Talking emotions in multilingual healthcare settings. A qualitative study of interpreted-mediated interaction in Italian hospitals

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Abstract

This contribution discusses the results of research on the treatment of emotions in interpreted-mediated interactions in healthcare settings, discussing examples of interpreters' choices excluding or promoting the emotions of the patients in the interaction. The corpus consists of 40 Italian/Arabic interactions and 15 Italian/Chinese interactions. Analysis draws upon Conversation Analysis as well as on studies on Dialogue Interpreting and intercultural communication. Findings suggest that the activity of interpreters may prevent patients' emotions from becoming relevant in the medical encounter, but also that interpreting may promote an emotion-sensitive healthcare, in the interest of a patient-centred model of inter-linguistic medicine.

Introduction: the meaning of interpreted-mediated interaction

Research shows that differences concerning the meaning of health and illness or in the expectations towards the roles of doctor and patient may discourage people from linguistic and cultural minorities from accessing medical care (see American Psychiatric Association 2013). However, citizenship in late modern societies underpins the right of equal access to medical care. Moreover, if social groups are excluded from medical care, this may jeopardize strategies of sanitary control, blinding the "*medical eye*" which is a characteristic of European modernity (Foucault 1973). To help ward off this risk, resources are invested in developing instruments and pro-

cedures to support minority groups in accessing public facilities. Examples of such instruments are social advertising or the employment of health visitors. The focus of this contribution is on another instrument: interpreted-mediated interaction.

Interpreted-mediated interaction is triadic, in involving two primary participants (a service provider and a service user) as well as a third participant (the interpreter) who is required to support the user in accessing the service needed (Angelelli 2004; Baker 2006; Mason 2006; Pöchhacker/Kadrić 1999).

In order to explain the type of interactional work accomplished by interpreters, Wadensjö (1998) suggests that interpreters play a double role: they *translate* and they also *coordinate* the talk activity. Such coordinating activity is intended to facilitate the interaction between the participants of different languages and it is concerned with the promotion of their participation and understanding.

Hence, interpreting may be understood as a form of mediation, and interpreters may be understood as mediators in interlinguistic and intercultural settings. According to Wadensjö the most important function of the interpreter as mediator concerns the promotion of a shared knowledge, together with coordination (Wadensjö 1998: 108). The interpreter is an active participant who manages the flow of information and medical evaluations in the interlinguistic interaction (Davidson 2000: 400, 2001: 170).

As situations requiring mediation are increasingly common in Western medical systems, an important question concerns the effectiveness of mediation in empowering the migrant patient as an active participant in the medical encounter.

1. Methods

1.1 Context and outline of the study

This contribution discusses situations in which interpreters, as linguistic facilitators and as coordinators of intercultural communication, empower or inhibit migrant patients' emotional expressions. In particular, the article focuses on the treatment of patients' emotion in medical settings in the Italian National Healthcare districts of Modena and Reggio Emilia (Emilia-Romagna Region).

Last available statistics (Istituto Nazionale di Statistica 2014) indicate that immigrants in the Modena district are 92,998 (13.3% of the residents); in the Reggio Emilia district the number is 72,302 (13.5% of the residents). In both areas a major driver of organisational change in healthcare systems is the requirement to provide appropriate services for this large migrant population, including interlinguistic and intercultural mediation.

Both the General Hospital Board and the Local Health Board in Modena employ interpreters to help in reception, obstetrics, nursery, paediatrics, gynaecology, neonatology and the family advice bureau. The Reggio Emilia Local Health Board uses interpreters in the outpatients departments and specialized units for the care of women and children. Emilia Romagna Regional Law no.5 of 2004 states that

> the Region promotes, through institutions including Local Health Units and Hospitals, the development of informational channels aimed at immigrant foreign citizens,

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along with activities of intercultural mediation within the social-health field, with the objective of ensuring appropriate knowledge, in order to facilitate access to health and social-health services (Translated by the author).

This research involves four doctors, four nurses and four professional interpreters; all the healthcare professionals are native speakers of Italian. The interpreters are native speakers either of the Tunisian or Jordanian variants of Arabic on the one hand, and of Mandarin Chinese on the other. All the interpreters involved in the research are qualified professionals.

Interpreters working in the research settings are expected to promote the coordination between healthcare providers and migrant patients, in order to enhance the functionality of the healthcare system. Therefore, they are expected to be linguistic interpreters and intercultural mediators, bridging the interlocutors' "cultural reality" and their intercultural relationships when differences in meanings and expectations are observed in communication (Carbaugh 2005; Koole/ten Thjie 2001; Verschueren 2008).

