. Like a pen, like an X-ray or an ultrasound, I have another tool, which is the interpreter, who acts as an intermediary between the patient and the doctor, and therefore becomes aware of things of a subjective and intimate nature of the patient, and the patient will recognise the interpreter as the doctor's tool.

This excerpt clearly denotes the salience of hierarchy in institutional ethics (Freidson, 2001). It exemplifies how practice ethics cannot be complied with due to the institutional ethics and the professional stratification within this system. This subordination is characteristic of a secondary institutional sphere, where the traditional authority as well as the status and the prestige belong to the main actors – medical professionals. This subordination results in a total instrumentalisation of medical interpreters *in statu nascendi* and this subtheme will seek to discover how hierarchical and institutional instrumentalisation leads to profile hybridisation by means of five key principles (described in Bucholtz & Hall, 2005) in intersubjective identity construction during interaction. After having collated all the excerpts where my informants were revealing their workload and assignments according to their schedule, I have curated and itemised the following list of functions along with the details and comments on each of these functions that my informants have shared with me. Thus, I have been able to identify 10 roles that in my opinion determine the medical interpreters' professional identity in the study-relevant geographic region.

a) 1º role - INTERPRETER, CONDUIT, MEDIATRIX[147]

Doctors

According to the Participant nº 35 (female doctor, Department of Gynaecology, 7 years of professional experience, International Department coordinator):

> Un intérprete es aquella persona que es capaz de *transmitir las instrucciones vía oral* [...] por una parte tanto las pautas digamos estrictamente médicas, pero siendo capaz de *integrar la parte cultural* [...] saber *alertar cuando hay discrepancias* en la forma de ver las cosas o la forma de entender las cosas para saber transmitirlas en la manera correcta que no haya malentendidos tampoco socioculturales
>
> An interpreter is a person who is [not only] capable of conveying the instructions [consisting of] strictly medical guidelines orally [...], but [who also] is able to integrate the cultural part [...] and knows how to alert [the doctor] to any discrepancies in the way of seeing or understanding things in order to transmit them in the correct way so that there are no sociocultural misunderstandings.

Participant nº 36 (male doctor, Gynaecology department, 23 years of professional experience) shared the following thoughts:

> [L]o que debería de permitirnos [este servicio] es una comunicación fluida con el paciente, explicarle en qué consisten los procedimientos, podernos transmitir todas las dudas y todos los pensamientos del paciente y poder trasladar al idioma del paciente todos los consentimientos informados y la documentación relativa a los procedimientos que realizamos.
>
> [T]his service should allow for smooth communication with the patient, explaining what the procedures consist of, being able to convey all the patient's doubts and thoughts, and being able to convey

[147] Please do not confuse "mediatrix" with "intercultural mediator".

in the patient's language all the informed consents and documentation relating to the procedures we perform.

Patients

Participant nº 29 (65-year-old male Russian speaking patient) also identifies the mediatrix or conduit role as one of the main functions or positions of medical interpreters:

[И] неоднократно мы были и у врачей и на процедурах по перевязке и на инъекциях и она во всех вопросах детально и тщательно мне помогла я очень ей благодарен за это и считаю что в таких медицинских учреждениях обязательно должен быть переводчик.

We had several appointments with doctors, visits to change the dressings and receive the injections and she helped me with all the details and care I am very grateful for that and I think that medical facilities of similar characteristics should have an interpreter.

b) 2º role- TRANSLATOR

Interpreters

Participant nº 12 (female non-professional interpreter, 14 years of professional experience) reports that one of the key functions of medical interpreter is the translation of all sorts of medical documents:

- Medical reports in the original language of the patient that the patient brings from the country of origin/residence.
- Medical reports that patients send before travelling to Spain in order to determine whether the medical facility where they plan to undergo the treatment performs these sorts of procedures.
- (Discharge) medication administration instructions
- Discharge summaries are also important as the patient may show them to the aftercare providers in their respective countries of origin
- Medico-legal documents such as patient decree, advance decision (living will and end of life care) and precautionary mandate
- Translation and/or sight translation of informed consents
- Information booklets

c) 3rd role - INFORMATION GATEKEEPER

Patients

Participant nº 58 (71-year-old male German speaking patient) shares his experience with the non-professional medical interpreter:

Also mir ist gestern im Krankenhaus ein großes Problem im Bereich der Dolmetscherei passiert und zwar war die Simultanübersetzung sicherlich sehr schlecht und ich hatte ### Eindruck dass der Arzt sehr sehr viele Fragen zu mir hatte aber ich hatte nicht das Gefühl dass das die Dolmetscherin die

> sagen wollte, sondern hat die Dolmetscherin nur gesagt Sie kommen jetzt im erste Stock Ambulanz und kriegen eine Blutübertragung. Ende der Durchsage. [...] Das war alles. [Ein Studium] Abschluss wäre schön. Viel besser. Ja, ja professionell.
>
> So, yesterday I have experienced a major problem in the area of interpreting of this hospital, namely the simultaneous translation was definitely very poor, and I had the impression that the doctor had many questions for me, however I did not have the feeling that the interpreter wanted to verbalise those questions, instead the interpreter had just said that I was going to be brought to the first floor out-patient area and that I was going to get a blood transfusion. End of the message. [...] That was all. A degree would be nice. Much better. It would be professional.

Awareness of the concept of professionality. It is my contention that the patient constructs the identity of the non-professional interpreter fully consciously. This particular professional identity is "produced through contextually situated and ideologically informed configurations of self and other" using the relationality principle (Bucholtz & Hall, 2005, p. 606). This excerpt definitely showcases doctor's unwillingness to properly exercise his professional autonomy and agency as he dismisses the necessity to medically cross-examine the patient and remains lackadaisical and unconcerned. By omitting information the interpreter acts as an information gatekeeper/screener, provider proxy, decision-maker, and possibly even co-diagnostician. The non-professional interpreter neglects her role of a mediatrix and proceeds to decide what to convey by filtering information in a way that clearly offends the patient, who booked himself in the cubicle at the ED in order to ferret out his health status. Thus, the patient was dismissed. As relationality principle views identity as a "relational phenomenon", and not an isolated or socially detached psychological idea (Bucholtz & Hall, 2005, p. 598), the workplace identity of non-professional interpreter gained social meaning through intersubjective identity negotiation (doctor, patient, interpreter, researcher) and juxtaposition with the position of professional or graduate interpreter. A certain person –the non-professional interpreter who was working with this particular patient–, is being framed as an incompetent, unethical, negligent, unqualified person who dismisses moral imperatives of their occupation in relation to a professional graduate.

Interpreters

Participant nº 34 (female lay person interpreter, 2 months of professional experience as interpreter on daily basis and indefinite period of time of sporadic, piecemeal interpretations) has managed to express the "information gatekeeper" concept very clearly.

> Estás totalmente expuesta al riesgo de equivocarte entonces tienes que estar muy segura claro que yo he tenido situaciones que *al no haber estudiado nada de medicina he tenido algunos momentos de confusión algunos momentos de estar no muy segura de lo que tenía que traducir* pero al hablarlo con el médico pues enseguida me lo ha resuelto y *de una forma humana se lo he intentado comunicar al paciente ya que el paciente tampoco entiende mucho de términos médicos.*
>
> You [as an interpreter] are totally exposed to the risk of making a mistake, so you have to be very sure [...] because I have had *situations [in which] I have had some moments of confusion [due to the fact that I haven't] studied medicine at all.* [These were] moments of *not being very sure of what I had to translate*, but when I spoke to the doctor, he immediately resolved my doubts and *I tried to communicate it to the patient and in lay terms, since the patient does not understand much about medical terms either.*

By perusing this excerpt the question arose as to how dangerous it may be for a layperson interpreter to withhold information from the patient by determinologising it? Does a layperson interpreter know how to determinologise (correctly)? Which option will be more beneficial for the patient: determinologisation or terminologisation? Is despecialisation or democratisation of specific medical terminology necessary in the case of non-Romance languages, such as Germanic languages for example? Does the role of mediatrix imply despecialisation? Does the intercultural mediator role imply this transition from the esoteric verbiage into common parlance or lexicon? Are we paid to interpret cross-linguistically or intralinguistically? Have we learned how to determinologise? It must be determined up to what extent the interpreter is allowed to restructure, transform and adapt the message taking into account differences in the patients' lay knowledge and the practitioners' expert knowledge. Thus, the question arises whether or not and up to what extent the interpreter should or could de-terminologise Latinisms and technical terms converting them into the common parlance, or adapt the register.

All these questions require a deep scrutiny as the topic of the necessity of medical determinologisation is still a hotly debated one, and apparently to the best of my knowledge no consensus has been reached as to whether terminological democratisation is indispensable in medical interpreting, especially in the case of non-Romance languages. It is my contention that medical interpreters must learn Ancient Greek (this idea was also upheld by Participant nº 48) and Latin apart from at least an introduction to medicine (to say the least). This mediatrix role may not be as hybridised as others, but it is equally problematic.

Also the problem of interpreters' inability to understand medical discourse when it comes to bringing the message across and the incapacitating bewilderment, mentioned by this interpreter in her unvarnished statement, may be based on a generalised unenlightenment and lack of learnedness. This was also pointed out by Feinauer and Lesch in 2011 in their article "Health workers: idealistic expectations versus interpreters' competence"[148]. According to these authors, in some situations interpreters fail to provide a conveyance that would allow for an informed decision precisely due to the low level of education. The authors conclude that "health care professionals sometimes have expectations that interpreters cannot meet" (2011, Abstract section). In this study, interpreters showcased reluctancy to "declare in writing that they assisted the medical investigator to explain the information in consent forms for patients" and that these patient fully understood "the content of the relevant document" (Feinauer & Lesch, 2011). This demonstrates that these "interpreters did not fully understand the information that they have to explain" (Feinauer & Lesch, 2011It is worth reminding that Participants nº 28 and nº 56 have also commented on the necessity of generalised erudition as well as healthcare literacy and T&I expertise based on language proficiency. The concept of "knowledge" both general and specialised is yet again becoming the theme par excellence.

d) 4th role- PROVIDER PROXY

Interpreters

[148] Full article can be found here: https://www.academia.edu/11734891/Health_workers_idealistic_expectations_versus_interpreters_competence?email_work_card=title

Participant nº 37 (female graduate translator and interpreter, 21 years of professional experience) has revealed the following information about her workplace reality:

- Traducción en consulta, a veces haces una pequeña conversación antes de entrar a la consulta porque veces no sabes a lo que viene el paciente [...] para agilizar luego la conversación con el médico pues aunque no se debería sí que resumes lo que te han contado en el pasillo para poder hacerlo todo un poquito más ágil y no tener que sacarle información dos veces a un paciente. [...] la conversación o anamnesis en el pasillo, en la sala de espera, en el ascensor, lo mismo da o por el teléfono antes de que venga el cliente o paciente ayuda muchísimo a agilizar el trabajo, eso sí, tienes que saber cómo es el médico con el que vas a entrar y saber que ese médico te va a permitir esa libertad de explicación y que se va a fiar de tu criterio. [H]ay médicos que se fían más de tu criterio como persona y te permiten que tú le hagas preguntas [...] muchas preguntas sencillas que luego entras en la consulta y te dice el médico cuéntame, qué le pasa e este paciente.

- Visita planta normalmente acompañado del médico aunque luego el médico te diga pues explícaselo tú y tú le dices al médico, vale pues explícame tú primero a ver qué le tengo que explicar yo a este señor y a veces te lo dicen, a veces no te lo dicen.

- Acompañar en pruebas [diagnósticas], explicar cómo se van a sentir (p. ej., cuando se hacen un tac, que el contraste les puede hacer sentir mareados, que les puede hacer sentir calor, que pueden tener una reacción alérgica y me tiene que avisar, respire, no respire [todo esto se hacía] con la auxiliar técnico del aparato. nunca o se intenta nunca tener la responsabilidad final, siempre teniendo a alguien que haya estudiado y que tenga esa responsabilidad y esté seguro sobre ese tema).

- Translate during medical encounters. Sometimes you make a small conversation before entering the consultation room because sometimes you don't know what brought the patient to the hospital [and in order to] to streamline the conversation with the doctor, although you shouldn't [do that], you summarise what you have been told in the corridor to expedite the encounter and not have to get information out of a patient twice. [...] [T]he conversation or anamnesis in the corridor, in the waiting room, in the lift, whatever, or on the telephone before the client or patient comes in helps a lot to expedite the process, but you have to know what the doctor you are going to see is like and know that this doctor will allow you to take the freedom of explanation and that they will trust your criterion. There are two types of doctors: there is a doctor who trusts your discretionary judgement as a person and allows you to ask [the patient] [...] many simple questions that you then go into the consulting room and the doctor says, tell me what is wrong with this patient.

- Visit the ward normally accompanied by the doctor, even if the doctor then tells you to explain it to [the patient] and you tell the doctor, well, you explain it to me first to see what I have to explain to this gentleman, and sometimes they tell you, sometimes they don't tell you.

- Accompany [patients] in [diagnostic] tests, explain how they are going to feel [e.g.] when they have a CT scan, that the contrast can make them feel dizzy, that it can make them feel hot, that they can have an allergic reaction and they have to tell me, breathe, don't breathe. [All this was meant to be done] with the technical assistant of the [corresponding] device. We would always try not to have the final responsibility [by] always having someone who has studied and who has that responsibility and who masters that subject).

d) 5th role - CO-DIAGNOSTICIAN, CO-THERAPIST, "INTERNATIONAL NURSE"[149]

Doctors

Participant nº 35 (female doctor, Department of Gynaecology, 7 years of professional experience, International Department coordinator) believes interpreters have to assume the following tasks:

> *Una persona con la que [el paciente] llega a tener más relación: es la tutora o la asistente médico* como lo llamemos, *que es la que está haciendo el tratamiento*. Por lo tanto [...] aquí no hay neutralidad. Hay otra parte también que es muy necesaria que es *la parte burocrática, digamos la parte de a) organización de un tratamiento o de b) pedir analíticas, c) resolver dudas, entonces esa parte también tiene que ser capaz de hacerla, no solamente la parte de traducción*. [...] *yo no pretendo que sean médicos* de la noche a la mañana, pero hay conceptos muy básicos de la biología muy básica que son erróneos, porque hay muchos mitos y creo que *el personal que trabaja en una clínica como asistencia médica* tiene que ser capaz de saber la realidad de la biología y no dejarse llevar por los mitos porque si no es muy difícil *tranquilizar a los paciente sobre determinadas cuestiones*.
>
> The tutor or the medical assistant as we call it, who is the one responsible for the treatment, is the person with whom [the patient] comes to build the closest rapport. [...] Therefore, there can be no neutrality here. There is another part that is also very necessary, which is the bureaucratic part, let's say the part of a) organising the treatment or b) ordering tests, c) resolving doubts. The interpreter has to be able to do this part as well, not only the translation part. I don't expect them to become doctors overnight, but there are very basic concepts of very basic biology that are erroneous, because there are many myths surrounding these concepts, and I think that the staff working in a clinic as medical assistance has to be able to know the reality of biology and not get carried away by myths because otherwise it will be very difficult to reassure patients about certain issues.

Participant nº 36 (male doctor, Gynaecology department, 23 years of professional experience) states the following:

> ¿Cree que el intérprete tiene que hacer todo eso estando el médico delante?
>
> No necesariamente.
>
> La clave está en conocer en que ese intérprete tenga también la formación adecuada sobre los procedimientos que realizamos. Yo creo que hay una parte que es indispensable que es la entrevista del médico con el paciente en la cual sí que debe estar presente el médico para aclarar sobre todo las dudas del paciente [...] es fundamental que en un quirófano esté porque si un paciente se despierta o tiene una complicación y no está para comunicárnoslo eso es gravísimo [...] [...] que despierte un paciente en un quirófano y no sepa si tiene una reacción o una complicación allí nos la estamos jugando [...] y luego lo que es la parte general del procedimiento así como la traducción de la documentación un intérprete adecuadamente formado en nuestro terreno puede realizarlo perfectamente sólo. Y si surge una duda trasladársela al médico porque es una tarea en equipo al fin y al cabo.
>
> [The doctor does] not necessarily [need to be present]. The key is to ensure that the interpreter also has an adequate training in the procedures being performed here in this particular medical facility. I believe that there is an essential part in which the doctor must be present especially when it comes to clarifying the patient's doubts. This is the doctor's interview with the patient. [...] It is essential that the interpreter be in the operating theatre, because the fact that the patient wakes up or has a

[149] This is an actual designation of medical interpreters in one of the medical centres where research was conducted. My participants shared with me numerous documents where it is revealed that "enfermería internacional" is an actual figure in the hospital hierarchy enacted by multilingual personnel.

> complication and the interpreter is not there to report it to us is extremely serious [...] we are taking a huge risk by allowing a patient to wake up in the operating theatre and not knowing whether he or she has a reaction or a complication [...]. *And then when it comes to the general part of the procedure and the translation of the documentation, an interpreter who is properly trained in our field can do it perfectly well on their own.* And if a doubt arises, it should be passed on to the doctor, because in the end it is a teamwork.

Participant nº 36 (male doctor, Gynaecology department, 23 years of professional experience) reveals the following ideations, whereby he, on the one hand, deprecates this role, but on the other hand justifies such phylogeny as normal given the routinised character of some protocols of treatment.

> Yo creo que lo que no debemos, o sea, sí que es una parte fundamental lo que hacéis, pero hay cosas a veces que la responsabilidad es nuestra [la del médico], vosotras no tenéis que tomar decisiones médicas, que las tomáis a veces, porque no os queda más remedio, porque no tenéis una formación para eso. [...] Yo lo tengo claro pero eso es lo que hay que tratar de solucionar ahora [...] Vosotras no tenéis que tomar esas decisiones vosotras tenéis que limitaros a ser una cadena de transmisión entre el médico y el paciente y saber qué es lo que paciente quiere para trasladárnoslo a nosotros. Pero como muchas cosas son rutina y como es la práctica que hace más que un título, pues [es lo que pasa].

> I think that what we should not do, I mean, yes, *what you [interpreters] do is a fundamental part [of the whole service], but there are things that are sometimes our [the doctor's] responsibility, you do not have to make medical decisions, which you sometimes do, because you have no other option, because you do not have the training for that.* [...] It seems clear to me, but that is what we have to try to solve now [...] You don't have to make these decisions, you have to limit yourselves to being a chain of transmission between the doctor and the patient and to know what the patient wants in order to pass it on to us. But since many things are routine and since it is the practice that determines more than a title, well [this is what happens].

These excerpts substantiate the fact that medical professionals defer to medical interpreters on the practical application of regularised and routinised medical protocols encouraged by the institutional ethics. There is clearly a demand for multilingual medical services with two blocks of tasks: those related to medicine and those related to translation and interpreting. In this case, instead of being further developed, interpreting-related tasks are rather reinvented, extinguished or usurped by other actors, who Dingwall calls "occupiers". In this case, *some* of these medical professionals[150] "struggle to improve their status by new acquisitions" (Dingwall, 2016, Introduction section, § 10-11) such as foreign language proficiency. At the same time, some of these "prestigious and powerful" occupiers seek to "relinquish less attractive properties" of their professional modus operandi, such as routinised protocols and procedures. Of course, as in any other evolutionary process, medical interpreters need to (re)establish themselves by completing professionalisation, which is challenging due to ever changing market demands and new technologies (Dingwall, 2016, Introduction section, § 10-11). Therefore, the "general" and routinised medical procedures/protocols/modi operandi are being relinquished to interpreters, whereas the employers prefer to defer to the allegedly proficient doctors on cross-linguistic communication. Pursuant to this logic, "since many things are routine and since it is the practice that determines more than a title", "an interpreter who is properly trained in our field can do" the "the general part of the procedure [...]perfectly well on their own" (Participant nº 36).

[150] Please see conversation analysis.

It is absolutely essential that we scrutinise this extract from Bucholtz and Hall's (2005) perspective. Such synchronisation of duties may be explained by the relation pairs attributed to the relationality principle. The authentication/denaturalisation relation pair may be described as a social process whereby certain rights intrinsic to a particular professional identity (generated in this particular medical facility and in this specific socioprofessional context) are granted to the holders of this identity. In this case, these rights, authorisation, entitlement, power and liberty to make medical decisions are granted through the process of denaturalisation. The following excerpt is essential in showcasing how these rights and authority are being negotiated:

> What you [interpreters] do is a fundamental [of the whole service], but there are *things that are sometimes our [the doctor's] responsibility, you do not have to make medical decisions, which you sometimes do, because you have no other option, because you do not have the training for that.*

Thus, medical interpreters are authorised or authenticated to claim partial ownership over the physicians' modus operandi. Realness, also referred to as authentication, serves to construct an interactional identity that would work in the context of professional interoperability. In this case, my participant explicitates that part of the doctor's *modus operandi* is being entrusted to interpreters, which is diagnostic of denaturalisation process, whereby the inevitability or inherent rightness of identities is being subverted. Traditionalised (Bauman in Bucholtz and Hall, 2005) physicians denaturalise the identity of medical interpreters as well as its discretionary specialisation and problematise adherence to the existing codes of ethics and codes of conduct. By openly acknowledging that "making medical decisions" and "assuming doctors' responsibilities" constitutes a "fundamental part" of medical interpreters' job, this informant is creating a hybrid identity, which violates traditionalised ideological expectations (polyglot/bilingual medical assistant vs. simultaneous or conference interpreter). This participant acknowledges that institutional ethics may overpower practice ethics by hindering proper exercise of task discretion (e.g. rejection of "assignments beyond their professional skills, language fluency, or level of training", IMIA, 2006). Institutional order/system in this particular case has successfully imposed an identity through structures of institutionalised power and ideology (as referenced by Freidson, 2001). Given that medical interpreting is an occupation lacking collective identity, it is more vulnerable to the influence of the institutional ethics. Thus, graduate medical interpreters lack agency and autonomy to duly exercise task discretion by rejecting those assignments, which are not inherent in, intrinsic to and natural of medical interpreting. In accordance with the IMIA code of ethics, "interpreters will refrain from accepting assignments beyond their professional skills, language fluency, or level of training". Consequently, medical interpreters cannot authenticate themselves as professionals in control of thier own expertise, discretionary specialisation and task allocation. They cannot claim ownership of their own *modus operandi*.

I came to notice that graduate specialists in interpreting that seek to preserve their professional integrity and act in accordance with the practice ethics of their profession, may be written off as if they did not want to collaborate with the facility, as if they failed to showcase responsible, sympathetic, compromising, and most importantly flexible attitude towards their employers. Therefore, such instrumentalisation implies that those willing to preserve their position may end up acquiescing to such over-involvement by forsaking compliance with the corresponding code

of ethics and even by neglecting their moral compass, professional integrity and –most importantly– the do-no-harm principle, automatically extended to them as hospital workers.

With regard to the partialness principle, we may say that this hybrid identity is constructed in a fully conscious and deliberate way. It is the outcome of interactional negotiation and contestation, as well as perceptions and representations of relevant social actors. These representations are, of course, the result of larger pan-European ideological processes (as we have seen in the previous chapters). In conclusion, identities tend to shift as interaction unfolds across different contexts exceeding the individual self.

As regards the indexicality principle it is worth noting that the indexical process of implicatures also plays a key role in identity formation. Personal pronouns "ellas" (they, 3rd person plural feminine) and "vosotras" (2nd person plural feminine) indicate that all the interpreters are female. I believe that this fact merits closer attention as an additional inferential interpretation process may reveal a potentially important latent factor. The fact that the official professional category of "administrative assistant" allocated to medical interpreters in the study-relevant area is strikingly similar to "executive assistant" and "secretary" is disquieting, because these professional categories have fallen out of favour and may no longer be considered as highly regarded and well respected. Apart from being considered a female occupation, the term "secretary" carries the undertone and connotation of subordinate worker, who always reports to the management. Thus, we can no longer be talking about double allegiance or neutrality as the key tenets of medical interpreters' code of ethics, because the term "secretary" or "administrative assistant" implies unilateral allegiance to the employer. Moreover, the fact that medical interpreters are viewed as administrative assistants or secretaries only strengthens their image of unseen administrative underclass.

Interpreters

The data educed from the interview I had with Participant nº 1 and 2 (female lay person interpreters) are consistent with and fully mirror the statements expressed by Participants nº 35 and 36. For instance, Participant nº 1 has shared the following reflexion:

> Muchas veces el médico efectivamente no te dice lo que tú tienes que dar, tú tienes que saber lo que tú tienes que dar por ejemplo muchas veces te van a llamar de: una consulta y decir doctor tal pide que bajes a la consulta a dar pautas de: de=˜ cirugía y tú tienes que saber qué pautas de ˜cirugía son [...] Las chicas que llevan mucho tiempo lo hacen todo todo solas todo como si fueran un médico### [...] teóricamente como es el trabajo del médico y lo hacen ellas para quitar el trabajo #a #los médicos deberían responder los médicos porque es como yo estoy haciendo tu trabajo pero lo deberías de estar haciendo tú lo que pasa es que #ellas no se equivocan mucho o sea nada porque tienen muchísima experiencia [...] y también preguntan mucho. Hay muchas cosas que ellas no hacen pero hacen mucho cosas que tampoco deberían de hacer. Lo hacen por eso no #querrían hacer pero lo hacen po:r porque ha evolucionado de una manera.. sabes.. que ellas han ido haciendo más y más y más y como a los médicos les viene bien [...] ellas saben muchísimo entonces: ehh pero:.. pero hay que preguntar todo [...]
>
> Many times the doctor does not tell you what [medication guideline] needs to be given [to the patient] you have to know what you have to give [what type of guideline is being referred to]. For example many times you are going to receive a phone call from the doctor's office and say Dr. X requires that

> you to go to the consultation in order to provide guidelines for ~surgery and you are the one who has to know what these surgery guidelines are [...] The girls who have been working here for a very long period of time do everything everything on their own everything as if they were doctors### [...] Theoretically, since this is the doctors' work and [yet] they-F.PL [end up] doing it in order to reduce their [doctor's] workload, the doctors are the ones who should be held accountable [in the case of medical error] because it's like I'm doing your job but it is you who should be doing it the thing is that [interpreters] #they're not often wrong I mean [they are] never [wrong] because they have a lot of experience [...] and they also ask a lot. There are many things that they-F.PL don't [have to] do but [yet] they do many things that they shouldn't do either. That's why they do it they wouldn't want to do it but they do it because [overtime] it has evolved in a way.. that you know.. they-F.PL have been progressively doing more and more and more and since this suits the doctors right down to the ground [...] They-F.PL [the interpreters] know a lot so: uhh but: but: you have to ask everything.

Participant nº 2 (female lay person interpreter, 12 years of professional experience) stated the following:

> Pero hay otros médicos que esperan que tú lo sepas. Como ellas saben porque llevan mucho años qué pasa? que hacen el trabajo del médico pero no deberían hacerlo aunque lleven ~30 años porque no #lo son pero esto es la gente que hay mucho aquí. Entonces realmente aquí te tienes que cubrir mucho la espalda porque al final son temas médicos.
>
> But there are other doctors who expect that you know [how to do it]. Since they-F.PL [the interpreters] know [how to do it] because they have been working here for many years what happens? they-F.PL [end up] doing the work of a doctor but they-F.PL shouldn't do it even if they had been working here for ~30 years for they are not doctors. so you really have to watch your back because after all these are medical issues.

