Non-professional volunteer interpreting as an institutionalized practice in healthcare: a study on interpreters' personal narratives

Maria Aguilar-Solano
University of Massachusetts Boston
maria.aguilar-solano@umb.edu

Abstract: This article discusses the process of institutionalization of a migrant-oriented NGO where volunteers work as non-professional interpreters and where this had led to the integration of volunteer interpreting services in two hospitals in the Costa del Sol region in southern Spain. It explores the processes of socialization of volunteers and institutionalization of interpreters, leading to the development of an official NGO, drawing on the personal narratives of volunteers collected through focus groups and participant observation. The article begins by looking at the early stages of socialization of volunteers, through which they internalize the field structures and a series of dispositions shaped by empathy and compassion, resulting in volunteers adopting different positions available to them such as interpreters, caretakers and patient advocates. After the initial process of socialization, a process of institutionalization was requested by the regional government for the official establishment of the NGO. Drawing up the constitution of the now official NGO entailed the bureaucratization of the volunteers' position as interpreters, which provided them with a series of assets and the legitimization of their activity as institutional agents. This study demonstrates how in this particular case volunteer non-professional interpreting became essential for the institutions in which the services are provided. The volunteer interpreters of this NGO are now legitimate institutional agents with a strong degree of professional autonomy that allows them to adopt a series of positions that belong to the domain of intercultural mediators and cultural brokers.

Keywords: volunteerism, non-professional interpreters, healthcare provision, institutionalization, and focus groups.

1. Introduction

Non-professional interpreters often provide an essential service in multilingual societies that lack professional interpreting services (Baraldi & Gavioli, 2014). In some European countries non-professional interpreting services, often found in migrant-oriented NGOs, tend to be conceived primarily as a form of intercultural mediation, a modality that goes beyond linguistic mediation, even though this is one of the principal tasks carried out by the volunteers (Valero-Garcés, 2008). However, these interpreters generate trust among service users by adopting additional roles such as caretakers and patient advocates.[1] These roles adopted by migrant-oriented NGOs more and more often seem to be considered as a valid option for bridging the cross-cultural communication gap in healthcare settings in countries such as Italy and Spain, where interpreters are encouraged to serve as cultural brokers or intercultural mediators (Pöchhacker, 2008).

---

[1] See Edwards, Temple, & Alexander, 2005; Hsieh, Ju, & Kong, 2010; Robb & Greenhalgh, 2006; Rosenberg, Seller, & Leanza, 2008.

Despite their significant contribution to supporting the construction of multilingual societies, non-professional interpreters are often marginalized from mainstream research for fear that they may further damage the professional status of public service interpreting (Baraldi & Gavioli, 2014). Research into non-professional interpreting based on the critical analysis of audio-recorded interpreter-mediated events has provided valuable data on such interpreter performance and the perception of service providers and service users of their services.[2] The researchers conducting these studies generally point out the interpreters' lack of professional training, interpreting skills and awareness of issues such as medical confidentiality, impartiality, and neutrality, and emphasize the negative consequences of the services rendered by non-professional interpreters.[3] However, the existing literature offers little help in revealing how non-professional interpreting is organized and structured more concretely, and how agents position themselves, are positioned or are encouraged to position themselves in the public institutions in which they operate. Very little has been done to explore the experiences and self-perceived role of non-professional interpreters and to place them within the larger field of public service interpreting (hereinafter PSI) as social agents with a specific position within that field (Martin & Marti, 2008; Valero-Garcés, 2003).

Unlike previous studies, the majority of which investigate ad hoc non-professional interpreters (i.e. family, friends, children or bilingual staff) (Angelelli, 2010; Bezuidenhout & Borry, 2009; Edwards, Temple, & Alexander, 2005), this article discusses the self-perception of volunteers organized through the migrant-oriented NGO *Asociación de Intérpretes Voluntarios para Enfermos* [Organization of Volunteer Interpreters for Patients] (hereinafter AIVE) located in the Costa del Sol region in southern Spain. These volunteers position themselves as interpreters at two healthcare institutions. Unlike ad hoc non-professional interpreters, they are highly institutionalized within these two healthcare institutions. This article attempts to situate the volunteers in question, who operate as non-professional interpreters within the field of PSI, by 1) exploring their historical trajectories; 2) examining their role in relation to the social context in which they operate; and 3) analysing the emergence of their strong professional identity as interpreters. Through the analysis of interpreters' personal narratives, obtained primarily through focus group discussions, this article examines the process of institutionalization of these volunteers into interpreters within their specific healthcare settings. It argues that the volunteers' self-perception as interpreters emerged after they had passed through a process of legitimization by the healthcare institutions and the regional government.

2. Research methods

The findings presented in this article are part of a larger study that examines the positioning and self-perception of non-professional interpreters in different healthcare institutions in the Costa del Sol region. The data analysed throughout the article consists of four focus group discussions[4] and participant observation

---

[2] See Bührig & Meyer, 2004; Edwards et al., 2005; Knapp-Potthoff & Knapp, 1987; Ku & Flores, 2005; Meyer, 2012; Monroe & Shirazian, 2004; Phelan & Parkman, 1995, p. 156; Villarruel, Portillo, & Kane, 1999.

[3] Non-professional interpreters tend to adopt an active role as communicative agents that often means that they: control turn-taking and intervene in the communication as a third party (Bezuidenhout & Borry, 2009); change the content of utterances (Aranguri, Davidson, & Ramirez, 2006); distort the message (Flores, Rabke-Verani, Pine, & Sabharwal, 2002); omit relevant content (Bührig & Meyer, 2004); and interfere in the direct relationship between providers and patients (Hsieh, 2013; Rosenberg et al., 2008).

[4] The focus groups were conducted in English and Spanish, a choice that was left to the discretion of participants. Each focus group had between 3 and 4 participants and lasted between 45 and 75 minutes. Throughout the focus groups interpreters who were called in for work left the room momentarily. Focus group questions followed a questioning route that was developed in advance,

of 31 interpreter-mediated encounters and routine patient visits.[5] From a methodological standpoint, although focus group interviews have not been extensively used in interpreting studies, when used they have elicited interesting and useful data for a number of researchers in combination with other methodological tools such as participant observation.[6] While the core data of this article remains the output of focus group discussions, where relevant I will draw on participant observation to strengthen the analysis.

The purpose of this investigation was not to conduct a critical analysis of linguistic exchanges but rather to look at the overall meaning of utterances; accordingly, a simplified transcription method using Transcriber 2.0 was chosen, since a detailed phonetic transcription was not required (Diriker, 2004). In those cases where linguistic exchanges took place in Spanish, a translation[7] into English has been provided. The data was coded manually on a hard copy of each transcript using different colours and labels according to each identified theme and category, and was analysed using a qualitative content analysis approach (Hammersley & Atkinson, 2007). In the excerpts and the following discussion, for the sake of anonymity each participant is referred to only by a single pseudonym. These names are followed by an indicative superscript: I=interpreter; C=coordinator; S=secretary; P=president.