Data discussed in this article were collected as part of a research project entitled *Interlinguistic and intercultural communication: analysis of interpretation as a form of mediation for the bilingual dialogue between foreign citizens and institutions*. The research project was supervised by a Management Coordination Committee (MCC), composed of the research coordinator and the coordinators of healthcare services. The MCC was in charge of decision making on knowledge protection, ethical and legal issues. The privacy of participants was preserved according to the Italian Data Protection Act 675 (31.12.1996).

1.2 Methodology

The analysis discussed here is based on 40 Arabic-Italian and 15 Chinese-Italian conversations recorded in two public healthcare service centres in Italy's Emilia Romagna Region: 1) *Centro per la salute delle famiglie straniere* (the Healthcare support centre for foreign families) in Reggio Emilia, and 2) *Consultorio* (the Local centre for health and social services) in Vignola (Province of Modena). In most cases, the conversations concerned issues related to obstetrics, pediatrics, gynecology and neonatology (47 cases, 85.4%).

Transcription was carried out by the researchers, with the help of non-researching interpreters. All conversations were transcribed following Conversation Analysis (CA) conventions (see Figure 1 below). In all excerpts presented, D is for Doctor, P is for Patient and M is for Interpreter-Mediator. Each line of talk is numbered before the letter used to identify the speaker.

A "three lines" format is used to transcribe the multilingual talk: the first line reproduces the transcribed talk in the original language, the second offers an English word-by-word gloss, and the third a functionally equivalent translation in idiomatic English.

[ ]	Brackets mark the start and end of overlapping speech
(.)	A micropause, hearable but too short to measure
Te:xt	Colons show degrees of elongation of the prior sound
Tex-	Hyphens mark a cut-off of the preceding sound
((comment))	Additional comments from the transcriber
Text	Italics is used for *English translations*
<u>Text</u>	Emphatic utterance
°Text°	Low voice

Figure 1. Transcription conventions (Jefferson 2004)

The conversations are analysed using two sociolinguistic methodologies. The first is based on CA and focuses on how participants co-construct medical conversations through a coordinated system of turn-taking (Sacks *et al.* 1974). The second derives from studies on intercultural communication (Gudykunst 2005; Samovar/Porter 1997; Ting-Toomey/Kurogi 1998). In line with the perspective of intercultural communication studies, the aspect of whether the features of multilingual talk in the data either reproduced or tackled particular cultural aspects of the medical system is analysed, for instance, the marginalisation of emotional expressions.

The excerpts discussed here were selected for their clarity; however, they can be considered fully representative of the kind of mediation processes observed in the entire collection of data.

2.   Results

In the last three decades, the facilitation of emotionally-sensitive relationships between doctors and patients has become an area of primary interest for healthcare professionals. Professionals' engagement in the patients' life-world, including their emotions, is now widely recognised as a key component leading to the successful outcome of medical treatment and care (Mead/Bower 2000; Schouten *et al.* 2007). Doctors' affective involvement in the interaction is considered of primary importance in helping patients comply with treatment (Barry *et al.* 2001; Heritage/Maynard 2006; Robinson/Heritage 2005; Stivers 2002). As a result, healthcare providers are now invited to observe illness through the patient's lens and "treat the patient, rather than just the disease" (Heritage/Maynard 2006: 355).

However, numerous studies show that the patient-centred approach encounters severe difficulties in the case of multilingual medical interaction. Migrant patients struggle to express their emotions and to present their case histories and medical concerns (Davidson 2001; Baraldi/Gavioli 2011). This communicative difficulty can significantly impact the success of medical intervention as well as patients' motivations to follow a prescribed course of treatment (Hsieh 2010).

This section discusses two types of interactions: 1) those in which interpreters exclude migrant patients' emotional expressions, and 2) those in which interpreters promote patients' emotional expressions.

2.1 Interactions that exclude patients' emotional expressions

In the corpus of data, *reduced-* or *zero renditions* (Wadensjö 1998) are the most common types of action limiting the possibility of a direct connection between the doctor and patient's emotions. When producing a reduced rendition, the interpreter excludes some component of a translatable turn, while a zero rendition is the missed translation of the whole translatable turn.

