Exploring the Boundaries: Attitudinal autonomy in healthcare interpreting

Maria A Aguilar-Solano, University of Massachusetts Boston

Available at: https://works.bepress.com/maria_aguilar/3/
Exploring the Boundaries: Attitudinal autonomy in healthcare interpreting

This paper is part of an ongoing PhD thesis that examines the self-perception of several groups of healthcare interpreters / different professional prestige and status / This thesis explores the relationship between interpreters and both service providers and service users and of their own position within Spanish hospitals. Today I would like to discuss the value of the theoretical concepts of “boundary” (Bourdieu) and “attitudinal autonomy” (F&D) and how their combination can provide a better understanding of how public service interpreters in healthcare settings in Spain can set, maintain or shift the boundaries of the field while creating a professional identity and gaining prestige and status (Waden 1999, Bourdieu 1993/2009).

Research into Interpreting Studies, particularly in the area of Public Service Interpreting, has slowly been changing its focus from research into the interpreting product, such as transcripts of interpreted interaction, to a more humanistic approach that studies the interpreter as a social agent, as we can observe in studies by Wadensjo (1998), Inghilleri (2003) or Tate & Turner (2002), etc. Although research such as that by Angelelli (2004), Tipton (2008 & 2009) or Sela-Sheffy & Shlesinger (2010) offers a closer look into the interpreter’s role and identity, there are still relatively few studies that provide healthcare interpreters with the opportunity to tell us more about themselves, their work, their perceptions and how they handle the conflict between what is expected from them and what they can deliver, the eternal dilemma between doxa, based on the principles of neutrality and impartiality, and the requirements of the field in practice.
The approach to the study of interpreters’ professional identity that I am about to present is particularly relevant since most studies dealing with the professional identity of interpreters and other professionalization issues focus on ideas such as authority control or the institutionalization of the field rather than on how interpreters’ perceive themselves as a in-group. They tend to give more importance to external features and structural components than to interpreters’ self-perception, as we can see in the work of Valero (2004), Rudvin (2007) or Angelelli (2006) where the main focus is codes of ethics, standards of practice or training programmes.

First I will present a brief overview of the healthcare interpreting context relevant for this study. Then I will discuss Bourdieu’s notion of boundary – its value as a concept and some deficiencies in Bourdieu’s description of the term, and finally I will explain what is meant by “attitudinal autonomy” and how I intend to investigate it in this particular context.

Although I am not going to enter into great detail about the overall study, it is necessary to present the Spanish context due to the complexity found. According to data collected at the 7 largest healthcare institutions along the Spanish Southern coast, we can identify several types of agents acting as interpreters: non-trained volunteers who are very well established in the healthcare institutions and work as part of the medical team, trained interpreters who work at the hospital only when they are called on and who are hired through local translation agencies, T&I students from local universities who wish to gain some experience as PSI as part of their final year assignment, and the usual ad hoc bilingual staff members, friends or relatives of patients. Moreover, the Spanish healthcare context is also special in that there is a wide range of patients, including tourists and EU-retired citizens from the UK and Germany, Eastern European immigrants with residence status, and undocumented
immigrants from the Maghreb and central Africa. Such variety means a wide range of languages, cultures, and particularly different needs when it comes to healthcare solutions and requirements. In this sense, interpreters face ever-changing power inequalities between service providers and service users depending on patients’ cultural and social capital, such as their social status or their familiarity with Spanish healthcare institutions.

There have been very few achievements within the Spanish field of healthcare interpreting with regard to the public recognition of the figure of the healthcare interpreter.

In this sense, healthcare interpreting is a particularly problematic area not only for practitioners, but also for academics who find it very difficult to identify a common point that brings cohesion to the field. Unlike conference interpreting or other highly regulated PSI settings such as court interpreting, healthcare interpreting is an unregulated, flexible, loose field where interpreters lack prestige and public recognition, or what B calls ‘symbolic capital’. In other words, it is a field where individuals are constantly struggling to identify a legitimate definition of the interpreter. This flexibility and lack of a legitimate professional identity with its own mental dispositions or ‘habitus’ means that interpreters are constantly creating new positions within the field, posing a challenge for the field boundaries which are constantly shifting according to the field activity.

Boundary as defined by Bourdieu in his Theory of practice indicates the autonomous status of the field with regard to other fields around, and in this particular case the medical field would be the main adjacent field to the field of healthcare interpreting. The autonomous status of fields allows them to define its own activity.
Field boundaries start to build up when there is a gap within an existing field; this gap means an opportunity to create a new common practice. For example, in the Spanish medical field whenever a non-Spanish speaking patient requires assistance an opportunity is generated for healthcare interpreters to fill in that gap by providing a service.

