

# **Meanings and forms of intercultural coordination: the pragmatics of interpreter-mediated healthcare communication**

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**Abstract:** Relying on a corpus of interactions in Arabic, Chinese and Italian collected in two public healthcare services in Emilia-Romagna, a region of Northern Italy, this chapter proposes an analysis of healthcare communication involving speakers of different languages.

Studies from the field of applied linguistics show that interpreters are active participants in the interaction, and suggest that they translate but also coordinate the talk. The interpreter is the only participant in the interaction who is able to understand everything that the others say; therefore, s/he is responsible for the flow of information. Focusing on the actions of interpreters as coordinators of the talk activity, this contribution suggests that the analysis of pragmatic phenomena may provide an empirically-based route to create guidelines for effective interpreting in medical settings and may thus have an impact on professional practice.

As affectivity is nowadays considered a key factor for both relational effectiveness and the success of medical therapies, within so-called patient-centred care, this discussion will consider the emotional and identity-oriented dimensions of communication by examining different consequences of interpreters' actions when migrant patients' emotion are made relevant in or excluded from the interaction.

Data indicate that the interpreter has a discriminating power to define the context of the medical encounter, also with regard to the importance of patients' emotional status. Therefore, it is suggested that guidelines for practice and training programmes acknowledge the potentialities of an emotion-sensitive form of interpreting, in order to offer the healthcare personnel the opportunity of accessing the many facets of the patient's situation on both personal and cultural level.

## **1. Introduction**

This chapter proposes an analysis of healthcare interactions involving speakers of different languages and an interpreter. In particular, the analysis focuses on the actions of the interpreter. Pioneering research suggests that interpreters play a crucial role in the medical encounters in that they coordinate talk activity by selecting information to translate, asking and providing clarification, and giving support to the interlocutors (Wadensjö, 1998; Bolden, 2000; Davidson, 2000; 2001; 2002).

In the context of Western medical systems, one of the most important practices used by institutions to encourage foreign groups to access public facilities is interpreter-mediated interaction (henceforth mediation) (Angelelli, 2004; Baker, 2006; Baraldi & Gavioli, 2011; Niemants, 2013; Pöchhacker & Kadric, 1999; Schouten et al. 2012). Mediation is a form of triadic interaction involving two primary participants (the service provider and the service user) and a third one (the interpreter), who is required to support the user in accessing the service needed (Mason, 2006).

Wadensjö (1998) suggests that interpreters play a double role in healthcare communication: they translate and coordinate the talk activity. Such coordinating activity is aimed at making the interaction between the participants of different languages possible and successful and promotes their participation and understanding.

The use of mediation to support the access to medical care is developing in the context of healthcare systems that are gradually acknowledging the importance of patients' emotions for successful treatment and care (Barry et al., 2001; Epstein et al., 2005; Mead & Bower, 2000; Zandbelt et al. 2006).

In opposition to the cultural presuppositions of *doctor-centred healthcare* (Mishler, 1984; Barry et al. 2001), in which the patient is expected to follow instructions delivered by the technical experts in the care of the body, in the framework of a *patient-centred healthcare* it is assumed that doctors' affective involvement helps patients to comply with treatment (Kiesler & Auerbach, 2003; Mangione-Smith et al. 2003; Robinson & Heritage, 2005; Stivers, 2002). In patient-centred healthcare, providers are invited to observe illness through the patient's eyes and "treat the patient, rather than just the disease" (Heritage & Maynard, 2006: 355). In patient-centred healthcare, the most important function of the interpreter-mediator (henceforth: the mediator) is not simply that of translating faithfully what the participants say; rather, it includes coordinating the information flow and promoting interpersonal relationship between the patient and the doctor (Davidson 2000, 2001).

Given that affectivity is nowadays considered a key factor for both relational effectiveness and success of therapies (Charles et al., 1999; Epstein et al., 2005; Mead & Bower, 2000; Zandbelt et al., 2006), the current paper focuses on the emotional dimension in healthcare communication, and discusses interactions in which mediation activity includes or excludes migrant patients' emotions in the healthcare relationship. Integration between translation and coordination is a complex process: the actions of the mediator have an impact on the possibility of the participants to express their personal and cultural views (Baraldi & Gavioli, 2008, 2012; Davidson, 2002; Leanza et al., 2010; Maynard & Heritage, 2005). By analysing the treatment of patients' expressions of emotions in interpreter-mediated medical encounters, this chapter discusses how participants in multilingual encounters co-construct their interactional identities as doctors with specific goals, patients with specific needs, and interpreters with specific responsibilities.