Excerpt 1, which culminates in a long dyadic sequence in Mandarin Chinese (lines 8-27, including an incomplete turn in Italian produced by the interpreter). In the dyad, the interpreter plays a pedagogical role, advocating the use of Western medicine against traditional remedies, which the patient is reluctant to abandon.

Excerpt 1

```
1D:   adesso la pressione é a  posto (.) martedì è sette, vero?
      now   the pressure is in place (.) Tuesday is seven, true?
         now blood pressure is OK, next Tuesday, it is the 7ᵗʰ, right?

2M:   °mmh, mmh°

3D:   allora, gli   dici di portare pazienza perché:
      so,    to him tell of bring   patience because:

4     per  le   prime due settimane ci vedremo spesso
      for  the  first two weeks      us see    often
         now tell him to be patient because in the first two weeks we'll meet very often

5M:   ok, però  l'  orecchio-
      ok, but   the  ear-
         ok, but his ear-

6D:   no, no, no adesso ci occupiamo  dell' orecchio,
      no, no, no now    we work   of the    ear

7     intanto   digli    che    deve  portare    pazienza.
      for now   tell him that   must  bring      patience.
         no, no, no. now we'll take care of his ear, for the moment, tell him that he has to be patient.

8M:   ok (.)  nǐ zhèigè  yuè       jǐnliàng  duō,
      ok (.)  as much    as possible this    month

9     xià gè xīngqī èr, qī hào, xiàwǔ liǎng
      next Tuesday,     the 7th,  at    2:30

10    diǎn   bàn lái     zhèli,
      in the afternoon and come here

11    wǒmen zài gěi nǐ  zuò  xuèyā     jiǎnchá
      we give   you to  do   blood    pressure check
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12   *xīnzàng jiǎnchá*
      heart   check

13   *chī zhège yào,   zhōngyào   bùyào   <u>chī le</u>*
      eat this medicine, traditional Chinese medicine <u>must</u> <u>not eat</u>
         this I recommend you, next Tuesday, the 7[th], at 2:30 you come here so that we check your blood pressure, your heart. And take this medicine, don't take the Chinese medicine any longer.

14P: a:h zhōngyào   bùyào   chī le?
      a:h traditional Chinese medicine,   must not eat?
         ah, I don't take Chinese medicine?

15M: zhōngyào   yīgài bùyào   chī le,
     traditional Chinese   medicine   <u>must</u> <u>not</u> <u>eat</u>,

16   bùyào wàng le,   dào Yìdàlì lái   bùyào chī le,
      must not to forget,   to Italy to come <u>must</u>   <u>not</u> <u>eat</u>

17   tīngdǒng   le méiyǒu?
      to understand not to have?
         no, remember this, you have come to Italy so you
          do not have to take don't eat traditional medicine, don't forget you come to Italy don't take, do you understand?

18P: zhōngyào   bù   lún zhī liàn,
     traditional Chinese medicine   not good,

19   bù néng chī?
      can't   to eat?
         the Chinese medicine, is it not good so I can't take it?

20M: bù néng chīde::   ok?   qīngchu le?   hái yǒu méiyǒu
      can't   eat:: ok? to understand?   still to have or

21   bù qīngchu de?
      not to have unclear?
         you can't ok? Is it clear? Is it clear now or is it still unclear?

22P: zhè yào   gěi W ǒba.   °zhège   yào°
      this medicine they give me.   °this medicine°
         they have given me this medicine
23M: zhège yào   bù yào chīde, ok?
      this medicine not to   eat it, ok?
         you do not have to take this medicine okay?
24   ((to D in Italian)) allora sto   cercando di::
                     so   I am   trying of::
         so I'm trying to

25P: bù   shì   yào   zuò xuèyā dema?
      not to be medicine to do blood pressure?

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26   bù yòng   chī   yào   piàn?
     need not to take medicine sheet?
        aren't those medicines right for my blood  pressure? Shouldn't I take the medicine sheet
        ((of the Chinese medicine))?


27M: bù   yòng   chī   yào   piàn
     need  not  to take medicine sheet
        no, you don't have to take it
```

In lines 1-7 the doctor negotiates which information to pass to the patient with the interpreter. Already from the first lines of the excerpt, the model of consecutive interpreting is abandoned. The doctor addresses the interpreter who becomes immediately a ratified participant in the medical encounter. In excerpt 1, linguistic mediation is a two-phase process. The first phase consists of a dyad involving the doctor and the interpreter (lines 1-7) and the second phase consists of a summarized translation for the patient (lines 8-13).

