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Co-agency in healthcare interpreting: The interpreter's sociocultural and interpersonal role in clinical communication

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This study examines interpreter co-agency in healthcare settings through three French–Hungarian medical interpreting assignments conducted in Hungary between 2023 and 2025. Moving beyond the traditional conduit model, it conceptualizes healthcare interpreters as co-agents whose work is shaped by the clinical situation and co-constructed with patients and healthcare professionals. Adopting a participant-researcher design, the analysis draws on data triangulation across written agreements, pre-assignment correspondence, and post-assignment field notes. The findings show that healthcare interpreters are expected to manage sociolinguistic and pragmatic choices (e.g., forms of address, degree of formality, register shifts, and culturally sensitive terminology), to mediate administrative and systemic differences between healthcare systems, and to contribute to the interpersonal organization of clinical interaction. In high-stakes contexts such as cancer, HIV diagnosis, and emergency care, these expectations extend to negotiating emotional presence, physical proximity, gendered constraints, and interpreting modes. The study concludes that co-agency is an expectation-driven and structurally embedded feature of healthcare interpreting, shaped not only within consultations but also through institutional arrangements and preparatory communication.

Keywords: *healthcare interpreting, interpreter co-agency, sociolinguistic mediation, cultural mediation, interpersonal communication*

Introduction

As decades of research into doctor–patient interactions have demonstrated, healthcare communication is a dynamic process shaped by changing clinical practices, patient expectations, and sociocultural factors (Bigi, 2016). Effective communication in healthcare plays a critical role in enhancing positive patient outcomes, comprehension, supporting adherence to treatment plans, and increasing overall patient satisfaction (Ghosh–Joshi–Ghosh, 2020). Conversely, breakdowns in doctor–patient communication – such as poor information exchange, limited emotional responsiveness, and inadequate patient involvement in decision-making – undermine trust, mutual understanding, and adherence. These breakdowns are associated with reduced treatment compliance and lower patient satisfaction (Street et al., 2009).

In interpreter-mediated encounters, communicative demands become even more complex due to the need to negotiate sociolinguistic, cultural, and interpersonal boundaries (Wadensjö, 1998). This study adopts a sociolinguistic perspective on interpreting competence, focusing on how the interpreter negotiates roles, makes pragmatic choices, and manages interaction in institutional healthcare encounters. Interpreting competence is therefore not understood as a purely linguistic skill, but as a practice that is shaped by the concrete clinical situation (such as the type of medical setting, institutional constraints, and emotional stakes) and co-constructed through the interpreter's interaction with patients and healthcare professionals.

The roles of the interpreter in institutional discourse have received growing scholarly attention, particularly in the fields of community and healthcare interpreting (e.g., Angelelli,

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2019; Hale, 2015; Horváth, 2021; Horváth–Gabányi, 2025; Leanza, 2005; Wadensjö, 2009). Traditionally, interpreters were conceptualized as neutral and invisible language conduits (Reddy, 1979), based on a model of communication that views meaning as a fixed message transmitted linearly from sender to receiver (Horváth, 2021). Within this framework, the interpreter's task was limited to transferring information between languages without influencing content, interactional dynamics, or interpersonal relations. The interpreter was therefore likened to a "modulator/demodulator": a purely technical relay that converts linguistic input into output, without exercising agency, interpretive or contextual evaluation. This was especially true for conference interpreters working in booths, physically separated from other participants of the event, with little opportunity for interaction and with a role largely restricted to message transmission (Pöchhacker–Shlesinger, 2002).

In contrast, the past two decades of empirical research have challenged this paradigm (e.g., Angelelli, 2019; Horváth, 2021), as studies increasingly demonstrate that interpreters function as co-participants rather than neutral intermediaries (Wadensjö, 1998; Roy, 2000). Interpreters frequently extend their role beyond linguistic mediation, undertaking intercultural facilitation and, in many cases, accompanying individuals in their interactions with institutional authorities (Horváth–Gabányi, 2025). Interpreted encounters are embedded in social, cultural, and emotional expectations, as well as asymmetrical knowledge structures. All participants – including interpreters – bring their own social identities (e.g., age, gender, ethnicity, class, professional status) that shape the interaction (Angelelli, 2019). Research has therefore redefined the role of the interpreter as that of an active co-agent who contributes not only to message transfer, but also to the facilitation of communication at a sociolinguistic, cultural, and interpersonal level.