Participant nº 37 (female graduate translator and interpreter, 21 years of professional experience) has revealed the following information:

- Pero realmente llega un momento en que muchas cosas ya las sabes porque las has ido aprendiendo con la experiencia y puedes explicarlas sin tener que molestar o acudir o interrumpir a un médico, cosa que no se debe hacer, pero siempre te lo piden: oye es que me ha salido esto, qué hago, pacientes que te llaman por teléfono: tengo este problema a qué médico acudo? no sé qué especialista necesito.
- preparar una receta médica, incluso firmar una receta médica por el médico
- interpretar un diagnóstico [...] en fin, dar una explicación que le correspondería dar a un médico incluyendo la conversión de distintas unidades de medidas (por ejemplo, pmol/L a pg/ml, noml/L a ng/ml), como también conocer todos los equivalentes de medicación en distintos países, por ejemplo, en el Reino Unido es prácticamente imposible que les receten la prednisona o el Dacortin a no ser que tengan artritis reumatoide severa. El equivalente allí para las enfermedades que lo prescribimos aquí es Prednisolone y se puede conseguir en comprimidos de 5mg.
- explicar consentimientos informados unas 15 veces al día [...] sin médico es un trabajo administrativo no es un trabajo médico ci no tiene nada que ver con un médico tiene que ver con la protección y la responsabilidad civil del hospital.
- But there really comes a time when you already know a lot of things because you have been learning them with experience and you can explain them without having to bother or go and interrupt a doctor, which should not be done, but [patients] always ask you: hey, I have this

problem, what should I do, patients who phone you, I have this problem, which doctor should I go to? I don't know which specialist I need.

- prepare medical prescriptions and even sign them instead of the doctor
- interpreting a diagnosis [...]which in short is giving an explanation that would rather be expected to be given by a doctor. Such interpretation includes the conversion of different units of measurement (e.g. pmol/L to pg/ml, nmol/L to ng/ml), as well as knowing all the (relevant?) medication equivalents in different countries, e.g. in the UK it is virtually impossible to get prescribed prednisone or Dacortin unless you have severe rheumatoid arthritis. The equivalent there for the conditions we prescribe prednison for here is Prednisolone and it is available in 5mg tablets.
- explain informed consents about 15 times a day [...] without the doctor being present as it is an administrative job, it is not a medical job, informed consent has nothing to do with a doctor it has to do with the protection and civil liability of the hospital.

Participant nº 6 (female graduate interpreter, 5 years of professional experience) clarifies that the *assignments she would usually perform on a daily basis without any health professional being present during such performance* included the following:

Pasar primera consulta, abrir anamnesis, explicar tratamiento y pruebas, pautar tratamiento, organizar el tratamiento indicando qué medicación debe tomar el paciente y cuándo de acuerdo con el protocolo de actuación indicado por el médico, hacer recetas médicas, introducir información a las historia clínica del paciente, orientar al paciente en cuanto al tipo de tratamiento que se va a realizar y explicárselo, llamar a los pacientes para hablar de una situación extremadamente delicada y médicamente compleja (por ejemplo, un aborto espontáneo), de un tratamiento fallido y de la revisión del caso, explicar por qué ha fallado el tratamiento, qué hacer a continuación y por qué se van a necesitar más pruebas adicionales, gestionar e informar al paciente del resultado de las pruebas realizadas, enviar correo informativo al médico remisor, elaborar y gestionar informes de resultados remitidos por los pacientes, redactar informes de alta con instrucciones de administración de medicamentos[151], indicar cuándo hay que hacer pruebas diagnósticas y no diagnósticas, a veces incluso los propios médicos nos preguntan a nosotras por protocolos de medicación, a veces le preguntas al médico si puede aclarar la pauta de medicación y la respuesta es "pregúntale a alguna compañera tuya que lleve más tiempo aquí"[152], médicos dejan instrucciones incompletas de medicación dando por hecho que la ATP sabrá pautar todo, y se dan instrucciones incompletas a los pacientes generando quejas hacia nosotras, estar	Conduct the first consultation, collect a detailed anamnesis of the patient, explain treatment and tests, prescribe treatment, organise treatment by indicating which medication the patient should take and when, in accordance with the protocol indicated by the doctor, peruse medical guidelines and treatment guidelines before each procedure and advise the doctor of any particular detail therein that deserves special attention, write medical prescriptions, introduce data such as test results into the patient's clinical history, advise of the patient of the type of treatment that they are going to be undergoing and explain it, call the patient to talk about extremely sensitive and medically complex situation (e. .g. miscarriage), unsuccessful treatment and case review, explain why the treatment failed, what to do next, why further tests are going to be needed, inform the patient of the results of the tests they have undergone, keep the referring doctor posted, draw up reports on the test results that have been previously performed on them and that they have kindly facilitated, draw up discharge reports with medication administration instructions, indicate when to undergo diagnostic and non diagnostic tests, sometimes even the doctors themselves ask us for medication protocols, sometimes you ask the doctor if he/she can clarify the course of treatment and the answer is "ask one of your colleagues who has been working here longer that you", our doctors leave incomplete medication instructions, assuming that the international

[151] Please check the example of a document with discharge instructions below.

[152] This informant proceeded to show me an email as an example containing a conversation between her and a doctor where she translated a patient's ultrasound asking for further instructions and the doctor suggested she should ask a "senior tutor" for help: "pídele a una tutora senior de ayudarte a darle instrucciones para alta [...]". I still have the screenshot of this email, I cannot however share it here without revealing the identity of the doctor, the interpreter and the hospital/clinic.

familiarizados y saber cómo emplear todos los protocolos médicos, cuando descubrimos que hay un caso de posible infección tenemos que interpretar el protocolo y tomar nosotras las decisiones: a menudo el medico no está disponible o tampoco sabe más que nosotros, nosotras nos tenemos que limitar a la parte administrativa, explicar los CI y la logística de cómo funciona el seguimiento de su tratamiento, eso implica que sea el médico quién explica el tratamiento y en qué consiste por tanto es imprescindible tener un médico en el departamento como antes ya que se ha desviado la función del departamento: nos contrataron para traducir no para todo lo que hacemos. Las pacientes no son nuestras, por lo tanto llamar a la intérprete durante un puente por un caso difícil de hepatitis que ella conoce es inapropiado por no decir otra cosa.	medical assistant will know how to prescribe everything, and we end up giving incomplete instructions to patients, thus generating complaints against us, be familiar with and know how to apply all medication protocols, when we discover that there is a case of possible infection, we have to interpret the protocol and make the decisions ourselves: often the doctor is not available or does not know more than us either, we have to limit ourselves to the administrative part, explain the informed consents and the logistics of how the follow-up of their treatment works, which means that it is the doctor who explains the treatment and what it involves and it is therefore essential to have a doctor in the department as it used to earlier, in that the function of the department has been diverted: we were hired to translate, not to do everything we do. The patients are not ours, therefore calling an interpreter during her long weekend break because the patient that she was normally working with has a difficult case of hepatitis is inappropriate to say the least.

The following is an example of a WORD document containing final discharge instructions, which according to this informant were to be filled in by the interpreter:

Please find below the last instructions concerning your treatment:

- Keep on taking 1 tablet of xxxx per day until xxxx.
- Stay on the same dosage of Elija un elemento. and xxxx until the Haga clic aquí para escribir una fecha. (included).
- From the day after onwards reduce the medication to Elija un elemento. and xxxx of xxxx every xxxx hours.
- Stop both Elija un elemento. and xxxx on the Haga clic aquí para escribir una fecha.
- If you are taking any other drugs such as Clexane/Aspirine/Hidroxil/ Heparin carry on with the same treatment until xxxx. At that point please seek advise [sic] from your xxxx as to whether extend them or not.

e) 6th role - MEDICAL WORKER

Interpreters

Participant nº 37 (female graduate translator and interpreter, 21 years of professional experience) has revealed that she had to carry out tasks, which fall under the medical professional's remit, be it under the purview of the doctors, nurses or auxiliary nurses:

- coger una vía o hacer una radiografía, o poner una inyección intramuscular o sacar sangre
- place an IV, do an x-ray, or administer an intramuscular injection or take bloods

Before we proceed with the following roles, I would like to clarify that all of the interviewed interpreters indicated off-camera that they, as well as their colleagues, were suffering serious health issues due to insurmountable work load and great responsibilities they were burdened with when they acquiesced to take on the aforementioned roles. They all commented that at a certain moment it was no longer possible to keep up the appearances that everything is going

well, because indiscriminate eligibility to access the niche in the currently established professional stratification system, as well as advanced hybridisation processes seriously compromising the quality of medical care have led a number of interpreters to the state of desperation due to the sense of "neglect" and "deplorable impotence, powerlessness and helplessness" (Participant nº 6). Unrealistic expectations and work overload left these interpreters overcommitted beyond the capacity for realization and encumbered the correct functioning of their department. I was told that this situation induced states of deep desperation and emotional distress in many interpreters. All the interpreters that I had the chance to interview stated that there is no logical distribution or allocation of tasks, there is no such thing as a rational division of labour, Participant nº 6 said that: "nos contrataron para traducir, no para todo lo que hacemos [we were hired to translate, not to do all the things that we end up doing]". But, most importantly, these unrealistic expectations end up translating into constant stress and pressure, that leads to all sorts of psychological and physiological disorders such as anguish, panic attacks, anxiety, depression, high blood pressure, etc. Participant nº 6 shared the following experience:

> Me dieron la baja porque he tenido graves problemas de salud, he tenido que tomar ansiolíticos y tranquilizantes. No podía parar de llorar porque no me podía creer que un trabajo haya podido causar este tipo de problemas.
>
> I was given medical leave because I had serious health problems, I had to take anxiolytics and tranquillisers. I could not stop crying because I could not believe that a job could be causing this kind of problems.

After some time, I contacted a number of participants inquiring about this situation, I was told that nothing had changed. These statements indicate both burnout and vicarious trauma. In this case, the vicarious trauma is not caused exclusively by a visceral approach to work, or by work-related trauma exposure, but also by a continuous exposure to pressure and by pollyannish or even blasé expectations of the organisations, whereby huge challenges are imposed on multilingual staff. The major challenge consists in asking interpreters to do something that they are not prepared to do, something that they do not feel comfortable doing, something they had never received a training for. This disquieting lack of preparation, orientation, training and supervision makes interpreters more vulnerable to suffer vicarious trauma. Thus, we are not dealing with an occupational challenge intrinsic to a type of activity, but with an imposed challenge, which is the pressure that is being placed upon the interpreters to fulfil the expectations that overwhelm the interpreters' ability to cope but are necessary to keep their position. This vicarious traumatisation is reported to have caused a range of reactions starting with a distorted sense of self-blame for the decline in job performance, followed by anxiety, to prolonged psychological distress.

f) 7th role - PSYCHOLOGIST, COUNSELLOR, CONFIDENTIAL ADVISER

Doctors

Participant nº 35 (female doctor, Department of Gynaecology, 7 years of professional experience, International Department coordinator) believes interpreters have to ALSO assume the role

of a psychologist, a quasi-psychologist, a counsellor or a confidential adviser. This is how she describes it:

> A veces hay otra *parte que es más psicológica* [el intérprete debe] *reconfortar a los pacientes*. Entonces no se puede limitar solamente a una traducción, se tienen que limitar a una a) *organización del tratamiento*, a b) reconfortar a los pacientes también en cuanto a la parte psicológica, el c) poder *hablar con ellos*, [...] escucharlos, invertir ese tiempo, eso también es una parte fundamental del trabajo.
>
> Sometimes there is yet another part that is more psychological [whereby the interpreter must] comfort the patients. Thus, they cannot limit themselves to just translating, they have to limit themselves to a) organising the treatment, b) comforting the patients on a psychological level c) being able to talk to them, [...] listen to them, invest the necessary time, that's also a fundamental part of the work.

Interpreters

Participant nº 6 (female professional interpreter, 5 years of professional experience) shares the following experience, which is totally consistent with the data facilitated by the Participant nº 35:

> Hacemos de psicóloga. Los pacientes están mal y tenemos que estar al teléfono media hora escuchándoles
>
> We operate as a psychologist. The patients are distressed and we have to be on the phone for half an hour listening to them

g) 8th role - SOCIAL WORKER

Interpreters

Participant nº 37 (female graduate translator and interpreter, 21 years of professional experience) has also identified the position of social worker:

- [U]n intérprete no está preparado para ver una persona fallecida [o] tranquilizar al paciente, ni [tampoco] está preparado para este trabajo social que es acoger a un familiar que está a punto de perder a su ser querido, aun así, como no hay nadie más en el hospital que pueda hacerlo estás tú y si tú eres una buena persona [pues] lo que quieres es que todos tus pacientes/clientes y los que están a su alrededor estén lo mejor que puedan estar. Yo lo veo como una labor social.
- [A]n interpreter is not prepared to see a deceased person [or] to reassure the patient, nor is he/she prepared for the social work, which consists of cosseting, rallying around or molly-coddling the family members who are about to lose their loved ones, because there is no one else in the hospital who can do it, so you are there and if you are a good person then what you'd want is for all your patients/clients to be as comfortable as possible. I conceive of it as social work.

Participant nº 46 (female doctor, Accident and Emergency Department, 28 years of professional experience) highlights the social worker role of medical interpreters:

> Los intérpretes nos ayudan tanto en la tarea social como en las tares de apoyo al paciente como en la traducción para la anamnesis clínica, exploraciones y es [un servicio] absolutamente esencial.

> Interpreters help us in social work as well as in patient support tasks such as translation for clinical anamnesis, examinations and it is absolutely essential [a service].

h) 9th role EMPATHETIC SUPPORT STAFF, HOSTESS

Doctors

Participant nº 35 (female doctor, Department of Gynaecology, 7 years of professional experience, International Department coordinator) also views interpreters as empathetic hostesses:

> Allí hay una parte emocional y no puede ser neutral [...] No es lo mismo traducir un libro que estar con un paciente cogiéndole la mano mientras le están operando o mientras el médico le está dando una mala noticia, para eso hay que prepararse.
>
> There is an emotional involvement as well, therefore the interpreter cannot remain neutral [...] Translating a book is not the same as being with a patient holding their hand while they are being operated on or while the doctor is giving them bad news, you have to be prepared for that.

We can see how this informant systematically and intentionally enacts behaviours that imbricate with the providers' responsibilities and overlap with the medical professionals' expertise. This institutionally imposed overinvolvement clashes with the guidelines laid out in practice ethics codes, in that the relationship between the patient and the interpreter in this case goes far beyond politeness, deferential behaviour, distant cordiality, emotional detachment and professionality. I believe it is clear that "ordering or running tests or analysis", "organising the treatment", "answering patients' queries" cannot be referred to as "bureaucracy" even if the intention here is highlight that officially medical interpreters are formalised and designated as "auxiliar administrativo [administrative assisstant]". The excerpt "esa parte también tiene que ser capaz de hacerla, no solamente la parte de traducción [he/she has to be able to do that part as well, not only the translation part]" showcases how relationality principles of denaturalisation and authorisation construct a new identity intersubjectively:

> In denaturalization, by contrast, such claims to the inevitability or inherent rightness of identities is subverted. What is called attention to instead is the ways in which identity is crafted, fragmented, problematic, or false. Such aspects often emerge [...] in some displays of hybrid identity (e.g. Bucholtz, 1995; Jaffe, 2000; Woolard, 1998), but they may also appear whenever an identity violates ideological expectations (e.g. Barrett, 1999; Rampton, 1995) [...] Authorization, involves the affirmation or imposition of an identity through structures of institutionalized power and ideology, whether local or translocal. The counterpart of authorization, illegitimation, addresses the ways in which identities are dismissed, censored, or simply ignored by these same structures. (Bucholtz & Hall, 2005, pp. 602-603)

Interpreters

The following are the itemised tasks, which are fully consistent and compatible with the figure of a hostess, educed from the interview with the Participant nº 12 (female graduate interpreter,

14 years of professional experience). She reports that the routinised assignments displayed below were to be performed on daily basis:

- Bringing the remote control for the TV
- Finding a TV channel
- Bringing a book to read
- Switching on or off the air conditioning
- Putting personal belongings that the patient had on them upon admission to the hospital into a safe
- Sight translating menus for each patient individually and inform the kitchen of each patient's culinary choices and preferences
- Delivering free press
- Bringing an extra blanket or an extra pillow
- Escorting patients and their family members across the facility and its premises

The nature of these tasks is fully consistent with the outfits that some medical interpreters have to wear and which were discussed in the previous chapters of this thesis[153]. The fact that these tasks are more mechanical than discretionary is obvious and does not require any further explanation. The fact that these mechanical tasks are being ascribed to medical interpreters means that the employers remain ignorant regarding the actual knowledge and skill underlying medical interpreting, which is the main reason why this occupation has not completed its professionalisation yet.

i) 10th role - TELEPHONE OPERATOR, RECEPTION STAFF, ADMINISTRATIVE ASSISTANT

Interpreters

Participant nº 37 (female graduate translator and interpreter, 21 years of professional experience) identifies yet another function of medical interpreters, which is telephone operator, reception staff and administrative assistant. Here is the corresponding excerpt:

- A las 9:00 tienes un montón de llamadas perdidas que tienes que ver de dónde vienen [...] [a lo largo del día había que] atender llamadas el desvío para la atención en idiomas [...] dar citas médicas [...] trabajo administrativo que sería llamar a los seguros extranjeros para ver si en algún momento te pueden mandar una autorización si se puede hacer alguna cosa respecto a un cliente si se puede repatriar o no repatriar, reclamación de facturas a extranjeros, cambio de citas, realmente todo
- [R]ellenar todo el papeleo de la funeraria, de los seguros [incluso] fuera de mi horario laboral
- At 9 am you have a lot of missed calls that you have to see where they come from [...] [during the day you have to] take calls that were diverted to you via call forwarding [so that the

[153] Please check the chapter on Multimodal analysis.

patients can talk to somebody who speaks their language] [...] book medical appointments [...] [carry out] administrative work which would entail calling foreign insurances to see if at some point they can send you an authorisation, [...] ask whether they clear or decline a repatriation, claim bills from foreigners, change appointments, everything really.

- [F]ill out all the paperwork for the funeral parlour or insurance [even] outside my working hours.

Participant nº 6 (female graduate translator and interpreter, 5 years of professional experience) also reports on the tasks which would normally fall within the purview of an administrative assistant:

- gestionar el ingreso, el pre-operatorio (incluyendo el estudio preanestésico sobre antecedentes familiares, hábitos de alcohol y tabaco, alergias, alergias a medicamentos, reacciones a anestesias previas, intervenciones previas, medicación actual, confirmación ayuno 8h) y post-operatorio, reclamación de deudas, digitalización de todas las analíticas de los pacientes
- admission, pre-operative (including preanesthetic study on family medical history, drinking or smoking habits, allergies, drug allergies, previous surgical interventions, previous reactions to anesthesia, medication currently being taken by the patient, confirm an 8 hour fast) and post-operative management, debt claiming, digitalization of all the patients' analysis results

Patients

The data educed from the interview with the Participant nº 29 (65-year-old male Russian speaking patient) also mirrors the importance of the social worker role:

Ко мне отнеслась доброжелательно внимательно и все что я просил она переводила и даже общалась с моей страховой компанией чтобы помочь мне в оформлении документов.

She treated me with kindness and attention and translated everything I asked for and even contacted my insurance company to help me with the paperwork.

Thus, as a conclusion of this subtheme on the spectrum of functions performed by medical interpreters I would like to share a comment of Participant nº 37 (female graduate translator and interpreter, 21 years of professional experience) about her workplace reality:

Los contratos suelen ser siempre de auxiliar administrativo, pero trabajas de todo: de telefonista con idiomas, de intérprete hospitalario, de asistenta de médico, de asistenta de auxiliar de enfermería realmente y también de acompañante.

In the labour contracts [interpreters] are usually always formalised as 'administrative assistants', but in reality you work in all kinds of jobs: as a telephone operator with languages, as a hospital interpreter, as a doctor's assistant, as a nurse's assistant, as a nurse's assistant, and also as a companion.

Thus, all participants demonstrate that the profile hybridization in some medical facilities of the VC has been fully completed. The interpreters have forsaken all attempts to professionalise and now came to fully embrace their new profiles as medical assistants.

2. Subtheme 12: Participants' desiderata in terms of medical interpreters' role and how participants view interprofessional encroachment and role usurpation

After having broken down the actual spectrum of roles undertaken by medical interpreters in the study relevant areas, I shall now proceed to parse the participants' opinions regarding what these participants would desire medical interpreters to be like, what roles do they think these professionals must assume, what behaviours and attitudes do they think interpreters should adopt and what tasks should be rejected.

1st Desideratum - CLEAR DEFINITION OF INTEROCCUPATIONAL JURISDICTIONAL BOUNDARIES: PARTICIPANTS CAUTION AGAINST THE ADOPTION OF CO-DIAGNOSTICIAN AND CO-THERAPIST ROLES

Interpreters

Participant nº 2 (female lay person interpreter, 12 years of professional experience) regrets having assumed the role of the co-diagnostician and co-therapist and having taken matters into her own hands:

> Pero hay otros médicos que esperan que tú lo sepas. Como ellas saben porque llevan mucho años qué pasa? que hacen el trabajo del médico pero no deberían hacerlo aunque lleven ~30 años porque no #lo son pero esto es la gente que hay mucho aquí. Entonces realmente aquí te tienes que cubrir mucho la espalda porque al final son temas médicos.

> But there are other doctors who expect that you know [how to do it]. Since they-F.PL [the interpreters] know [how to do it] because they have been working here for many years what happens? they-F.PL [end up] doing the work of a doctor but they-F.PL shouldn't do it even if they had been working here for ~30 years for they are not doctors, but this is exactly what many people here do. So you really have to watch your back because after all these are medical issues.

The interpreter went to explain that there was a case of a serious medical error on her part: willing to save doctor's time and work she proceeded to consult a senior colleague instead of the treating doctor. This senior medical assistant, who had been working there for over 15 years, prescribed a series of inappropriate drugs and tests for the patient. Upon finding out, the doctor called her guidelines inadequate and incorrect and changed the patient's treatment plan. Of course, this patient never found out about this grievous mistake as they were called and told that in order to improve the treatment, the doctor had decided to change the treatment. "Ese día me arrepentí, porque siempre todo se lo pregunto al médico [...] I regretted it that day, because I always ask the doctor about everything" my informant added.

Participant nº 37 (female graduate interpreter, 21 years of professional experience as medical interpreter) cautions interpreters not to accept the tasks and responsibilities traditionally ascribed to medical professionals:

> Se intenta nunca tener la responsabilidad final, siempre teniendo a alguien que haya estudiado y que tenga esa responsabilidad y esté seguro sobre ese tema, pero realmente llega un momento en que muchas cosas ya las sabes porque las has ido aprendiendo con la experiencia y puedes explicarlas sin

> tener que molestar o acudir o interrumpir a un médico, cosa que no se debe hacer, pero siempre te lo piden
>
> You try to never have the final responsibility by always having someone who has studied and who has that responsibility and whose expertise on that subject is reliable, but there really comes a time when you end up knowing a lot of things because you've learned them through experience and you can explain them without having to *bother* or approach or interrupt a doctor, which is something that you should avoid doing, but that is [precisely] what you are always asked [or required] to do.

She went on to say:

> Te enseñan a hacer de todo y como quieres aprender y quieres complacer a tus superiores, quieres tener una buena relación con ellos, pues aprendes a hacer muchísimas cosas que realmente no te corresponden, cosas tan básicas como preparar una receta médica o escribir una receta médica incluso firmar una receta médica [...] o poner una inyección o hacer una radiografía o revelar unas radiografías porque hace 20 años eso no era todo automático, sino que había dos cubos con contraste y revelador y metías una radiografía dentro la sacabas la colgabas y la mirabas a ver si estaba todo bien. [...] o poner una inyección intramuscular o sacar sangre. [...] a base de observación y de explicación del médico que está a tu lado y te dice oye, la próxima vez lo puedes hacer tú, mira tienes que hacerlo así, así y así y cuando te das cuenta de que te están intentando exprimir al máximo, que no las quieres volver a hacer intentas llegar a un acuerdo con el siguiente jefe que vayas a tener en el cual eso no vaya a pasar.
>
> [Doctors] teach you how to do everything and as you want to learn and you want to please your superiors, you want to have a better relationship with them, you learn how to do a lot of things that don't really correspond to your position. [These things range from] [...] preparing a prescription or writing a prescription or even signing a prescription [...] to giving an injection or doing an x-ray or developing x-rays, because 20 years ago that wasn't all automatic, there were two buckets with contrast and developer and you put an x-ray in it and you took it out and hung it up and looked at it to see if it was all right. [...] or giving an intramuscular injection or taking blood. [...] Based on observation and explanation from the doctor who would be always next to you and who would tell you hey, next time you can do it yourself, look you have to do it like this, like this and like this and when you realise that they are trying to squeeze you dry, that you don't want to do it again, you try to reach an agreement with the next boss so that this will not happen again.

Doctors

Participant nº 10 (male doctor, ICU, 16 years of professional experience) argues that: "las percepciones personales de alguien que no es médico, aunque lleve muchos años dedicándose a esto [la interpretación médica] pueden llegar a tener repercusiones graves [the personal perceptions of someone who is not a doctor, even if they have been doing this [medical interpreting] for many years can lead to serious implications]". Participant nº 14 (male doctor, ER, 11 years of professional experience) said that medical interpreters' personal opinions (especially) on medical issues are uncalled for: "no transmitir su película mental a partir de lo que uno cree [the interpreter must not make stories up in their head based on their (mis)perceptions]".

Participant nº 36 (male doctor, Gynaecology department, 23 years of professional experience)

> Lo que no debemos hacer es, o sea sí que es una parte fundamental lo que hacéis, pero hay cosas a veces que la responsabilidad es nuestra [la del médico], vosotras no tenéis que tomar decisiones médicas, que las tomáis a veces, porque no os queda más remedio, porque no tenéis una formación para eso. [...] Yo lo tengo claro pero eso es lo que hay que tratar de solucionar ahora [...] Vosotras no tenéis

> que tomar esas decisiones vosotras tenéis que limitaros a ser una cadena de transmisión entre el médico y el paciente y saber qué es lo que paciente quiere para trasladárnoslo a nosotros. Pero como muchas cosas son rutina y como es la práctica que hace más que un título, pues [es lo que pasa].
>
> I think that what we shouldn't do, I mean, it is a fundamental part of what you do, but there are things that sometimes the responsibility is ours, you don't have to make medical decisions, which you sometimes do because you have no other choice, in that you don't have the training for that. [...] You don't have to make these decisions, you have to limit yourselves to being a chain of transmission between the doctor and the patient and to knowing what the patient wants in order to pass it on to us. But given that many things are routine and given that it is the practice that makes more than a title, well [that is what happens].

This informant clearly does not want interpreters to make medical decisions, he feels that it is incorrect or unacceptable, and must be dealt with, however he also realises that it is something imposed by the institution (institutional ethics), and thus the phrase "you have no other choice" indicates new identity imposition. He goes on to clarify that:

> La formación es sobre los procedimientos que se van a realizar no sobre cómo realizarlos es decir en ningún caso debe o sería preciso que realizara las tareas propias de una enfermera o de una auxiliar de enfermería.
>
> The training must be all about the procedures to be performed, not about how to perform them, i.e. in no case should or would it be necessary for him/her to perform the tasks corresponding to a nurse or an orderly nurse.

This participant is yet again revisiting the salience of sufficiently distinctive tasks (Halliday in Freidson, 2001) and the allocation of these sufficiently distinctive tasks in a way that would allow for clear interoccupational jurisdictional boundaries. The very fact that the informant felt the need to provide the interviewer with this extra clarification indicates that some people do not (want?) to understand the difference between being acquainted with the nature of the procedures being performed and acquiescing to learning how to carry out those medical procedures. This excerpt is intimately linked with the previous extracts, where this informant openly admits that the interpreters he has been working with were acting as co-diagnosticians and even as co-therapists by making medical decisions, thus, taking the concept of "provider proxy" to a whole new (and in my opinion up to date underexplored) level.

Participant nº 60 (male doctor, Paediatrics Department, over 40 years of professional experience) cautions against unhealthy interoperability:

> Lo más importante es que tanto el intérprete como el médico en este caso el médico tengan claro cuales son las eh el el marco en el cual se va a circunscribir su la función de cada uno
>
> The most important thing is that both the interpreter and the doctor understand clearly the framework in which their respective roles are to be circumscribed.

Patients

I would like to conclude this section with a brief excerpt extracted from the interview with Participant nº 43 (61-year-old male Ukrainian speaking patient), who explains what he believes interpreters are there for:

Перекладач має займатися безпосередньо своєю роботою коли лікар випише рецепт перекладач має перекласти письмово цей рецепт, інструкції для прийому лікарських засобів, історію хвороби; як приймати ліки; по скільки раз в день, по скільки міліграмів, це все має бути точно так як сказав лікар.