By engaging in a common interest (an inclination and ability to succeed in a given endeavour), individuals differentiate themselves from outsiders who do not do the same and they produce a series of resources which they can accumulate and use as bases of power. Since the activity of the healthcare interpreting field in Spain is so loose and chaotic there is a need to find a focal point that helps bring the activity of the PSI field together on a common ground which will help set its boundaries. Boundaries are essential for both practitioners and academics alike, in the sense that boundaries delimit the activity of the field and also allow practitioners to impose their own dispositions; and also for academics in the sense that there is a more concrete field of research.

Although Bourdieu provides the main theoretical framework for my research project due to its extensive use in researching a wide variety of social settings, particularly those with a lack of institutionalized boundaries, including the field of public service interpreting (see Inghilleri 2003, 2005a and 2005b), it does have a number of limitations, particularly the concept of boundaries. A number of scholars have criticized Bourdieu’s concept of boundaries for its high level of abstraction and generalization, something which can make the researcher’s task more difficult (Jenkins 2002). These criticisms are of great importance for this particular research study. In this sense, despite Bourdieu’s emphasis on empirical research as the basis for analysing the boundaries of fields, he does not provide a
solution to identifying these boundaries effectively (Jenkins 2002) for this concept is too broad to apply it to a concrete body of research (Brubaker 2004).

In order to overcome the problem that the conceptualization of the field boundaries represents for this study, I will be drawing on the concept of attitudinal autonomy as defined by F&D which I believe can help setting the boundaries of the field of healthcare interpreting, as I will now go on to explain.

Attitudinal autonomy is a concept introduced by F&D (1985) as part of a model of professionalization. This model is interesting because unlike traditional models of professionalization that focus on formal and authoritative control of the field activity, such as professional associations, academic training institutions, codes of conduct or other administrative bodies, it centres on the internal dispositions and power of individuals, bringing it closer to a bourdieusian perspective. F&D’s model is based on the relationship between individual practitioners and society and places more emphasis on individuals and their environment than on the organizational structures of the field.

From this perspective, developing attitudinal autonomy and acquiring a professional identity can be viewed as a social trajectory where practitioners struggle for prestige and status and utilize their specialized knowledge (or cultural capital) as a tool to differentiate themselves from others and set the field boundaries (Randall and Kindiak 2008). There are similarities between this view and Bourdieu’s idea of ‘field’ as a field of struggle revolving around the search for power and prestige (or symbolic capital) to acquire an autonomous status. Accordingly, it is necessary to consider the power that practitioners of certain professions exert over their clients and the wider community (Forsyth and Danisiewicz 1985) when they provide a service which is essential to society and perceived as such (Cree 1995). In the case of PSI, interpreters
hold an enormous amount of potential power since they are the only ones that can put different languages and cultures in contact (Sela-Sheffy & Shlesinger 2008).

The concept of attitudinal autonomy has hardly been explored in relation to the field of PSI. Autonomy allows practitioners to make their own decisions without external pressures from their clients and their employing organization (Hall 1969:82) which is essential to achieving a professional status. Autonomy, “the freedom to make discretionary and binding decisions consistent with one’s scope of practice and freedom to act on those decisions” (Batey & Lewis 1982), can thus be applied to any field of practice. Attitudinal autonomy provides individuals with the belief that they are free to exercise judgement in decision making, it reflects the way individuals feel and view their work. In this sense, attitudinal autonomy allows individuals to exercise freedom despite organizational and structural constraints and freedom to act within the context of responsibility and caring for others (Lach 1992).

Autonomy is thus understood as clients’ trust that practitioners will carry out their task successfully according to their competence (Anderson & Western 1976) since “professionals provide work that is important for the well-being of individuals and society” (Rudvin 2007:53). Attitudinal autonomy is an attribute that is born inside the individual rather than acquired through the power invested by professional associations and other administrative bodies.

In order to develop attitudinal autonomy, F&D explain that the first step would be to develop a predisposition towards 3 characteristics for the job: essentiality, complexity and uniqueness. Consequently, interpreters would need to promote those characteristics among their clients and employing organization in order to achieve successful public recognition.
- Poor adherence to follow up visits and treatment regimes, often attributed to poor comprehension on both sides, can lead to costly complications of the disease, medical services and comparatively poor quality of care. According to the reviewed works, such inequalities often correspond to and are exacerbated by language barriers. In this way, patients with limited autochthonous language proficiency constitute a highly vulnerable population. (Ribera et al. 2008)

- We can identify plenty of examples which illustrate how the use of professional interpreters can significantly improve both quality of care and equity of care for foreign patients.

- The literature demonstrates how linguistic barriers have negative implications for quality of care.