3. The professional autonomy of volunteers as non-professional interpreters: interpreters' self-perception

The sociology of translation and interpreting has provided researchers of PSI with a unique set of theoretical frameworks for the investigation of interpreter-mediated communicative events, which allow for the analysis of the macro-structures surrounding such events.[8] Considering that the objective structures of professional fields (i.e. the cultural norms and values of professions) vary across societies (Bourdieu, 1990), it could be argued that the underlying social structures of the healthcare field in Spain, the approach to patient care, and, as a result, the social practices of PSI in healthcare settings, allow for the establishment of contextually specific positions for interpreters that may not exist elsewhere. Accordingly, the role of the interpreter can be better understood if one takes into consideration the social macro-structures that shape the positions available to agents performing as interpreters as well as the positions that they actually adopt and/or are encouraged to adopt in interpreter-mediated communicative events (Inghilleri, 2006). The social structures of professional fields thus shape individuals' behaviour and inculcate a specific set of dispositions in them during their professional trajectory in a given professional field (Bourdieu, 1998, pp. 1-14). The term disposition refers to individuals' attitude and agency, a *habitus*. It is a way of being or a tendency that can be ingrained and long-term (Bourdieu, 1998, pp. 35-37). In this sense, habitus is a historical concept that is intrinsically linked to each individual's personal trajectory. Although habitus predisposes individuals to act according to the rules

---

and which was not altered throughout the fieldwork in order to maintain consistency and reliability of the data.

[5] AIVE has a total of 32 volunteers performing as interpreters. However, only 16 volunteers work on a weekly basis. The remaining 16 volunteers work on an ad hoc basis or through telephone interpreting. The study focused on those members who performed as interpreters on a weekly basis. While all 16 regularly active members of AIVE were invited to participate in the study, only 11 of the 16 agreed to do so. The selection of participants was thus based on voluntary participation. Participant information sheets were distributed among participants and consent-forms were duly signed.

[6] See Hsieh, 2004; Hsieh & Hong, 2010; Hsieh et al., 2010; Hsieh & Kramer, 2011; Koskinen, 2008; Tipton, 2010.

[7] All translations into English of excerpts in Spanish are by the author.

[8] See Angelelli, 2004; Diaz Fouces & Monzó, 2010; Inghilleri, 2004; Lázaro Gutiérrez, 2014.

and conventions of a field, it also gives individuals the opportunity to choose among the possibilities available to them (Bourdieu, 1998). Accordingly, by tracing the historical trajectory of volunteers of AIVE and inquiring into their self-perception as interpreters, we are able to understand how the underlying social structures have shaped their habitus, and ultimately, the positions they occupy within the field.

3.1 The social habitus of volunteers performing as interpreters: empathy and compassion at the basis of social recognition

The Costa del Sol region started to receive large numbers of retirees from Northern European countries in the 1980s. Its economic, social and environmental conditions and its accessibility have continuously made it one of the most popular destinations for 'lifestyle migrants'.[9] One aspect that this type of migration has brought to the area is 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, where charity and volunteerism have been displaced by the strong social and family network that has been at the basis of Spanish society for centuries (Haas, 2013). This was pointed out in one of the focus groups by current AIVE president Helen, a retired former translator who is originally from the UK: "*Yo creo que el voluntariado es como si lo hubieran descubierto hace poco aquí en España porque ahora hay voluntarios por un tubo*" [It seems that volunteering has been recently discovered in Spain, because suddenly loads of volunteers are available].

Considering the difficulties that regional public hospitals in the Costa del Sol, such as the *Hospital Clínico* (hereinafter *El Clínico*) and the *Hospital Costa del Sol* (hereinafter *El HCS*) experienced in the 1980s with the increase in the number of patients with limited Spanish proficiency (hereinafter LSP patients), a Dutch doctor, Dr Marko Franke, and other bilingual doctors started to act as interpreters for Spanish-speaking doctors. This resulted in the emergence of an ad hoc group of volunteers performing as interpreters at *El Clínico*. One of the first volunteers to join was Jackie, the former president and current coordinator at *El Clínico*. Originally from the UK, she is a retired EFL teacher. When asked how they became volunteers during one of the focus groups at *El Clínico*, Jackie responded: "*A mí por una vecina que era enfermera en el Hospital Civil y me contó la necesidad que tenía el doctor Franke para gente para ayudar a traducir, ahí empecé*" [In my case it was through a neighbour who was a nurse at *El Clínico* and who told me that Dr Franke needed people to help him translate. That's how I started]. All the interpreters in this focus group explained how they connected with AIVE and how they were motivated largely by their

---

[9] Although Spain and, particularly the Costa del Sol region, have traditionally been a tourist destination and, more recently, a highly popular retirement destination for northern Europeans (Rodríguez, Betancor, Delgado, Rodríguez, & Pacios, 2008), its proximity to the African continent and the change of migration patterns from northern African countries have further contributed since the 1990s to the increase in the number of residents with limited Spanish proficiency in the area (Valero-Matas, Coca, & Valero-Oteo, 2014). According to *Extranjeros Residentes en España a 31 de diciembre de 2014* [Foreign-born residents in Spain as of December, 31st 2014] published by the Spanish Ministry of Work and Immigration, by the end of December 2014 it was estimated that a total of 4,925,089 foreign-born documented residents lived in Spain, representing 10.7% of the total population of Spain [available at http://extranjeros.empleo.gob.es/es/Estadisticas/operaciones/concertificado/201412/Residentes_Principales_Resultados_31122014.pdf; last accessed April 2015]. According to this report, Andalusia has the third largest immigration population with 13.7% of the total number of immigrants in the country. The foreign-born sector in Andalusia, which is 8.3% of the total population of the region, consists of a mixed group of residents who are attracted to the area by a variety of factors, ranging from better economic conditions –with a majority from Eastern Europe and North Africa (Navaza, Estévez, & Serrano, 2009, p. 141), to milder weather –with a majority from Northern European countries known as 'lifestyle migrants' (Benson & O'Reilly, 2009, p. 2). Due to the lasting importance of the Costa del Sol for EU retirement migration, Andalusia is one of the regions where EU migrants still comprise around 50% of the total foreign-born population (Rodríguez et al., 2008).

own individual experience as LSP patients or as friends or family of LSP patients. Salvador, the current secretary, who is Spanish but lived in Germany until his retirement, explained: "*Yo cuando me operaron de la pierna estuve bastante tiempo inmovilizado y me enteré que había más o menos una agrupación de intérpretes y me puse con ellos*" [In my case, I was hospitalized for some time because of surgery on my leg and I found out that there was some sort of group of interpreters and that's when I started]. Progressively, new volunteers, most of whom were foreign-born residents from northern European countries (the UK, Germany, Belgium, the Netherlands and Denmark, among others) who had moved to the Costa del Sol for work and/or retirement, joined the volunteer group at *El Clínico*. In the following excerpt from a focus group at *El HCS,* members discuss how they became volunteers.