In line 14 the patient opens the sentence that responds to the last statement in the interpreter's translation with an acknowledgement token, *ah,* which suggests that the previous turn of talk made a difference in his cognitive landscape (Heritage 1984). From this line, a monolingual dyadic sequence generated by the summarised translation develops as a conflict between the interpreter as an agent of Western medicine and the patient, who is reluctant to abandon traditional Chinese medicine.

There are three points worth highlighting in the analysis of the dyadic sequence. The first point concerns the way in which the patient resists the interpreter's instructions. In the turn following the interpreter's instruction (lines 15-17), the patient is expected to react either by accepting (the preferred action) or refusing the instruction.

However, human interaction offers resources to avoid the constraints posed by a polar yes/no question. In this sequence, the patient produces a second question, asking for clarification, thus releasing himself from the pressure placed on him by the question (lines 18-19).

The whole dyadic sequence in Mandarin Chinese may be understood as an exchange between the interpreter's relayed instructions (lines 20-21, 23 and 27) and the patient's interactive attempt to avoid accepting the instructions without explicitly refusing them (lines 22 and 25-26).

The second point is the missed re-inclusion of the doctor in the interaction within (check with the author) the Mandarin Chinese dyad. The doctor, who is the technical expert, is excluded from an interaction of medical relevance. Only in line 24 does the interpreter attempt to explain to the doctor what is going on, to be immediately re-engaged in the dyadic conversation by the patient (line 25).

The third point concerns access to the triadic medical interaction of the social and personal worlds of the patient. In the course of the Mandarin Chinese dyad, the patient tries four times to defend the use of traditional Chinese medicine; however, none of these attempts reaches the doctor, because the interpreter does not translate them. The interpreter systematically produces zero renditions; instead of translating the patient's contributions for the doctor, she answers the

patient directly. Hence, it is the interpreter, rather than the doctor, who manages the patient's reluctance to abandon Chinese medicine.

In the context of medical encounters, narrations are evaluated for the ways in which they contribute to a coherent explanation of disease (Heritage/Lindström 2012). In excerpt 1, the interpreter thinks that the patient's contributions are useless for treatment, so she does not translate them. The interpreter's zero renditions prevent the patient's personal and social world, which includes the use of traditional Chinese medicine to treat blood pressure, from being included in the medical consultation.

It could be argued that the interpreter's zero renditions enable the medical consultation to proceed faster, thus supporting the functionality of the system. However, it could be asked what kind of functionality is supported by these actions. Research by Leanza *et al.* (2010) suggests that zero renditions keep the interaction coherent. Zero renditions may exclude from translation components of the medical discourse parts not comprehensible or manageable by the patient, or part of the patient's discourse not relevant to healthcare treatment. But the same research shows that these types of actions on the part of interpreters hinder the trust building process between patient and the healthcare provider. By creating more distance between the principal participants, zero renditions pose risks to the therapeutic process and, paradoxically, compromise the core values (e.g. self-determinism and informed decision-making) of the Western medical system (Hsieh 2010).

2.2 Interactions that promote emotional-sensitive healthcare

2.2.1 Dyadic interactions

In the corpus it is also possible to appreciate doctors' and interpreters' actions encouraging patients' emotional expressions, giving voice to their concerns, doubts, needs and requests.

The data suggest that doctors' actions promoting patients' emotional expressions are rare, probably because of the difficulty in interacting directly with the patients. For this reason, interpreters' promotional actions are more common than doctors'. Interpreters may promote patients' emotional expressions through different interactional practices, depending on the nature of the interaction, either dyadic (patient-interpreter) or triadic (patient-interpreter-doctor).

In dyadic interactions, the expression of emotions is mainly accomplished through *backchannelling* (Schegloff 1982; Schiffrin 2001), using feedback tokens, continuers or echoing to manifest attentiveness and involvement in patients' emotional expressions.

In excerpt 2, the interpreter displays her attentiveness and understanding of patient's emotional status by producing feedback tokens ("Ah", line 116, "mmh", line 118, "Ah I understand you", line 120).