## **2. Methods**

### **2.1 Context and outline of the study**

This contribution focuses on mediators' linguistic choices and their consequences for the development of emotional-sensitive healthcare in multilingual settings.

The corpus was collected within a research project undertaken in the districts of Modena and Reggio Emilia in the Emilia-Romagna region (Italy), an area with a long tradition in efficient healthcare services including so called "migrant-friendly" services (Chiarenza, 2004). Data from the latest national Census (2012) indicate that immigrants in Modena district are 89,346 (12.7% of the resident population), and in Reggio Emilia district, they are 69,060 (13% of the resident

population). Therefore, in both districts a major driver for the institutional change in healthcare systems is the need to provide appropriate services for migrants. The General Hospital Board and Local Healthcare Board in Modena employ mediators to help in reception, obstetrics, nursery, paediatrics, gynaecology, neonatology and the family advice bureau. Reggio Emilia Local Healthcare Board employs intercultural mediators in the outpatients' departments and specialised units for the care of women and children.

Four doctors, four nurses and four mediators were involved in the research. All the healthcare professionals were of Italian origins and native speakers of Italian. The mediators came from Tunisia, Jordan and China. At the moment of data collection, the mediators had been living in Italy for at least 6 years and had followed formal training towards professional qualification.

The privacy of participants was preserved according to the Italian Data Protection Act 675 (31.12.1996). Written information about the project was provided for doctors, mediators and patients. This included details about the aim of the project, and requests for permission to audio-record each conversation from patients, mediators and doctors. Before each recording, the participants were reminded about the aims of the research, what taking part involved, and their right to withdraw. The participants were also assured that they would remain anonymous; anonymity was important to avoid anyone being blamed or stigmatized as a result of taking part in the research.

## **2.2. Data and methods of analysis**

The current paper discusses the results of a research project based on 300 audio recorded medical encounters involving Arabic or Chinese patients, bilingual mediators and Italian professionals in two healthcare districts in the Emilia-Romagna region of Italy, the Modena district and the Reggio Emilia district. The analysis concerns medical encounters with the presence of a mediator who is expected not only to translate what the participants say, but also to mediate between the parts of the interaction and promote intercultural coordination between healthcare personnel and patients. The conversations analysed involve at least one Italian healthcare provider (D), an Arabic-speaking or Chinese-speaking mediator (M) and an Arabic-speaking or Chinese-speaking patient (P). Transcriptions were carried out by researchers and Arab or Chinese native speakers together. All conversations were transcribed according to Conversation Analysis (CA) conventions (see Table 1).

[ ]	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
<i>Text</i>	Italics is used for <i>English translations</i>

Table 1: transcription conventions (from Jefferson, 2004)

The excerpts discussed in this chapter have been chosen in that they respect the prevalent organizations of sequences in the whole corpus of data, and they can be considered fully representative of the kind

of mediation processes observed. For the sake of clarity, however, the excerpts shown here are those where organizational patterns are more clearly represented.

The interactions are analysed using two socio-linguistic methodologies. The first methodology is based on Conversation Analysis (CA) and looks at the mechanisms through which participants take part in the medical conversations, according to a coordinated system of turn-taking (Heritage, 2008). This includes the interactive management of acceptance or rejection of participants' contributions (Schegloff, 1980; Pomerantz, 1984). CA suggests that responses to contributions are very important in explaining how each participant reacts and how they achieve understanding of what is going on. So, along this line, this analysis is largely based on interlocutors' responses.

The second analytical approach underpinning this research derives from studies on Dialogue Interpreting (Wadensjö, 1998; Mason, 1999; Angelelli, 2004), intercultural pragmatics (Tannen, 2009) and intercultural communication (Gudykunst, 2005; Samovar & Porter, 1997; Ting-Toomey & Kurogi, 1998). Following these studies, the use of language and language diversity in the interaction is analyzed from the perspective of intercultural communication, observing whether the features of bi- or multi-lingual talk either reproduce and/or tackle particular cultural aspects of the interaction.

In the following sections two types of interaction are discussed: those in which the mediators exclude migrant patients' emotions, and those in which mediation promotes the expression of patients' emotions in the medical encounter.