Translators should be involved exclusively in doing their job: interpreters must translate the prescriptions written out by the physician, instructions on drug administration (how many times a day, how many milligrams, it should all be exactly as the doctor said), as well as the patients' medical history.

2nd Desideratum - EMPATHETIC INTERPRETER PROVIDING MOTHERLIKE CARE. THE IMPORTANCE OF NOT FALLING INTO TEMPTATION OF KEEPING DISTANT CORDIALITY, COMPLETE EMOTIONAL DETACHMENT AND COLD DEFERENCE

While the participants in the previous section all advocated for clinical detachment and clear jusridictional boundaries, the data educed from the interview with the Participant nº 41 (61-year-old female Ukrainian speaking patient) indicates the importance of avoiding complete emotional detachment and cold indifference. She explained that professional neutrality or objectivity in the sense of avoiding the institutional ideology of "the doctor is always right" must not be confused with humane treatment of all patients and sincere interest in their wellbeing. In other words, she meant that a worker (any worker) in the medical sphere must never be expected to robotise their functions, as it is precisely in a hospital where people may feel more vulnerable and where their integrity must be effectively safeguarded. She specified that we are talking about people, who are sick, who may be experiencing excruciating pain, who may be disabled or paralysed, distressed, frightened, depressed, shy, and –on top of it all– unable to understand and communicate in the language spoken at the this hospital.

Перше і обов'язкове завдання перекладача – допомагати пацієнтові зрозуміти все що [пацієнт] не зрозумів. [...] Те що хоче лікар сказати то повинен професіонал точно перекласти пацієнтові. Якщо [перекладач] буде мати вільну хвилинку і підійде і підтримає чи запитає чи ви все зрозуміли, чи в вас все добре [...] чи може ще покликати лікаря, чи [може] ви щось не розумієте то це людині на психологічному рівні дуже допоможе.

[Undoubtedly] the first and foremost task of an interpreter is to help the patient understand everything that [the patient] has not understood. [...] Whatever the doctor wants to say, must be translated to the patient in all its accuracy. If [the translator] happens to have a spare moment and comes to support the patient or to ask whether [the patient] has understood everything, whether s/he is feeling alright [...] whether they need to see a doctor, etc. that will help the person a lot on a psychological level.

This ideation goes perfectly in line with the remark made by Participant nº 49 (male doctor, Internal Medicine Department, 30 years of professional experience):

Ahora una cosa muy importante para matizar es decir en el ámbito sanitario [...]el intérprete [...] no puede ser un ente neutro completamente [...] porque en el ámbito médico en cualquier ámbito pero más en el médico el intérprete [...] pasa a conocer cosas de carácter subjetivo de carácter íntimo del paciente y el paciente va a reconocer al intérprete como esa herramienta del médico y va a llamar y a requerir la ayuda del intérprete para determinadas cosas para avisar al médico de esto para decir que tiene que ver la televisión que se le apaga que pierde el grifo agua que se diga al médico que le ha

> salido un sarpullido entonces va a llamar continuamente y el intérprete no podrá contestar lo siguiente yo no soy médico ¿vale? Eso no lo podrá contestar tendrá que ir allí recoger esa opinión del paciente y hacérselo llegar como instrumento que es al médico.
>
> Now, one very important thing to clarify is that in the healthcare field [...] the interpreter [...] cannot be a completely neutral entity [...] because in the medical field, in any field actually, but even more so in the medical field, the interpreter [...] becomes aware of things of an intimate nature of the patient and the patient will recognise the interpreter as the doctor's tool and will call and require the interpreter's help for certain things [for example] to tell the doctor they want to watch the television, which turns off by itself, that the tap is dripping, to tell the doctor that they have broken out in a rash, so they will call continuously and the interpreter will not be able to answer the following "I am not a doctor, OK?" The interpreter won't be able to answer that, the interpreter will have to go there to collect the patient's opinion and transmit it to the doctor as the doctor's instrument, which is what they are.

In the same vein, Participant nº 36 (male doctor, Gynaecology department, 23 years of professional experience) also refers to the role of "empathetic interpreter" within the framework of interpreting:

> Es fundamental que en un quirófano esté porque si un paciente se despierta o tiene una complicación y no está para comunicárnoslo eso es gravísimo [...] [...] que despierte un paciente en un quirófano y no sepa si tiene una reacción o una complicación allí nos la estamos jugando [...]
>
> It is essential that the interpreter be in the operating theatre, because the fact that the patient wakes up or has a complication and the interpreter is not there to report it to us is extremely serious [...] we are taking a huge risk by allowing a patient to wake up in the operating theatre and not knowing whether he or she has a reaction or a complication.

Participant nº 48 (male radiation oncologist, MD-PhD, Oncology department, over 35 years of professional experience) portrays this empathetic motherlike figure very accurately:

> El intérprete hace una labor como la mamá con lo niños en las familias clásicas mediterráneas de las cuales yo provengo. El padre es la persona autoritaria, enérgica sobre las que recaía la responsabilidad de alimentar la familia y defender la familia, y eso era lo importante. Normalmente estaba trabajando, estaba fuera, venía cansado y a veces no contactaba con los niños. ¿Qué hacen las madres en esos casos? Le cuentan a sus hijos lo bueno que es su padre y lo que les quiere su padre. Entonces el hijo aunque el padre no esté sonriendo interpreta que sí y aprende a interpretar los gestos de cariño del padre. Eso lo que hace un intérprete.
>
> The interpreter's job is similar to that of a mother in a classic Mediterranean family [...].The father is an authoritarian, energetic person who is responsible for feeding the family and defending the family, which used to be the most important thing. Usually he would work outside his home, he would return tired and sometimes he would not interact with the children much... What do mothers do in such cases? They tell their children how good their father is and how much their father loves them. Then the child, even if the father is not smiling, interprets that he actually is, and learns to interpret the father's gestures of affection. That is what an interpreter does (Participant nº 48, male radiation oncologist, MD-PhD, Oncology department, over 35 years of professional experience).

Please note that this role of an "empathetic interpreter" is very different from the "hostess", "support staff", or "quasi-psychologist" roles fiercely advocated for by Participant nº 35 (female doctor, Department of Gynaecology, 7 years of professional experience):

> A veces hay otra *parte que es más psicológica o con una persona con la que llega a tener más relación es la tutora o la asistente médico* como lo llamemos *que es la que está haciendo el tratamiento*. Por lo tanto no es obviamente aquí *no hay neutralidad*. [...] Allí hay una parte emocional y no puede ser neutral [...] No es lo mismo traducir un libro que *estar con un paciente cogiéndole la mano mientras le están operando o mientras el médico le está dando una mala noticia*, para eso hay que prepararse.

> Sometimes there is *another facet [to this figure], a psychological bonding with the person, with whom the patient comes to develop the closest rapport*, which is *the tutor or the medical assistant* as we call it, *who is the one responsible for the treatment* [...] Therefore, there can be *no neutrality* here. [...] There is *an emotional involvement* as well, therefore *the interpreter cannot remain neutral* [...] Translating a book is not the same as *being with a patient holding their hand while they are being operated on or while the doctor is giving them bad news*, you have to be prepared for that.

The "empathetic interpreter" role described by Informants nº 41, 49 and 36 does not fall outside the occupation's purview because these tasks are strictly related to the activity of conveying the message in the operating theatre (nº 36), upon admission as incoming patient (ER, ICU), during the hospital stay on the ward or ICU as inpatient, during a consultation as outpatient, etc. (nº 41, 49). This role pursues to ensure an informed and comfortable stay of the patient, whereas the more overinvolved role described in excerpt nº 35 implies that the message conveyance or interpreting component is gone. This latter role has therefore nothing to do with ensuring language provision by linguistic interaction, but is rather all about bonding with the patient, developing a rapport with the patient, interacting with the patient for the sake of emotional and psychological support, and not for the sake of bridging the gap between the patient and the provider in the most cordial, humane, involved, empathetic and sympathetic way. Participant nº 35 opts for denaturalisation of the traditional figure by an uncalled for overinvolvement, whereas nº 41, 49 and 36 portray a professional with a charisma similar to that of a doctor. Participant nº 49 highlights the interpreters' adequation or similarity (according to the Bucholtz' and Hall's, 2005, pp. 587-588 relationality principle) with the doctor, in that according to this informant in spite of the different hierarchical positions both of these professionals share professional charisma as well as the "guilty knowledge" (Dingwall, 2016, § 13). The doctor is an expert on treating the disease, whereas the interpreter is an expert in understanding and conveying the essence of this disease, its symptoms, and its impact on the patient's physical and psychological state in a way that would allow the doctor to properly treat this disease. The doctor "intervenes in our bodies" (Dingwall, 2016, § 13) directly, whereas the interpreter does so indirectly. Participant nº 49 advocates for a clear division of labour and his portrayal clearly deprives the figure of medical interpreter of the mystery, but he ascribes to this professional the knowledge to recognise patients' needs, gain their trust, and act quickly, efficiently and effectively in a medical team, because in spite of their differences, both professionals share a "privileged status is an inducement to maintain their loyalty in concealing the darker sides of their society and in refraining from exploiting their knowledge for evil purposes", but only for the benefit of all the involved parties" (Dingwall, 2016, § 13).

To conclude I would like to quote Seale et al., who highlight "the power that interpreters wield in such situations" (2013, p. 147). The authors warn us that:

> Embracing the broader role of advocate rather than interpreter may influence them both to volunteer information on behalf of the patient and to not translate certain statements from the patient to

> nurses, thus shaping the patient's moral reputation. What is clear [...] is that this can produce frustration for patients denied access to care providers in this way. (Seale et al., 2013, p. 147)

Therefore, the activity of medical interpreting exacts tremendous knowledge and skill because it is a highly complex hermeneutic process involving comprehension, deverbalization and reformulation (Seleskovitch, 1970)[154], but in the medical field the concept of "bridging the gap" goes beyond utterances, but not in the sense of becoming an autonomous mediator with the power to change the discourse on a whim or becoming somebody's uncalled-for-advocate, but rather in the sense of sharing the medical workers professional morals and charisma, without falling into the temptation of incurring the horrible error of purporting to also share (some of) the medical profession's mystery, just like in the case of co-diagnosticians and co-therapists.

3rd Desideratum - DESIDERATA CONCERNING THE PERFORMANCE OF INTERPRETERS PREMISED ON THE PARTICIPANTS' ASSUMPTIONS DERIVED FROM PREVIOUS INTERACTION WITH LAY PERSON INTERPRETERS

The following desiderata were formulated as the result of getting to work with both professional (graduate) and amateur interpreters. Such work experience may have contributed to the physicians' familiarisation with the differences in the way of working between professionals and non-professionals. As the quantitative data analysis will seek to reveal, some of the participating medical facilities have shown a tendency to hire graduate interpreters, which in my humble opinion can hardly be seen as a catalyst of the advent of professionalisation due to role hybridisation, however this gravitation towards professional interpreting could have elicited medical practitioners' awareness of the difference between professional and non-professional performance. The incipient tendency to compare the two groups may have made the practitioners realise what the glaring shortcomings of amateur renditions may entail. Some of these observations prove that graduated interpreters and scholars are not the only voices of dissent. Indiscriminate eligibility to practice may mean compromise of quality because the interpreting activity does not depend on the commitment to deliver to the best of one's abilities, but quality is rather subject to the lengthy formal training. It is my contention that the opinions verbalised by my informants which I shall display in this section educe multiple useful insights.

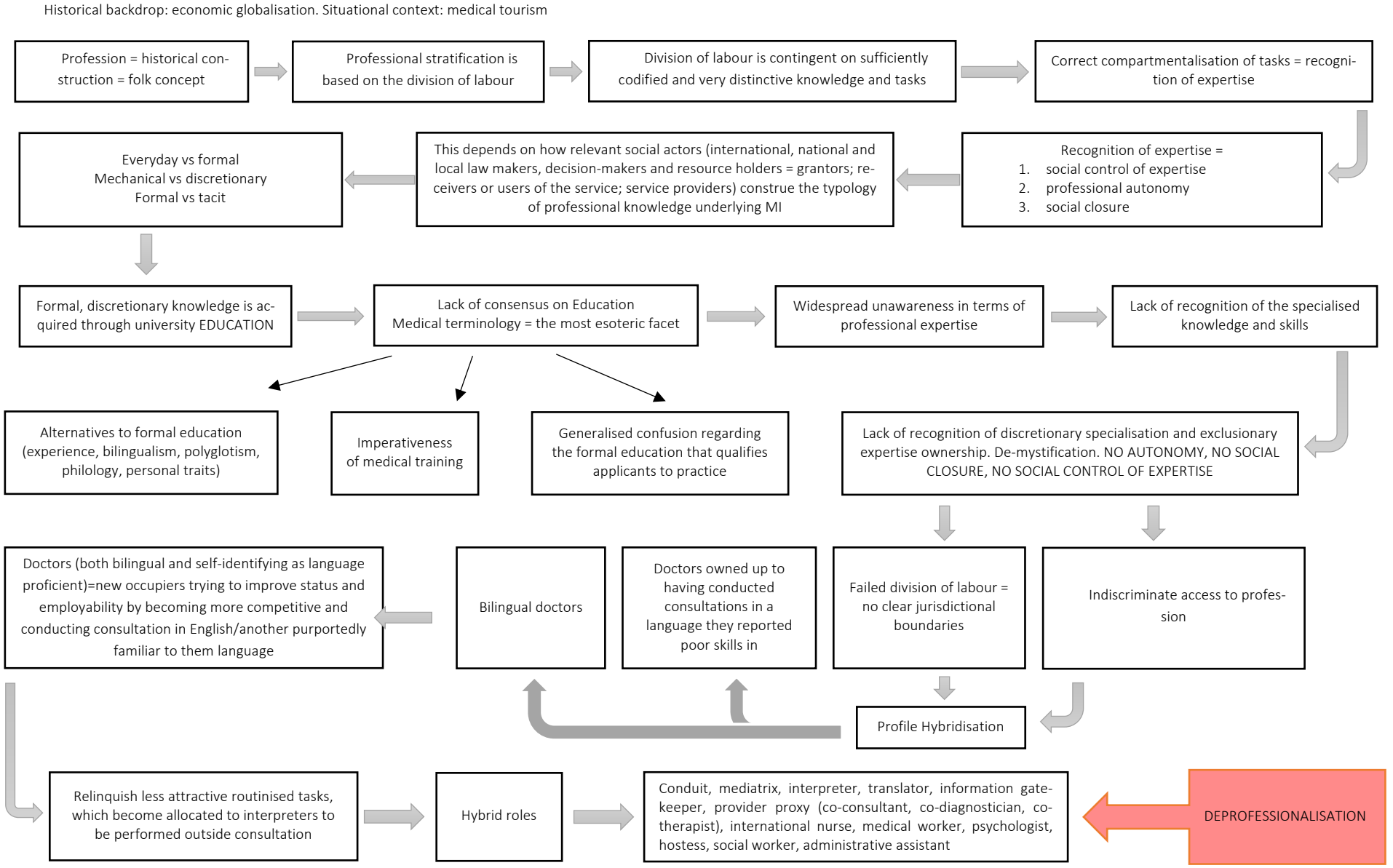
Doctors

Participant nº 3 (male doctor, Trauma and Orthopaedic Surgery Department, 27 years of professional experience) suggests that medical interpreters should: "que se limite a realizar la interpretación, no que añada ni quite elementos; el mensaje médico no puede ser adulterado de ninguna de las maneras [keep to delivering the interpretation, he/she *must not add or edit out elements*, *the medical message cannot be adulterated in any way*]". Participant nº 5 (female doctor,

[154] For further information on Interpretative Theory of Translation please visit https://en.wikipedia.org/wiki/The_Interpretive_Theory_of_Translation

Department of Paediatrics, 18 years of professional experience) indicated that it is necessary that interpreters: "que tome notas para no fallar en la transmisión secuencial de las ideas [the interpreter should take notes so as not to fail in the sequential transmission of ideas]". Participant nº 13 insists that interpreters ought to: "transmitir el mensaje con la mayor exactitud posible [transmit the message as accurately as possible]", since according to Participant nº 18 (female physician, Internal Medicine, 13 years of professional experience) "estamos hablando de cosas que pueden tener trascendencia [we are talking about things that may have implications]". Participants nº 16 and nº 17 agree that personal qualities such as stress management skills, self-control, forbearance, composure and diligence are also extremely important in medical interpreting: "transmitir tranquilidad, ya que muchas veces no es lo que dices, sino cómo lo dices [interpreters should be able to transmit composure because because many times it is not what you say, but how you say it]" (Participant nº 16). Thus, "no transmitir excesivo nerviosismo y no enfadarse con el paciente [interpreters should not transmit excessive nervousness or get angry with the patient]" is absolutely crucial for this position (Participant nº 17).

15.1.3.3.Final thematic map



15.2. QUANTITATIVE ANALYSIS

This chapter will be dedicated to quantitative analysis. By way of a reminder, it is worth clarifying that three different questionnaires were administered to medical professionals (it contained 25 questions, see Appendix O,P, Q, R, S, T, U), interpreters (comprised by 8 questions, see Appendix V, W) and patients (formed by 11 questions, see Appendix X,Y). These questionnaires were answered by 24 medical professionals (9 physicians and 15 nurses), 21 interpreters and 8 patients over the course of 5 years (from 2015 to 2020). The participants were practitioners at 5 different private facilities located in the VC and geared towards medical tourism. These surveys were administered to those participants who refused to be interviewed and/or audio-recorded. All of these surveys were canvassed anonymously, just as it was previously agreed with the hospital administration. Quantitative analysis in this case was designed to support the findings obtained by CA, MCDA and TA.

1st Finding Medical professionals self-identified as inefficient users of English and French, recognising the need for medical interpreters on daily basis

The first major finding that I want to report on is the fact that the vast majority of health professionals –22 out of 24– capitalised on their foreign language skills, however all of them emphasised that in order to do their job they require both translation and interpreting services on daily basis. Twelve participants indicated very poor command of English, eight participants assessed their English language skills as "good", one participant rated their skills as "very good" and one informant self-identified as English native speaker. Seven participants assess their command of French as "very poor", and two participants rated their French skills as "good". Two participants indicated "poor" command of German. As I have demonstrated in the previous chapters (please check chapter 8.3 on Medical staff doubling up as interpreters), numerous private facilities in the study-relevant area market bilingual/multilingual doctors and staff as an optimal alternative to medical interpreters. However, we must learn to see a difference between bilingual medical professionals and those healthcare providers who self-identify as purportedly language proficient. Due to dysconsciousness and naïve incognizance the general public disregards the difference between the actual proficiency and the alleged proficiency, as well as the difference between mastering a language and using a limited knowledge in an attempt to communicate. The wording "multilingual staff"[155] may lead potential clients into a conceptual tripwire because this phrase does not necessarily imply that candidates were subject to a language test to determine whether they are actually proficient or not. Moreover, this finding is totally compatible and consistent with the subtheme nº 10, whereby it was showcased that a number of physicians have actually self-assessed as inexpert and inefficient foreign language users and stated that linguistic self-sufficiency in doctors is a relatively rare phenomenon, thus rendering the hybridisation attempts unavailing unless the doctor is bilingual.

[155] Very popular wording used on numerous websites, for example: https://ivi-fertility.com/blog/ivi-baby-plan-fertility-clinics.

2nd Finding Participants' perceptions on the education of medical interpreters: dichotomy between formal knowledge and everyday foreign language knowledge

Sixteen respondents (6 doctors and 10 nurses) argue in favour of the formal knowledge being the cornerstone of quality and professionalism in the case of medical interpreting. Six participants contend that a Degree in Translation and Interpreting would be necessary to practice as professional medical interpreter, four respondents advocate for both a Degree in Translation and Interpreting and a Master's Degree in Medical Translation and Interpreting, six informants suggested that only a Master's Degree in Translation and Interpreting is needed to guarantee proper quality of performance (without clarifying what undergraduate degree would they deem suitable), three participants indicated that any Master's Degree in Translation and Interpreting would be sufficient, while others (three remaining participants) highlighted the importance of it being a Master's Degree specifically in medical translation and interpreting.

Eight participants (3 physicians and 5 nurses) maintain that having a good knowledge of the alleged working languages, be it certified or purported, would be sufficient for this role. One participant has even clarified in a comment at the end of the questionnaire that a formal university education would not be necessary in order for the bilingual amateurs to be able "to help the patients", however a sufficient language level is deemed to be absolutely indispensable. Please note how the "power in language" is manifested through the phrasing "help the patient": the host language is deemed to be the "default language" and "the interpreter has been called in for the client" only, "not the service provider", as reported by Rudvin (2005, p. 169). Thus the service provider, who in this case happens to be a doctor, needs to have certain information at their disposal to be able to diagnose and treat the patient, and therefore the interpreter is needed to put the doctor in a position to understand. The patient is being problematised as some doctors believe that miscommunication is not their problem, when in fact the indiscriminate eligibility to gain entry to the niche of medical interpreting may lead to the loss of trust, tarnished reputation and serious consequences precisely for the medical staff, as in the case of a lawsuit it is the medical professional who is most likely to be held liable.

"Caveat emptor" may very well be practiced in the "market place", but not in the doctor's consultation or office due to strong "public commitment, special treatment form the state, the community and the client" (Thomas & Mungham, 2016, Chapter 6 Solicitors and Clients: Altruism or Self-Interest?, Introduction section, § 1), and in this case medical interpreters happen to be those who enable the practice of medicine. It is therefore that the primum non nocere principle cannot be subjected to the caveat emptor of the patient, in that by purporting to offer multilingual staff, English-speaking doctors, counsellors or personal medical assistants the private clinic must commit itself to guaranteeing safety and deliver on high quality medical care.

The exercise of the due diligence on the part of these people cannot be guaranteed when the market is crammed with colonisers and "occupiers" (Dingwall, 2016, Introduction section, § 10-11), who marginalise professional interpreters. But again, amateurs with dubious professional background are hired due to the fact that 8 respondents out of 24 were led to believe that meritocracy based on formal education is only applicable to Medicine. Thus, this numeric value (8 out 24) datum offers a more facilitative vision of the importance of generalised recognition of the

complexity of knowledge and skill underpinning medical interpreting. These 8 informants reduce medical interpreting to common, generally accessible, everyday, natural and automatised activity that every self-identified bilingual or self-proclaimed language proficient user can undertake. This gravitation towards de-specialisation, mechanisation and vulgarisation of the interpreting activity strips this occupation of its symbolic, social and community values. This finding is totally compatible with the 1st latent theme on the lack of consistency or consensus regarding the typology of knowledge and education that medical interpreters-to-be should pursue. Both the qualitative and the quantitative analyses reveal the existing although not an overpowering gravitation towards alternatives to formal education.

3rd Finding Participants' perceptions on the type of functions that should be allocated to medical interpreters

The third finding goes in line with the 2nd latent theme, whereby I sought to fathom out the impact of market demands on the hybridisation of profiles. In the second part of that latent theme I was focusing on the interpreters' transition from mediatrix/conduit role to medical co-adjutrix/co-diagnostician/co-therapist role through usurpation of medical expertise in compliance with the grantors' and receivers' expectations as well as consumer demand. The results showcased shocking revelations of highly complex medical tasks being allocated to medical interpreters, which attests to the accomplished fact of profile hybridisation. In the same vein, the third finding of my quantitative analysis also bears out the fact that the consumer demand and the "grantors' (decision-makers and resource holders)" (García-Beyaert, 2015, p. 46) expectations instigate usurpation of medical expertise. Thus, 9 respondents (8 nurses and 1 doctor) view medical interpreters as "assistant with medical and health related functions who facilitates the work of the doctor and/or nursing staff by being directly involved in the process of diagnosis and treatment of the patient". Ten respondents (6 nurses and 4 doctors) contend that interpreters should undertake merely language-related assignments. They advocate for triadic communication (doctor-patient-interpreter) during medical encounter, instead of dyadic interaction outside. Only two participants (1 doctor and 1 nurse) view interpreters as administrative assistants, which is the professional category assigned to them officially (see the classification of occupations CNO-11 and ISCO-08).

4th Finding Polyglotism as a sine qua non prerequisite sought by potential employers when recruiting personnel for this position

After having perused the quantitative data corpus I noticed that the majority of interpreters claim to be polyglots. Only one person said they were proficient in one foreign language, the rest self-identified as polyglots reporting proficiency in 3 (6 informants), 4 (10 informants), and 5 (5 people) languages.

The most common language people claimed mastery of is, of course, English, purportedly spoken by 20 interpreters. English is followed by Italian, reportedly mastered by 15 participants, German allegedly spoken by 11 informants and French also putatively mastered by 11 participants, while 3 interpreters claimed to have Dutch as their mother tongue and other 3 participants

– Russian (2 thereof are dual role doctors who double up as interpreters when needed). Two participants claimed to be bilinguals in Spanish and Portuguese, and other two participant avowed to be bilinguals in Spanish and Norwegian. One person self-identified as the native speaker of Polish. Thus, this finding is fully consistent with subtheme nº 3 on Polyglotism as an Alternative to Formal Education. The tendency to hire alleged polyglots is absolutely clear. It seems to be true that there is a certain tendency to view alleged polyglotism as a practical alternative to formal education, because many respondents stated that they learned foreign languages without becoming university students. Thus:

- Nine participants out of twenty two assured that they took a formal university Degree in language-related disciplines: six participants self-identified as holders of Translation and Interpreting Degree, one person assured that she gained a Degree in Tourism, and two informants reported having done a Degree in Philology.
- Six participants self-identified as bilingual speakers of the languages, which happened to belong to the language combinations that the clinic showed special interest in.
- Thirteen respondents out of twenty two stated that they learned foreign languages while living abroad, be it via a long-term residence, a short-term sojourn, a long or a short stay abroad, or by earning a Degree in a University abroad as overseas students.
- Five informants undertook language courses in Official School of Languages (Escuela Oficial de Idiomas), which is a network of non-university level centres which allows the adult population residing in Spain to learn foreign languages and to obtain a certificate attesting to the level of linguistic competence they possess. The EE.OO.II (Official School of Languages) is regulated by the Ministry of Education and Vocational Training as well as by educational administrations.
- Five participants informed me that they are holders of TOEFL, IELTS, Cambridge Proficiency, DELE superior certificates, or other certificates attesting to their language level.
- Six interpreters said that they learned their foreign languages in school.
- One person mentioned that while she was studying her non-language related Degree at the University she had attended language courses.
- Two participants mentioned that they had private tutors and teachers.
- One person said that online language courses were of great help to learn the language they reportedly ended up mastering.
- One interpreter said she learned a lot and enjoyed attending language in-house courses organised by the company.
- One person refrained from answering how they learned the languages they are purportedly proficient in.

However, the real problem may not even be the fact that a polyglot seeks to claim ownership of certain type of knowledge and skill, but rather the fact that a number of self-proclaimed polyglots lack formal certification or accreditation that would attest to their language skills. Hence, the fact that a person who is not a graduate interpreter but who genuinely masters two or more

language may not be the biggest problem. The obvious failure of meritocracy to be a mechanism of professional exclusion by implying that the aspirant fails to measure up to certain benchmarks already constitutes a problem in terms of ensuring the do-no-harm-principle, however an even bigger problem is the fact that many times the candidates' claims of bilingualism, proficiency or polyglotism rest on extremely uncertain and even speculative foundations in the absence of actual proof of the real level of the purported language knowledge and skill. In this case, the materials obtained through surveys and information canvassing bear solid witness to the fact that many people may be indeed convinced of their own proficiency and disregard the fact that their willingness to deliver to the best of their ability does not depend on their positive attitude or willingness to help, but rather on the professionalism achieved only through objective and verifiable knowledge, which they lack. If the employers do not uphold high education standards, I wonder what touchstones and benchmarks –if any– they use to select candidates.

5th Finding Survey reveals recruitment of non-professional interpreters with different non-language or non-translation-related professional backgrounds, career paths and vocational experiences.