Excerpt 2

```
113P alnmra btaa almhmol     btaak btktbiliaha
     number of your mobile, can you write for me
          your phone number, can you write it for me?
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114M eh
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115P .hhh °oatoni shi haja orqa  mshan     alfhs°
     .hhh °I have received   the   paper examintation°
          I have received the invitation for an examination
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116M ah (.) ah
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117P kl thlath     snoa:t adoz     alfhs         llrhm
     every three year:s  pass the examination uterus
          I pass the examination for the uterus every three years
```

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118M ॑०
     Mmh
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119P .hh  jtni    alorqa oma bghit   nmshi    lan   lazm
     .hh  received paper   and   don't   go  want  because  I
     would        nfhamham                 ani  amlt alamlia
     have explained   I put the         coil
          I received the paper and I don't want to go, because I would have to explain I put the coil
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120M ah  (.) fhmt aliki
     ah (.) understood you
     ah (.) I understand you
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```
121P knt astna
     You waiting to ask
          I was waiting for you to ask
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```
122M °khfti°  .hh  ank  tiji  otkoni,
     °Afraid°  .hh  were come and being,
          so you were afraid to come and being
```

```
123P ah ano iqlboni almkina oala shi alamlia (.)  alahsn
     yes me examine machine and move the coil (.) I need
```

```
124  Ano itni orqa oiqolo ani mshan alml (.) bs ano iani
     Me better you give   me paper says  (.)I did the
```

```
125  iqlboni
     operation
          yes that they examine me and move the coil or whatever so it's better if you give me a
          paper saying I made the operation so they examine me because they examine the uterus
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In line 116, the interpreter uses a feedback token to support the incipient narration of the patient, which is further promoted by the continuer in line 118.

When the patient expresses her concern (line 119), the interpreter produces the acknowledgement token to display her understanding of the patient's emotions.

In line 122, the interpreter encourages the patient to express her concerns; this is accomplished by producing an *upshot* that advances an interpretation of the patient's emotional stance (Antaki *et al.* 2005). The interpreter's upshot makes the expression of either agreement or disagreement by the patient relevant in the following turn. In both cases further knowledge about the patient's emotions and concerns will be produced. The interpreter's upshot is not a translation; rather, it is a discursive initiative taken by the interpreter that elicits more contribution from the patient.

In lines 123-125, the reiteration of affective and promotional actions culminating in the upshot succeeds in encouraging the patient to express her doubts about the therapy.

In the corpus of data, consecutive translation is often intermingled with other actions which are relevant for the achievement of interactional goals. In many instances, after a translatable turn the interpreter reacts by producing items which differ from translation (acknowledgment tokens, continuers, requests for clarification or direct replies). Such types of actions suspend consecutive interpreting, which is substituted by subsequent summarised renditions of the dyadic sequence. When summarised renditions are provided, the interaction moves to a triadic format, with the re-inclusion of the doctor.

2.2.2 Triadic interactions

The main difference between dyadic and triadic interactions is the inclusion of the doctor in the interaction, which in turn depends on the interpreter's actions. The most important interactional resource used to involve doctors in patients' emotional contributions is *affective formulations*. Formulations are a conversational object recognized and analysed by Conversation Analysis (Antaki *et al.* 2005; Bolden 2010; Heritage 1985). Formulations are summaries of previous turns, which provide directions for subsequent turns by inviting a reaction from the recipients. Formulations

> advance the prior report by finding a point in the prior utterance and thus shifting its focus, redeveloping its gist, making something explicit that was previously implicit in the prior utterance, or by making inferences about its presuppositions or implications (Heritage 1985: 104).

In the data reported on here, interpreters' formulations are interpretations following patient-interpreter dyadic sequences, with adaptations in order to build, expand and recreate the meanings of the dyadic sequences. Formulations, therefore, are not word-for-word translations of contributions in prior dyadic sequences; rather, they rely on the interpreter's discursive initiative and willingness to create common ground between patients and doctors (Cirillo 2010). Specifically, interpreters use formulations as conversational resources that (a) provide an interpretation which highlights content from dyadic monolingual

sequences; and (b) propose inferences about presuppositions or implications of patients' contributions (Baraldi/Gavioli 2008).

Affective formulations are formulations focusing on the emotional aspects of patients' utterances, giving the doctor the chance to share and get involved in the affective dimension of the interaction. Affective formulations make doctors aware of patients' emotions; in this way, patients assume an identity that goes beyond the generic social role of the sick.

In excerpt 3, the patient, who is a woman in her seventh month of pregnancy, complains about a severe abdominal pain (line 1).