Excerpt 1 (FG 1)
> **Cordula[I]:** Well, I was a translator before (.) and I was asked by another colleague. We met in the hospital when I had my operation (.). Nobody spoke another language but Spanish. (.) We met later and she said to me: "Why don't you join us and work in the hospital as a translator?" And I said: "Yes, I would like to do this." Because I noticed in the hospital how important it is that somebody is there who speaks the language and I thought this is very important for ill people.
> **Julianne[I]:** How I started really was because my husband was in the hospital, and whilst he was in here, (.) the doctor and another interpreter came. They had a Danish patient who was very, very sick, and asked if I would translate, which I did, and then after that they asked if I would come along. […] And I was on a Monday afternoon right from the beginning and it must be about 15 years now, always on a Monday. Well, for the last 11, 12 years, before I was on different days.
> **Rebecca[I]:** Now we do Friday afternoon. […] In my case, to be honest with you, I wanted to give something back to the community because the community had been good to me. And you know one thing, because I have always worked for myself, I'm able to organize my time and so I just wanted to do something good for the community, and I thought it was a good idea.

This excerpt shows what motivated these foreign-born residents and members of the local community (i.e. the community of residents of the Costa del Sol region), to volunteer as interpreters. Cordula, originally from Germany and a retired freelance translator, explains how she started interpreting with Dr Franke, suggesting she was one of the first members to join the ad hoc group of volunteers performing as interpreters. As Cordula's narrative tells us, it was while she was hospitalized that she had the opportunity to observe the negative consequences of the linguistic barrier faced by LSP patients and this experience led her to develop feelings of empathy and compassion towards LSP patients. However, the data also show that empathy and compassion are not exclusive to Cordula. In fact, most AIVE volunteers, who once were neighbours, friends or family members of LSP patients or themselves LSP patients, observed or experienced the communication barriers faced by such patients when trying to access healthcare services in the hospitals under investigation, where a majority of the healthcare staff is monolingual. Empathy and compassion are recurring themes to the extent that, as discussed below, they become essential values underlying the volunteers' training and standards of practice.

For migrants from a wide range of socio-economic backgrounds with limited social networks, volunteering can be an important step to expanding their social network, since social recognition can increase the social capital of individuals (Handy & Greenspan, 2009). It is therefore no surprise that another recurring theme in the discussions of all the focus groups is that of the social recognition and appreciation the volunteers receive from healthcare institutions, their agents, and, of course, the LSP patients themselves. In all the focus groups, the interpreters discussed the different ways in which they experience that their work is recognized: they receive letters of appreciation from patients, awards from the regional government, they are written about in newspaper articles or

are invited to the hospital Christmas dinners. [10] In brief, the volunteers are motivated not only by their feelings of empathy and compassion, but also by their search for social capital in order to strengthen their position as members of the local community and society at large. This is discussed by Jackie: "*Lo más importante es que los pacientes están agradecidos, los médicos están agradecidos, y la gente aquí está agradecida*" [The important thing is that patients are grateful, doctors are grateful, and the people here are grateful]. She mentions the three levels of recognition including institutional and community-level from LSP patients as well as the local community.

Julianne and Rebecca joined AIVE fifteen years ago. Rebecca is originally from the United Kingdom and works as a freelance translator in Malaga. Julianne is originally from Denmark and works as a language teacher in a local academy in Malaga. While in Julianne's case, the motivation to join AIVE arose from her experience performing as an ad hoc interpreter for another patient, as indicated in the excerpt above, Rebecca does not explain her relationship with the institution and its members. However, in her account she displays a great sense of social responsibility towards the local community since as a freelance translator in Malaga her income very much depends on the local economy. This sense of responsibility towards the local community established by Rebecca is frequently hinted at throughout the focus groups. Additionally, Julianne and Rebecca both emphasize their strong commitment to AIVE as well as the high degree of organization of the volunteer interpreting services.

Over the years the ad hoc group of volunteers increased in number, socio-cultural background of participants and range of languages provided as the linguistic and social-cultural landscape of Spain began to change from the early 2000s (Valero-Matas, Coca, & Valero-Oteo, 2014). Interpreters of languages such as Chinese, Romanian and Arabic, the demand for which had increased significantly, were sought (Martin, 2006). Unlike the early volunteers, the newer members have a different socio-cultural profile. These members are no longer "lifestyle migrants" from northern Europe, but economic migrants from China, Romania or Morocco, among other nationalities (Benson & O'Reilly, 2009, p. 2). The participation of immigrants as volunteers is, in fact, an indicator of their integration in the host society as it shows a certain degree of adaptation, implication and integration in the political and social life of the new social context, an aspect of immigration which has been researched (Alarcón, 2011). One of the newer members recruited for Arabic was Fadilah, originally from Morocco and a freelance translator for Malaga City Hall. She has a university degree in English, and is also fluent in Spanish, French and Arabic. During the focus group, she explained how she found out about AIVE and gave her motivation for joining.

Excerpt 2 (FG 3)

Fadilah[I]: *Hace seis, siete años (.) Es que antes mi suegra, Aisa, estaba ingresada aquí. Y vino Jonás y me ha dicho: "¿Aisa habla español?" Digo: "No, es que solo árabe." Y dice: "¿y usted qué habla?" y digo, bueno, de broma: "yo hablo francés, inglés, español, árabe." Me dice: "¿por qué no vienes con nosotros?" Así digo: "Claro que si queréis, sí." Le di mi teléfono, y entonces empecé a venir al training. Y mira en un mes, la verdad que conozco el hospital como la palma de la mano. […] Y bueno yo siempre esperando que llegue el miércoles. Es que no viene uno porque está obligado. Vienes porque sabes que, por ejemplo hoy, dos*

---

que me lo han agradecido, pero de una manera que sientes cariño de los pacientes. Son enfermos que están aquí de más de dos, tres meses, entonces unos que están esperando principalmente que yo llego.

[I have been here for six or seven years (.) The thing is that my mother in law, Aisa, was hospitalized here. And Jonas came in and said: "Does Aisa speak Spanish?" I said: "No, only Arabic". And he said: "What languages do you speak?" and I said jokingly: "I speak French, English, Spanish, and Arabic." He said: "Why don't you join us?" So I said: "Of course, if you want me to". I started coming to the training for one month. And look, in one month, now I can find my way around the hospital with my eyes closed. […] And I'm always looking forward to Wednesdays. I don't come because I have to. I come because I know that, for example, two people were so grateful today in a way that you can feel the love from patients. There're patients who remain hospitalized for two, three months, and they're always looking forward to my visit.]