One of the most important questions of this quantitative analysis is how many non-professional employees are being actually recruited by private healthcare facilities in percentage terms. I figured that the best way to make an objective assessment was to learn about my respondents' educational and professional background, their career paths and their vocations. The results showcase that only 5 respondents out of 22 (23%) took the Degree in Translation and Interpreting, while 17 respondents out of 22 (77%) pursued different career paths, being only 3 of these career choices related to translation and interpreting. The following list contains all educational backgrounds of my informants.

Non-language/T&I-related higher education degrees	
• Licenciatura en Comunicación Audiovisual	• Degree in Audiovisual Communication
• Grado en Magisterio	• Degree in Teaching
• Licenciatura en Instituto Nacional de Educación Física	• Degree in National Institute of Physical Education
• Licenciatura en Administración de Empresas	• Degree in Business Administration
• Licenciatura en Periodismo	• Degree in Journalism
• Licenciatura en Enfermería	• Degree in Nursing
• Licenciatura en Ciencias Políticas y Empresariales	• Degree in Political and Business Sciences
• Diplomatura en Tributación y Asesoría Fiscal	• Diploma in Taxation and Tax Advice
• Licenciatura en Ciencias de Educación	• Degree in Education Sciences
• Licenciatura en Derecho	• Law Degree
• Grado en Diseño Gráfico	• Graphic Design Degree

Language/T&I-related higher education Degrees	
• Diplomatura en Turismo	• Degree in Tourism
• Técnico de Turismo	• Holder of an associate degree in Tourism
• Grado en Estudios Ingleses	• Degree in English Studies
• Filología Inglesa	• English Philology
• 5 personas tenían Licenciatura o Grado en Traducción e Interpretación	• 5 people had a Degree in Translation and Interpreting

Non-language/T&I-related occupations	
• Fisiokinesioterapeuta	• Physiokinesiotherapist
• Auxiliar administrativo	• Administrative Assistant
• Auxiliar de farmacia	• Pharmacy Assistant
• - Esteticién	• Beautician

By way of conclusion, these findings go in line with all the previous findings revealed in the preceding chapters of this thesis.

6th Finding The typology and nature of the tasks which fall within the remit of hybrid profiles

This last finding will be dedicated to calculating the number of interpreters who avow having carried out tasks of medical nature and who self-identify as "auxiliar con funciones médico-sanitarias que facilita el trabajo del médico y/o personal de enfermería involucrándose directamente en el proceso del diagnóstico y tratamiento del paciente [an assistant with medical functions who facilitates the work of the doctor and/or nursing staff by being directly involved in the process of diagnosis and treatment of the patient]". Thus, the 8th question of my questionnaire contained three not mutually exclusive options denoting three types of roles or identities, which medical interpreters may be willing to attribute themselves to.

The first option was "auxiliar administrativo o trabajador que sin iniciativa ni responsabilidad se dedica a los servicios auxiliares de la administración [administrative assistant or worker who, without initiative or responsibility, engages in auxiliary services of the administration]".

The second option was "auxiliar con funciones médico-sanitarias que facilita el trabajo del médico y/o personal de enfermería involucrándose directamente en el proceso del diagnóstico y tratamiento del paciente [an assistant with medical functions who facilitates the work of the doctor and/or nursing staff by being directly involved in the process of diagnosis and treatment of the patient].

The third option referred to the traditional conduit figure of the interpreter, who would be expected to undertake "tareas meramente lingüísticas: interpretación absolutamente objetiva y neutra en consulta con el médico y con el paciente [purely linguistic tasks: absolutely objective and neutral interpretation in consultation with the doctor and the patient]".

Please note that it is a very specific question as it explicitly states "in consultation with the doctor". This was done deliberately in order to differentiate triadic communication from dyadic communication, conduit role form co-diagnostician and co-therapist role, traditional doctor-interpreter-patient interpretation during medical encounter from "denaturalised" (Bucholtz &

Hall, 2005, p. 601) and artificially imposed role of a mediator outside the consultation or encounter, who not only co-diagnoses (Hsieh, 2006; Angelelli, 2011), but also co-treats the patient.

My ultimate goal was to confirm my theory on profile hybridisation and to determine the extent of its entrenchment into the current professional stratification system. The results were shocking to say the least. Only 5 participants confirmed they were acting as interpreters in the traditional sense of the word working with the healthcare providers during medical consultation, while 4 informants self-identified as administrative assistants. The rest of the respondents –17 out of 22 (77%)– confirmed that their daily work implied "direct involvement in the process of diagnosis and treatment of the patient". The 7th question sought to discover the number of participants who received training in medicine or medical interpreting and if so what kind of training. The survey showcased that 16 interpreters (73%) had no training whatsoever in medicine or medical interpreting.

Two respondents mentioned that they did receive a training in medical interpreting, but they never specified what kind of training. One person holds a Master's Degree in Medical Translation, but has also undergone an in-situ training by shadowing. One interpreter clarified that she underwent training in medical interpreting through Estudio Sampere, offered by the Sampere School for Translators and Interpreters located in Madrid which offers ad hoc courses privately (Estudio Sampere, 2020). Lastly, only one person reported official training in the medical field. She holds a Degree in Nursing and has previously practiced her profession abroad.

15.3. TRIANGULATION

This study is relying heavily on the data triangulation, which in Munday's terms is "a multi-methodological perspective which aims at explaining a given phenomenon from several vantage points combining quantitative and qualitative methods" (2009, p. 237). Such data cross-fertilisation will allow for a greater reliability, trustworthiness, validity and transparency by refining and upgrading the mutually enriching results in order to obtain a clearer understanding of the phenomena in question. It will permit a more accurate depiction of the problem related to these phenomena (Alves and Gonçalves, 2003). The canvassed data was collated, conflated and curated in a way that would allow us to see how the ideational content of my participants' accounts constructs a scientifically valid and reasonably lucid pattern of theorisation. The use of triangulation permits attainment of more robust results, which could more easily withstand the scrutiny of rational critique.

It is worth noting that the quantitative analysis was never intended to add credibility to the research, but to enrich the results that I have already obtained, to expand the scope of the research and confirm the accuracy of my interpretation of data. The data in the qualitative analyses was not quantified, as I fully concur with Pyett (2003, p. 1174) on the fact that reporting percentages or frequencies may reflect anxiety regarding the validity, genuineness, authenticity, legitimacy or truthfulness of the data, which is not the case because the information provided in Part I and Part II of this thesis bears out the patterns of the qualitative analyses. Pyett (2003, p. 1174) also argues that the frequency does not necessarily adjudge value or unique contribution to the

research. The answers to the questionnaires afford some truly remarkable and revealing insights in spite of their ostensible simplicity at the first glance.

The observational data collected in the private clinics of the Valencian Community allow the participant-observer to detect the existence of a recurrent problem in the current recruitment policies of the language provision services. There are more non-professional interpreters than graduate MI, which is due to under-recognition of the uniqueness and complexity of the MI's professional expertise, which in its turn leads to profile and identity hybridisation. In the present study, quantitative data serve as a reinforcement of qualitative data, as can be seen from the general patterns that emerge from their analysis. Thus, the data collected through qualitative analyses showcase that:

I. Conversation Analysis within the framework of the discursive psychology:

- During the social positioning process accomplished through dialogic interaction, the interpreter tries to claim ownership and legitimise jurisdiction over expertise, but fails to position herself, negotiate and maintain her professional identity as it gets constantly contested, challenged and altered
- The ostracised and marginalised MI lacks professional autonomy as she fails to exercise task discretion
- New "temporary and intentionally specific" (Bucholtz and Hall, 2'15, p. 592) professional identity emerges in the context of the power imbalance both in and behind discourse, spurred by institutional ethics of the secondary institutional sphere and its existing hierarchical stratification
- Despite egregious underperformance (false fluency) and the availability of the professional graduate interpreter all four doctors keep on using English as an internationalised lingua franca, thus alienating the interpreter from her domain of competence
- By communication in English doctors endeavour to improve their status by usurping new acquisitions and by relinquishing unattractive routine tasks and allocating them to the interpreter. This language choice constructs the doctors as modern, sophisticated and internationalised, while the medical centre gains in competitiveness and appeal to international patients

II. Multimodal critical discourse analysis within the framework of social psychology, which focuses on semiotics expressed through alternative forms of text, substantiates the above mentioned phenomena and reveals that these phenomena, if not generalisable, are certainly not isolated:

- MCDA substantiates the role, profile and identity hybridisation by allocating repetitive, routinised and time-consuming tasks to multilingual "coordinators"
- MIs become instrumentalised and authorised to operate as the doctor's "extension" or as "duplicates" (Hsieh, 2010; Hsieh & Kramer, 2012). Polyvalence replaces clearly

delimited jurisdictional boundaries based on sufficiently codified and very distinctive knowledge (Halliday, 1987 as indicated in Freidson, 2001).

- MI per se no longer exists in the researched setting, in that the purview of competencies is so broad that this occupation is losing its distinctiveness and uniqueness, and its professional members have to reinvent their professional identity by broadening the scope of non-language-related skills
- By "invoking" this hybrid identity and orienting towards it (Edwards and Potter, 2019, p. 2), the grantors and receivers, the traditional interpreter-as-the-conduit- figure is "subverted and ignored".
- The acquiescence to undertake "assignments beyond MI's competencies" (IMIA, 2006) is misconstrued as acquisition of "immediate functional value" (Freidson, 2001), esoterisation and mystification of expertise (Horobin, 2016), which spurs its institutionalisation and institutional recognition. However, from the perspective of social psychology, such recognition is based on vested interests of grantors and receivers (medical professionals), and does not necessarily translate into higher status, prestige or remuneration.
- MCDA reveals the bifurcation of professional identities and categories:
  - Receptionist
  - Hostess (bears strong resemblance to the figure of flight attendant)
  - Coordinator (combination of an interpreter and a nurse)
  - Interpreter
  - Orderly and/or assistant nurse

III. Thematic analysis goes in line with the CA findings on the usurpation of MI expertise as it identifies 2 different types of doctors:

- Genuine bilinguals (clever business strategy to replace MI)
- Those who self-identify as proficient users, but whose proficiency may be categorised as a stereotypical categorisation on and overestimation of their foreign language skills. The latter can be divided into 2 categories:
  - Occupiers who seek to improve status and employability and dislodge MIs from their niche by imposing knowledge mandate as they believe that MI can be "extinguished" as they "struggle to improve their status by new acquisitions" (Dingwall, 2016, Introduction section, § 10-11). As seen in CA, due to the epistemological foundation of their discipline, their alleged language skills are extolled, while mediocrity is imposed on the knowledge of other less established occupations.
  - Doctors, who in spite of capitalising on their limited language skills still recognise the need for MI, in that real linguistic self-sufficiency in doctors is a relatively rare phenomenon.

Not all medical professionals support MI profile heterogeneity (TA). In fact, many caution against the adoption of the co-diagnostician and co-therapist roles and wish there was a clear definition of interoccupational jurisdictional boundaries (TA). However, TA clearly substantiates the existence and the gravitation towards hybrid profiles described in CA and MCDA. The following are the hybrid roles identified through the TA:

- Interpreter as conduit and mediatrix
- Translator
- Information gatekeeper
- Provider proxy
- Co-diagnostician and co-therapist
- Medical worker
- Psychologist, counsellor and confidential adviser
- Social worker
- Empathetic support staff, hostess
- Telephone operator, receptionist, administrative assistant

IV. The data collected through the qualitative questionnaires go in line with the TA finding on the usurpation of MI expertise by medical professionals:

- 22 out of 24 self-identify as inefficient users of the languages they purportedly speak and recognise the need for interpreters, thus they do no seek to usurp MI's expertise by claiming ownership over their tasks.
- However 9 respondents out of 24 (37,5%) view MIs as assistants with medical and health-related functions, who facilitate the work of the doctor and/or nursing staff by being directly involved in the process of diagnosis and treatment of the patient.

With regard to formal education, TA revealed that in the majority of cases alternatives to formal university education were preferred:

- Experience and/or on-the-job training
- Bilingualism
- Polyglotism
- Philology
- Personal traits

Quantitative questionnaires reveal polyglotism as sine qua non prerequisite sought by employers:

- 21 out of 22 interpreters self-identified as polyglots reporting proficiency in 3 to 5 foreign languages

No preference for graduate interpreters was shown in the case of recruitment:

- Even though 17 out of 22 (77%) interpreters confirmed that their daily work implied direct involvement in the process of diagnosis and treatment of the patient, 16 interpreters (73%) had no training whatsoever in medicine or medical interpreting. Instead, 77% of respondents (17 out of 22) reported through the quantitative questionnaire having pursued non-language and non-T&I-related professional career paths, denoting multiplicity of educational backgrounds not related in any way to languages, philology, linguistics, translation or interpreting.

The patterns identified throughout this multi-method qualitative research and quantitative questionnaires furnish a quite plausible, rational, likely and satisfactory explanation of the current state of affairs.

15.4. CONCLUSION

15.4.1. Contextualisation

The preliminary research showcased that there is an existing gap in academic work on MI within the context of medical tourism. This sociodemographic context changes the scope of the traditional research on MI completely. First, this context is interesting, novel and extremely relevant, in that Spain ranks sixth in Europe and eighth in the world in this sector according to a report issued in 2020 ("Turismo de salud: 1.000 millones de euros de impacto económico", 2020). It is estimated that in 2019 a total of 140,000 visitors underwent health treatments or medical interventions in private centres in Spain. As for economic estimates, according to a report by Spaincares ("Turismo de salud: 1.000 millones de euros de impacto económico", 2020), the Spanish Health Tourism Cluster in Spain, this type of tourism accounted for a turnover of 500 million euros in 2017 and it is expected that this year 2020 the figure of 200,000 tourists will be reached, achieving a contribution to the Spanish economy of around 1,000 million euros.

Second, the state is no longer the grantor of the service, because now it is the patient who holds the economic resources to cover the costs of quality healthcare. The prospects of professionalisation in/through the private healthcare are quite attractive and plausible due to the fact that healthcare and medical tourism are a burgeoning source of revenue within the tourism industry, accounting for at least 13% of the country's total GDP. The patients in this case are both "grantors" and "resource holders" (García-Beyaert, 2015) as well as receivers of the medical interpreting service. These patients, who intentionally seek to undergo a planned elective treatment which became the main purpose for their journey abroad, would not normally bring ad hoc interpreters with them (children, family members, neighbours, etc.), as for the price they are paying they would normally expect this service to be provided as part of the whole medical treatment. It is a process that in many cases starts before the patient would even come to the clinic. Thus, there is an undeniable need for language accommodation, however this necessity does not translate into a burgeoning demand for professional medical interpreters.

Also, as it was showcased during the preliminary research, the languages spoken by the medical tourists are normally European languages, predominantly, English, German, Dutch, Norwegian, French, Italian or Russian. Many of these languages are taught at the Spanish universities and

therefore there is no reason to state that there are no professional graduate interpreters with the required language combinations.

Having determined the context of the phenomenon it was important to understand why MI has still not professionalised. It is slowly becoming a full-time occupation and Spanish universities do offer different study courses, academic degrees and research programmes to expand the knowledge base. However, no mechanisms such as market, social or occupational closure, monopoly, formal education credentialing, voluntary certification, representation of association, licensing, unionisation were being implemented. In spite of exponential increase in demand, there is no supply restriction and all the efforts that are being made by the professional MIs and the higher education institutions are not as successful as they should be.

There is clearly no endorsement or patronage of the state or the relevant decision-makers at government level. We need a state-endorsed and state controlled enforcement of supply-side restrictions, whereby the state grants permission 1) to identify oneself by an occupational title by meeting predefined set of eligibility criteria, and 2) to practice particular set of skills (Weeden, 2002, p. 62), which when undertaken by a non-qualified person would be declared a crime (Wilensky, 1964, pp. 142-146, as cited in Neal & Morgan, 2000, p. 12). These premises are key to guarantees safe high quality care and compliance with the primum non nocere principle, which MIs share with medical personnel. However the relevant decision-makers do not seem to recognise MI as a profession, this occupation was deprived of its professional mystery and charisma by means of profile hybridisation, which supposedly add immediate functional value to this activity.

The following alternatives are being sought to address the demand for language provision in this geographical area:

- Allegedly language proficient medical staff who can purportedly double up as interpreters or use English as lingua franca (Angelelli, 2015, pp. 55, 60-61, Pascual & García, 2017; Adecco, 2017, pp. 1-5, Niño Moral, 2008, p. 1066). Although many healthcare workers would capitalise on foreign language skills to increase employability, only 7,4% out of 432 doctors from 4 different medical centres[156] turned out to be genuine bilingual representatives of professional migration, which gives me a basis to speculate that appealing advertisements of some clinics regarding the availability of plurilingual doctors may be a gimmick, as the research shows that not all of the centres advertising such services actually deliver on the provision thereof, in that the actual linguistic skills of those who self-identify as English language proficient users are not verified.
- Creation of new profiles (personal/international medical assistants, clinic assistants, administrative interpreters, etc.) substantiated by my investigation of a series of job advertisements, which all showcase that polyglotism and/or plurilingualism constitute the most prioritised competencies. With regard to the statement of duties, assignments of medical nature were particularly prevalent (for example "making sure that the medical history is complete [and no] data required for treatment and subsequent follow-up

[156] For more information on these facilities, please visit the following links: https://bit.ly/3gr8eT7; https://bit.ly/3EnSJmS

[is lacking]. [The patient care manager] will also coordinate the follow-up of the patient along with the doctors, address their doubts [...]" Job advert. N°1).

The failed division of labour and blurred interoccupational jurisdictional boundaries bring interoperability to a new level, where usurpation of roles constitutes a norm.

15.4.2. Rationale explained from the Freidson's Professional Knowledge Theory Approach

Instead of reaffirming the need of professionalisation and exploring different stages of professionalisation and their application to MI in the study-relevant geographical area, this thesis seeks to go further and inquire into what the main driver for professionalisation is and why some occupations succeed in professionalising while others struggle to get the necessary recognition. The aim was to ferret out what exactly it was that required recognition and what differentiated one occupation from another. After a long period of research and deliberation I came to the conclusion that it was the underlying professional knowledge and the complexity thereof. Freidson's book "Professionalism: The Third Logic" was the major inspiration and the main source for the present research. The main novelty of this thesis consists in determining whether the knowledge and skill underpinning MI is complex, unique, irreplaceable and indispensable enough for it to attain the coveted label of "profession".

The rationale behind the lack of professional recognition in the case of MI has proven to be the under-recognition, insensibility and unappreciative attitude towards the complexity of professional knowledge underpinning medical interpreting, as well as the mainstreaming of multilingualism in globalised societies. After applying Freidson's criteria of professional knowledge classification, it was absolutely clear that it takes a high level of sophistication to interpret, however very few social interactants seem to be aware of the complexity of professional knowledge and skill underpinning MI. Many people believe that this knowledge is everyday knowledge that any bilingual person possesses, that it is tacit, intuitive, unselfconscious, and natural in character. Many people believe the process to be mechanical (cognitively effortless) in the sense of perceiving MI as a human dictionary. The society at large and the relevant social actors in particular do not realise that MI requires:

- mental discretionary specialisation
- relatively high level of practical knowledge
- high level of formalised knowledge and skill
- specialised academic knowledge
- high level of diagnostic and prescriptive working knowledge

This statement is predicated on the scientific facts that the corpus of MI knowledge is based on the:

- Bilingual or quasi-bilingual language skills of the interpreter determined by the genetic and neurophysiological factors, which condition cognitive processes. These processes include innate genetically driven factors such as inborn brain architecture and brain plasticity determined by the expression of particular genes, processing capacity,

memory capacity, working memory (enables to retain and immediately retrieve verbal and lexical units and syntax), phonological short-term memory (enables to memorise non-native sounds and articulate them correctly), rote memorisation ability, phonetic coding ability, grammatical sensitivity, declarative memory, procedural memory, stamina and stress tolerance, fatigue resistance and self-confidence

However this neurophysiological and genetic predisposition (otherwise referred to as the talent) can only become a profession when it is combined with the scientific knowledge achieved through formal education and forms a formal corpus of codified technique. The crux of the matter and the key difference between a bilingual person and a professional interpreter is that the latter must hold continuous executive control over his/her bilingual or quasi-bilingual linguistic fluency and this control must be manifested through self-conscious exercise of discretion on numerous levels, including:

- Language level
  - Grammar
  - Pragmatics
  - Register
  - Homonymy
  - Loan terms
  - Style
  - Figures of speech
- Interpreting level
  - Interpreting skills
  - Mastery of interpreting modes
  - Mastery of note taking techniques
  - Clear understanding of own function and role
  - Professional ethics
  - Professional conduct
  - Conveyance of professional mystery, charisma and trust in the professional through verbal and non-verbal communication
- Medicine level
  - Medical concepts
  - Medico-legal concepts
  - Pharmacological concepts
  - Diagnostic concepts
  - Medical terminology (in at least over 50 different medical specialties)
  - Quick and effective decision-making in the context of stressful situations in the secondary institutional sphere, which adds pressure, feeling of anxiety and fear of making a possible life-changing mistake

"If the translator or interpreter want to performe [sic] a good job, he or she must [...] "become", in a certain way and in most occasions, the Science professional of these specific fields [...]" (Ruiz Mezcua, 2014, pp. 265, 267).

- Profession level
  - Degree of formality, number of participants
  - The participants' interactional skills – including awareness of the specific nature of interpreted interaction
  - Expected mode(s) of interpreting; and accommodation thereof
  - Participants' mode of speech; dialogue or lecture style; planned or spontaneous speech
  - Speech quality, e.g. diction, speed, clarity
  - Accommodation of the situation for interpreting
  - External interference or noise
  - Stress management
- Ethics level
  - Compliance with the correspondent code of ethics and conduct
  - Task discretion
  - Being knowledgeable about the belt of restrictions surrounding the domain of expertise and a clear delimitation of the professional boundaries
  - Correct exercise of *Phronēsis* even in the context of contingencies and unique challenges presented by real life situations

In other words, "[i]nterpreters in their everyday work are akin to discourse analysts, who need sophisticated skills to assess context (language, participants, relationships, etc.) in order to guide their decision-making process" (Major, Napier, & Stubbe, 2012 cited in Major & Crezee, 2017). The ability to apply all these types of professional knowledge and technique through the exercise of discretion seeking collective good, ethical righteousness and integrity of professional practice constitutes the core of the Aristotelian concept of *Phronēsis* (Kinsella and Pitman, 2012b, p. 9 as cited in Phelan et al., 2019). The relevant social actors must be persuaded that such ability can only be achieved through:

- Episteme or theoretical, formal(ised), methodised, codified, prescriptive and institutionalised knowledge and rules stipulated in codified tests taught in the university degree, which is why interpreting has been institutionalised, formalised and disciplinarised through highly specialised vocational training
- Techne or practical knowledge or mastery oriented towards the correct execution of the professional assignment

The acquisition of the practical expertise and the theoretic knowledge through education is absolutely essential to achieve eupraxia, which can be said to combine all three types of working knowledge (diagnostic, prescriptive and practical). The acquisition of diagnostic knowledge entails the assimilation of extensive groundwork and interiorisation of concepts, which translates

into effective trouble-shooting, decision-making and problem-solving. Prescriptive knowledge involves the employment of a repertoire of tested procedures and techniques, while practical knowledge implies team cooperation, interoperability, stress management, etc.

The university must exercise its "cognitive authority" (Freidson, 2001) in order to re-establish meritocracy for this discipline by convincing the key external players (García-Beyaert, 2015) that licencing and credentialism are the key mechanisms of social closure. The relevant social interactants must come to realise that MIs share doctors' guilty knowledge, they work with the peoples' bodies, just like medical workers, MIs "carry out some of the most dangerous tasks of our society": they "intervene in our bodies" (Hughes as cited in Dingwall, 2016, Introduction section, § 10-12). It is through the MIs that the doctors decide whether and how to intervene into their patients' bodies. Therefore, social closure is absolutely key to build the professional trust. The medical professionals and the patients must learn to trust the profession and the profession, not somebody who speaks their language.

15.4.3. Evidence

The mix-method approach based on the different types of discourse analyses constitutes a novel approach to this area of research. The aim thereof was to investigate how the professional knowledge in perceived by MIs themselves and by the relevant social actors and what the relationship is between the concept of "professional knowledge" and "professional identity".

Given that "profession" is a "folk concept" (Freidson, 2016, 2001) and therefore a historical construct, professional stratification is based on a clear division of labour, which is contingent on sufficiently codified and very distinctive typology of knowledge and skill underpinning very concrete expertise and task discretion. The correct compartmentalisation of tasks is absolutely essential for the recognition of expertise, which results in the social control of expertise, professional autonomy and social closure. However, the recognition of the uniqueness of an expertise, the exclusionary shelter, the professional autonomy and the task ownership are contingent on how relevant social actors (international, national and regional law makers, decision-makers, grantors, resource holders, service providers and service receivers or users[157]) construe the typology of professional knowledge underlying medical interpreting.

The multi-methodological research carried out within the framework of this thesis substantiates the above explained rationale for the impasse in professionalisation of MI. The quantitative data analysis indicates that the tendency to hire self-reported polyglots coming from non-language and non-translation-and-interpreting-related educational/professional backgrounds is currently hitting a crescendo, as 77,2% of the employees constituting the so-called international departments in some private medical centres of the area of interest were not professional interpreters.

This goes in line with the TA findings, which indicate a clear tendency towards alternatives to higher specialised education in T&I in candidates for the position of MI: on-the-job training, shadowing, previous experience in similar positions, bilingualism, polyglotism, philology and personal traits. Some participants declared that they viewed a formal degree in T&I as an

[157] For more information on the "Key External Players in the Development of the Interpreting Profession" please read García-Beyaert (2015).

overqualification. Many respondents (TA), who advocated for the formal education in T&I, postulated that medicine- or health-sciences-related knowledge and terminology should constitute the most important and esoteric part of MI education. They just do not conceive of MI as a fallible activity requiring complex discretionary specialisation. Therefore, medical terminology is viewed as the most esoteric facet of this occupation, which clearly de-mystifies it and proletarianizes it.

This is diagnostic of the fact that the typology of knowledge underlying MI is not perceived as complex, esoteric, or formalised enough, in that the participants' discourse reveals lack of professional mystery and charisma in the participants' conceptualisations of MI. Therefore, this ever increasing tendency to profile hybridisation, totally substantiated by CA, MCDA, TA and the quantitative data analysis, may be perceived as an attempt to add immediate functional value and merit to the profession. Such hybrid professional identity is imposed on the MIs, who, at first, would try to reject it, but then they would end up embracing it. The CA and TA showcase how professional interpreters' "language use does not conform with the social category to which they are being assigned", because their self-perception did not match the "ideological expectations" and the "essentialist preconceptions" of their co-workers (Bucholtsz and Hall, 2005, p. 588). Professional interpreters tried to negotiate and reject the imposition of hybrid identity exercised by the "structures of institutionalised power and ideology" (hospitals/clinics), which was done through the "authorisation" to undertake medical tasks (Bucholtz and Hall's relationality principle). There are different types of hybrid identities being imposed on multilingual staff, however they can be divided into two overarching groups:

- interpreters or assistants (as they are unofficially identified) with medical functions who facilitate the work of the doctor and/or nursing staff by being directly involved in the process of diagnosis and treatment of the patient (77% of those who responded the questionnaire confirmed that) without having ever undergone medical training of any type (82% of the respondents confirmed zero (16 people) and some unspecified (2 people) medical or health-related training). This professional identity was specific to the cases where the doctors self-identified as English-language-proficient-users, which the CA proved to be a rather questionable statement.
- interpreters or multilingual staff, whose professional identity resembled that of a flight attendant or administrative assistant (4 informants or 18% confirmed having engaged in auxiliary services of the administration without any responsibilities).

Given the complexity of institutional ethics, legal vulnerability and peer pressure coming from doctors and non-professional colleagues, professional MIs accept the imposed roles and professional identity via "normative conformity" (Asch, 1951), whereby the subject is forced to deny their pre-conceptions on their own professional identity, role, ethics, moral compass and professionality and yield to group influence or "group think mentality" (Asch, 1951). Fearful and apprehensive that the management will disapprove of their adherence to the professional norms and terminate their contract, professional interpreters conform to the expectations of their employers. The CA, for example, showcases how the speaker always seeks to invite the listener to assume a particular identity (Gee, 2014, p. 21).