### **3. Exclusion of emotions**

Data suggest that mediation activity may exclude the emotions and concerns of the patients when 1) the mediator acts as the principal interlocutor of the patient, substituting the doctor, 2) the mediator produces *reduced renditions* or *zero renditions* (Wadensjö, 1998) of patient's and doctor's turns of talk. Reduced and zero renditions often exclude some or all of the emotional contents of either patients' or doctors' turns to talk from the translation.

In the course of excerpt 1, for example, the patient asks two questions to find out whether the doctor is going to treat her leg now in the surgery; instead of translating the patient's questions for the doctor, the mediator responds directly, accessing the role of responder.

#### Excerpt 1

- 1 D Allora signora (.) possiamo provare a dare (.) del Fastum gel in  
 2 pomata (.) che però se lo deve comprare perché non ce l'abbiamo  
 3 (.) due  
 4 volte al giorno  
 5 *So madam (.) we can try (.) Fastum gel ointment (.) but she*  
 6 *has to buy it herself because we don't have it (.) twice a day*  
 7 M تشتريها لما تعمليها "بوماتا" (.) بتعطيك  
 8 فهمتني "الفارماجيا" من  
 9 *She gives you (.) ointment you put it (.) buy it at the pharmacy*  
 10 P بتعطينيها؟ ما *Does*  
 11 *she give it to me?*  
 12 M فهمتني هنا عندهم موجودة مش خاطر

- 13 *It is not available here she's not giving it to you*
- 14 P تعطينيها؟ بدها ما
- 15 *Doesn't she want to give it to me?*
- 16 M بيعطوك عندهم لو كيف (تبتم)..ايه مشكل مش معندهمش ,معندهمش  
 17 حاجة مفيهوش هو غالي مش (. ) يعني بنفسهم همة  
 18 فهمتي غالية
- 19 *That's not the issue ((smiling)) they don't have it (.) really*  
 20 *don't*
- 21 *have it*

In line 8, the mediator produces a *reduced rendition* of the doctor's contribution in the prior turn ("*she gives you the ointment*"), leaving out the information about the unavailability of the treatment at the doctor's office. This *reduced rendition* selects doctor's instructions as the most important item to pass through and thus shows an orientation to a doctor-centred culture (Barry *et al.* 2001) in which the patient is expected to follow instructions given by the technical expert. Rather than making the encounter proceed faster, immediately achieving patient's compliance, this *reduced rendition* inaugurates a monolingual dyad in Arabic. In the rendition, following the doctor's choice, the mediator uses "*give*" to mean "*prescribe*". The development of the dyadic sequence, involving the mediator and the patient, suggests that this choice might create misunderstanding; the patient understands "*gives you ointment*" as "*puts the ointment on your leg*". As a part of the turn (that concerning the instruction of buying the ointment at the pharmacy) is omitted, the patient is uncertain about the doctor's intentions. As the mediator did not include this piece of information in her reduced rendition in lines 4-5, the patient does not know that the medication is not available,



therefore she has no reason to believe that the doctor will not treat her leg. In order to solve this uncertainty, the patient asks the mediator about the doctor's intentions (line 6: "*Does she give it to me?*"). The mediator responds directly to the patient without translating the request to the doctor: "*It is not available here she's not giving it to you*" (line 7). However, because of the missing information about the availability of the ointment in the first rendition, no continuation from the doctor supports the mediator's reply.

The development of the interaction suggests that the patient interprets the mediator's reply in line 7 as an attempt to cover the fact that the doctor does not want to treat her. The reiteration of the question in a different format (line 8) is evidence of a dissatisfaction which is noticed by the mediator, who tries to mitigate it. For the third time, however, the mediator does not pass the question to the doctor but provides a direct answer (lines 9-11), increasing the distance between the healthcare professional and the patient. Accessing the role of responder, the mediator reduces the possibility of a direct connection between the patient and the doctor.

In all types of interactions, including interpreted medical interactions, the participation framework is necessarily co-authored through interactional moves and activities between the participants. In excerpt 1, the mediator prevents patient's doubts, requests and concerns to become relevant in the triadic medical interaction and thus the possibility for the three participants to contribute in such co-authoring.

In excerpt 2, a zero rendition excludes the emotions of the patients from the medical encounter.

