Living Interpreting: role conflict in medical settings from a sociological perspective

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The role of interpreters, associated with a “social position”(Pöchhacker, 2016), has wide-ranging connotations in community interpreting. It has been explored extensively in various terms such as bridge (Angelelli et, al., 2007; Pöchhacker, 2000), interpreter’s alignment (Goffman, 1981; Wadensjö, 1998; Merlini & Favaron, 2005), and co-participant or co-constructor of meaning (Angelelli, 2004a, 2004b; Davidson, 1998; Metzger, 1999; Bolden, 2000). The roles of medical interpreters, however, are different from (or perhaps bigger than) those in legal or sign language settings given the different nature and goals of their communicative functions (Mikkelson & Jourdenais, 2015; Angelelli, 2004a).

Role conflicts arise when there are different role expectations for one or more participants, interpreters in particular, in an interpreting event. It is found more in conflict-related scenarios, such as court or public services interpreting (Inghilleri, 2003, 2005, 2015). Drawing on Pierre Bourdieu’s sociological theory, this qualitative study analyzes the role conflicts in medical settings by viewing interpreting practices as social, cultural and institutional acts intrinsically connected to power relations and control involving three parties/agents. The data include one Mandarin interpreter’s three-month interpreting experience in local hospitals in Hawaii, field notes, and a series of semi-structured post-interpreting interviews. All were recorded and transcribed with informed consent.

Adopting such key concept as *field, habitus*, *capital* and *illusio* as the research framework, this paper first explains the *field* in which medical interpreting occur, then point out that out of the *habitus* and sustained by *capital* and *illusio* each possess, which constitute the multi-sided medical interpreting practices, role conflicts arises. By triangulating data, this paper finds role conflict may appear: 1) within the interpreter herself (one-sided), 2) between the interpreter and service-providers / patients respectively (two-sided), and 3) among them (multi-sided). This happens mainly due to the inter-related relationship between *capital* and *habitus* possessed by different agents. Specifically, the reasons behind include: 1) more cultural *capital* from the interpreter than the patient, 2) shared cultural and/or social *capital* between the interpreter and the patient, 3) different *habitus* of each agent respectively, and 4) the interpreter’s *illusio*. Implications for practicing professionals in medical interpreting are discussed and suggestions for further studies also provided.