This analysis reveals how the speaker (doctor) "actively" attempts to "entice" the interpreter to be who or what he needs her to be (Gee, 2014, p. 21), which is medical assistant, secretary, "extension" or "duplication" of the clinician (Hsieh, 2010, cited in Hsieh & Kramer, 2012, p. 158). This is why the pronoun "we" is being constantly used. When we speak, we a) say something; b) do something; c) are something, in other words we construct our identity (Gee, 2014, p. 21). Professional graduate interpreters can either accept or reject the original speakers' identity design that is being allocated to them, as well as the way in which the medical professionals may seek to position interpreters (Gee, 2014, p. 21). As it was showcased in the CA, a condescending, arrogant and demeaning tone, pitch or intonation can indicate the doctor's supremacy in this secondary institutional sphere and the impact of the institutional ethics on the graduate interpreter, who after unsuccessful negotiation and positioning and unwilling to lose the source of income fails to reject the newly imposed hybrid identity by tacitly acquiescing to the demand. Every time that this hybrid identity gets enacted, it becomes more instituted, which eventually will make it more challenging in the future to re-negotiate. As stated by Gee, identity is a performance and:

> Like all performances it will not work unless at least some people recognize what you are and what you are doing in your performance [...] it's like lines in a play: the actors and the audience both need to know who the actors are supposed to be, what they are supposed to be doing and what it all portends". [...] Leaving it too vague on real life can be dangerous. (Gee, 2014, p. 24)

Professional graduate interpreter in the CA fails to properly negotiate and accomplish their identity, the official legal use of their title and their professional positioning in everyday work life. As the "spokesmen" of a professionalising occupation we must "formulate and reflexively construct our work" in order to "accomplish" our profession in our "day-to-day work" and during "contact with other occupations" (Horobin, 2016, Professional Mystery: The Maintenance of Charisma in General Medical Practice, The meaning of Profession section, § 3).

This is happening because some doctors are "redeveloping" their traditional blocks of tasks. The doctors are "occupiers, competing for access and struggling to improve their status by new acquisitions", which in this case are foreign language skills. Foreign language knowledge and skills are viewed as an asset that improves employability. The tendency to hire bilingual medical professionals resonates perfectly with this statement. However, this is not only applicable to the bilingual medical professionals, but also to those medical professionals who self-identify as foreign-language-proficient-users or English-language-proficient users. Given that medical professionals are "prestigious and powerful" and the foreign language skills cannot be declared the exclusive expertise of translators, interpreters, linguists, philologists, or other language specialists, any person who claims proficiency in this expertise can also claim ownership over this expertise. Thus, both bilingual medical professionals and medical professionals with poor foreign language knowledge are the "new occupiers" (Dingwall, 2016) of the medical T&I niche.

Hybrid profiles emerge as these healthcare practitioners are convinced that they no longer need interpreting service during the consultation and relinquish a series of less attractive and more routinised tasks upon interpreters to be performed upon the completion of the medical encounter. The concept of "professionalism" in medical interpreting is simply dismissed and ignored by the institutionalised structures, as this activity is equated with bilingualism, polyglotism and self-reported language proficiency. A newly emergent profession is more vulnerable and

susceptible to alterations produced by power relations (Rudvin, 2005; Swinglehurst et al., 2014; Burr, 2015; Burr & Dick, 2017).

The power relations at the social level and between individuals condition professional interpreters to come to terms and embrace the imposed identity. The professional MI's claim to "inherent rightness of their identity" is "subverted" through denaturalisation, because it violates the ideological expectations of the involved social actors (Bucholtz & Hall, 2005). It is worth clarifying that even accredited healthcare interpreters in countries such as New Zealand, where medical interpreting has long reached advanced stages of professionalisation, have been recently reported to have experienced slight role and identity subversion: "[o]ften, [patients' and medical professionals'] perceptions and expectations go beyond the interpreter's role and ethical boundaries, posing interpersonal demands for interpreters", therefore the latter "may at times deviate from ethical and professional requirements as a result of patients' and health professionals' expectations, or their own desires to facilitate effective communication and positive relationships" (Gao, 2022). Another difficulty that professional interpreters are faced with is the institutional ethics governed by power relations and ideology, which are particularly difficult to deal with given the fact that hospitals or clinics in this case is the "secondary institutional spheres" (Freidson, 2001), where doctors find themselves at the top of professional hierarchy.

Generalised lack of recognition of the complexity of professional knowledge underpinning medical interpreting, its de-mystification, oversimplification, de-specialisation, negation of professional charisma, failure to implement licencing as the key to social closure/ professional autonomy/ market monopoly leads to a rapid and progressive colonization of the market niche by amateur bilinguals and self-proclaimed foreign language proficient users. In Spain no legal protection of this title has been put in place, which is why my quantitative analysis showcased that 77% of the so-called "medical assistants" did not pursue any translation-and-interpreting-related career path. Professional interpreters have no control over their own expertise or autonomy even in spite of being holders of an official diploma qualifying them to practice.

Such market colonisation, whereby practically anybody can claim ownership over the T&I expertise, signifies that the professional interpreters willing to defend their occupation are very few in number (only around 23% according to my research) and the vast majority of "medical assistants" come from different professional backgrounds, and therefore there is no collective identity. Professional T&I degree holders are not willing to work for extremely low engagement fees, especially taking into account low occupational prestige manifested in asymmetric doctor-interpreter relationship[158]. No code of ethics is being complied with, no common knowledge is being shared, no guidance concerning modus operandi is being shared, no jargon is being used (Bouchard, 1998). There is no "shared identity with its unique set of praxeological, deontological and epistemic constituents" (Clarke & Kredens, 2018, p. 20).

As the result of all the aforementioned, job levelling –"process that defines and evaluates the knowledge and skills that are necessary to perform the job and establishes the job's duties, responsibilities, tasks, and level of authority within the organization's job hierarchy" (O'Malley &

158 Conversation analysis clearly showcases that some doctors (belonging to a prestigious professional caste and an exclusive socio-professional coterie) may display a rather condescending, dismissive or paternalistic attitude towards interpreters and tend to treat them inferiorly.

©Sibson Consulting, 2015)– in this case is quite atypical, unconventional or even erratic. Despite the fact that translation and interpreting are considered to be actual professions with the highest level of competence according to international ISCO-08 and Spanish CNO-11, non-professional allegedly bi- or plurilingual candidates are being selected for the position. And the value that is being assigned to this position or the official contractual professional category is that of an "administrative assistant"[159], however the unofficial designation is "international/personal medical assistant" (IVI, 2022; Pascual & García, 2017), "personal healthcare assistant [APS asistentes personales sanitarios]", "enfermería internacional [international nurse or nursing care]"[160], "international patient assistant", "administrative interpreter"[161], etc.

The tasks that are being allocated and re-allocated to these employees correspond to doctors, nurses and other medical professionals, and the pay levelling or the rate of payment for this grade of job and this grade of complexity correspond with the official category of "administrative assistant", which ranges from 800€ to 1200€ (Angelelli, 2015, pp. 73-74). In this case of job levelling, the official category and the job hierarchy do not match the complexity of knowledge and skill and the education level required for this position in order to guarantee safety of the patient. The broad scope of knowledge and skill and extensive formal university education are viewed as unnecessary overqualification, which lack monetary value, leading professional graduates to settle for severe under remuneration provided that they decide to keep the job. Many graduate interpreters leave the profession, which leads to an open expertise usurpation.

The internal value that some medical centres place on the T&I services or on the position of translator and interpreter, and the value that the labour market places on this type of job, as well as the pay determination level –that goes in line with the work complexity and the work load–, does not correspond with the actual knowledge and skill and educational level of the T&I graduates. In other words, in these precise case the knowledge and the education are a matter of generalised indifference. This workplace reality may shatter the graduates' idealistic expectations and lead to professional disenchantment.

15.5. X-RAYING POTENTIAL SOLUTIONS TO THE PROBLEM

Despite the rather negative results of the data obtained during the course of this research, we must not forsake the idea of professionalisation and succumb to the temptation of inaction. However, we must not harbour Pollyannaish hopes for immediate and self-generated top-down recognition either. In the absence of a utopic solution we must devise avenues and commit ourselves to the pursuit of these avenues in order to approach professional recognition. A bottom-up professionalisation model is in this case the only viable option we can work towards, although it can only be accomplished by impressing on the relevant decision-makers –the "elites" (Freidson, 2001), "grantors", "resource holders", "decision-makers" and "receivers" (García-Beyaert, 2015)–, and the society at large –prospective service users–, that amateur interpreting in all its forms may end up causing potentially grievous consequences (Singh, 2018; Quan, 2010).

159 Figure nº 4.
160 Personal experience and personal communications of participants.
161 Job advertisement nº 8.

In the light of all the theoretical contributions, analyses that have been carried out and results that were obtained, this thesis seeks to offer the possible avenues for improvement though a series of actions that have to be carried out, which could be the following:

What do we have to do?

Convince all relevant social interactants (grantors and receivers[162]) that MIs should control their own work because the underlying knowledge MIs need to formally acquire to do this work is so intrinsically complex, unique, heterogeneous and specialised, that it is inaccessible to those lacking the highly specific formal university education. This knowledge cannot be standardised or "commodified" (Abbott, 1991b, p. 22 in Freidson, 2001) and therefore requires the exercise of *Phronēsis*, which is based on discretionary specialisation in unique circumstances.

How?

Starting on the premise that an a priori self-conception housed within an individual mind can only gain social meaning through dialogic interactional discourse, we must maximise awareness and sensitise the society by seeking out the stakeholders who are confronted with this problem on a daily basis and talking to them directly. The main thrust of this idea is that language affords its users an actual capability to define, predict and influence human ecologies and identities, affect human activities on individual, group and populational levels, and influence human relations and postures on a particular level.

I say "particular" or "local" level because on a general level we are all products of an artificially created pecking order that is beyond our control, but we can still possess minimal agency to discursively construct our proximate environment without immediately influencing (let alone dismantling) major social structures and algorithms. Given that power relations and ideologies discursively generate our reality, knowledge and description of the world as we know it (social determinism and critical realism), our agency to discursively (re)construct our identities and our proximate environment by influencing major social structures and algorithms is minimal.

However, we as agentic and conscious social actors, must try to use this agency in order to reposition ourselves and re-negotiate the professional category that is being allocated to us. We must exercise our power in discourse (linguistic choices) when conversing with those whose power behind discourse could allow them to alter or dismantle the existing ideologies. We must convince the key external players as García Beyaert (2015) calls them (grantors of the service and the users of the service) that our professional knowledge and expertise is unique and indispensable. According to Martin: "for those who are no 'in the field', interpreting is often just as a technical and linguistic expertise confined to translating words, and not a 'complex cognitive activity with a distinct professional profile and the need for specific training'" (as cited in Valero, 2008, p. 3).

Therefore, *ideologies* or *elements of an ideology* are construed as tools to garner political and economic resources in order to anchor the discipline's status, justify "the privileged position of the institutions of an occupation in a political economy as well as the authority and status of its members." (Freidson, 2001, § 4). The ideology of professionalism must "neutralize" the opposing

[162] Terms originally used by García-Beyaert (2015).

ideologies (in this case the perception of MI as practicing vocation rather than an academic discipline), which extenuate the control of work by the market (*consumerism*) and by bureaucracy (*managerialism*). *Persuasion* is the key feature of ideology. We need to gain the full political, economic, and social recognition, as well as support necessary for establishing and consolidating professionalism (Freidson, 2001, Bodies of knowledge section, § 2).

- We must approach the medical community, talk to the medical associations, the health authorities, do outreach campaigns in the medical associations and in the patient care departments. As maintained by Tomassini, "qualified healthcare interpreters should be considered as an integral part of the health professionals' community" (2012, p. 52), because the main tenet of the Hippocratic Oath, which is to abstain from doing harm, depends on MI's professionalism. Deficient interpretation may lead to truly detrimental consequences, as it was exposed in Singh, 2018 and Quan, 2010, and herein lies the seriousness of the problem. In MI the de-professionalisation is not the major problem, crippling consequences of miscommunication such as death, permanent or temporary disability of the patient and/or tarnished reputation of the doctor and lawsuits are the real danger of non-professional language provision. Therefore, "the professions are licensed to carry out some of the most dangerous tasks of our society - to intervene in our bodies" (Hughes in Dingwall, 2016, Introduction section, § 12).
- There must be "persistent political agitation to obtain the support of public power and to achieve state patronage as well as protection by law for our occupation" (Wilensky (1964, pp. 142-146, as cited in Neal and Morgan, 2000, p. 12). This national approach to the figure of MI must be based on the fact that the do-no-harm-tenet is also applicable to MI, as the harm that a subpar rendition can provoke (Singh, 2018; Quan, 2010) is sometimes far worse than one can expect. Following the example of Australia and New Zealand, countries where MI has reached advanced stages of professionalisation, we must insist on the absolute necessity of considering credentialism, licencing, certification and accreditation as sine qua non recruitment prerequisites. Thus, NAATI (national standards & certifying authority for translators and interpreters in Australia) must be viewed as a blueprint for the creation of the national state-endorsed non-for-profit T&I certification organisation.
- A court sentence could be a very powerful recourse as well. Legislative protection could signify a clearer delimitation of the area of competence, legal recognition of the title and the importance of formal education. There is a precedent in the EU of such professional recognition and liability for malpractice. Polish judge ruled against the "a fifth-year Computer Science student who had won a national English language competition for high school students" (Marking, 2021), who was hired to translate a book from Polish into English in 2013 and delivered a deficient product generated by Google Translate, which was proven to be unacceptable. "In its ruling, the court concluded that the person whom the LSP hired to perform the translation cannot be considered a professional translator. The court stated that a professional translator must (a) have proper university training in translation techniques; (b) be knowledgeable in

the rules of translation; and (c) have practical experience and substantive knowledge in the field of the translation task" (Marking, 2021[163]). Woloszyk, who was appointed an expert witness to this case, elucidated that: "Even though the profession of a translator (who is not a certified/sworn translator) has not been regulated by Polish lawmakers, this does not mean, however, that each person who does a translation in exchange for money may be called a professional translator. The fact that there is no legal definition does not open the way to unrestricted discretion in construing a given concept" (Marking, 2021).

It would be interesting to know whether a judge in Spain would condemn the low priority that is being placed on the provision of quality interpreting, and whether he/she would recognise MI as the major determining factor of the primum non nocere tenet and the condition for the compliance with the Hyppocratic Oath. It would be interesting to see whether a judge would recognise quality MI as an imperative to comply with the patient's right to quality medical care and their right to access medical information, and whether these rights are being delivered on and safeguarded in the case of layperson interpreters. In order for a lawsuit to take place, a party that was negatively impacted by the deployment of layperson language providers must sue the medical centre. However, the patients do not usually sue medical centres, because they are simply not aware of the whole "situation" going on. One of the participants[164] conceded that by trying to "reduce the doctor's workload" she prescribed medication to the patient after having consulted a senior medical assistant. This medical treatment guideline turned out to be incorrect and was afterwards changed by the doctor, however the patient never found out that there had been a mistake, as they were called and told that in order to improve the treatment the doctor had decided to change the guideline. Thus, given that the medical assistants' errors are not exactly as evident as one would expect them to be, it is difficult to sensitise the public.

The grievous consequences or implications may only be of concern if the hospital or clinic administration incurs serious financial damages or loss of reputation. In other words, if the relevant social actors were aware of the problems that are caused by the incorrect exercise of discretion carried out by non-professional plurilingual personnel, and were affected by it, they could become interested in providing professional interpreting.

- Given that the body of knowledge underlying MI has already been codified, formalised and disciplinarised since 1972, year in which the first university school for translators and interpreters was established in the Autonomous University of Barcelona, the universities should now improve the training of the students by multiplying subjects with specialised knowledge in medicine and law, which would help the occupation gain

[163] For more information visit https://tlumaczenia-prawnicze.eu/lsps-responsibility-for-the-process-of-translation-and-the-rules-of-using-machine-translation/ and for the original verdict in polish visit https://tlumaczenia-prawnicze.eu/wp-content/uploads/2021/01/20200813_wyrok-SR-Poznań-Stare-Miasto_XII-GC-669-17_Google-Translate.pdf

[164] Audio recorded personal communication.

immediate functional and social value as these are the branches of major public interests. A specific curriculum for healthcare interpreters within the interpreting in public services syllabus must be created. Moreover, the students must acquire "knowledge of the profession [and] professional identity" (Sawyer, 2004, p. 60 as cited in Major & Crezee, 2017) through the "context-dependent [...] situated learning approach" or through exposure to real-life tasks and environments, both inside (e.g. replicating real-life interactional interpreting demands) and outside (e.g. practicum placements) classroom (González-Davies & Enríquez-Raído, 2016, p. 1 as cited in Major & Crezee, 2017). "Situated cognition and reflective practice" at the very beginning of the professional career trajectory may help avoid disenchantment and frustration of students caused by the lack of professional recognition, thus serving as a deterrence mechanism for those seeking immediate professional success. We need to focus on the recognition of specialised knowledge underlying medical interpreting, otherwise the usurpation of our expertise by other occupiers shall become our nemesis. Even though healthcare topics may be subsumed under some subjects taught at the faculty, no specific training modules in health sciences have been developed at the national level to address the need for health literacy in T&I graduates. The outstanding work of Ineke Crezee, renowned expert in the field of healthcare translation and interpreting and New Zealand's Professor of Translation and Interpreting, can serve as the cornerstone for the official specialisation of medical interpreting. She has authored a book of introduction to healthcare translation and interpreting used by practitioners of this field worldwide. This book[165] is available for MI&T[166] practitioners Spanish, Turkish, Russian, Chinese, Japanese, Arabic and Korean. Crezee's approach to MI challenges the traditional way of teaching this discipline, in that it does not focus on terminology as the most esoteric part of MI. Instead, Crezee advocates and promotes acquisition of medical knowledge as the anchor of MI, whereby the healthcare interpreters-to-be are initiated into the field. This book introduces the learners to the idiosyncrasies and intricacies of healthcare settings, anatomy, physiology, pathology, frequently encountered medical conditions and the most common treatment option, and regularly abbreviations, which may come in particularly useful for translators working with written reports. In order to become recognised, regulated and registered the interpreter-to-be must prove excellent quality of performance achieved through different stages of formal university education, and medical specialisation would definitely contribute to an increment in social value.

Public services are based on these spheres, and vital aspects of the lives of the people depend on these spheres. A subpar interpreting quality in medicine or law may lead to major life-changing implications, which is exactly why it should be explained to the relevant social actors that "the length of training, the depth of special knowledge and the codes of behaviour" are absolutely vital in professions "concerned with people"

[165] The books are available for purchase here: https://benjamins.com/catalog/persons/206040310
[166] Medical interpreting and translation practitioners.

(McCormick, 1979, p. 13, in Horobin, 2016, The Meaning of Profession section, § 4). This is exactly why the professions with "guilty knowledge" carrying out "some of the most dangerous tasks of our society", such as "interven[ing] in our bodies" or "regulat[ing] the conflict of rights and obligations" (Dingwall, 2016, Introduction section, § 12) must be licenced and must undergo extensive formal university training. It is worth noting that the Subtheme 7 and 8 of the TA showcase a clear interest of the vast majority of participants on the imperativeness of medical specialisation and on the importance of medical terminology as the most esoteric part of MI's body of knowledge. The theme 1 (more specifically part II Typology of formal education. Juxtaposition of ill-defined and underrecognised T&I education versus a clearly expressed need for medical specialisation and subthemes 6,7 and 8) of the TA demonstrates that a narrower specialisation of medical interpreters may redound to the graduate MI's recognition as professional. Practically all the participants of the TA mentioned the importance of medical specialisation. However:

- It remains to be seen how the double degrees (interdisciplinary training programmes), which are starting to gain popularity among Spanish undergraduates, will influence the dynamics of MI professionalisation. It may be a conceptual tripwire as it may distort the logical division of labour characterised by the compartmentalisation of the assignments or tasks allocated to the members of each occupation by leading the cluster of tasks belonging to interpreting to disappear and be subsumed under a more established profession, whose members would be considered the occupiers of the MI niche and would seek to improve their status by new acquisitions, such as linguistic expertise (Hughes, in Dingwall, 2016, Introduction section, § 10):

  > A given terrain of demands for "goods and services was divided into blocks of tasks, which might be developed, redeveloped or extinguished. These blocks had successive occupiers, competing for access and struggling to improve their status by new acquisitions or the relinquishment of less attractive properties. Some occupiers were prestigious and powerful, others disregarded. All were caught up in a constant evolutionary process as demands and technology changed, either from clients or from internal attempts to influence the market.

  In this case scenario, these training programmes (double degrees) may lead to further confusion, and even to the profession's disappearance.

- However, double degrees do not necessarily need to be a bad thing: they may also be viewed as an opportunity to narrow down the specialisation and upgrade the professional speacialisation, adding more mystery and charisma to the profession. Also, these double degrees are supposedly more geared towards the institutions' needs, and tend to be more lengthy, which may also result in greater prestige and recognition.
- It also remains to be seen whether the previously acquired foreign language mastery should become a prerequisite for enrolment. Spanish universities offering

Translation and Interpreting Degrees merely recommend a level of language proficiency prior to university entrance, but do not position it as a sine qua non requirement for enrolment. There is a recommended language profile that the applicants should have in order to be able to complete this degree successfully, however it remains a mere recommendation. The following excerpt exemplifies such recommendation:

> In order to be able to study the Degree in Translation and Interpreting, it is recommended that students have an entry level of proficiency in language B (English) equivalent to B1, according to the CEFRL (Common European Framework of Reference for Languages: Learning, Teaching, Assessment).[167]

Back in the 70' and 80' the situation was rather different as there used to be a certain tendency to screen out the unprepared or untalented candidates, the fact that is critisised by Freidson:

> [The members of the academic professions] do worry about maintaining the student enrolment which indirectly supports them, but as their administrative supervisors often complain, they worry even more about the theories, concepts, and data that are their primary interest, and about publishing articles in journals which yield no income and are read only by each other. Furthermore, in the interest of improving the quality of their work, they sometimes try to raise standards so as to reduce rather than expand the number of their student consumers, often to the detriment of their economic self-interest. (Freidson, 2001, Ideological Shibboleths Surrounding Monopoly section, § 5)

Now, however, such tendency is no longer detectable in this specific career path, so the question that arises is whether a pre-entry foreign language proficiency screening would guarantee better proficiency and professionality of the graduates, thus contributing to their recognition.

I believe that the detrimental complications and consequences arising from inaccurate interpreting and translation within the hospital walls have been tremendously underreported and underestimated in medical literature and this could be one the reasons for desensitisation to the possible consequences of non-professional interpreting.

Thus, I think that having T&I academics write scientific articles and publish them in medical literature such as medical and scientific journals may constitute an important step toward education and awareness raising among medical professionals. The counterexamples to illustrate the pernicious consequences of interpreting errors may prove to be particularly useful and eye-opening. Medical professionals must learn to associate poor interpreting with prospective damage to their reputation and their patients' health state. Another crucial step would be to publish in medical tourism brochures and magazines geared towards potential cross-border patients. This will help educate them and raise awareness of the fact that they are entitled to access medical

[167] For more information, please visit: https://www.uji.es/estudis/base/2022/graus/traduccio/seccions/acces-admisio

information concerning their health state. This information will contribute to patient empowerment as they will know what to expect from the interpreting service

Who has to do it?

- "We" in this case can signify either a professional association, or institutions with social prestige such as the universities. Obviously, as the results of this research have shown, the private clinics, as resource holders and decision-makers, are not interested in providing professional language provision, but rather have vested interests in other expedient solutions, which they view as more fitting in terms of maximising the profits.

  > If the occupation members have any sense of community by virtue of their shared work experience, they are also likely to claim a mandate to define, for themselves and others, proper conduct in relation to their work, to influence its technical content, styles of delivery and, most crucially, the patterns of public demand and response. Hughes emphasises that both licence and mandate should be thought of in the broadest terms. (Hughes, in Dingwall, 2016, Introduction section, § 11)

  However, in the case of MI no professional associations have been established as of yet. Although MI is slowly becoming a full-time occupation, 77% of respondents (17 out of 22) reported through the quantitative questionnaire having pursued non-language and non-T&I-related professional career paths, denoting multiplicity of educational backgrounds not related in any way to languages, philology, linguistics, translation or interpreting. This means that no collective identity has been established yet, without which non-unionised graduate MIs will be dismissed as side-lined voices of dissent belonging to isolated individuals. Interpreters on their own will simply be unable to claim ownership over their specialism and area of competence.
- Institutions with social prestige, such as universities, could carry out this type of action, as they are groups involved in the training of translators and interpreters and are therefore interested in having the training they provide recognised and demanded. Universities need to exercise their cognitive authority (Freidson, 2001), because MI was disciplinarised and formalised.

In the case of T&I discipline it is not mere force-feeding and peddling of the idea of indispensability of university education for the purpose of making profit from the enrolment fees. As maintained by Freidson (2001):

> [The members of the academic professions] do worry about maintaining the student enrolment which indirectly supports them, but as their administrative supervisors often complain, they worry even more about the theories, concepts, and data that are their primary interest, and about publishing articles in journals which yield no income and are read only by each other. Furthermore, in the interest of improving the quality of their work, they sometimes try to raise standards so as to reduce rather than expand the number of their student consumers, often to the detriment of their economic self-interest. (Freidson, 2001, Ideological Shibboleths Surrounding Monopoly section, § 5)

So there is obviously an economic self-interest, which consists in maintaining enrolment levels high, but economic self-interest is not the predominant drive, the members of academic professions have a great interest in the subject matter they teach, they are committed to their particular

body of knowledge and skill, and one of the main goals of their profession is to protect its integrity and advance. In some cases the advancement may also include partial dissemination of knowledge and skill, but never its popularisation, de-mystification or accessibility for the uninitiated.

In order to improve our epistemological status we need to impose our knowledge mandate and redefine our professional self-image.

Our overriding goal should be to retract the mediocrity, denigration and occupational subjugation that is being imposed on us by the heavily politicised initiatives deeming multilingualism to be accessible and indirectly compulsory for everyone. Otherwise we will not be able to achieve the optimal cognitive basis (Halliday, 1987, in Freidson, 2001) for a discipline.

The hybridisation of tasks, roles and profiles which exponentially metastasises the profession blurs the jurisdictional boundaries and makes the already sufficiently codified knowledge and tasks (via academisation, intellectualisation and disciplinarisation) much less distinctive, more vague and therefore far more contestable by non-professional interpreters and experts belonging to other professions who consider themselves sufficiently competent and qualified to usurp our expertise. Thus the sufficiently distinctive tasks whose performers should occupy a distinctive niche in the division of labour lack compartmentalisation opportunities due to constant trespassing of the volatile jurisdictional boundaries. Current market demands, employers' expectations, lack of licencing and legal supervision, inadequate legal monitoring allow for over-involvement, interference with treatment being undertaken by the patient, blurring the ethical lines, fuzzy interoperability limits.

What some employers may call "adaptation", the cognitive authorities must define as "encroachment" on the jurisdictional boundaries of MI occupation and blatant usurpation of expertise and task ownership.