Excerpt 3

```
1P:  rhuti     almasha (.) ((Arabic untranscribable))
     emergency went to (.) ((I had pain in my belly))
        I went to the emergency room (.) ((I had pain in my belly))

2M:  ehm  dolori  forti  crampi: (.)
     ehm  pains  strong cramps: (.)
     ((to P)) igiaki        iluagiaa?

3    contractions  did you have?
        ehm, she had a lot of pain with cramp ((to P)) did you have contractions?

4P:  mhm  uagiaa
     mhm  yes

5M:  mmh mmh ((to D)) è  andata   al    pronto soccorso,
     mmh mmh ((to D)) is  gone   to the  emergency room,

6    perché  ha  avuto  del  dolore
     because  has  had  some  pain
        mmh mmh ((to D))she went to the emergency room because she had pain-

7D:  ah un' altra volta?
     ah one other time?
        ah, again?
8M:  sì
     yes

9D:  ((to P))  ti    volevo  chiedere (.)
              to you  wanted   ask    (.)

10   come mai  hai  la faccia così sofferente?
     how  ever have the  face  so suffering?
        ((to P)) I wanted to ask you (.) what's causing all this suffering?

11M: lesh uigihik hek  tabaan bain aleki
     why  face   your  tired is   much
        why do you look so tired?
```

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12P:  .hhh °((Arabic untranscribable))°
      .  hhh °((Partly because of this pain))°

13M:  fi hagia     muaiana  mdaiktk
      is there     something wrong

14    uiani  mdaiik,  blbit    mushkila?
      in your house,  that you  worries?
          is there anything wrong that worries you at home?

15P:  lha (.) [khaifa hhhh.
      no  (.) [frightened hhhh.
          no (.)  [I'm frightened

16D:          [>no   mi sembra a  me:< che abbia
              [>no to me seems to me:< that  has

17    la  faccia sofferente
      the face    suffering
      [no it seems to me that she has a suffering face

18M:  .hh  un po'spaventata perché diciamo pe::r
      .hh  a bit frightened because we say fo::r

19    la pancia
      the belly
          hh a bit frightened because let's say because of her belly

20D:  e:h  ma  è   bellissima  la tua pancia!
      e:h but  is  beautiful   the your belly!
          e:h but your belly, it's beautiful!