Healthcare settings highlight this shift most clearly, given their high-risk and emotionally charged nature, where misunderstandings can have immediate consequences for diagnosis, treatment decisions, patient safety, and trust. Even when institutional policies advocate for interpreter neutrality, interpreters often report perceiving themselves as visible and emotionally engaged (Angelelli, 2004). For example, medical interpreters report higher levels of affective involvement and cultural mediation than legal or conference interpreters (Angelelli, 2004). These findings suggest that interpreter visibility is not fixed but dynamic and context-dependent. As Leanza (2005:171) observes, strict impartiality may not only be unfeasible in healthcare settings but also counterproductive when cultural or emotional mediation is necessary for mutual understanding.

In this study, interpreter co-agency is examined along two interrelated dimensions: (1) a sociolinguistic–cultural dimension, encompassing register, address forms, degree of formality, and lexical choice; as well as (2) an interpersonal dimension, including role negotiation, alignment with participants, management of turn-taking, spatial positioning, and emotional presence. The aim of the paper is to demonstrate how interpreter co-agency manifests in healthcare settings through the analysis of three French–Hungarian medical interpreting assignments. Conceptualizing the interpreter as a co-agent enables a practice-based understanding of the complex tasks interpreters are expected to perform in medical contexts. This study is guided by the following research question: *How does interpreter co-agency manifest in healthcare settings, based on patients' and healthcare professionals' expectations?*

Data and methods

The analysis draws on three data sources: (1) written agreements between the language service provider and the clients, which outline patient and institutional expectations; (2) pre-assignment email correspondence, which provides insight into logistical planning and expected roles; and (3) field notes compiled immediately after each assignment to reduce retrospective rationalization, offering reflections on interpersonal dynamics and sociolinguistic factors. The

study is based on three interpreter-mediated French–Hungarian medical encounters conducted in Hungary between 2023 and 2025 (see Table 1). The three cases were selected purposively because they represent different medical settings (long-term care, outpatient consultation, emergency care), patient profiles, and institutional arrangements. Together, they allow for reflection on how interpreter co-agency manifests in medical interpreting. All encounters occurred in Hungary, with anonymized identifying data (e.g., the city, patient origin, names, hospital and language service provider) anonymized. Ages are reported in decade ranges to protect participant confidentiality. An overview of the three cases is presented in Table 1.

Table 1. Three healthcare interpreting assignments

	Patients' gender and age	**Medical context**	**Patient's companion**	**Assignment**
Case 1	woman (70–80)	hospitalization for advanced breast cancer treatment (2 weeks)	accompanied by husband	via language service provider
Case 2	man (20–30)	HIV testing and diagnosis in outpatient clinic (2 hours)	unaccompanied	initiated directly by the patient
Case 3	woman (40–50)	emergency care following a car accident with multiple fractures (3 days)	accompanied by husband	arranged via the French embassy in Hungary

The author occupies a dual role as both interpreter and researcher, because access to naturally occurring data is limited by ethical, institutional, and confidentiality constraints. Although based on a small number of cases and on a researcher-participant paradigm, the study presents data triangulation and reflexive analytic steps, combining contractual documents, correspondence, and field notes to examine interpreter co-agency from complementary perspectives. The aim is not generalization, but analytical insight into expectations placed on interpreters in specific clinical contexts. To mitigate the risk of self-evaluation bias, the analysis does not focus on the quality of the interpreter's renditions, but on externally observable expectations, requests, and interpersonal positioning. Analysis proceeded in three stages: (1) close reading of agreements and correspondence to identify explicitly formulated expectations; (2) thematic examination of field notes focusing on moments of role negotiation, sociolinguistic choice, and interpersonal positioning; and (3) cross-case comparison to identify recurring patterns of expected interpreter behavior.