By the time Fadilah became a volunteer member, AIVE had already been established as an official organization and training had already been institutionalized, as described below, which explains her reference to 'training'. In addition, there are several issues in her comment that should be highlighted. On the one hand, it reinforces the narrative of previous members describing their social trajectory as friends or family of LSP patients and/or patients themselves. Fadilah was a LSP patient's family member and was asked to join AIVE by another member. She also emphasizes that AIVE is well organized and confirms the extent of her commitment to the institution, as did the other members: "*los miércoles son sagrados para mi. Mi familia lo sabe eso. Hasta en Marruecos lo saben*" [Wednesdays are sacred for me. My family knows it well. They know it even in Morocco]. Moreover, she points out her strong degree of empathy and compassion towards patients and also the importance of patients' recognition and gratitude. Actually, not only the patients' gratitude and recognition are important, the appreciation shown by the doctors is equally important: "*los médicos también te lo agradecen*" [Doctors are very grateful as well].

The early social trajectories of these volunteers, the development of feelings of empathy and compassion, and the volunteers' desire to gain social recognition not only from the institutions, and their members, but also from LSP patients and society at large, have shaped their social dispositions and therefore their habitus. The habitus of these non-professional interpreters will eventually lead them to occupy additional positions available as caretakers and patient advocates for LSP patients, as will be discussed below.

3.2 The professional habitus of volunteers performing as interpreters: institutional trust at the basis of professional autonomy

Individuals construct and evaluate the objective structures of a field through a process of familiarization with social practices, starting with the family and then proceeding to broader institutional domains (Bourdieu, 1990, p. 58). Translation studies scholars have identified different types of habitus, a primary (or social) habitus, which corresponds to primary socialization (i.e. within one's family, school and group friends), and a secondary (or professional) habitus, which corresponds to secondary socialization (i.e. the development of a professional identity) (see Abdallah, 2014; Inghilleri, 2005b). The transformation of a social habitus into a professional habitus yields insights into the ways in which practitioners adapt to new professional contexts (Bourdieu, 1990). With reference to the field of PSI, Inghilleri (2005a) has argued that an interpreter's habitus develops through the reproduction of the structures of the professional field where agents are positioned through their everyday practice. This view on the development of an interpreter professional identity takes into consideration the relationship between individual practitioners and society at large, thus

placing the emphasis on individuals and their interaction with the environment rather than on the acquisition of skills through training (Klegon, 1978).

At the centre of this approach is professional autonomy, which provides agents with stronger agency since it is supported by a network of trust and recognition from agents with a stronger habitus (i.e. healthcare and/or managerial staff) (Forsyth & Danisiewicz, 1985). In this context, there is an essential condition that lays the foundation for the relationship of trust established between volunteers and the healthcare institutions, and their agents, and that is the power that volunteers possess as the agents with the linguistic capital that is valued as essential by the other agents. In this specific case, the acquisition of professional autonomy, and a strong professional habitus resulting from the internalization of the field structures by volunteers, allowed volunteers to define a broader interpreter role with several positions available which they can negotiate depending on the individual circumstances of each encounter. This is discussed by Helen below.

Excerpt 3 (FG 4)

Helen[P]: *Lo difícil es saber qué nivel de comunicación entablar con los enfermos, con el tiempo yo lo he hecho a mi medida. Porque hay lógicamente gente que necesita más y otros que necesitan menos. Y personalmente considero que más y más los médicos hablan inglés y algunos se comunican relativamente bien con sus pacientes y, por lo tanto, nuestro trabajo de intermediario, de traducción, interpretación bicultural, bidireccional es a veces menos frecuente.*
[The difficult part is to know the level of communication we need to establish with patients, and in time I have been able to establish it myself. Because of course some people need more help than others. 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.]

In this excerpt, Helen discusses two positions available to volunteers (i.e. as interpreters and caretakers) demonstrating her awareness of PSI as a professional practice, while reflecting upon the internal changes that are taking place in the field of healthcare in the Costa del Sol region and how these affect the demands placed upon volunteers by the institutions and their agents. The development of a strong secondary or professional habitus can also be observed in the references to the volunteers' activity as *trabajo* [job], as mentioned above by Helen and discussed here by Salvador: "*Lo más importante es que hemos realizado un trabajo y que vemos que hemos sido importantes en realizarlo (.) un trabajo incluso que nos hemos visto imprescindibles*" [The most important thing is that we have completed a job, and we can appreciate that it is important to do that job (.) a job for which we are essential]. The reference to the acquisition of trust and professional autonomy as a result of the essential nature of the job, in this case the *trabajo* carried out by volunteers, has been previously discussed by researchers drawing on attitudinal models of professionalization, where the attitude of practitioners towards their practice is perceived as one of the essential elements in the formation of a professional habitus (Forsyth & Danisiewicz, 1985).

Throughout the focus groups, volunteers discussed the different positions they occupy while performing as interpreters, such as caretakers or patient advocates. This perception of themselves as interpreters and the different positions they occupy as volunteers stems not only from their lack of professional training but also from an actual gap in the delivery of care, resulting from the structure of the healthcare system in Spain, which relies heavily on the patient's family to facilitate patient care (Fuertes & Martín Laso, 2006). This is a state of affairs that was discussed in all the focus groups. While conducting participant observation, I was able to observe the dynamics between volunteers and healthcare staff while they were performing their duties, and the trust placed

on the volunteers, who were expected to perform additional tasks which are usually carried out by family members, administrators and social workers.[11] Some of these tasks were pointed out by Salvador: "*Y vemos si uno no quiere intérprete, si otro tiene otras necesidades, si tenemos que ponernos en contacto con la asistente social*" [And we see whether a patient needs an interpreter, whether another patient has other needs, whether we need to get in touch with the social worker]. This statement describing the volunteers' routines shows the extent to which the established institutional structures trust volunteers to assess the individual circumstances of each patient as also discussed above by Helen.

In fact, the positions occupied by volunteers at *El Clínico* were further legitimized as their interpreting services became more organized in 1993 when Dorothy, a senior member at *El Clínico,* was asked to start a new ad hoc team at a new hospital.

Excerpt 4 (FG 1)
> **Dorothy[C]:** The doctor who actually started it, Dr Franke, he said to me when I was there for the Fridays: "They're going to build a hospital in Marbella, why don't you go and speak to Dr Bermudez, the new director?" So we went down and he said: "Give me a proposal, what do you want to do". So I gave him a proposal, and so you know I wrote down the whole thing of what we wanted to do, what I thought should happen, and he said: "Fine". And that's how it started. So we were here when the doors opened. So I've been here for 16 years, you know?