- Absence of interpreting has been associated with a higher utilisation of diagnostic investigations (Hampers et al. 1999), lower uptake of preventive services such as breast examinations (Woloshin et al. 1997), lower adherence to self-monitoring of blood glucose (Karter et al. 2000) and lower patient satisfaction (Baker et al. 1998; Cararasquillo et al. 1999; Morales et al. 1999).

- Patients who were assisted by professional interpreters exhibited a higher willingness to return to the same ED in case of new problems than those who were not assisted by an interpreter (Cararasquillo et al., 1999).

- Other studies also show an increase in satisfaction when professional interpreters were used (Ku & Flores, 2005; Bischoff & Grossmann, 2007).

- The literature goes on to show that the use of professional interpreters increases trust as well as satisfaction and reduces the risk of health problems related to language barriers (Ku & Flores, 2005; Bischoff & Grossmann, 2007).

- The use of relatives is frequently highly problematic, both for the patients themselves, who have to reveal extremely sensitive and distressing personal information that they may not want
family members or friends to know, and for the relatives or friends, who are interpreting distressful content (Bischoff & Loutan 2004).

- bilingual staff found it difficult to separate their role as healthcare professionals from their role as interpreter which lead them to make assumptions about patients’ conditions based on their medical expertise (Angelelli 2006).

- patients may not be as forthcoming about their behaviour, symptoms or concerns, due to the lack of confidentiality that having family or friends in the room entails. And vice versa, for friends or relatives may decide to hide some information to protect the patient’s feelings or to act on behalf of the patient (Rosenberg et al 2008).

- Volunteers are often untrained and are not aware of issues such as medical confidentiality. Moreover, they lack interpreting skills and knowledge of the healthcare terminology and functioning of the healthcare system (Phelan & Parkam 1995).

 Complexity: the job requires a combination of skills and techniques.

- Robb & Greenhalgh (2006): interpreters with linguistic skills, knowledge of the NHS system and a commitment to confidentiality were highly regarded among hospital members of staff and they gained the trust of the service provider

- Mayoral Asensio (2003:78):

  - Knowledge of languages
  - Knowledge of the functioning of governmental administrative services.
  - Knowledge of medical terms and procedures, and general knowledge of the functioning of healthcare services.
  - knowledge and skills related to social work
  - Interpreting skills, particularly in the case of consecutive interpreting and note-taking

In order to examine attitudinal autonomy F&D developed a 3 phase model that I am presenting slightly simplified here. The 1st phase is where individuals internalize the belief that the activity they do is complex, essential and unique. The 2nd phase is where individuals develop strategies to promote these characteristics among their
client and employing organization. Finally, the third phase looks at whether these strategies to promote the activity as complex, unique and essential have achieved successful recognition.

Since my project only focuses on interpreters’ self-perception, only phase 1 and 2 are relevant. In this sense, data will be collected using focus groups as a qualitative research method which has proved very useful to study cross-cultural and healthcare contexts (Kitzinger 1995, Colucci 2008). Focus groups have not been extensively used in PSI, although some examples can be found in Tipton, Angelelli or Hsieh. 8 focus groups of 5/6 participants will be organised in a total of 4 Spanish healthcare institutions. A focus group guide will be developed, consisting of open-ended questions followed by prompts with the aim of gaining a detailed understanding of interpreters’ experiences and perceptions regarding their professional autonomy. Focus groups will be video recorded, transcribed and coded accordingly.

By developing these three characteristics and promoting them among their clients and employing organizations, HI can acquire attitudinal autonomy which can then lead to a professional identity and will allow them to negotiate the boundaries of their activity and create positions which provide solutions for both service users and service providers.

Attitudinal autonomy will thus permit interpreters to openly challenge the doxa based on neutrality and impartiality and other structural constrains externally imposed by healthcare authorities who often place the interpreter outside the interaction.

In summary, a high degree of attitudinal autonomy (Bourdieu & Wacquant 2005) is a sign of the autonomous status of fields which are characterised by sharp boundaries and cohesive identity. In this sense, by combining both frameworks, it will be possible to effectively identify the internal boundaries of the field of healthcare interpreting by
considering 3 essential aspects of autonomy which include the categorization of the service provided by healthcare interpreters in Spanish hospitals as essential, exclusive and complex. Internal boundaries will allow interpreters to actively use their dispositions and strategies to provide a better service for both doctors and patients and therefore gain prestige and status.

Further research will include a third phase consisting on a study of doctors’ and patients’ perception of the autonomy of healthcare interpreters. This third phase will show whether interpreters’ strategies to promote their work as complex, unique and essential have been successful. Successful public recognition can lead to awareness and institutional support on the part of the healthcare institutions which can help establish structural autonomy in the form of institutional boundaries.