Interpreters' co-agency

The analysis of the three interpreter-mediated French–Hungarian medical encounters reveals that interpreter co-agency extends beyond linguistic transfer to encompass sociolinguistic, cultural, and interpersonal dimensions. In each case, the interpreter was not merely expected to reproduce utterances faithfully, but to respond to patient preferences, professional requests, and environmental constraints. Co-agency is thus embedded in the healthcare interpreter's expected role as an actor within the broader communicative event.

Sociolinguistic and cultural dimension

Based on the three cases presented above, clients and healthcare professionals expected the interpreter to navigate sociolinguistic features of communication (particularly forms of address, register, degree of formality, and cultural elements). These linguistic choices index social relationships, institutional authority, and degrees of emotional proximity, thereby shaping how participants position themselves and each other within the interaction.

In Case 1, the elderly patient explicitly requested to be addressed by her first name and used the informal pronoun *tu* 'you [informal]' when speaking to the interpreter, thereby creating a personalized tone. Conversely, the patient and the medical professionals consistently used the formal tone with one another (e.g., *vous* 'you [formal]', *madame* 'madam', *monsieur* 'sir', *docteur(e)* 'doctor'). Interestingly, the healthcare professionals requested that the interpreter avoid using first-person singular forms when interpreting clinicians' speech, favoring third-person references to maintain institutional boundaries (e.g., not *I will prescribe*, but *the doctor will prescribe*). These requests reflect an institutional effort to delimit interpreter visibility, and they require the interpreter to create their own agency during the encounter.

In Case 2, the young male patient preferred a highly informal style, requesting mutual use of *tu* 'you [informal]' and frequently employing non-standard lexical items during the consultation (e.g., *choper le VIH* 'to catch HIV', *flipper* 'to freak out'). The interpreter was asked by the medical professional to accommodate this tone while rendering emotionally sensitive terms such as *HIV-positive* in appropriate and non-stigmatized ways (e.g., *personne vivant avec le VIH* 'person living with HIV', *séropositif* 'serum-positive'), aligning with public health discourse norms. This hybrid register – combining medical terminology, emotionally charged and informal lexical items – required continuous sociolinguistic awareness and adaptation.

In Case 3, both the patient and her husband consistently addressed the interpreter using formal pronouns and address forms (e.g., *vous* 'you [formal]', *monsieur* 'sir'). The healthcare professionals likewise maintained a formal and professional register. In this context, the interpreter was expected to reinforce institutional authority and interpersonal distance by sustaining a consistent formal discourse across all participants.

The interpreter was also called upon to mediate institutional and systemic differences between the French and Hungarian healthcare contexts. For instance, in Case 1, when the patient experienced a medical complication while temporarily staying outside the hospital, she and her husband attempted to seek emergency assistance. However, they expected the emergency service to function as it does in France, where the fire brigade is often the first responder to medical emergencies and is trained to intervene in both fire and medical situations. In Hungary, by contrast, emergency medical response is provided by a specialized ambulance service. This mismatch created confusion about whom to contact. The interpreter was called upon to clarify the difference between the two emergency systems to both the patient and the medical staff. This situation exemplifies how interpreter co-agency extended beyond language mediation to encompass institutional orientation, helping align differences in the two healthcare systems. In Case 2, the patient presented French medical documents, including a diagnostic summary that lacked the physician's stamp. The interpreter was asked to contextualize the document, explaining that stamped validation is not uniformly required in the French outpatient system.

Across all three cases, co-agency was not limited to transferring a message but extended to sociolinguistic awareness and cultural clarification. The interpreter was expected to draw on knowledge of both healthcare systems to resolve ambiguity, legitimize documentation, and prevent misunderstanding. As such, co-agency here consisted of responding to cultural expectations that positioned the interpreter as a knowledge broker between systems, not merely a language mediator.