In this excerpt Dorothy, the current coordinator at *El HCS,* originally from Canada and a retired journalist, explains how the new ad hoc group of volunteer interpreters was constituted. This process added an additional layer of legitimacy to the *El HCS* ad hoc group of volunteer interpreters, since it was, from the beginning, officially ratified by the hospital director and, after its inception, slowly developed in the official organization, as described in the next section. Unlike the first ad hoc group at *El Clínico*, which was initiated rather randomly, as pointed out by Salvador below, the ad hoc group at *El HCS* was initiated at the time the hospital opened, and the volunteer interpreting service was immediately integrated into the functioning of the hospital dynamics as part of the services provided to LSP patients. This expansion of the patient services at the new hospital through a formal initiative served as the foundation for the NGO that was established later on, as also indicated by Salvador in the following excerpt.

Excerpt 5 (FG 2)
> **Salvador[S]:** *Sí, al principio, no existíamos como organización, automáticamente se iba. Es decir había poca disciplina. Lo que ocurre es que nos ha obligado el gobierno a formarnos, o sea, a declararnos como asociación, precisamente hemos hecho todos los trámites necesarios y demás. Y se ha visto por otra parte de que hay un rechazo en los antiguos que no asimilan muy bien eso de la asociación, preferirían ir por libre como antes, pero no puede ser, ya que desde el gobierno, ya nos exige.*
> [In the beginning we didn't exist as an NGO, we would automatically join in, so there was little discipline. What happened was that the Government asked us to establish ourselves as an NGO. And we have taken all the necessary bureaucratic steps. But some members didn't agree with this process, they didn't want to be part of an NGO. But that is no longer possible, because the Government asked us.]

---

[11] Some of the tasks observed included: calling patients about upcoming appointments; helping patients to fill out forms; calling patients' families to inform them about the condition of their relatives health; accompanying patients to consultation rooms; notifying of the death of patients in person or by phone; visiting patients to ensure they are receiving the care they need; and interpreting between doctors, nurses and patients on a regular basis.

The new team of volunteers at *El HCS* was set up according to a written proposal presented by Dorothy. This proposal became the basis for AIVE standards of practice in 2002. Standards of practice are important since they establish the boundaries of the interpreters' role in a given setting. The AIVE standards of practice (see 3.3) were designed in accordance with the dispositions internalized during the social trajectory of volunteers performing as interpreters at *El Clínico* between 1988 and 1993, as well as the interpreting practices legitimized by the healthcare institutions and their agents. This proposal laid the groundwork for the official organization of AIVE. The process of constitution as an official NGO was requested by the *Junta de Andalucía* regional government in 2002, a process that had its supporters and its detractors, leading some of the original members to leave.

3.3 Bureaucratization and legitimacy of volunteers: the institutionalization of interpreting practices

Legitimization and bureaucratization are formal aspects of institutionalization, with the former representing the symbolic recognition by institutional members and the latter the material realization of this recognition (Kitchener, 2000). The legitimization of the volunteer interpreters' positions by other institutional agents (i.e. healthcare and managerial staff) within *El Clínico* and *El HCS* provided volunteers with a high degree of professional autonomy. However, since such legitimization depends on the attitude of institutional agents with a stronger habitus, it can fluctuate, which then destabilizes the volunteers' professional autonomy (Bourdieu, 1990). Bureaucratization, on the other hand, is a more stable element since it involves tangible assets to which interpreters become entitled as institutional members (Bourdieu, 1998). This is an aspect that is pointed out by Cordula when she explains: "New doctors and new nurses sometimes think we are intruding. But we don't go after 16 years here to nurses who are new here, I am so and so, because we have our badge, we have our badge, and all the colleagues know what it means."

In the excerpt above, Cordula emphasizes the importance of the ID card (which she refers to as "badge") as an official document confirming the volunteers' professional identity and legitimacy. In addition to the ID card, the white coat the volunteers habitually wear is one of the most valuable assets that provides interpreters with a degree of legitimacy, as pointed out by Helen: "*Porque otra cosa es el 'síndrome de la bata blanca' y es que la gente te pregunta y yo les tengo que decir, pues mire es que yo con eso no le puedo ayudar*" [Another thing is the 'white coat syndrome', which means that people are constantly asking you for help and I have to explain to them that I can't help them]. The ID card and the white coat are the two most visible assets that volunteer interpreters have received as institutional members, two assets that increase their degree of legitimacy and strengthen their professional habitus. In addition to these assets, the increased organization of their work goes hand in hand with the organizational bureaucratization of the practice involved and its structural incorporation in the field in question (Hall, 1968; Wilensky, 1964).[12] Besides the provision of these and other tangible assets,[13] three major structural changes took place that had a large impact on the positions available to volunteers performing as interpreters: a) the existence of an administrative body with responsibility for monitoring practitioners; b) the development of standards of practice; and c) the implementation of training.

---

[12] Although bureacratic processes are generally found in the literature on professionalization, the manifestation of these processes has also been identified by scholars studying the development of non-profit organizations (Amis, Slack, & Berrett, 1995).

[13] The tangible assets received upon the process of organization include ID cards, hospital pagers, a white coat, office space, financial resources to help pay for gas, insurance coverage, and food vouchers for the staff canteen.

The first result of the increased organization of the volunteers was an administrative body, which was established with a president, a secretary, a treasurer and two coordinators, one at each of the hospitals. The task of this body is to ensure that the developed standards of practice are being followed and that new volunteers conform to them, a task that is carried out mostly by the two coordinators. Despite initial resentment towards this process of institutionalization, which was requested by the regional government, it was clear throughout the discussions held in the focus groups that the financial assistance (one of the tangible assets resulting from the institutionalization) provided in the form of food vouchers, insurance cover and transportation was welcomed by those members who decided to continue.

The second structural change was the development of the standards of practice, mentioned above, based on an agreement between the volunteers, more specifically the proposal drawn up by Dorothy in 1996 for the new ad hoc group at *El HCS*, and the hospital directors at *El Clínico* and *El HCS*. These standards of practice (developed by AIVE) were eventually included in the organization bylaws and officially ratified by the hospital directors and the regional government. The following is a summary of the most important standards of practice as stated in AIVE handbook. It states that volunteer interpreters should:

- show empathy and compassion without giving advice on medical procedures, except when asked by the practitioner (in mental health cases),
- accompany patients to consultation rooms (interpreters will not assume the role of the healthcare provider),
- interpret between healthcare staff and patients and their families in any area of the hospital,
- offer moral support to patients and their relatives where necessary and contact religious representatives at the request of the patient,
- maintain confidentiality,
- never provide written translations,
- visit LSP patients on a daily basis in order to assess their communicative needs and sort out any problems they may be experiencing as a result of not speaking Spanish,
- make careful notes in the report book after a shift to keep the next shift informed of any changes.