Universities need to persuade the relevant social actors that only the formal education will allow interpreters-to-be to exercise *Phronēsis* successfully. An injunction must be sought by Universities and professional associations banning the health care providers form hiring dilettanti and other profiles plaguing this stratum and claiming ownership over its expertise. The lack of critical yardsticks of eligibility criteria, apart from constituting a glaring shortcoming, also mirrors deskilling, trivialisation and proletarianising of the work undertaken by medical interpreters. Therefore, it is of paramount importance that the knowledge base and the skillset of medical interpreters be formally recognised as a major determinant in the Culture of Safety:

> The result of an organizational commitment to safety permeating all levels from frontline personnel to executive management. Features of a culture of safety include acknowledgment of the high-risk, error-prone nature of an organization's activities, a just environment where individuals are able to report errors and near misses without fear of reprimand or punishment, an expectation of collaboration across ranks to seek solutions to vulnerabilities and a willingness on the part of the organization to direct resources for addressing safety concerns.[168]

The law must contain stringent patient safety regulations and rigorous regulatory safeguards as well as efficient law enforcement strategies, which would stipulate how discretion or professional judgement is to be exercised and, most importantly, who is eligible to practice. The criteria

[168] Please, visit: https://www.centerforpatientsafety.org/patient-safety-glossary

for candidate eligibility requirements should be clearly defined by law, especially taking into account the fact that MI is an inchoate occupation. A less elusive statutory regulations would signify a huge step towards professionalisation. Without a protection by law granted by state as a sign of patronage all attempts to professionalise will be reduced to anaemic striving which will eventually result in failure, and the universities are the only actors who can convince the relevant decision-makers that all MIs ought to be suitably qualified, accredited and registered with an appropriate independent not-for-profit regulator. They ought to undergo all relevant inspections, verifications and clearance in conformity with a series of statutory regulations, which should serve as the gatekeeper foreclosing any type of colonisation of the MI's occupational niche by emerging profiles which adulterate the very essence of this occupation, and thus jeopardise patients' wellbeing and undermine their rights. Therefore, the relevant legal norms need to be revamped to enforce a set of rules which would place strict limits on the entry of the outsiders into the profession's realm. By not barring the access to the occupation, the law-makers and the decision-makers are legitimising encroachment by occupiers. The universities, as institutions with social prestige, must vie for legislative protection that would imply exclusive ownership over the correspondent area of competence, ensure clear delimitation of the area of competence as well as legal protection of the title and the underlying knowledge and skills, whereby the mere performance of the act by a non-qualified person would be declared a crime (Wilensky, 1964). No occupation is labelled a profession without a legal protection of the title and skills (Weeden, 2002). It is essential to guarantee that the professional will incur legal liability in case of harm infliction in order for the general public and the service users to gain professional trust in MI. For this to happen, "the communicative problem must first be recognised as such" (Monzó Nevot, 2009 cited in Álvaro-Aranda & Lázaro-Gutiérrez, 2021, p. 70) and the relevant stakeholders must be convinced that any alternative solution is an expedient solution, whereas the recruitment of legitimate professionals on the basis of the "the skills they deploy to break down linguistic barriers" (Álvaro-Aranda & Lázaro-Gutiérrez, 2021, p. 70) is the only optimal solution.

The emphasis must be made on the fact that attempts to economise by engaging cheap pseudo-interpreters can be viewed not only as false economy, but also as severe abuse of clients' or patients' trust and a threat to their health and life. No funding for MI should be allocated on the basis of expedient parsimonious frugality and at the expense of quality (Orlov, 2019). Proper regulations would allow to safeguard the first-do-no-harm precept as it would help minimise the risk of crippling misdiagnosis, patient safety incidents (Perreault, 2015), drug underuse, overuse or misuse, lack of adherence or compliance, sentinel events, near misses, iatrogenic injuries, ensure correct administration of the high alert medications, enhance health literacy.

> Individually and, in association, collectively, the professions 'strike a bargain with society' in which they exchange competence and integrity against the trust of client and community, relative freedom from lay supervision and interference, protection against unqualified competition as well as substantial remuneration and higher social status. As guarantees of this self-control they point to careful recruitment and training, formal organisation and informal relations among colleagues, codes of ethics, and professional courts or committees enforcing these codes. (Rueschemeyer, 2016, Professional Autonomy and the Social Control of Expertise section, part II, § 2)

I have tried to render the most reality-close assessment of the current situation, however it will always remain a subjectively experienced reality. Therefore, the present study is certainly not designed to be the last word on the subject, but rather an approximation to the current status quo of MI in the private sphere in the VC and a contribution to the professionalisation of this discipline in the nearest future.

15.5.1. Future research avenues

Medical interpreting is gradually becoming a full-time job in the private medical sphere of the study-relevant geographical area. There is a code of ethics issued by International Medical Interpreters Association which MI can use. The Translation and Interpreting Degree in Spain exists since 1972, and the training programmes in many universities include training in public service interpreting, and some Spanish universities, such as Jaume I University even offer a Master's Degree in Medical Translation[169].

However, in order to succeed in the "political agitation for protection" (Wilensly, 1964) of the T&I title by law, the exclusive area of competence of this profession must be recognised, thus rendering the "mere performance of act by a non-qualified person [...] a crime" (Wilensly, 1964). This would protect the clients from caveat emptor by barring access to the "unscrupulous" and "unqualified" (Wilensly, 1964). The regulatory authorities, as well as the society at large must first and foremost recognise the complexity of knowledge and skill underlying the interpreting activity. If this is not achieved, medical interpreting will cease to exist as occupation, because usurped by external occupiers it will transition into "international medical assistance", "intercultural mediation", etc. In fact, this transitioning has already started. And I am afraid, those who think otherwise gravitate in my opinion towards a rather myopic and pollyannish reasoning.

While I do believe that it could be possible to call people's attention to the question of interprofessional encroachment, profile hybridisation would still in my opinion be an irreversible process. Therefore, the incorporation of new breeds of language specialists with combined expertise into the marketplace with the purpose of maximising profit have not only been normalised as a business strategy, but also as a formalised career path.

Subsequently, the major future research avenue may be related to the profile hybridization on a more formal academic level. Information on the double hybrid degrees is available on the El País website[170], where the students who wish to enrol at a university in Spain can find information on the available degree options, the respective cut-off marks, and the national universities that offer these degrees. I have identified six double or dual degree possibilities, where Translation and Interpreting Degree is combined with International Relations Degree, Degree in Tourism, Degree in Hispanic Philology, Degree in English Studies, Degree in Interlinguistic Mediation, and lastly, Law Degree.

[169] For more information, please visit https://ujiapps.uji.es/sia/rest/publicacion/2020/estudio/42166. Its programme is mostly focused on medical translation but it includes a couple of medical interpreting optional courses.
[170] For more information, please visit https://elpais.com/especiales/universidades/titulacion/notas/medicina/376

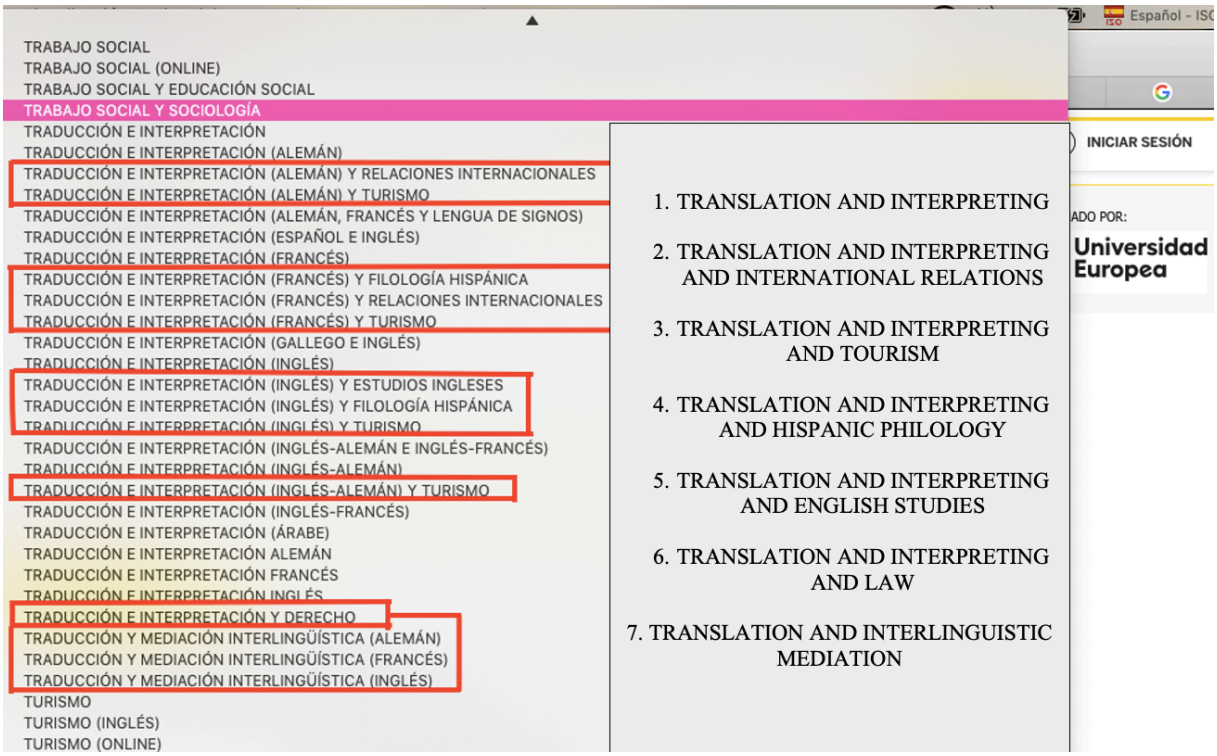


Figure 52. Dual Degrees in Translation and Interpreting offered by Spanish Universities, extracted from https://elpais.com/especiales/universidades/titulacion/notas/medicina/376

The duration of these double or dual degrees exceeds the 4 year duration of normal 260 ECTS credits Bachelor's Degrees. The duration and ECTS credits vary from 5 years/350 ECTS (Dual Degree Program in Translation and Interpreting, and International Communication/ Bachelor's Degree in Global Communication)[171] to 6 years/363 ECTS (The Double Degree in Translation and Interpreting and Law)[172]. It is very interesting how the latter offers "personalised training with a high degree of professionalisation in both degree programmes" (Universidad de Salamanca)[173]. As for me, this is an absolutely clear indicator that a number of potential/prospective applicants for enrolment may have questioned the occupational status as well as employment opportunities of at least one of these career paths.

Obviously law along with medicine is one of the most well established and prestigious professions, however it is not clear how this profession will work in combination with translation and interpreting. The purported career opportunities listed on the official website of the University of Salamanca advertising the double degree in Translation, Interpreting and Law include the following: teaching and research in Translation and Interpreting and Law (national and international), professionals in the legal field, state lawyers, etc., professionals in cultural institutes, libraries, research centres, publishing houses, tourism, etc., access to legal and sworn translator competitive examinations.

[171] For more information, please visit https://www.comillas.edu/en/degrees/dual-degree-program-in-translation-and-interpreting-and-international-communication-bachelor-degree-in-global-communication-ti-com
[172] For more information, please visit: https://www.usal.es/doble-titulacion-de-grado-en-traduccion-e-interpretacion-y-en-derecho and https://www.usal.es/files/folletos/dg_traducinterp_derecho.pdf
[173] For more information, please visit https://www.usal.es/files/folletos/dg_traducinterp_derecho.pdf

Double Degree in Translation, Interpretation and Law offered at the University of Salamanca[174] (syllabus consisting of a total of 363 ECTS) became an institutional double degree programme, regulated by the Regulations on Double Degrees and Simultaneity of Official Studies of the University of Salamanca, approved by the Governing Council of the same university and implemented in the academic year 2015-2016. This is logical taking into account the EU mainstreaming of multilingualism as a major factor of employability improvement (Krol-Hage & Kircher, 2020; Mickan et al., 2019b). Therefore, the multi-layered hybridisation of tasks, roles and profiles should no longer be perceived as a metastasis of our under-recognised profession, but rather as a possible solution to interoccupational encroachment. Such curricula and expertise cross-pollination could elevate or upgrade our discipline bringing the concept of "high specialisation" to a new level. By being grafted onto another far more established expertise such as law, which is the prototype of an ideal typical profession, interpreting could instantly gain all the attributes of a profession, gain professional visibility and attain social closure through licencing.

It has caught my attention that the double Degree in T&I and Law is becoming more popular, advertised and capitalised on that other double degrees. This is happening probably due to the fact that Law is an ideal typical and long established prestigious profession. Englishspanish[175], for instance, advertises this hybrid profile by stating that: "Englishpanish only works with translators with a degree in law, solicitors, lecturers or other legal experts who work as part-time or full-time translators" (Englishpanish Translation & Communication, S.L., 2022).

Thus, I see five possible research avenues in the foreseeable future:

- The first one is, of course, the ways in which we can sensitise the society at large and the relevant actors to the uniqueness and inaccessibility of the professional knowledge underpinning medical interpreting, its mystique and its charisma
- The second research avenue is more realistic though, and it consists in yielding to the current market demands, accepting profile hybridisation in this particular field as something normal, and working towards the creation of officialised and formalised university education aimed for the normalisation of double degrees, which has already been materialised in a number of Spanish universities. If we opt for the latter:
  - we must think what professional combinations other than translation-interpreting-law may be interesting
  - whether these new combinations are beneficial for the graduates in terms of employability
  - whether they offer an immediate functional value, and immediate practical benefit
  - whether the curricula created and administered by the higher education institutions respond to the demand in a more effective way
  - whether these double degrees may lead to the ostracism of those graduates who have acquired a traditional T&I degree

[174] For further information: https://bit.ly/3TWfbtc
[175] This is the website: https://www.englishpanish.com/es/traduccion-juridica

- whether the employers would end up preferring double degree graduates over the traditional T&I graduates

However, instead of burgeoning, the T&I Degree may cease to exist as it would be "revamped" to fit the new expectations of the powers behind discourse.

- The third research avenue is the exploration of the professional identity of the double degree graduates after the aforementioned professional transitioning.
    - Who are they? Lawyers? Interpreters? Legal translators and/or interpreters? Perhaps sworn translators and interpreter? This research avenue is particularly interesting and thrilling. What professional identity would these double degree graduates attribute themselves to?
- The fourth research avenue could be dedicated to the investigation of the unmet language needs of non-Spanish-speaking patients in the public medical centres during the global Covid-19 pandemic. Migrants have clearly been excluded from receiving basic information on Covid 19, and according to Achotegui (2020) there was an urgent need for a plan to transmit quality information on the health situation to all members of society, as many migrants were have reportedly lived uninformed and disconnected from the host society, which is dangerous and distressing during a pandemic. Yet nothing has been done to improve the situation.
- The fifth research avenue is the professional role and identity of interpreters and translators in a technocratic context or in a future governed by technocrats, if you will, where a number of occupations and professions will disappear due to radical social changes and the Fourth Industrial Revolution (WEF, 2016).

Ruth Parlot, chief financial officer at Alphabet has predicted during a panel discussion at Davos, Switzerland, (Thompson et al., 2022) that the 6G deployment within the framework of the industrial metaverse revolution around 2030 will allow for high quality holograms as one of the "the big advantages of augmented reality". This is intended to purportedly solve "problems here on earth and it will be things like having glasses and being able to translate as you speak". Obviously she was referring to the communication problems of the globalised multilingual societies, and the ability to instantly translate conversations using augmented reality (AR) glasses: "You'll be able to wear AR glasses and translate languages as you speak". This would (or will?) obviously make translation and interpreting accessible to virtually anyone, which would result in its instant de-professionalisation.

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APPENDIXES

APPENDIX A. SCREEN SHOT TAKEN FROM THE ORIGINAL JOB ADVERTISEMENT "ATENCIÓN AL PACIENTE"

IVI 30/12/19 14:25

Inicio (../Default.aspx) ES ¿Aún no eres usuario? Nuevo usuario (/General/Alta.aspx) | Iniciar sesión

Ofertas de empleo (Ofertas.aspx)

IVIRMA Global

(../Default.aspx)

Ofertas de empleo

Atención al Paciente IVI Valencia

Inscribirme a esta oferta

Localidad: Valencia
País: España
Provincia: Valencia
Nº Vacantes (puestos): 1

Descripción

IVI nace en el año 1990 como la primera institución médica en España especializada íntegramente en Reproducción Humana. Desde entonces ha ayudado a nacer a más de 160.000 niños gracias a la aplicación de los más novedosos métodos de reproducción asistida.

A principios de 2017, IVI llega a Estados Unidos de la mano de RMANJ. La fusión, que da lugar a IVIRMA Global, consolida a IVI como mayor grupo de reproducción asistida del mundo.

Actualmente, contamos con más de 65 centros en todo el mundo, en los que se realizan todos los tratamientos, test y técnicas de reproducción asistida que existen en la actualidad: inseminación artificial (IA), fecundación in vitro (FIV), donación de ovocitos, inyección intracitoplasmática de espermatozoides (ICSI), Diagnóstico Genético Preimplantacional (DGP) y vitrificación de ovocitos. Se trata de uno de los centros con las mejores tasas de embarazo; de hecho, 9 de cada 10 parejas que consultan en IVI por problemas de infertilidad consiguen su objetivo. Los trabajos e investigaciones científicas de IVI han sido galardonados con algunos de los premios más representativos de la profesión, como los otorgados por la American Society for Reproductive Medicine, la Society for Gynecological Investigation, la Fundación Salud 2000 o la Sociedad Española de Fertilidad.

Esto ha sido posible gracias al trabajo de un equipo multidisciplinar integrado por más de 2.000 profesionales altamente especializados en Ginecología, Obstetricia, Genética, Biología, Andrología, Cirugía, Medicina Materno-Fetal, Anestesia, etc. y es que en IVIRMA Global creemos que las personas que forman el Grupo son la razón de nuestro éxito como institución. Por ello, promovemos una cultura de desarrollo de personas que permitan a nuestro equipo llevar a cabo su trabajo con motivación. Nuestro compromiso es ofrecer el mismo nivel de excelencia a nuestros pacientes que a los profesionales que logran hacer sus sueños realidad.

Funciones

Para nuestro centro de Valencia seleccionamos un/a Auxiliar de Atención al Paciente.

La persona seleccionada se responsabilizará de recepcionar las consultas de pacientes, gestionar la agenda de citas, registrar la información de los pacientes, controlar que el historial está completo con todos los datos necesarios para la realización del tratamiento y posterior seguimiento. Así mismo coordinará con los médicos el seguimiento del paciente, atenderá sus dudas, quejas y reclamaciones, y recogerá sugerencias con la finalidad de resolverlas o canalizarlas al puesto adecuado de la organización.
Finalmente atenderá la centralita y emitirá las facturas correspondiente a los pago realizados por los pacientes.

Requisitos

- Disponer del certificado de discapacidad igual o superior al 33%.
- Experiencia previa en puesto similar de al menos dos años.
- Persona comunicativa, empática, flexible y orientado al paciente.

https://ivi.epreselec.com/Ofertas/Ofertas.aspx?Id_Oferta=2228551 Página 1 de 2

IVI 30/12/19 14:25

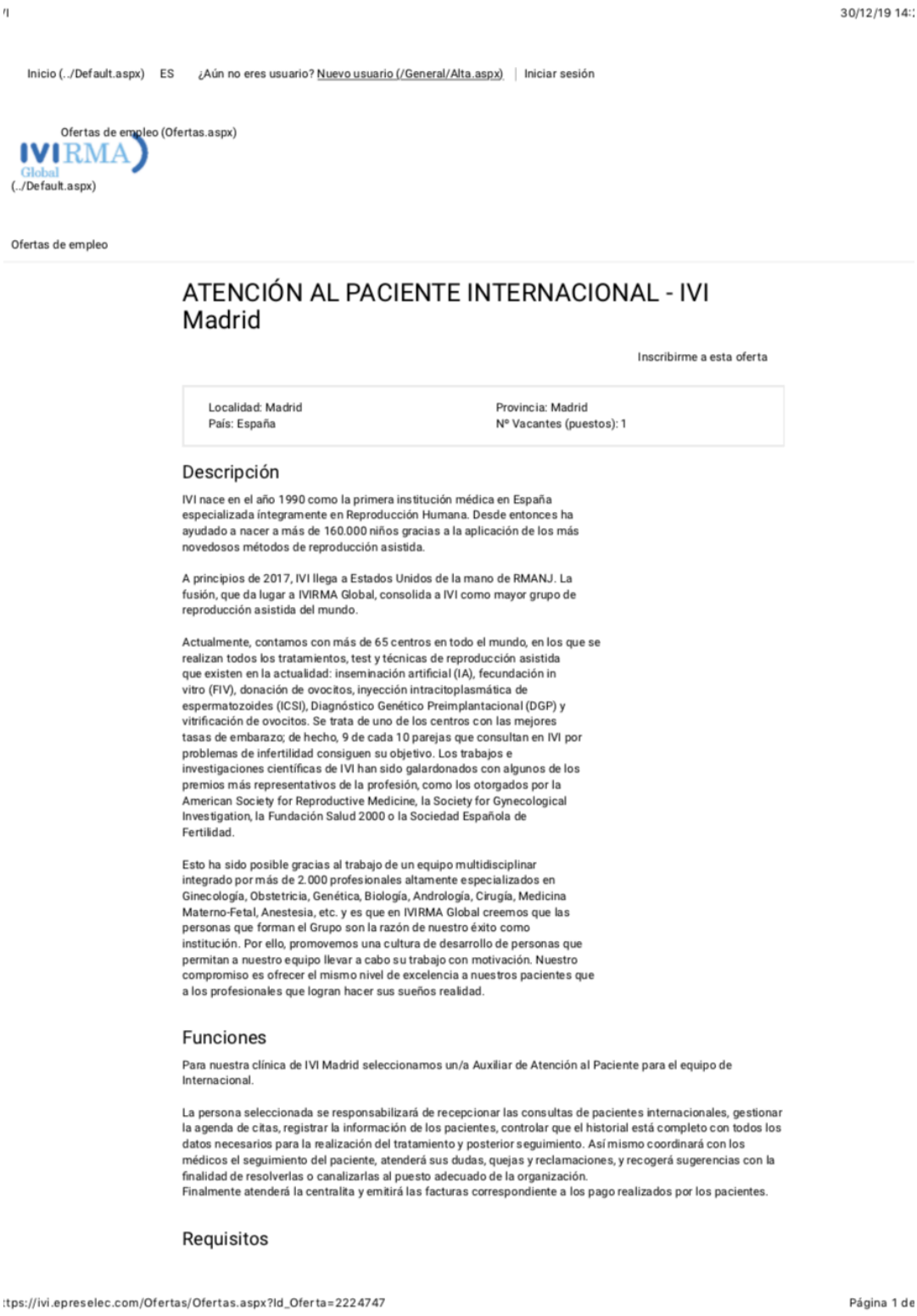
- Se requiere flexibilidad horaria.
- Será valorable disponer de idiomas (Francés o Inglés)

Se ofrece

Te ofrecemos la posibilidad de incorporarte a un equipo humano de reconocido prestigio. Podrás unirte a una organización donde el capital humano es primordial y en la que tendrás la oportunidad de desarrollarte profesionalmente.

Inscribirme a esta oferta

APPENDIX B. SCREEN SHOT TAKEN FROM THE ORIGINAL JOB ADVERTISEMENT "ATENCIÓN AL PACIENTE INTERNACIONAL"



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Ofertas de empleo (Ofertas.aspx)

IVIRMA Global
(../Default.aspx)

Ofertas de empleo

ATENCIÓN AL PACIENTE INTERNACIONAL - IVI Madrid

Inscribirme a esta oferta

Localidad: Madrid
País: España
Provincia: Madrid
Nº Vacantes (puestos): 1

Descripción

IVI nace en el año 1990 como la primera institución médica en España especializada íntegramente en Reproducción Humana. Desde entonces ha ayudado a nacer a más de 160.000 niños gracias a la aplicación de los más novedosos métodos de reproducción asistida.

A principios de 2017, IVI llega a Estados Unidos de la mano de RMANJ. La fusión, que da lugar a IVIRMA Global, consolida a IVI como mayor grupo de reproducción asistida del mundo.

Actualmente, contamos con más de 65 centros en todo el mundo, en los que se realizan todos los tratamientos, test y técnicas de reproducción asistida que existen en la actualidad: inseminación artificial (IA), fecundación in vitro (FIV), donación de ovocitos, inyección intracitoplasmática de espermatozoides (ICSI), Diagnóstico Genético Preimplantacional (DGP) y vitrificación de ovocitos. Se trata de uno de los centros con las mejores tasas de embarazo; de hecho, 9 de cada 10 parejas que consultan en IVI por problemas de infertilidad consiguen su objetivo. Los trabajos e investigaciones científicas de IVI han sido galardonados con algunos de los premios más representativos de la profesión, como los otorgados por la American Society for Reproductive Medicine, la Society for Gynecological Investigation, la Fundación Salud 2000 o la Sociedad Española de Fertilidad.

Esto ha sido posible gracias al trabajo de un equipo multidisciplinar integrado por más de 2.000 profesionales altamente especializados en Ginecología, Obstetricia, Genética, Biología, Andrología, Cirugía, Medicina Materno-Fetal, Anestesia, etc. y es que en IVIRMA Global creemos que las personas que forman el Grupo son la razón de nuestro éxito como institución. Por ello, promovemos una cultura de desarrollo de personas que permitan a nuestro equipo llevar a cabo su trabajo con motivación. Nuestro compromiso es ofrecer el mismo nivel de excelencia a nuestros pacientes que a los profesionales que logran hacer sus sueños realidad.

Funciones

Para nuestra clínica de IVI Madrid seleccionamos un/a Auxiliar de Atención al Paciente para el equipo de Internacional.

La persona seleccionada se responsabilizará de recepcionar las consultas de pacientes internacionales, gestionar la agenda de citas, registrar la información de los pacientes, controlar que el historial está completo con todos los datos necesarios para la realización del tratamiento y posterior seguimiento. Así mismo coordinará con los médicos el seguimiento del paciente, atenderá sus dudas, quejas y reclamaciones, y recogerá sugerencias con la finalidad de resolverlas o canalizarlas al puesto adecuado de la organización.
Finalmente atenderá la centralita y emitirá las facturas correspondiente a los pago realizados por los pacientes.

Requisitos

:tps://ivi.epreselec.com/Ofertas/Ofertas.aspx?Id_Oferta=2224747 Página 1 de

IVI 30/12/19 14:27

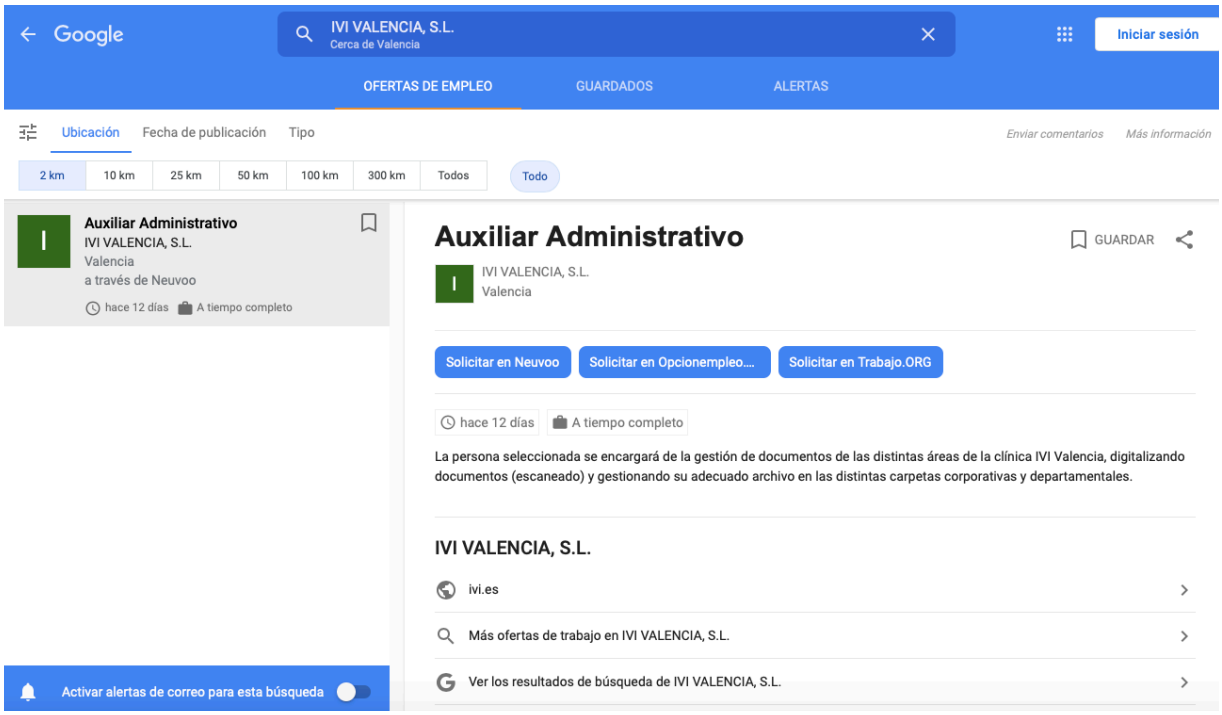
Buscamos un profesional con experiencia previa en puesto similar de al menos tres años, con nivel alto en italiano e inglés. Se valorará positivamente tener, además, conocimientos de francés y/o alemán. Comunicativo, empático, flexible y orientado al paciente. Con disponibilidad para trabajar en turno rotativos de mañana o de tarde.