## **Excerpt 2**

- 1 D Di notte dormi?  
2 *Can you sleep at night?*
- 3 M يمكنك النوم في الليل  
4 *Can you sleep at night?*
- 5 P لا إذا كنت لم [تعمل خلال النهار لا أستطيع أنا لا  
6 No if I haven't worked during the day I [can't. I don't-  
7 M [quando quando non è stanco  
8 non dorme  
9 *When when he's not tired he can't sleep*
- 10 P واسمحوا لي أن [أقول لك  
11 *may I [say-*
- 12 D [Quando non è stanco e non lavora  
13 *When he's not tired and doesn't work*
- 14 M Quando non è stanco e non ha lavorato  
15 *When he's not tired and doesn't work*
- 16 D Quando non ha lavorato. Per questo-  
17 *When he hasn't worked. For that -*
- 18 M Non riesce a dormire  
19 *He can't sleep*
- 20 D Ascolta vuoi che ti diamo qualcosina per riposare alla notte (.)  
21 sempre (.) indipendentemente dal lavoro e non lavoro?  
22 *Listen do you want we give you something to sleep at night (.)*

- 23 *Either if you have to work or not?*
- 24 M بتقولك (.) تحب نديك حاجة , نديك دوة حاجة تنام بيها بالليل , تعبان مش  
25 تعبان (.) تنومك بالليل والة ؟
- 26 *He says (.) do you want we give you something to sleep at*  
27 *night? Tired or not helps you at night or-?*
- 28 D una compressina?
- 29 *a little tablet?*
- 30 M - حاجة عشان تنام بالليل [  
31 *[something to sleep at night or-*
- 32 D ((to the nurse)) [Dammi del  
33 *[Gimmie some*
- 34 P ياريت
- 35 *I wish*
- 36 M Sì (.) sì (.) magari dice  
37 *Yes (.) yes (.) I wish, he said*
- 38 D Eh?
- 39 *Eh?*
- 40 P -اقول -  
41 *I will tell -*
- 42 M - اه -  
43 *Eh -*
- 44 P - الحاجة دي عملالي زهق في حياتي , لما مبنام ارواح للبالكونة وارجع -  
45 *I can't sleep I go back and forth to the balcony - (3.0)*

- 46 D Allora lui viene mercoledì pomeriggio alle 2/2.30 che gli facciamo il  
47 prelievo (.) poi per l'Aids così abbiamo fatto tutto, eh?  
48 *So he comes Wednesday afternoon at 2/2.30 and we take the*  
49 *blood sample (.) then everything will be done about Hiv, eh*

In the course of excerpt 2, the patient, who is insomnia-suffering being afraid of having contracted Hiv, makes three attempts to begin a narration about his personal experience of the disease, (lines 4, 9, 39). However, none of these attempts is successful. The first attempt (line 4) is frustrated by the mediator, who begins to translate as soon as the patient offers a relevant symptom in biomedical terms, thus overlapping with the incipient patient's narration (line 5).

In line 9, the patient tries again to initiate the narration, asking the mediator to access the role of story-recipient. This second attempt is frustrated by the doctor, who intervenes (line 10) connecting his contribution to mediator's previous turn (lines 5-6). The doctor takes the turn of talk, overlapping with the beginning of the patient's narration, therefore blocking it. In this phase of the interaction, the doctor is acting as an expert within a technical healthcare procedure, trying to relate patient's disease to physiological reasons. His intervention inaugurates a dyadic monolingual sequence in Italian, in which the doctor and the mediator negotiate the definition of a physiological reason for insomnia (e.g. the patient "is not tired enough"). In the first turn of the dyadic sequence, line 12, the mediator echoes doctor's previous turn, therefore not supporting the patient's ongoing attempt to access the role of narrator. In line 14 the doctor proposes a physiological reason for insomnia, which is confirmed by the mediator in line 18.

Notwithstanding his exclusion from the dyadic sequence, the patient does not give up the attempt to talk about his personal experience of disease, taking advantage of a problem in the mediator-doctor dyadic interaction to present his narration for a third time.

In line 39, the patient informs the mediator of his intention to start a narration. Being aware of an incoming narration, the next relevant action for the mediator is to either accept or refuse the role of story recipient. For this reason, it is important to observe what happens in the following talk sequence.

In line 41 the mediator encourages the patient's narration through a minimal turn ("*eh*"). Despite its apparent simplicity, the mediator's reaction to the introduction of the trouble talk in line 41 accomplishes different pragmatic functions in the framework of story-telling, indicating that: 1) she understands that the patient is starting a narration; 2) she is attentive to that utterance and she is passing up the opportunity to take a turn of her own during the course of the narration; 3) she accepts the role of story recipient.