Unlike standards of practice developed by professional associations of PSI (Bancroft, 2005), AIVE standards were developed to fill a communication gap between the healthcare institutions and their LSP patients. They emerged as a result of the position that volunteers already occupied as interpreters, caretakers and patient advocates, based on principles of empathy and compassion. The standards expand the traditional notion of the ethical codes that are common in professional healthcare interpreting to include the assessments and actions involved in this particular type of volunteer interpreting activity in which care for others is not only permitted but also legitimized by the healthcare institutions and their members. The legitimacy of these principles and the tasks they allow interpreters to execute, turn them into active participants in the interaction with patients and gives them responsibilities that go beyond the task of translating as identified by previous research. Although some of these activities may be controversial in other social contexts, the particularity of the social structures of this context allows for their adoption since they fill a gap that would otherwise increase social inequality and decrease access to

healthcare for LSP patients.[14]

Finally, the third structural change includes the implementation of training. Coordinators are responsible for training new interpreters and ensuring that new members understand and follow AIVE's standards of practice. Coordinators are therefore agents of control. As shown in previous excerpts, *entrenamiento* [training] is viewed as an essential part of becoming a volunteer. In the following excerpts, Jackie and Salvador discuss its importance.

Excerpt 6 (FG2)

Jackie[C]: *Sí, existe un entrenamiento de cuatro semanas y si a ellos les gusta se quedan, y si nosotros pensamos que va bien, se quedan. Y ya está, se tiene que tener la voluntad y amabilidad con los pacientes.*
[Yes, we have a four-week training and if they like it, they can stay, and if we think they are doing well, they can stay. People must show goodwill and kindness towards patients.]
Salvador[S]: *Es imprescindible hablar inglés y español.*
[It's essential to speak English and Spanish.]
Jackie[C]: *Y hablar con los pacientes, sí, sí. En realidad, esto es lo más importante de nuestro trabajo hablando con los pacientes, ayudándolos. Pero es que hemos tenido gente que no le gusta hablar con los pacientes. Ellos solamente quieren interpretar para los médicos, y no ha funcionado.*
[And talking to patients, yes, yes. In fact, this is the most important part of our job, talking to patients, helping them. Because we have had people who didn't want to talk to patients. They only wanted to interpret for the doctors, and so it didn't work out.]

Jackie explains above how sometimes potential members expect they will only be translating for doctors, and are not willing to adopt additional positions essential for the organization. When new members join AIVE, they must undergo a process of socialization and training. Through this process they can internalize the social dispositions required to perform as interpreters. As a result, new members can develop a strong sense of the service they need to provide and embody their professional habitus as non-professional interpreters through their everyday practice. The above excerpts from the focus group discussions highlight the importance of controlling who enters AIVE, for new members often hold a different view of the interpreter's role and lack the principles of empathy and compassion that are essential characteristics of the AIVE model. As Helen points out: "Our aim is to humanize medicine. […] You have to fit a particular profile to do this kind of social translating, as it's not just about having the language skills. Some of the work we do can be heart breaking and you need to be prepared for that."

Moreover, the monitoring of volunteers does not end after they have been accepted into the organization. The exercise of the interpreting practice carried out by the volunteers and the positions adopted are also monitored beyond the administrative body. This monitoring takes different forms depending on the circumstances of each encounter. However, some instruments have been put in place such as the notebook that interpreters keep on a daily basis; the administrative body must ensure that these notes are kept up to date in case healthcare staff requests them. This task is twofold: it allows interpreters to navigate the hospital and visit patients without supervision, while asserting their autonomy as legitimate agents of the institution, and it allows them to perform as interpreters, caretakers and patient advocates when necessary. Volunteers explain it in the following excerpt:

---

[14] In countries such as the USA where liability in the healthcare system is a significant concern, restrictions on the role of the interpreter are encouraged. Despite this, scholars have uncovered interpreters' behaviour and demonstrated that they often go beyond the established boundaries of their role. Some of the tasks include: protecting institutional resources, reducing the cultural gap between healthcare providers and LSP patients, resolving conflicts between healthcare providers and LSP patients, and performing as patient advocates (Hannah, 2014; Hsieh, 2013).

Excerpt 7 (FG1)

Dorothy[C]: Here is the list that we get every morning and the girl has listed the foreign patients, right? Now obviously we also go check through to see if she got everybody on it. So we write down the name of the patient, where they are, this is the room and whether they are by the window or by the door, and we write down a list, then we write in our book.

Cordula[I]: We all do our little notes about each case for the next interpreter.

Dorothy[C]: So this is really for the next interpreter, so they know what's been done and also if there's problems. […] This is very important for us to keep as a record, because something could happen, maybe they're going to complain about the hospital so we can look back and see what actually happened. So it's important for us.

Julianne[I]: When I come in on a Monday afternoon, then obviously the interpreter who's been in the morning shift has reported any issues in the book. If there was anything pending with any of the patients she would tell me and I would try to see the patient.

In this excerpt, volunteers explain their routine, which starts at the beginning of their shift when they receive the list of LSP patients from the administration. They then proceed to visit as many LSP patients as they can in the breaks from their interpreting activities. At the end of their shift they make notes on the daily activities for the next shift of interpreters. The importance of the note keeping is explained in relation to the institution's need to monitor their activities, which itself takes place mostly unsupervised and is a further manifestation of the process of bureaucratization that requires clarity and transparency of interpreters' activities in the hospitals. The trust placed in interpreters by allowing them to visit patients unsupervised strengthens their professional autonomy while the notebooks and monitoring allow the hospital to keep a degree of control over the interpreting service. The way in which interpreters are asked to keep records of their activities with LSP patients is very similar to the way in which nurses and doctors keep records of their activities with patients. In other words, there is a high degree of internal organization characterizing the way the interpreters work that is comparable to the organization in place for other healthcare staff: they adopt a systematic approach to their work and are aware of their position and its boundaries.

The model developed at *El Clínico* during the early stage of socialization, replicated at *El HCS*, and formally ratified after a process of institutionalization, has become a well-functioning system of routinized structures allowing volunteers performing as non-professional interpreters to position themselves as institutional agents, as caretakers and patient advocates. By establishing this routinized system, volunteers are able to constantly (re)integrate themselves within the functioning of the healthcare institution as non-professional but reliable interpreters (Schapira, Vargas, Hidalgo, Brier, Sanchez, Hobrecker, & Chabner, 2008).