Se ofrece

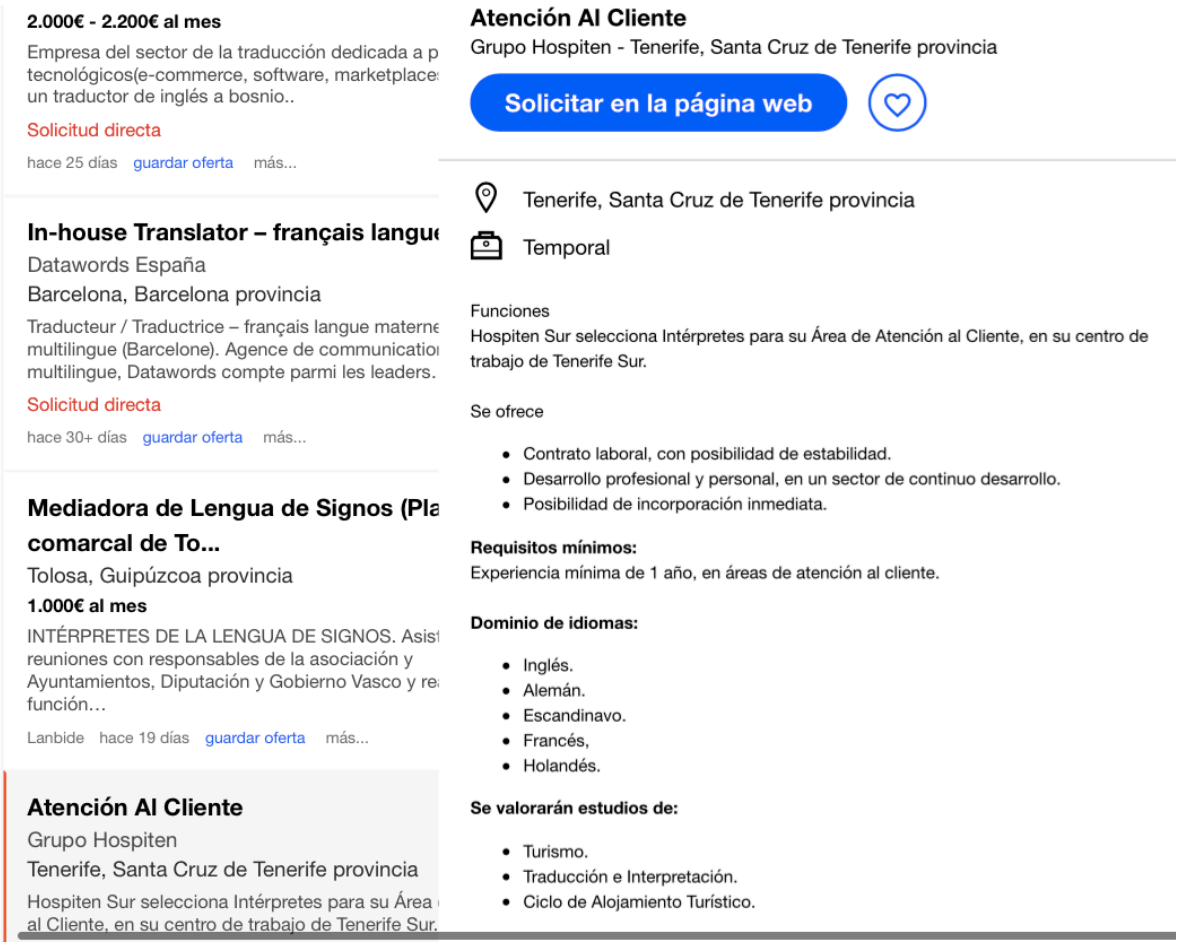
Te ofrecemos la posibilidad de incorporarte a un equipo humano de reconocido prestigio. Podrás unirte a una organización donde el capital humano es primordial y en la que tendrás la oportunidad de desarrollarte profesionalmente.

Inscribirme a esta oferta

APPENDIX C. SCREEN SHOT TAKEN FROM THE ORIGINAL JOB ADVERTISEMENT "AUXILIAR ADMINISTRATIVO"



APPENDIX D. SCREEN SHOT TAKEN FROM THE ORIGINAL JOB ADVERTISEMENT "ATENCIÓN AL CLIENTE"



APPENDIX E. SCREEN SHOT TAKEN FROM THE ORIGINAL JOB ADVERTISEMENT "ASISTENTE MEDICO INTERNACIONAL"

Ofertas de empleo (Ofertas.aspx)

IVI

(../Default.aspx)

Ofertas de empleo

ASISTENTE MEDICO INTERNACIONAL Barcelona

Inscribirme a esta oferta

Localidad: Barcelona
País: España

Provincia: Barcelona
Nº Vacantes (puestos): 1

Funciones

La persona seleccionada se responsabilizará de recepcionar las consultas de pacientes, gestionar la agenda de citas, registrar la información de los pacientes, controlar que el historial está completo con todos los datos necesarios para la realización del tratamiento y posterior seguimiento. Así mismo coordinará con los médicos el seguimiento del paciente, atenderá sus dudas, quejas y reclamaciones, y recogerá sugerencias con la finalidad de resolverlas o canalizarlas al puesto adecuado de la organización.

Requisitos

Buscamos un profesional con experiencia previa en puesto similar de al menos dos años, con alto nivel de Francés / Inglés, se valorará también el Alemán: comunicativo, empático, flexible y orientado al paciente.

Se ofrece

Te ofrecemos la posibilidad de incorporarte a un equipo humano de reconocido prestigio. Podrás unirte a una organización donde el capital humano es primordial y en la que tendrás la oportunidad de desarrollarte profesionalmente.

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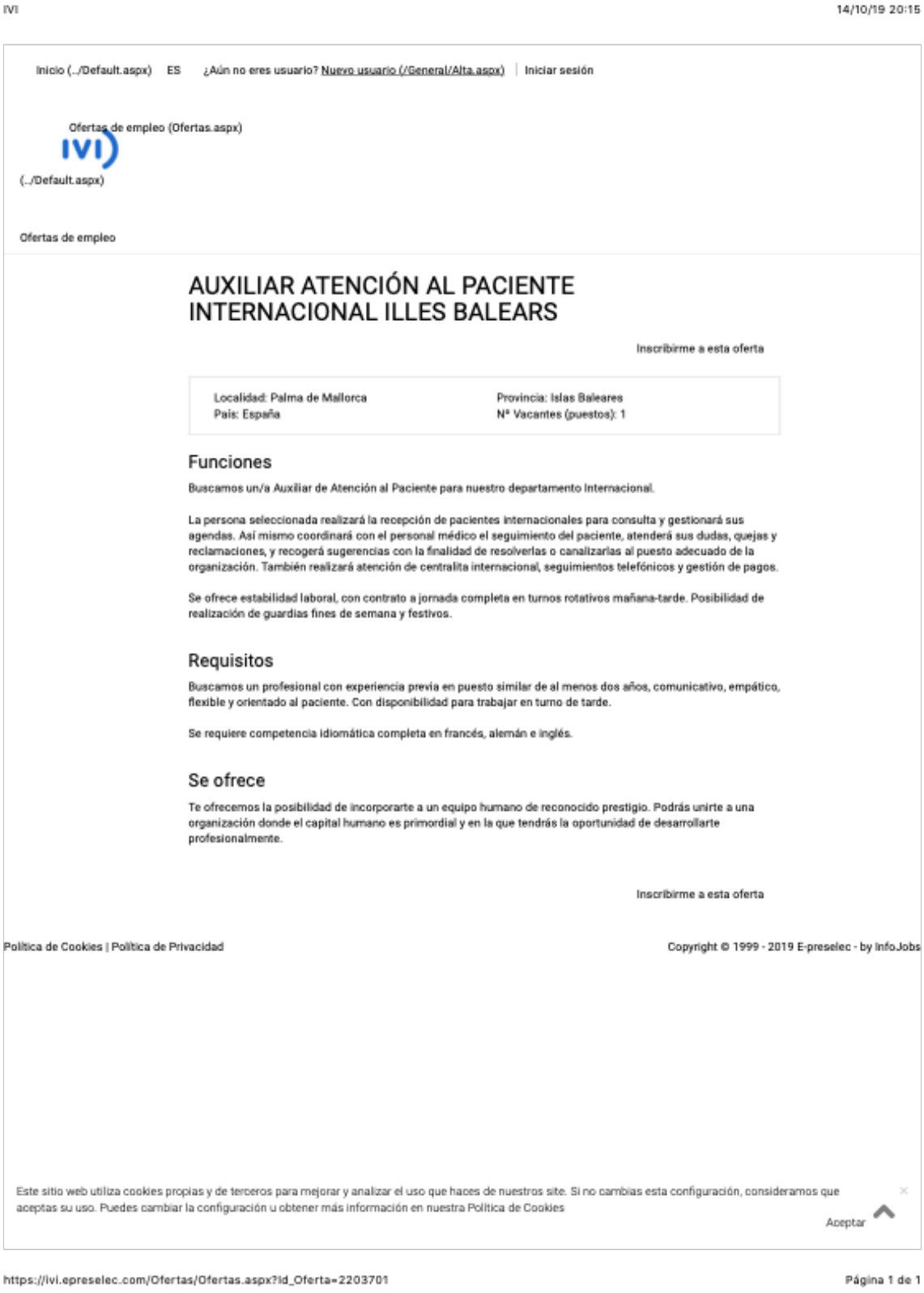
APPENDIX F. SCREEN SHOT TAKEN FROM THE ORIGINAL JOB ADVERTISEMENT "AUXILIAR ATENCIÓN AL PACIENTE INTERNACIONAL"



IVI 14/10/19 20:15

Inicio (../Default.aspx) ES ¿Aún no eres usuario? Nuevo usuario (/General/Alta.aspx) | Iniciar sesión

Ofertas de empleo (Ofertas.aspx)

(../Default.aspx)

Ofertas de empleo

AUXILIAR ATENCIÓN AL PACIENTE INTERNACIONAL ILLES BALEARS

Inscribirme a esta oferta

Localidad: Palma de Mallorca
País: España
Provincia: Islas Baleares
Nº Vacantes (puestos): 1

Funciones

Buscamos un/a Auxiliar de Atención al Paciente para nuestro departamento Internacional.

La persona seleccionada realizará la recepción de pacientes internacionales para consulta y gestionará sus agendas. Así mismo coordinará con el personal médico el seguimiento del paciente, atenderá sus dudas, quejas y reclamaciones, y recogerá sugerencias con la finalidad de resolverlas o canalizarlas al puesto adecuado de la organización. También realizará atención de centralita internacional, seguimientos telefónicos y gestión de pagos.

Se ofrece estabilidad laboral, con contrato a jornada completa en turnos rotativos mañana-tarde. Posibilidad de realización de guardias fines de semana y festivos.

Requisitos

Buscamos un profesional con experiencia previa en puesto similar de al menos dos años, comunicativo, empático, flexible y orientado al paciente. Con disponibilidad para trabajar en turno de tarde.

Se requiere competencia idiomática completa en francés, alemán e inglés.

Se ofrece

Te ofrecemos la posibilidad de incorporarte a un equipo humano de reconocido prestigio. Podrás unirte a una organización donde el capital humano es primordial y en la que tendrás la oportunidad de desarrollarte profesionalmente.

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Aceptar

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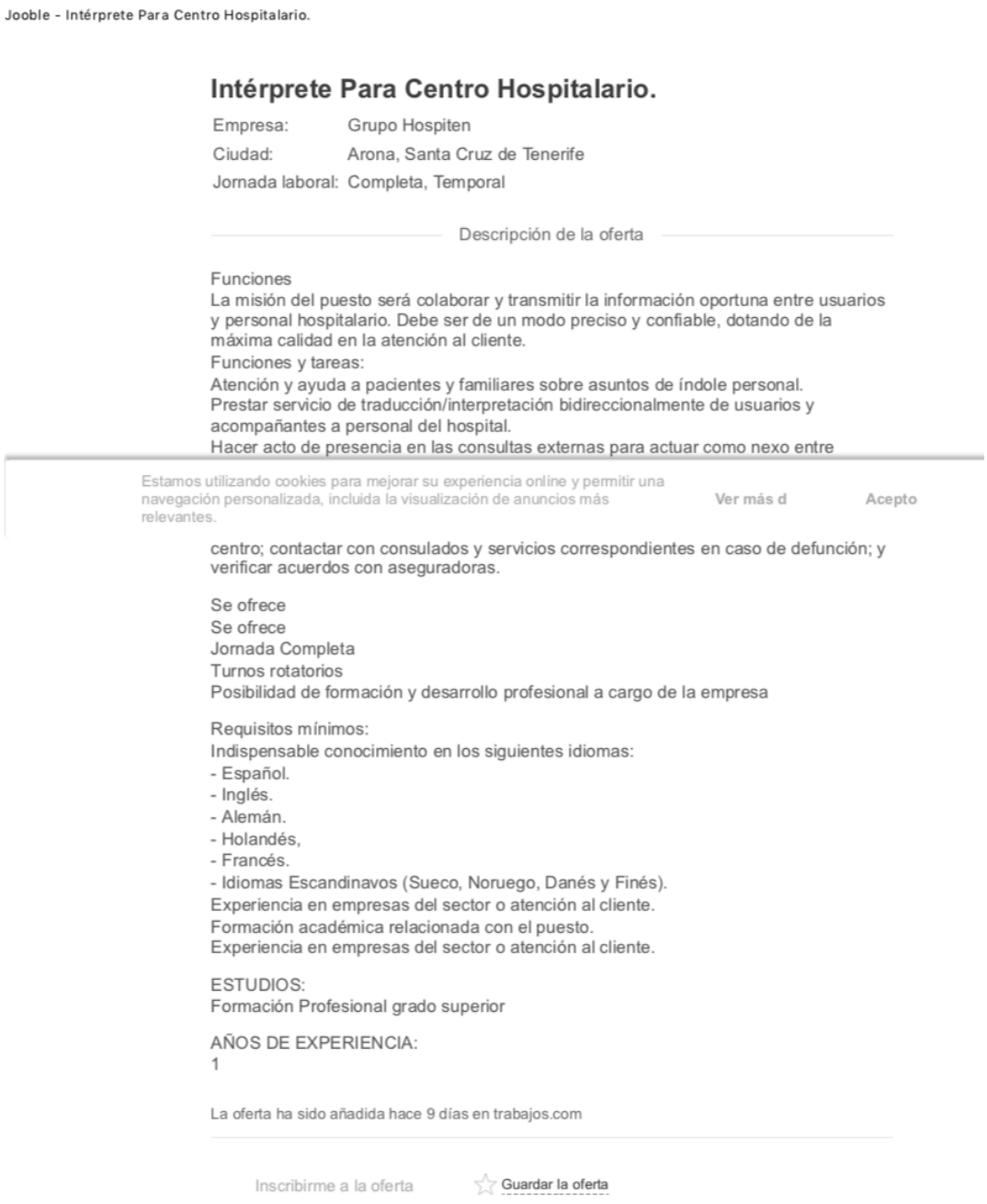
APPENDIX G. SCREEN SHOT TAKEN FROM THE ORIGINAL JOB ADVERTISEMENT "INTÉRPRETE PARA CENTRO HOSPITALARIO"



Jooble - Intérprete Para Centro Hospitalario.

Intérprete Para Centro Hospitalario.

Empresa: Grupo Hospiten
Ciudad: Arona, Santa Cruz de Tenerife
Jornada laboral: Completa, Temporal

Descripción de la oferta

Funciones
La misión del puesto será colaborar y transmitir la información oportuna entre usuarios y personal hospitalario. Debe ser de un modo preciso y confiable, dotando de la máxima calidad en la atención al cliente.
Funciones y tareas:
Atención y ayuda a pacientes y familiares sobre asuntos de índole personal.
Prestar servicio de traducción/interpretación bidireccionalmente de usuarios y acompañantes a personal del hospital.
Hacer acto de presencia en las consultas externas para actuar como nexo entre

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centro; contactar con consulados y servicios correspondientes en caso de defunción; y verificar acuerdos con aseguradoras.

Se ofrece
Se ofrece
Jornada Completa
Turnos rotatorios
Posibilidad de formación y desarrollo profesional a cargo de la empresa

Requisitos mínimos:
Indispensable conocimiento en los siguientes idiomas:
- Español.
- Inglés.
- Alemán.
- Holandés,
- Francés.
- Idiomas Escandinavos (Sueco, Noruego, Danés y Finés).

Experiencia en empresas del sector o atención al cliente.
Formación académica relacionada con el puesto.
Experiencia en empresas del sector o atención al cliente.

ESTUDIOS:
Formación Profesional grado superior

AÑOS DE EXPERIENCIA:
1

La oferta ha sido añadida hace 9 días en trabajos.com

Inscribirme a la oferta ☆ Guardar la oferta

Intérprete Para Centro Hospitalario.

Empresa: Grupo Hospiten
Ciudad: Santa Cruz de Tenerife
Jornada laboral: Completa, Temporal

Funciones
La misión del puesto será colaborar y transmitir la información oportuna entre usuarios y personal hospitalario. Debe ser de un modo preciso y confiable, dotando de la máxima calidad en la atención al cliente.
Funciones y tareas:
Atención y ayuda a pacientes y familiares sobre asuntos de índole personal.
Prestar servicio de traducción/interpretación bidireccionalmente de usuarios y acompañantes a personal del hospital.
Hacer acto de presencia en las consultas externas para actuar como nexo entre paciente y médico.
Llevar a cabo tareas de tipo administración y gestión tales como: gestionar las formas de pago con el paciente valorando las coberturas disponibles y confirmando a posteriori si el paciente cumple con las garantías de pago para la admisión en el centro; contactar con consulados y servicios correspondientes en caso de defunción; y verificar acuerdos con aseguradoras.

Se ofrece
Se ofrece
Jornada Completa
Turnos rotatorios
Posibilidad de formación y desarrollo profesional a cargo de la empresa

Requisitos mínimos:
Indispensable conocimiento en los siguientes idiomas:
- Español.
- Inglés.
- Alemán.
- Holandés,
- Francés.
- Idiomas Escandinavos (Sueco, Noruego, Danés y Finés).
Experiencia en empresas del sector o atención al cliente.
Formación académica relacionada con el puesto.
Experiencia en empresas del sector o atención al cliente.

ESTUDIOS:
Formación Profesional grado superior

AÑOS DE EXPERIENCIA:
1

La oferta ha sido añadida hace 8 días en trabajos.com

Inscribirme a la oferta ☆ Guardar la oferta

APPENDIX H. SCREEN SHOT TAKEN FROM THE ORIGINAL JOB ADVERTISEMENT "ATENCIÓN AL PACIENTE INTERNACIONAL"

De: tradmed@uji.es
Asunto: Oferta trabajo Departamento Internacional Corporativo de Quirónsalud
Fecha: 16 de diciembre de 2019, 9:34
Para: Bústia tradmed tradmed@uji.es
Cco: ninagavl@gmail.com

Buenos días:

Por si es de vuestro interés, os enviamos esta oferta de trabajo que nos ha llegado del Departamento Internacional Corporativo de Quirónsalud (Atención al paciente internacional). Están desarrollando un proyecto nuevo enfocado al sector turístico internacional y necesitan incorporar a alguien en el equipo con el siguiente perfil:

-Experto en traducción/interpretación médica inglés <> español
-Se valorarán segundos y terceros idiomas, en especial ruso, chino o árabe
-Manejo de Office a nivel usuario
-Experiencia en atención al cliente
-Se valorará experiencia previa en puesto similar y conocimiento de seguros internacionales

La persona seleccionada tendrá como funciones:
-Acompañamiento *premium* al paciente internacional
-Realización de labores administrativas derivadas de la atención sanitaria y gestión de coberturas de seguros internacionales
-Trabajo en equipo para facilitar la consecución de los objetivos del departamento

La oferta es en la ciudad de Madrid.

Si estáis interesados, mandad una copia de vuestro cv a la dirección: lucia.gomezp@quironsalud.es.

Un saludo.

Màster Universitari en Traducció Medicosanitària
Universitat Jaume I
Correu electrònic: tradmed@uji.es

APPENDIX I. SCREEN SHOT TAKEN FROM THE ORIGINAL JOB ADVERTISEMENT "AUX. ADMINISTRATIVO/A"

Aux. Administrativo/a Costa Adeje

Inscribirme a esta oferta

Localidad: Adeje
País: España
Nº Vacantes (puestos): 1
Tipo de oferta: Contrato

Provincia: Santa Cruz de Tenerife
Empresa: quirónsalud
Centro: Hospital Quirónsalud Costa Adeje

Descripción

Con más de 80 centros en toda España, Quirónsalud es la compañía líder en España en prestación de servicios sanitarios. Contamos con expertos de prestigio internacional en el ámbito biomédico y con un gran equipo de profesionales sanitarios y no sanitarios que trabaja día a día con el fin de ofrecer la mejor calidad asistencial y especializada de nuestro país.

En Quirónsalud queremos contar con el mejor talento profesional para seguir ofreciendo un servicio sanitario diferencial que se distinga por el cuidado de la salud persona a persona. Además de obtener una experiencia de gran valor en una compañía de prestigio, en Quirónsalud podrás formar parte de iniciativas realmente enriquecedoras, como nuestros programas de investigación o los planes personalizados de talento y desarrollo profesional, entre otras ventajas.

Un importante paso en tu carrera que te ayudará a crecer, evolucionar y a impulsar tu trayectoria profesional de la mano del mayor grupo hospitalario de España.

Funciones

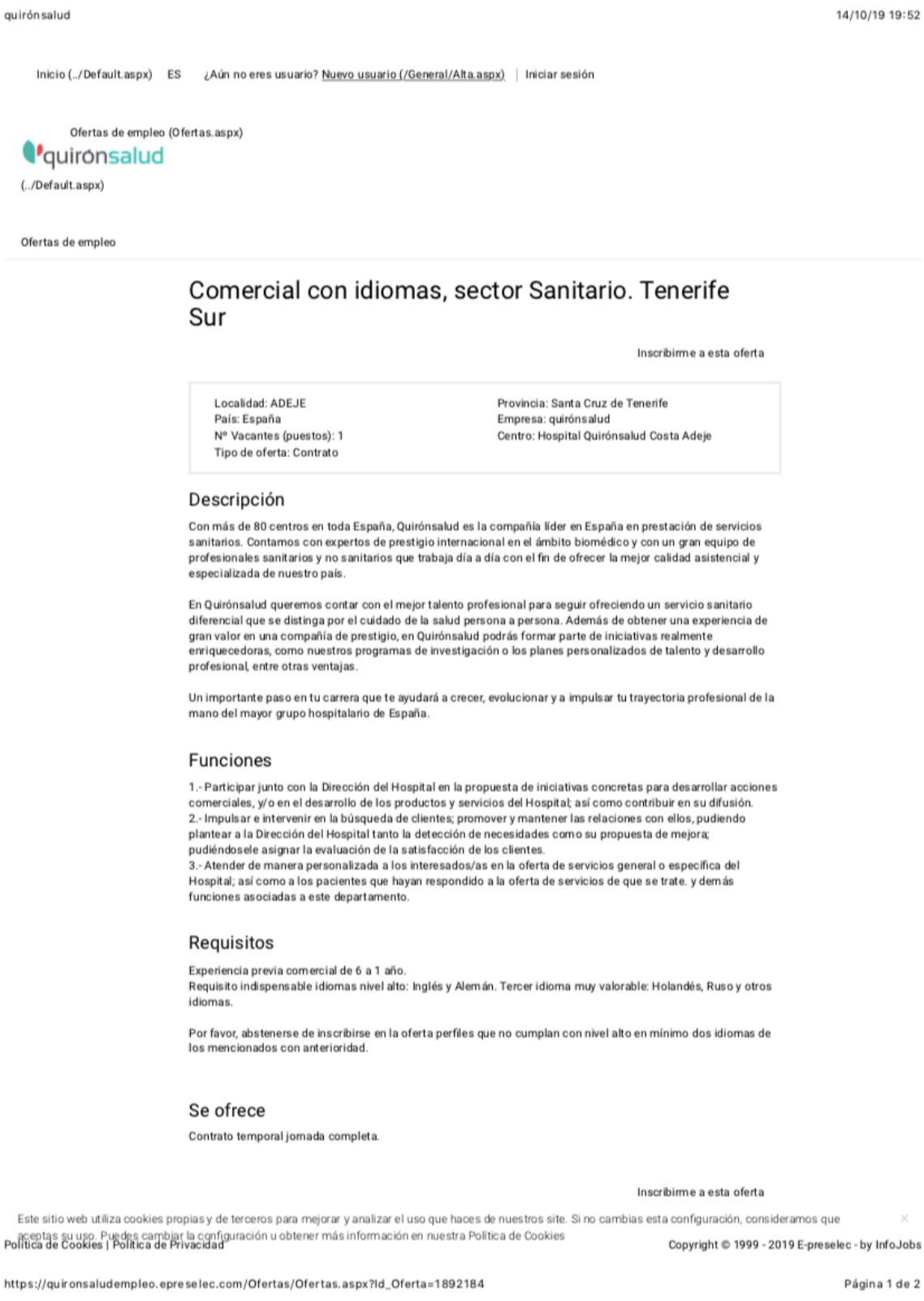
1.- Atender telefónicamente a las personas interesadas en la oferta de servicios del Hospital; especialmente a aquellas que responden a una oferta específica, asegurando una adecuada información al respecto.
2.- Coordinar la primera cita del interesado/a para la consulta externa, procurando responder a las preferencias y prioridades interesadas por éste; garantizando, en su caso, un tiempo mínimo de espera entre la llamada telefónica y la primera visita.
3.- Recepcionar al interesado/a en su primera visita al Hospital y entrevistarle asesorándole en torno a la oferta que le haya atraído; analizando las necesidades e intereses reales de éste.
4.- Colaborar con la Dirección del Hospital / Responsable de Comunicación y Marketing, en la propuesta de acciones comerciales y/o el desarrollo de productos y servicios del hospital.
5.- Elaborar informes y estadísticas de carácter mensual con la información suficiente respecto a la oferta de servicios: especialidades y tratamientos más demandados, número de personas que han contactado mediante una llamada, número de personas que han contactado telefónicamente y han acudido al Hospital, número de personas que habiendo contactado y acudido al Hospital han rechazado finalmente la oferta de servicios, número de personas que han contacto, acudido al Hospital y suscrito la oferta de servicios, etc.
6.- Contribuir, junto con la Dirección Médica del Hospital, en la difusión de la oferta de servicios entre el colectivo de profesionales médicos, favoreciendo una relación profesional óptima que facilite una ágil gestión de citas y una atención personalizada.
7.- Ser proactivo en la identificación y comunicación de las sugerencias, no conformidades, riesgos, etc. detectados en el área de trabajo. Cumplir con los procedimientos e instrucciones de trabajo de aplicación en sus procesos, incluidas las normas de seguridad y salud laboral. Cumplimentar los registros necesarios en el desarrollo de su trabajo.