21M:  btul shitabii    btiilik      ma   tilaii
      all  normal everything you is fine
          she is telling you that everything is normal, everything is fine
```

The patient's complaint is followed by a complex turn; the first unit of the turn is a translation, while the second unit of the turn is a question. The question projects an expectation of confirmation/disconfirmation of a possible cause of pain (line 3, *did you have contractions?*).

Following the patient's confirmation, the interpreter acknowledges receipt of the information (line 5, *mmh mmh*). The doctor's acknowledgement in line 7 is expressed as a news-receipt marker (*ah again?*), displaying the relevance of the information. In lines 9-10, the doctor displays her interest in the patient's situation with a question (*why you look so suffering?*), which opens the way for a translation by the interpreter and further explanations by the patient.

The doctor's question is followed by a short dyadic sequence in Arabic (lines 11-15) between the interpreter and the patient. The interpreter translates the doctor's question (replacing "*suffering*" with "*tired*") and subsequently displays interest in the patient's emotions.

The doctor interrupts the dyadic sequence to re-express her concern for the patient (line 16-17); however, the doctor's contribution is not translated by the interpreter, who formulates her own understanding of the patient's worry (*"a bit frightened because, let's say for her belly"*, lines 18-19). The interpreter's initiative makes some form of reassurance by the doctor relevant in the following turn (line 20). Finally, the interpreter translates the doctor's reassurance and provides further support to the patient (line 21).

3. Discussion and Conclusion

3.1 Discussion

In the analysed data, zero renditions are used to exclude the patient's emotional expressions from the medical interaction, when interpreters consider such expressions to be irrelevant to healthcare treatment. Narrations are co-authored through interactional activities between teller and recipients (Monzoni/Drew, 2009); the interpreters' support is necessary to the development of patients' expression of emotions.

When, on the other hand, interpreters promote patients' emotional expressions, the conversational resource used is affective formulations. Affective formulations are produced to provide the doctor with the opportunity to tune in to the emotional status of the patient. Affective formulations are inclusive because, while highlighting the emotions of the patient, they also involve the doctor in the formation of affective relations. By producing an affective formulation, the interpreter develops and emphasises an implicit emotional expression as a basis for subsequent interaction.

Zero renditions and affective formulations reveal the interpreter not as a neutral conduit, but as an active agent in the medical interaction. The interpreter's active participation may concern the management of the patient's implicit, difficult, and embarrassed emotional expressions, either excluding or promoting them in the medical interaction (Farini 2012).

3.2 Conclusion

When the interpreter acts as a mediator, otherwise hidden factors, such as patients' emotional expressions, can be relayed to the doctor, which in turn creates opportunities for him/her to respond. Where the interpreter does not act in this way, patients' emotions may be neglected.

The examination of patient-doctor mediated interaction in this study suggests that interpreters may support the relevance of patients' emotions in the medical encounters in two ways: 1) in dyadic interactions by affiliating with the patients, checking the patients' perceptions and emotions; and 2) in triadic interactions by promoting patients' emotional expressions.

In particular, the data show that a conversational resource, affective formulations, is effective in maximising potential empathic opportunities offered by

the patient in the course of dyadic sequences. Through affective formulations, interpreters introduce patients' emotions, doubts and concerns to doctors, making it possible for healthcare personnel to access the many facets of the patient's situation on both the personal and the cultural levels.

Analysis of emergency visits in two large pediatric departments in the USA suggests an association between interpreter training and errors in mediated interactions (Flores *et al.* 2012). Well-trained, professional interpreters demonstrated a significantly lower likelihood of errors than *ad hoc* interpreters such as family members or other hospital staff. The study suggests that training for interpreters may have a major impact on reducing interpreter errors and their consequences in healthcare, improving the quality of care and patient safety.

While the importance of technical competence is acknowledged, it is argued here that professional training should include consideration of the complexity of the interpreter's task. In triadic interactions, the interpreter is never a neutral conduit, so errors in translation are not the only issue; interpreters as mediators necessarily co-ordinate the contingent and changeable construction of multilingual healthcare communication, and the corresponding distribution of communicative opportunities.

Statement

I confirm that all patient/personal identifiers have been removed or disguised so that the patient/person(s) described are not identifiable and cannot be identified through the details of the story.

References

American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders*, Washington, DC, American Psychiatric Association.

Angelelli C.V. (2004) *Medical Interpreting and Cross-cultural Communication*, Cambridge, Cambridge University Press.

Antaki C. / Barnes R. / Leudar I. (2005) "Diagnostic formulations in psychotherapy", *Discourse Studies* 7, 627-647.

Baker M. (2006) "Contextualisation in translator- and interpreter-mediated events", *Journal of Pragmatics* 38, 321-37.