4. Conclusion

The vision of the interpreter as a neutral and impartial agent has long been the ideal that the profession of PSI has sought. The role of the public service interpreter as caretaker and patient advocate has been debated by the academy and criticized by the profession and employing institutions due to the repercussions that this position may have for said institutions and their members (Hsieh, 2013). In professionalized contexts, interpreters are generally not provided with sufficient professional autonomy to negotiate their position in the way social workers are as mediators between public serving institutions and service users. In the case of social workers, their position as institutional agents accords them a high degree of professional autonomy that allows them to "form relationships with people and assist them to live more successfully within their

local communities by helping them find solutions to their problems. Social work involves engaging not only with clients themselves but their families and friends as well as working closely with other organisations".[15]

This investigation has shown that volunteer non-professional interpreters of a migrant-oriented NGO in the Costa del Sol region have achieved a status similar to that of social workers. In this context interpreters are able to negotiate and channel the moral demands placed on them as volunteer interpreters, leading them to occupy a series of positions generally available to cultural brokers and intercultural mediators in other settings such as caretakers and patient advocates (Pöchhacker, 2008). Although previous research has shown that patient advocacy can pose problems for the development of patient autonomy and the relationship between healthcare providers and LSP patients (Hsieh, 2013; Hsieh & Kramer, 2011), in this particular context an authorization exists, allowing interpreters to proceed as indicated by the ratified standards of practice. The social dispositions of these volunteer interpreters and their habitus are shaped by empathy and compassion and are guided by their own standards of practice. This does not mean that their translatorial activity is secondary, but that it is subject to or rather concurrent with a particular articulated ethical stance and its resulting practices, demonstrating that volunteer non-professional interpreters in this context have acquired a stronger degree of professional autonomy than professional interpreters tend to acquire, despite the fact that professional interpreters often hold a larger volume of linguistic and cultural capital in the form of professional training.

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.

The findings of this case study are specific to the context of two hospitals in the Costa del Sol region. It is uncommon for volunteer interpreters to achieve the degree of institutionalization and recognition described here within any social field. This limitation of the current study must be taken into account. The positions discussed above may only be available to interpreters working in this particular context, and it is therefore not possible to generalize or extrapolate these findings to other contexts, whether in healthcare or other settings within the same region or national territory. It may well be that paid interpreters in the same sector or volunteer interpreters in other sectors within the same geographical area (or other areas) occupy different positions and adopt an orthodox discourse that places them in positions dominated by agents with stronger habitus (Simeoni, 1998). However, this study challenges PSI models that promote detachment and invisibility at the expense of professional autonomy in order to achieve greater degrees of professionalism and institutional trust. It further questions the assumptions underlying the belief that these important goals can be achieved only through neutrality and impartiality. Moreover, it has shown the implications of a socially progressive stance in which public service interpreters are able to act as socially engaged citizens by reclaiming a more interactive role, and where empathy and compassion become integral to that role. Finally, it offers the case of a PSI model oriented towards a socially engaged interpreter in the Costa del Sol region as an example of an

---

[15] This description of social work has been taken from the NHS website [available at http://www.nhscareers.nhs.uk/details/default.aspx?id=519; last accessed April 2015).

approach that has been shown to contribute to the establishment of stronger ties between migrant communities, local organizations and public institutions.

References

Abdallah, K. (2014). The interface between Bourdieu's habitus and Latour's agency: The work trajectories of two Finnish translators. In G. Vorderobermeier (Ed.), *Remapping Habitus in Translation Studies* (pp. 111-134). Graz: Rodopi.

Alarcón, V. (2011, February). *Voluntariado e inmigración. Tendencias y perspectivas.* Paper presented at the I Congreso Internacional sobre Migraciones en Andalucía, Universidad de Granada, Granada.

Amis, J., Slack, T., & Berrett, T. (1995). The structural antecedents of conflict in voluntary sport organizations. *Leisure Studies, 14*(1), 1-16.

Angelelli, C. (2004). *Revisiting the interpreter's role: A study of conference, court, and medical interpreters in Canada, Mexico, and the United States*. Amsterdam & Philadelphia: John Benjamins.

Angelelli, C. (2010). A professional ideology in the making: Bilingual youngsters interpreting for their communities and the notion of (no) choice. *Translation and Interpreting Studies, 5*(1), 94-108.

Aranguri, C., Davidson, B., & Ramirez, R. (2006). Patterns of communication through interpreters: A detailed sociolinguistic analysis. *Journal of general internal medicine, 21*(6), 623-629.

Bancroft, M. (2005). *The Interpreter's world tour: An environmental scan of standards of practice for interpreters*. Woodland Hills: The California Endowment.

Baraldi, C., & Gavioli, L. (2014, May). *On professional and non-professional interpreting in healthcare services: the case of intercultural mediators"*. Paper presented at the 2nd International Conference on Non-Professional Interpreting and Translation, Mainz University, Germersheim.

Benson, M., & O'Reilly, K. (2009). Migration and the search for a better way of life: a critical exploration of lifestyle migration. *The Sociological Review, 57*(4), 608-625.

Bezuidenhout, L., & Borry, P. (2009). Examining the role of informal interpretation in medical interviews. *Journal of medical ethics, 35*(3), 159-162.

Bourdieu, P. (1990). *In other words: Essays towards a reflexive sociology*. Cambridge: Polity Press.

Bourdieu, P. (1998). *Practical reason: On the theory of action*. Cambridge: Polity Press.

Bührig, K., & Meyer, B. (2004). Ad-hoc interpreting and achievement of communicative purposes in doctor-patient-communication. In J. House & J. Rehbein (Eds.), *Multilingual Communication* (pp. 43-62). Amsterdam & Philadelphia: John Benjamins.

Diaz Fouces, O., & Monzó, E. (2010). What would a sociology applied to translation be like? *MonTI, 2*, 9-18.

Diriker, E. (2004). *De-/re-contextualizing conference interpreting: Interpreters in the ivory tower?* Amsterdam & Philadelphia: John Benjamins.

Edwards, R., Temple, B., & Alexander, C. (2005). Users' experiences of interpreters: The critical role of trust. *Interpreting, 7*(1), 77-95.

Flores, G., Rabke-Verani, J., Pine, W., & Sabharwal, A. (2002). The importance of cultural and linguistic issues in the emergency care of children. *Pediatric emergency care, 18*(4), 271-284.

Forsyth, P. B., & Danisiewicz, T. J. (1985). Toward a theory of professionalization. *Work and Occupations, 12*(1), 59-76.

Fuertes, C., & Martín Laso, M. A. (2006). El inmigrante en la consulta de atención primaria. *Anales del sistema sanitario de Navarra, 29*(1), 9-25.

Haas, H. (2013). Volunteering in retirement migration: meanings and functions of charitable activities for older British residents in Spain. *Ageing and Society, 33*(8), 1374-1400.

Hall, R. (1968). Professionalization and bureaucratization. *American Sociological Review, 33*(1), 92-104.

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice*. London: Routledge.

Handy, F., & Greenspan, I. (2009). Immigrant Volunteering: A Stepping Stone to Integration? *Nonprofit and Voluntary Sector Quarterly, 38*(6), 956-982.

Hannah, S. (2014, December). *Organizational Structure, Local Ideology, and Diverse Approaches to Medical Interpreting.* Paper presented at the Annual Meeting of American Anthropological Association, Washington DC.

Hsieh, E. (2004, November). *'I was in such a turmoil!' Conflicts of Interpreters' Role Performances in Health Care Settings.* Paper presented at the Annual Meeting of National Communication Association, Chicago.