Requisitos

- Inglés Nivel Bilingüe.
- Valorable otros idiomas

Se ofrece

APPENDIX J. SCREEN SHOT TAKEN FROM THE ORIGINAL JOB ADVERTISEMENT "COMERCIAL CON IDIOMAS, SECTOR SANITARIO"



quirónsalud 14/10/19 19:52

Inicio (../Default.aspx) ES ¿Aún no eres usuario? Nuevo usuario (/General/Alta.aspx) | Iniciar sesión

Ofertas de empleo (Ofertas.aspx)

quirónsalud

(../Default.aspx)

Ofertas de empleo

Comercial con idiomas, sector Sanitario. Tenerife Sur

Inscribirme a esta oferta

Localidad: ADEJE
País: España
Nº Vacantes (puestos): 1
Tipo de oferta: Contrato

Provincia: Santa Cruz de Tenerife
Empresa: quirónsalud
Centro: Hospital Quirónsalud Costa Adeje

Descripción

Con más de 80 centros en toda España, Quirónsalud es la compañía líder en España en prestación de servicios sanitarios. Contamos con expertos de prestigio internacional en el ámbito biomédico y con un gran equipo de profesionales sanitarios y no sanitarios que trabaja día a día con el fin de ofrecer la mejor calidad asistencial y especializada de nuestro país.

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Un importante paso en tu carrera que te ayudará a crecer, evolucionar y a impulsar tu trayectoria profesional de la mano del mayor grupo hospitalario de España.

Funciones

1.- Participar junto con la Dirección del Hospital en la propuesta de iniciativas concretas para desarrollar acciones comerciales, y/o en el desarrollo de los productos y servicios del Hospital; así como contribuir en su difusión.
2.- Impulsar e intervenir en la búsqueda de clientes; promover y mantener las relaciones con ellos, pudiendo plantear a la Dirección del Hospital tanto la detección de necesidades como su propuesta de mejora; pudiéndosele asignar la evaluación de la satisfacción de los clientes.
3.- Atender de manera personalizada a los interesados/as en la oferta de servicios general o específica del Hospital; así como a los pacientes que hayan respondido a la oferta de servicios de que se trate. y demás funciones asociadas a este departamento.

Requisitos

Experiencia previa comercial de 6 a 1 año.
Requisito indispensable idiomas nivel alto: Inglés y Alemán. Tercer idioma muy valorable: Holandés, Ruso y otros idiomas.

Por favor, abstenerse de inscribirse en la oferta perfiles que no cumplan con nivel alto en mínimo dos idiomas de los mencionados con anterioridad.

Se ofrece

Contrato temporal jornada completa.

Inscribirme a esta oferta

Este sitio web utiliza cookies propias y de terceros para mejorar y analizar el uso que haces de nuestros site. Si no cambias esta configuración, consideramos que aceptas su uso. Puedes cambiar la configuración u obtener más información en nuestra Política de Cookies

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https://quironsaludempleo.epreselec.com/Ofertas/Ofertas.aspx?Id_Oferta=1892184 Página 1 de 2

APPENDIX K. SCREEN SHOT TAKEN FROM THE ORIGINAL JOB ADVERTISEMENT "TRADUCTOR/A ÁRABE Y/O RUSO – FREELANCE"

Traductor/a árabe y/o ruso - freelance

Empresa: Sha Wellness Clinic
Ciudad: Alicante
Jornada laboral: Temporal

Descripción de la oferta

OBJETIVO
Apoyo al area de Clinica y Wellness en todos los requerimientos relacionados con Traducciones y/o Interpretanciones que surgan en la organizacion.

Trabajaras de la mano con equipos internacionales dentro de las areas de Clinica y Wellness para ofrecer al huesped el mejor servicio posible durantes sus consultas medicas o tratamientos.

Requisitos

Titulación mínima: Diplomatura
Experiencia: De 2 a 3 años
Categoría profesional: Empleado
Residencia: Provincia vacante

La oferta ha sido añadida hace 1 mes en turijobs.com

Traductor/a árabe y/o ruso - freelance

Empresa: Sha Wellness Clinic
Ciudad: Alicante
Jornada laboral: Temporal

Descripción de la oferta

OBJETIVO
Apoyo al area de Clinica y Wellness en todos los requerimientos relacionados con Traducciones y/o Interpretanciones que surgan en la organizacion.

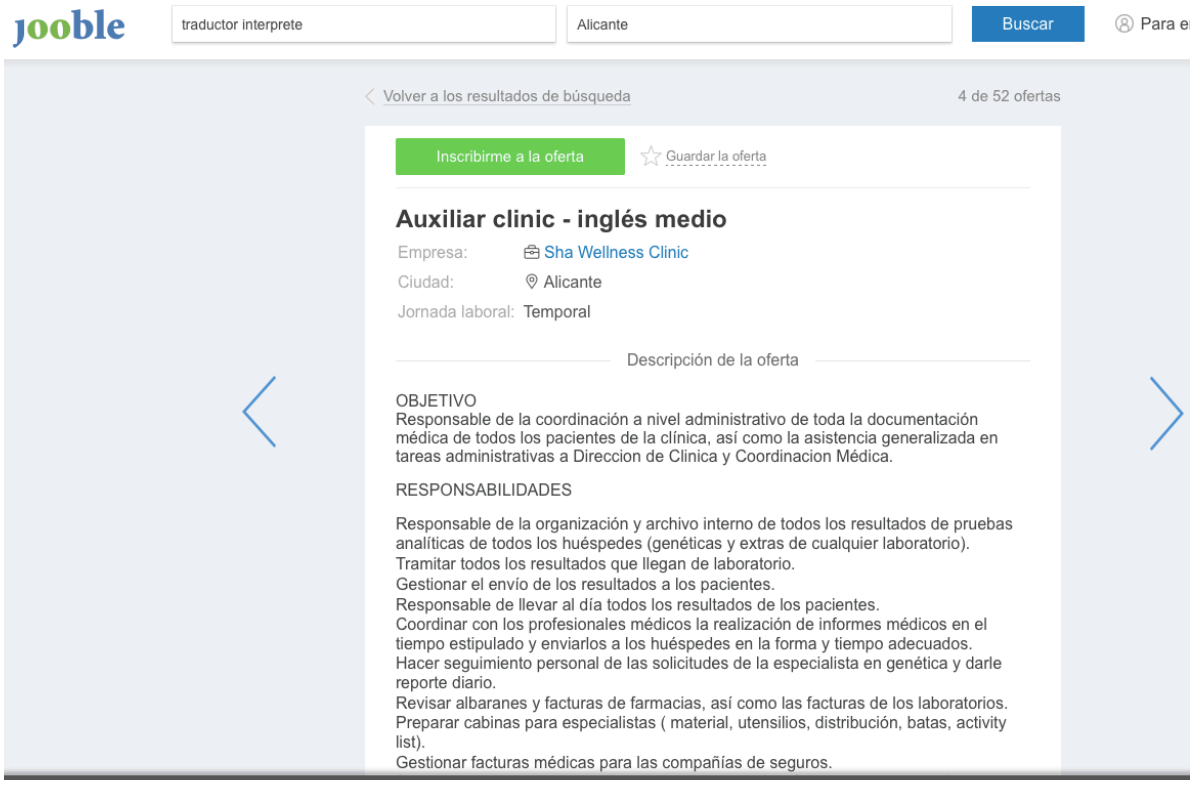
Trabajaras de la mano con equipos internacionales dentro de las areas de Clinica y Wellness para ofrecer al huesped el mejor servicio posible durantes sus consultas medicas o tratamientos.

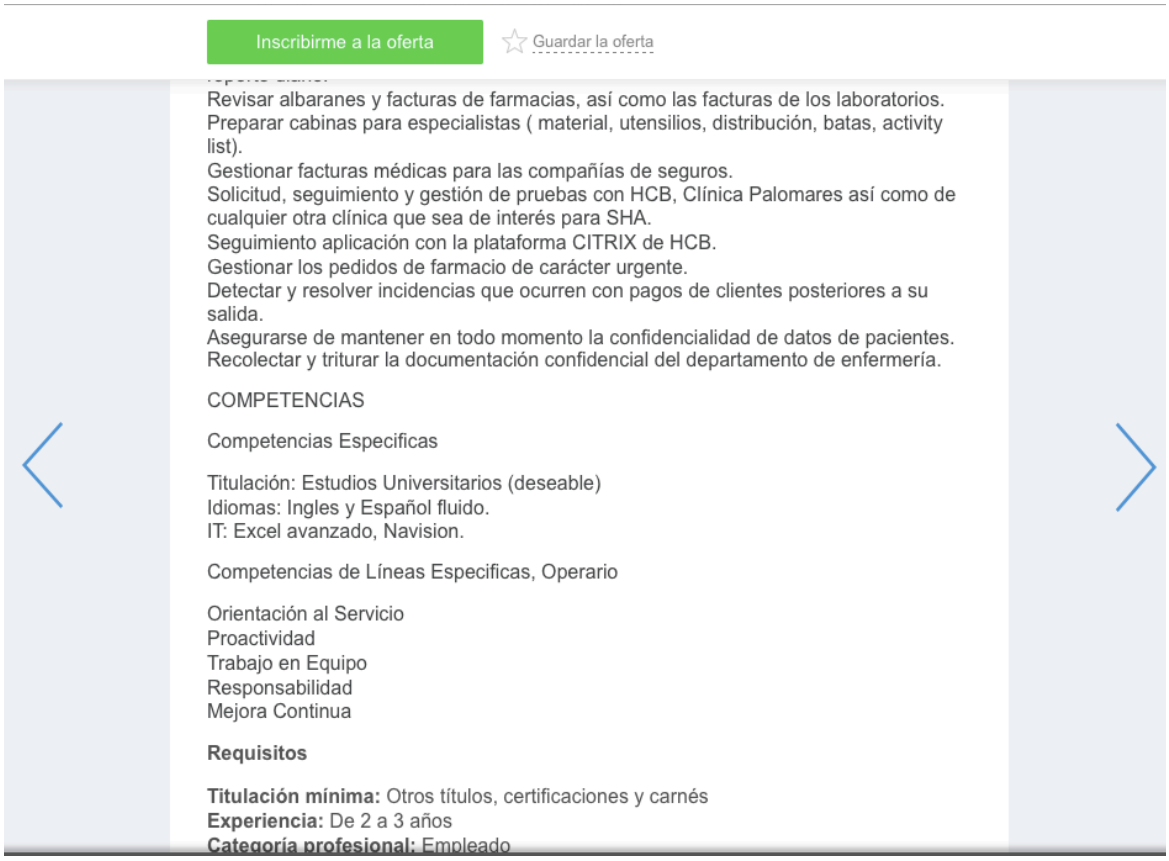
Requisitos

Titulación mínima: Diplomatura
Experiencia: De 2 a 3 años
Categoría profesional: Empleado
Residencia: Provincia vacante

La oferta ha sido añadida hace 1 mes en turijobs.com

APPENDIX L. SCREEN SHOT TAKEN FROM THE ORIGINAL JOB ADVERTISEMENT "AUXILIAR CLÍNICO – INGLÉS MEDIO"





APPENDIX M. SCREEN SHOT TAKEN FROM THE ORIGINAL JOB ADVERTISEMENT "HACEN FALTA 15 PERSONAS QUE HABLEN ALEMÁN Y ESPAÑOL. VAN A MANDAR MÉDICOS Y ENFERMERAS DE ALEMANIA PARA AYUDAR"

APPENDIX N. NON-DISPARAGEMENT AGREEMENT

According to which total anonymity of the participants and centres must be guaranteed for confidentiality reasons due to the sensitivity of data bieng analysed

UNIVERSITAT JAUME I
Facultat de Ciències Humanes i Socials · FCHS
Departament de Traducció i Comunicació

A QUIEN CORRESPONDA:

María Jesús Blasco Mayor, profesora del Departamento de Traducción de la Universitat Jaume I de Castello, Vicedecana del Grado en Traducción e Interpretación y Directora de la Tesis Doctoral de la interesada

HAGO CONSTAR Que doña **NINA GAVLOVYCH** está cursando en nuestra Universidad el Programa de Estudios de Doctorado "Lenguas Aplicadas, Literatura y Traducción".

Asimismo, hago constar que está realizando la tesis doctoral bajo mi supervisión y que el título de la misma es "La calidad de los servicios de interpretación en el contexto de turismo de salud de la Comunidad Valenciana". A tal efecto, necesita realizar una serie de cuestionarios y entrevistas a médicos, pacientes e intérpretes. Ruego, por tanto, le faciliten la realización de dichos cuestionarios que serán anónimos y únicamente se utilizarán con fines de investigación.

Y para que conste, firmo este documento,

María Jesús Blasco Mayor
Vicedecana del Grado en Traducción e Interpretación
Directora de la Tesis Doctoral de la interesada

Castellón de la Plana, 29 de enero de 2018.

APPENDIX O. QUESTIONNAIRE INTENDED FOR MEDICAL WORKERS PAGE 1

Encuesta sobre la traducción y la interpretación en los servicios médico-sanitarios en el ámbito de sanidad privada dentro del contexto de turismo de salud

Solicito su colaboración en esta investigación para la elaboración de mi tesis doctoral que llevo a cabo como estudiante del programa de Doctorado en Lenguas Aplicadas, Literatura y Traducción de la Universidad Jaume I e intérprete, traductora y asistente médico de este centro hospitalario. El objeto de este cuestionario es analizar la comunicación entre los profesionales de la salud y las personas usuarias de lengua extranjera. Su participación es plenamente voluntaria y consistirá en responder a las preguntas del siguiente cuestionario. Los datos recogidos no serán empleados con otro fin que no sea el de cumplir con los objetivos de investigación y en ningún caso se revelará el nombre de las personas que participen. Asimismo, en ninguna publicación de los resultados obtenidos se ofrecerán datos que puedan ayudar a identificar a los/as participantes, manteniendo de este modo su anonimato. Agradezco encarecidamente su colaboración.

1. **Edad**

2. **Sexo**
   Mark only one oval.
   - ◯ Hombre
   - ◯ Mujer

3. **Nombre del puesto/cargo que ocupa:**

4. **Experiencia (años) en este puesto o en puestos similares:**

Valore sus conocimientos de idiomas marcando en la siguiente tabla la opción correspondiente para cada lengua:

APPENDIX P. QUESTIONNAIRE INTENDED FOR MEDICAL WORKERS PAGE 2

	Poco	Regular	Bien	Muy bien	Nativo/Bilingüe
Inglés					
Francés					
Alemán					
Árabe					
Ruso					
Chino					
Otros:					

5. **En caso de dominar otro idioma distinto al de los citados anteriormente, indique cuál(es) son y su nivel:**

6. **Indique si a su trabajo acuden o han acudido personas usuarias que no hablan español:**
   Mark only one oval.
   - ◯ Sí
   - ◯ No
   - ◯ No lo sé

7. **Describa qué colectivos de personas usuarias que no dominan el español suelen requerir atención en su lugar de trabajo:**
   Tick all that apply.
   - ☐ Turistas (en el sentido convencional/tradicional de la palabra)
   - ☐ Extranjeros/as residentes regularizados
   - ☐ Extranjeros/as residentes no regularizados
   - ☐ Usuarios del turismo de salud
   - ☐ Otros

8. **Indique si se han experimentado problemas de comunicación con las personas usuarias de lengua extranjera:**
   Mark only one oval.
   - ◯ Sí
   - ◯ No
   - ◯ No lo sé

APPENDIX Q. QUESTIONNAIRE INTENDED FOR MEDICAL WORKERS PAGE 3

9. **En caso afirmativo, indique cuáles de los siguientes problemas han surgido:**
Tick all that apply.

- [ ] Los pacientes no se podían expresar en español de una manera comprensible
- [ ] Los pacientes no entendían las preguntas que les hacía el médico
- [ ] Había frecuentes malentendidos
- [ ] Otras personas como amigos o familiares actuaban como intérpretes ad hoc dificultando la comunicación
- [ ] Otras personas hablaban por los pacientes
- [ ] Los pacientes se ponían nerviosos o agresivos
- [ ] Los pacientes se sentían cohibidos y no se atrevían a hablar
- [ ] Los pacientes no se encontraban en condiciones de poder comunicarse (shock, coma, inconscientes, etc.)
- [ ] El médico no quería trabajar con el intérprete
- [ ] El médico no sabía cómo trabajar con un intérprete
- [ ] Otros (por favor, especifique cuáles)_____

10. **En caso de haber seleccionado otros, indique qué tipo de problema se ha presentado y con qué frecuencia:**

_____

11. **En los casos en los que ha habido problemas de comunicación, indique cómo se han resuelto:**
Tick all that apply.

- [ ] Por gestos
- [ ] Recurriendo a un compañero/a que se puede comunicar con el paciente en su idioma
- [ ] Recurriendo a alguien externo que se puede comunicar con el paciente en su idioma
- [ ] Pidiéndole al paciente que traiga a alguien que le ayude
- [ ] Pidiéndole al paciente que llame a alguien por teléfono para que haga de intérprete
- [ ] Con un software multilingüe (p. ej. traductor automático)
- [ ] Llamando al/ a la intérprete correspondiente
- [ ] Otros_____

APPENDIX R. QUESTIONNAIRE INTENDED FOR MEDICAL WORKERS PAGE 4

12. **Indique si en su trabajo se requieren o se han requerido servicios de traducción (de textos escritos) para poder atender a los pacientes que no hablan español:**
Mark only one oval.

- ◯ Sí
- ◯ No
- ◯ No lo sé

13. **En caso afirmativo, indique con qué frecuencia aproximada se han requerido servicios de traducción:**
Mark only one oval.

- ◯ Diariamente
- ◯ Semanalmente
- ◯ Mensualmente
- ◯ Esporádicamente
- ◯ Otros: _____

14. **En caso afirmativo, indique para qué tipo de documentos se han requerido los servicios de traducción (textos especializados o semi-especializados: informes médicos, voluntades anticipadas; textos de carácter divulgativo, etc.):**

_____

_____

_____

_____

_____

15. **Indique si en su trabajo se requieren o se han requerido servicios de interpretación lingüística para poder atender a los pacientes que no hablan español:**
Mark only one oval.

- ◯ Sí
- ◯ No
- ◯ No lo sé

APPENDIX S. QUESTIONNAIRE INTENDED FOR MEDICAL WORKERS PAGE 5

16. **En caso afirmativo, indique con qué frecuencia aproximada se han requerido los servicios de interpretación lingüística:**
Mark only one oval.

- ◯ Diariamente
- ◯ Semanalmente
- ◯ Mensualmente
- ◯ Esporádicamente
- ◯ Other_____

17. **En el caso de contar con traductores/as o intérpretes profesionales, indique el protocolo de contratación:**
Mark only one oval.

- ◯ Registro de traductores e intérpretes autónomos
- ◯ A través de una empresa de traducción subcontratada/licitada
- ◯ Interpretación telefónica ofrecida por empresa subcontratada/licitada
- ◯ Libre designación
- ◯ Otros

18. **Si ha experimentado problemas al trabajar con intérpretes profesionales indique cuáles:**
Mark only one oval.

- ◯ No tiene la certeza de que el/la intérprete haya entendido plenamente al profesional o al paciente
- ◯ El/la intérprete modifica el mensaje
- ◯ El/la intérprete toma partido (aconseja, asesora)
- ◯ El/la intérprete interrumpe a los interlocutores
- ◯ El/la intérprete mantiene conversaciones con el paciente que luego no traduce
- ◯ El paciente y el intérprete utilizan diferentes variantes dialectales, hecho que dificulta la comunicación
- ◯ Falta de disponibilidad horaria de los/las intérpretes en plantilla
- ◯ Desconocimiento del lenguaje y terminología especializados por parte del/ de la intérprete
- ◯ El servicio de interpretación telefónica (si lo hay) es muy complicado de usar
- ◯ No le genera confianza que el/la intérprete telefónico no se encuentre presente en la conversación
- ◯ Se pierde mucho tiempo para conectarse con el/la intérprete
- ◯ Dificultad para encontrar intérpretes de un cierto idioma
- ◯ Otros_____

APPENDIX T. QUESTIONNAIRE INTENDED FOR MEDICAL WORKERS PAGE 6

19. **Indique qué cualificación/cualificaciones considera que debe poseer el traductor/a o el intérprete para poder ofrecer un servicio adecuado (marque tantas opciones como considere necesario):**
Tick all that apply.

- [ ] Grado o Licenciatura en Traducción e Interpretación
- [ ] Máster o Posgrado universitario en otra disciplina diferente a la Traducción e Interpretación
- [ ] Grado o Licenciatura en Lenguas (Filología, Lenguas modernas)
- [ ] Conocimiento acreditado de las lenguas de trabajo
- [ ] Grado o Licenciatura en otra disciplina no lingüística
- [ ] Cursos de especialización universitarios
- [ ] Máster o Posgrado universitario en Traducción e Interpretación
- [ ] Máster o Posgrado universitario en Traducción e Interpretación médica
- [ ] Es suficiente un buen conocimiento de la/las lengua/s de trabajo aunque no esté acreditado
- [ ] Otros (indique cuál, por favor):

20. **¿Sabe si se realiza algún tipo de control de calidad del servicio que ofrecen los traductores/as o intérpretes?**
Mark only one oval.

- ◯ Sí
- ◯ No
- ◯ No lo sé

21. **En caso afirmativo, indique qué tipo de controles de calidad se realizan:**

_____

22. **En su opinión ¿cuál sería el proceso de contratación de servicios lingüísticos que garantizaría una mayor calidad y rapidez en el ámbito médico sanitario?**

_____

_____

_____

_____

_____

APPENDIX U. QUESTIONNAIRE INTENDED FOR MEDICAL WORKERS PAGE 7

23. **¿Qué cualidades personales y profesionales cree que debe poseer una persona para poder ejercer de intérprete médico sanitario?**

24. **¿Qué funciones cree que debe tener un intérprete médico sanitario para garantizar una mayor calidad y mejorar el funcionamiento de los servicios que se proporcionan en este centro sanitario?**
Mark only one oval.

- ◯ Auxiliar Administrativo o trabajadores/as que, sin iniciativa ni responsabilidad, se dedican a los servicios auxiliares de la administración.
- ◯ Auxiliar con funciones médico-sanitarias que facilita el trabajo del médico y/o personal de enfermería involucrándose en el proceso del diagnóstico y tratamiento del paciente
- ◯ Tareas meramente lingüísticas: interpretación absolutamente objetiva y neutra en consulta con el médico y con el paciente
- ◯ Otros (especifique cuáles, por favor):

25. **Si desea añadir algún otro comentario relacionado con los temas tratados en el presente cuestionario, puede añadirlo a continuación:**

APPENDIX V. QUESTIONNAIRE INTENDED FOR MEDICAL INTERPRETERS PAGE 1

Encuesta sobre los servicios de la interpretación y traducción en el ámbito médico-sanitario privado dentro del contexto de turismo de salud dirigida a intérpretes médico-sanitarios

Rogamos conteste las siguientes preguntas sobre su perfil profesional. Los datos recogidos no serán empleados con otro fin que no sea el de cumplir con los objetivos de la presente investigación y en ningún caso se revelará la identidad de las personas que participen. Asimismo, en ninguna publicación de los resultados obtenidos se ofrecerán datos que puedan ayudar a identificar a los/las participantes manteniendo de este modo su absoluto anonimato. Agradezco encarecidamente su colaboración.

*Required

1. **Sexo**
   Mark only one oval.
   - ◯ Hombre
   - ◯ Mujer

2. **Edad** *

3. **¿Cuál es su formación?** *

4. **¿Cuáles son sus lenguas de trabajo?** *

APPENDIX W. QUESTIONNAIRE INTENDED FOR MEDICAL INTERPRETERS PAGE 2

5. **¿Qué formación/acreditación recibió en sus lenguas de trabajo o cómo aprendió sus lenguas de trabajo?** *

6. **Años de experiencia como traductor/a, intérprete en el ámbito médico-sanitario:**

7. **¿Ha recibido usted formación específica de traducción e interpretación médico-sanitaria?**

8. **¿Cómo calificaría usted el tipo de tareas que realiza diariamente?** *
Mark only one oval.

- ◯ Auxiliar Administrativo o trabajadores/as que, sin iniciativa ni responsabilidad, se dedican a los servicios auxiliares de la administración.
- ◯ Auxiliar con funciones médico-sanitarias que facilita el trabajo del médico y/o personal de enfermería involucrándose en el proceso del diagnóstico y tratamiento del paciente
- ◯ Tareas meramente lingüísticas: interpretación absolutamente objetiva y neutra en consulta con el médico y con el paciente
- ◯ Otros:

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APPENDIX X. QUESTIONNAIRE INTENDED FOR PATIENTS PAGE 1

Survey Form on Medical Interpretation Services in private clinics within the context of medical tourism in Spain

Please take a few minutes to complete this form and return it to us as soon as possible. All information is confidential.

1. **Name (optional)**

2. **Age**

3. **Nationality**

4. **Native language**

5. **Gender**
   Mark only one oval.
   - ◯ Male
   - ◯ Female

6. **Do you think private hospitals should provide medical interpretation services for non-Spanish speaking patients?**
   Mark only one oval.
   - ◯ Yes
   - ◯ No

7. **Have you considered medical interpretation service to be useful in terms of facilitating your communication with the doctor?**
   Mark only one oval.
   - ◯ Yes
   - ◯ No

APPENDIX Y. QUESTIONNAIRE INTENDED FOR PATIENTS PAGE 2

8. **Do you consider it to be necessary for a medical interpreter to be a certified professional?**
   Mark only one oval.
   - ◯ Yes
   - ◯ No

9. **If so, do you think they should receive a university education, such as a bachelor´s or master´s degree?**
   Mark only one oval.
   - ◯ Yes
   - ◯ No

Immediate Evaluation

I would like to get your feedback on the medical interpretation you have just received.

10. **Please, rate my performance from 1 to 5 (1=very poor; 2=poor; 3=good; 4=very good; 5=excellent)**
    Mark only one oval.

	1	2	3	4	5	
Very poor	◯	◯	◯	◯	◯	Excellent

11. **Comments**

Powered by Google Forms

APPENDIX Z. TRANSCRIPTION CONVENTIONS DU BOIS

Du Bois: Comparison of Transcription Symbols

Comparison of Transcription Symbols

	MEANING	DT1	DT2	CA
Unit				
1.	word	SPACE	SPACE	SPACE
2.	intonation unit	LINE	LINE	
Pause				
3.	pause, timed	...(1.2)	(1.2)	(1.2)
4.	pause, short	..	..	(.)
5.	pause, long (untimed)	...	...	
6.	latching	(0)	=	=
7.	lag (prosodic length)	=	:	:
Sequence				
8.	overlap (single)	[ ]	[ ]	[ ]
9.	overlap (2nd)	[2 2]	[2]	[ ]
Disfluency				
10.	truncated/cut-off word	wor-	wor–	wor-
Vocalism				
11.	breathe (in)	(H)	(H)	.hhh
12.	exhale	(Hx)	(Hx)	hhh
13.	vocalism	(SNIFF)	(SNIFF)	(sniffle)
14.	click	(TSK)	(TSK)	.t
15.	laugh pulse	@	@	heh
16.	laughing word	wo@rd	wo@rd	wo(h)rd
17.	glottal stop, creak	%	(%)	
18.	glottalized word	w%ord	w%ord	w*gh*ord
Manner/Quality				
19.	manner/long feature	<A A>	<A> </A>	
20.	vox	<Q Q>	<VOX> </VOX>	
21.	piano, attenuated speech	<P P>	°words°	°words°
22.	smile quality	<SM SM>	<☺> </☺>	£
Metatranscription				
23.	unintelligible	XXX	###	( )
24.	uncertain	<X word X>	#word	(word)
25.	comment	((WORDS))	((WORDS))	((words))
26.	pseudograph		~Jill	
Participation				
27.	speaker/turn attribution	JILL:	JILL;	Jill:
28.	unidentified speaker	X:	#;	( ):
29.	uncertain speaker		#JILL;	(Jill):
Boundary/Closure				
30.	terminative	.	.	.
31.	continuative	,	,	,
32.	truncated intonation unit	--	—	
33.	appeal (final)	?	?.	?
34.	appeal (continuing)	?	?,	*?*
Prosody				
35.	primary accent	^	^	word
36.	secondary accent	`	`	word
37.	forte	<F word F>	<F> word </F>	WORD
38.	high pitch (top)		⤒	↑
39.	high pitch		↑	word
40.	low pitch		↓	
41.	low pitch (bottom)		⤓	↓