Baraldi C. / Gavioli L. (2008) "Cultural presuppositions and re-contextualisation of medical systems in interpreter-mediated interactions", *Curare. Journal of Medical Anthropology* 31, 193-203.

Baraldi C. / Gavioli L. (2011) "Interpreter-mediated interaction in healthcare and legal settings: talk organisation, context and the achievement of intercultural communication", *Interpreting* 13, 205-33.

Barry C.A. / Stevenson F.A. / Britten N. / Barber N. / Bradley C.P. (2001) "Giving voice to the lifeworld. More human, more effective medical care? A qualitative study of doctor-patient communication in general practice", *Social Science & Medicine* 53, 487-505.

Bolden G. (2010) " 'Articulating the unsaid' via and-prefaced formulations of others' talk", *Discourse Studies* 12 (1), 5–32.

Carbaugh D. (2005) *Cultures in Conversation*, New York/London, Lawrence Erlbaum.

Cirillo L. (2010) "Managing affect in interpreter-mediated institutional talk: examples from the medical setting", *The Journal of Specialised Translation* 14, 55-79.

Davidson B. (2000) "The interpreter as institutional gatekeeper: the social-linguistic role of interpreters in Spanish-English medical discourse", *Journal of Sociolinguistics* 4 (3), 379-405.

Davidson B. (2001) "Questions in cross-linguistic medical encounters: the role of the hospital interpreter", *Anthropological Quarterly* 74 (4), 170-178.

Farini F. (2012) "Interpreting as mediation for the bilingual dialogue between foreign citizens and institutions in Italian healthcare settings", *Diversity in Health and Care* 9, 179-89.

Flores G. / Abreu M. / Pizzo Barone C. / Bachur R. / Lin H. (2012) "Errors of medical interpretation and their potential clinical consequences: a comparison of professional versus ad hoc versus no interpreters", *Annals of Emergency Medicine* 60, 545-53.

Foucault M. (1973) *The Birth of the Clinic*, New York, Pantheon.

Gudykunst W.B. (ed.) (2005) *Theorising about Intercultural Communication*, Thousand Oaks, Sage.

Heritage J. (1984) "A change-of-state token and aspects of its sequential placement", in J. M. Atkinson / J. Heritage (eds.) *Structures of Social Action: Studies in Conversation Analysis*, Cambridge, Cambridge University Press, 229-345.

Heritage J. (1985) "Analysing news interviews: aspects of the production of talk for an overhearing audience", in T. Van Dijk (ed.) *Handbook of Discourse Analysis, Vol. 3. Discourse and Dialogue*, London, Academic Press, 95-117.

Heritage J. / Maynard D.W. (2006) "Problems and prospects in the study of physician-patient interaction: 30 years of research", *Annual Review of Sociology* 32, 351-374.

Heritage J. / Lindström A. (2012) "Knowledge, empathy, and emotion in a medical encounter", in A. Peräkylä / M.L. Sorjonen (eds.) *Emotion in Interaction*, Oxford, Oxford University Press, 256-273.

Hsieh E. (2010) "Provider-interpreter collaboration in bilingual health care: competitions of control over interpreter-mediated interactions", *Patient Education and Counseling* 78, 154-59.

Jefferson G. (2004) "Glossary of transcript symbols with an introduction", in Lerner G. (ed.) *Conversation Analysis: Studies from the First Generation*, Amsterdam/Philadelphia, John Benjamins, 13-23.

Koole T. / ten Thjie J.D. (2001) "The reconstruction of intercultural discourse: methodological considerations", *Journal of Pragmatics* 33, 571-587.

Leanza Y. / Boivin I. / Rosenberg E. (2010) "Interruptions and resistance: a comparison of medical consultations with family and trained interpreters", *Social Science and Medicine* 70, 1888-95.

Mason I. (2006) "On mutual accessibility of contextual assumptions in dialogue interpreting", *Journal of Pragmatics* 38, 359-73.

Mead N. / Bower P. (2000) "Patient centredness: a conceptual framework and review of the empirical literature", *Social Science and Medicine* 51, 1087-1110.

Monzoni C.M. / Drew P. (2009) "Inter-interactional contexts of story-interventions by non-knowledgeable story recipients in (Italian) multi-person interaction", *Journal of Pragmatics* 41, 197-218.

Pöchhacker F. / Kadrić M. (1999) "The hospital cleaner as healthcare interpreter: a case study", in I. Mason (ed.) *Dialogue Interpreting*, Manchester, St Jerome. special issue of *The Translator* 5 (2), 161-178.

Robinson J.D. / Heritage J. (2005) "The structure of patients' presenting concerns: the completion relevance of current symptoms", *Social Science and Medicine* 61, 481–493.

Sacks H. / Schegloff E.A. / Jefferson G. (1974) "A simplest systematics for the organisation of turn-taking for conversation", *Language* 50, 696-735.

Samovar L.A. / Porter R.E. (eds.) (1997) *Intercultural Communication. A Reader*. Belmont, Wadsworth.

Schegloff E.A. (1982) "Discourse as an interactional achievement: some uses of `uh huh' and other things that come between sentences", in Tannen D. (ed.) *Analyzing Discourse: Text and Talk. Georgetown University Roundtable on Languages and Linguistics,* Washington, Georgetown University Press, 71-93.

Schouten B.C. / Meeuwesen L. / Tromp F. / Harmsen H.A.M. (2007) "Cultural diversity in patient participation: the influence of patients' characteristics and physicians' communicative behaviour", *Patient Education and Counseling* 67, 214–23.

Schiffrin D. (2001) "Discourse markers: language meaning and context", in Schiffrin D. / Tannen D. / Hamilton H. (eds.) *Handbook of Discourse Analysis*, Oxford, Basil Blackwell.

Stivers T. (2002) "Participating in decision about treatment: overt patient pressure for antibiotics medication in pediatric encounters", *Social Science and Medicine* 54, 1111-1130.

Ting-Toomey S. / Kurogi A. (1998) "Facework competence in intercultural conflict: an updated face-negotiation theory", *International Journal of Intercultural Relations* 22, 187-225.

Verschueren J. (2008) "Intercultural communication and the challenges of migration", *Language and Intercultural Communication* 1, 21-35.

Wadensjö C. (1998) *Interpreting as Interaction*, London, Longman.