Interpersonal dimension

In Case 1, the interpreting assignment extended over a two-week hospital stay and involved multiple departments and healthcare professionals. As indicated by the patient, the interpreter's ongoing presence and growing familiarity provided a sense of continuity and stability within the hospital environment marked by frequently changing medical staff. The interpersonal

dimension of co-agency was reinforced by the patient's consistent use of informal language, which stood in contrast to the professional distance maintained by medical personnel. The interpreter was also expected to be reachable by phone at night in case of emergencies, reflecting the perceived value of interpersonal accessibility. The interpreter was also consulted in advance regarding preferred interpreting modes and was expected to alternate, based on their own professional judgment, between sight translation (e.g., translating French medical documents), liaison interpreting, consecutive interpreting, and chuchotage. These diverse communicative demands reflect an institutional framing of the interpreter as a multi-functional resource. Environmental conditions in the hospital further shaped the interpreter's role. Interactions often took place in shared patient rooms with multiple sources of background noise. The interpreter was expected to manage speaker positioning, request clarification, and adjust mode depending on acoustic constraints.

In Case 2, the interpreting assignment was initiated directly by the patient, who contacted the interpreter without institutional intermediation. He explicitly requested "sentence-by-sentence" interpreting, reflecting a need for enhanced cognitive processing and emotional reassurance during a sensitive consultation involving HIV testing and diagnosis. Throughout the encounter, the interpreter was positioned not only as a linguistic facilitator but as an interpersonal co-agent. The patient asked whether HIV remains a stigmatized condition in Hungary, thereby positioning the interpreter as a culturally competent interlocutor capable of framing illness within its broader social context. At another point, the patient reached out for a handshake and inquired, *As-tu peur de me toucher?* 'Are you afraid of touching me?' – a gesture that functioned both as an invitation for connection and as a test of perceived social distance following his status disclosure. The interpreter's decision and response in these moments contribute to the emotional dimension of the consultation, underscoring the interpersonal implication of co-agency.

In Case 3, although the interaction took place in an emergency setting with limited opportunity for rapport-building, the interpreter was nonetheless expected to demonstrate a high degree of interpersonal sensitivity. The female patient, accompanied by her husband and experiencing significant physical trauma, had explicitly requested a female interpreter in advance; however, no such professional was available at the time. During the encounter, the male interpreter was asked to remain in the room to interpret instructions while the patient was being undressed for examination and imaging procedures. At the same time, the patient requested that the interpreter turn away to preserve her modesty, indicating a simultaneous need for verbal support and spatial distance. In another moment, the patient experiencing visible distress reached out and requested to hold the interpreter's hand, seeking non-verbal reassurance.

As stated above, all clients expected the interpreter to contribute to the interpersonal dimension of the encounters. Particularly in emotionally sensitive or prolonged interactions, their presence was framed not simply as functional but as supportive. Interpreter co-agency also operated at the level of institutional and environmental adaptation. The interpreter was expected to manage turn-taking, choose interpreting modes, adapt to spatial constraints, and ensure availability beyond scheduled appointments. These responsibilities highlight the interpreter's role as an interpersonal co-agent.

Conclusion

This study has examined interpreter co-agency in three French–Hungarian healthcare encounters, highlighting how the interpreter is positioned as an active contributor to clinical communication rather than as a neutral linguistic conduit. Given the small number of cases and the participant-researcher design, the findings do not claim statistical generalizability. Instead, they offer insights into how interpreter roles are expected in specific healthcare contexts.

Across the three assignments, interpreter co-agency emerged as a multidimensional practice encompassing sociolinguistic, cultural, and interpersonal work. The interpreter was required to manage forms of address, degree of formality, and register shifts, balancing institutional norms with patients' preferences for informality or emotional proximity. Cultural co-agency involved clarifying differences between healthcare systems, professional roles, and administrative procedures, particularly in situations where misunderstanding could undermine trust or continuity of care. At the interpersonal level, interpreters were expected to negotiate emotional presence, physical proximity, and gendered expectations, adapting their behavior to the affective demands of cancer, HIV diagnosis, and emergency care.

In this study, co-agency thus emerges as an expectation-driven and structurally embedded feature of healthcare interpreting, rather than as an optional or individual interpreter choice. By foregrounding this dimension, the study contributes to ongoing debates on interpreter roles in clinical communication and underscores the need to conceptualize interpreting competence as sociolinguistic, relational, and responsive to the specific conditions of healthcare encounters.

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