Hsieh, E. (2013). Health literacy and patient empowerment: The role of medical interpreters in bilingual health communication. In M. D. G. Kreps (Ed.), *Reducing health disparities: Communication intervention* (pp. 35-58). New York: Peter Lang.

Hsieh, E., & Hong, S. J. (2010). Not all are desired: Providers' views on interpreters' emotional support for patients. *Patient Education and Counseling, 81*(2), 192-197.

Hsieh, E., Ju, H., & Kong, H. (2010). Dimensions of trust: The tensions and challenges in provider-interpreter trust. *Qualitative Health Research, 20*(2), 170-181.

Hsieh, E., & Kramer, E. M. (2011). The clashes of expert and layman talk: Constructing meanings of interpreter-mediated medical encounters. In C. Callahan (Ed.), *Communication, comparative cultures and civilizations* (pp. 29-44). Cresskill, NJ: Hampton.

Inghilleri, M. (2004). Aligning macro-and microdimensions in interpreting research. In C. Schäffner (Ed.), *Translation research and interpreting research: Traditions, gaps and synergies* (pp. 71-76). Clevedon: Multilingual Matters.

Inghilleri, M. (2005a). Mediating zones of uncertainty: Interpreter agency, the interpreting habitus and political asylum adjudication. *The Translator, 11*(1), 69-85.

Inghilleri, M. (2005b). The sociology of Bourdieu and the construction of the 'object' in Translation and Interpreting studies. *The Translator, 11*(2), 125-145.

Inghilleri, M. (2006). Macro social theory, linguistic ethnography and interpreting research. *Linguistica antverpiensia, 5*, 57-68.

Kitchener, M. (2000). The 'Bureaucratization' of Professional Roles: The Case of Clinical Directors in UK Hospitals. *Organization, 7*(1), 129-154.

Klegon, D. (1978). The sociology of professions. *Work and Occupations, 5*(3), 259-283.

Knapp-Potthoff, A., & Knapp, K. (1987). The man (or woman) in the middle: Discoursal aspects of non-professional interpreting. In K. Knapp, W. Enninger, & A. Knapp-Potthoff (Eds.), *Analyzing intercultural communication* (pp. 181-211). Berlin: Mouton de Groyter.

Koskinen, K. (2008). *Translating institutions: An ethnographic study of EU translation.* Manchester: St Jerome.

Ku, L., & Flores, G. (2005). Pay now or pay later: providing interpreter services in health care. *Health Affairs, 24*(2), 435-444.

Lázaro Gutiérrez, R. (2014). Use and abuse of an interpreter. In C. Valero-Garcés (Ed.), *(Re) considerando ética e ideología en situaciones de conflicto* (pp. 214-221). Alcalá de Henares: Universidad de Alcalá, Servicio de Publicaciones.

Martin, A. (2006). La realidad de la traducción e interpretación en los servicios públicos en Andalucía. In C. Valero-Garcés & F. R. Gimeno (Eds.), *Retos del Siglo XXI en Comunicación Intercultural: Nuevo Mapa Lingüístico y cultural de España* (pp. 129-150). Logroño: Reproziur.

Martin, A., & Marti, I. A. (2008). Community interpreter self-perception. In C. Valero-Garcés & A. Martin (Eds.), *Crossing borders in community interpreting: Definitions and dilemmas* (pp. 203-220). Amsterdam & Philadelphia: John Benjamins.

Meyer, B. (2012). Ad hoc interpreting for partially language-proficient patients. In C. Baraldi & L. Gavioli (Eds.), *Coordinating Participation in Dialogue Interpreting* (pp. 99-113). Amsterdam & Philadelphia: John Benjamins.

Monroe, A. D., & Shirazian, T. (2004). Challenging linguistic barriers to health care: students as medical interpreters. *Academic Medicine, 79*(2), 118-122.

Navaza, B., Estévez, L., & Serrano, J. (2009). 'Saque la lengua, por favor': Panorama actual de la interpretación sanitaria en España. *Panace, 10*(30), 141-156.

Phelan, M., & Parkman, S. (1995). How to do it: work with an interpreter. *Bmj, 311*(7004), 555-557.

Pöchhacker, F. (2008). Interpreting as mediation. In C. Valero-Garcés & A. Martin (Eds.), *Crossing borders in community interpreting: Definitions and dilemmas* (pp. 9-19). Amsterdam & Philadelphia: John Benjamins.

Robb, N., & Greenhalgh, T. (2006). 'You have to cover up the words of the doctor': The mediation of trust in interpreted consultations in primary care. *Journal of health organization and management, 20*(5), 434-455.

Rodríguez, A., Betancor, V., Delgado, N., Rodríguez, R., & Pacios, A. (2008). Los turistas nos visitan, los inmigrantes nos invaden: Un estudio de la percepcion de amenaza desde el concepto de grupalidad percibida. *Revista de Psicología Social, 23*(1), 41-52.

Rosenberg, E., Seller, R., & Leanza, Y. (2008). Through interpreters' eyes: comparing roles of professional and family interpreters. *Patient Education and Counseling, 70*(1), 87-93.

Schapira, L., Vargas, E., Hidalgo, R., Brier, M., Sanchez, L., Hobrecker, K., & Chabner, B. (2008). Lost in translation: Integrating medical interpreters into the multidisciplinary team. *The oncologist, 13*(5), 586-592.

Simeoni, D. (1998). The pivotal status of the translator's habitus. *Target, 10*(1), 1-39.

Tipton, R. (2010). On trust: Relationships of trust in interpreter-mediated social work encounters. In M. Baker, M. Olohan, & M. Calzada Pérez (Eds.), *Text and context: Essays on translation & interpreting in honour of Ian Mason* (pp. 188-208). Manchester: St. Jerome.

Valero-Garcés, C. (2003). Una visión general de la evolución de la Traducción e Interpretación en los Servicios Públicos In C. Valero-Garcés (Ed.), *Traducción e Interpretación en los servicios públicos: Contextualización, actualidad y futuro* (pp. 3-35). Granada: Editorial Comares.

Valero-Garcés, C. (2008). Hospital interpreting practice in the classroom and the workplace. In C. Valero-Garcés & A. Martin (Eds.), *Crossing borders in community interpreting: Definitions and dilemmas* (pp. 165-187). Amsterdam & Philadelphia: John Benjamins.

Valero-Matas, J. A., Coca, J. R., & Valero-Oteo, I. (2014). Análisis de la inmigración en España y la crisis económica. *Papeles de población, 20*(80), 9-45.

Villarruel, A. M., Portillo, C. J., & Kane, P. (1999). Communicating with limited English proficiency persons: Implications for nursing practice. *Nursing Outlook, 47*(6), 262-270.

Wilensky, H. L. (1964). The professionalization of everyone? *American Journal of Sociology, 70*(2), 137-158.