Therefore, in line 43 the patient is in the sequential position to start a narration. Rather than providing objective symptoms, the patient narrates the impact of symptoms on his personal life. When the patient completes the description of a first insomnia-related trouble, different options are available to the mediator: she may translate the troubles-talk to the doctor, she may solicit the continuation of the troubles-talk by providing another continuer or she may request clarification.

However, she drops the narration by producing a zero rendition: she does not translate the turn at all, remaining silent. Within a doctor-centred culture, narratives are evaluated for the ways in which they contribute to a coherent explanation of disease: in this excerpt it seems that the mediator (not the doctor) evaluates the patient's trouble talk as useless for the treatment. After the zero rendition, the course of the interaction shows that this action was unexpected: the long silence following the zero rendition indicates that the patient is withholding his trouble-talk, waiting for some kind of contribution from the mediator (another continuer, a question, the translation for the doctor etc.).

Following three seconds of silence, the doctor intervenes, thus advancing the encounter to the treatment phase (line 44). In the treatment phase, the patients are expected to listen to the doctors' instructions; they may ask for clarifications but the opportunity to express their psychological experience and personal meaning of the perceived disease has vanished.

It is of the greatest importance to note that narrations are co-authored through interactional moves and activities between teller and audience. Narrations need to be collaboratively sustained by participants, and the recipients of the narrations influence the details that make up the story and how the story is told. For instance, a story can be encouraged by prompting it through questions or by showing appreciation (Monzoni & Drew, 2009). In excerpt 2, the mediator accepts the role of recipient of the incoming narration, only to immediately abdicate it, because she does not support the patient's trouble-talk. In terms of the information flow in the medical encounter, zero renditions as exemplified in excerpt 2 exclude patients' emotional expressions and personalized contributions from the interaction.

In excerpt 3, the doctor is closing the encounter having arranged the follow-up phase. However, a summarized translation provided by the interpreter inaugurates a dyadic monolingual sequence in Chinese (starting line 13).

### Excerpt 3

- 1 D allora gli dici di portare pazienza perché per le prime due
- 2 settimane ci vedremo spesso
- 3 *now tell him to be patient because in the first two weeks we'll*
- 4 *meet very often*

- 5 M ok, però l'orecchio -  
6 *ok, but his ear -*
- 7 D no, no, no. adesso ci occupiamo dell'orecchio, intanto digli che  
8 deve  
9 portare pazienza.  
10 *no, no, no. in a minute we'll take care of his ear, for the*  
11 *moment tell him that he has to be patient.*
- 12 M 翻译: 你这个月尽量多, 下个星期二, 七号, 下午两点半来这里,  
13 我们再给你 做血压 检查, 心脏检查, 吃这个药, 中药不要吃了。  
14 *This I recommend you, ((??)), next Tuesday, the 7<sup>th</sup>, at 2:30 you*  
15 *come here so that we check your blood pressure, your heart. And*  
16 *take this medicine, don't take the Chinese medicine any longer.*
- 17 P 患者: 中药不要吃了?  
18 *ah, don't I?*
- 19 M 译: 中药一概不要吃了, 不要忘了, 到意大利来不要吃了, 听懂了没有?  
20 *No, remember this, you have come to Italy, you do not have to*  
21 *take those more, you understand?*
- 22 P 患者: 中药不好, 不能吃?  
23 *the Chinese drug is not good? You can't eat it?*
- 24 M 翻译: 不能吃的, ok? 清楚了? 还有没有不清楚的?  
25 *no, ok? Is it clear? Is it clear now?*
- 26 P 患者: 这药给我吧。这个药。  
27 *this medicine, they've given me*
- 28 M 翻译: 这个药不要吃的,

- 29            *You do not have to take this medicine okay?*
- 30    P 患者：不是药做血压的吗？不用吃药片？
- 31            *aren't those the medicines for my blood pressure? Shouldn't I*  
 32            *take the medicine?*
- 33    M 翻译：不用吃药片。
- 34            *it's useless.*

Following a dyadic sequence between the doctor and the mediator (lines 1-10) in which the relevance of the patient's ear disease is negotiated, the mediator informs the patient about her next appointment, adding an instruction which was not given by the doctor, that is, quitting Chinese traditional therapy (lines 13-15). Probably on the basis of her experience in Italian doctors' attitude towards Chinese therapies, the mediator accesses the role of co-representative of the medical system, giving instructions to the patient. In line 17, the patient responds to the last statement included in the mediator's translation with a news-receipt token ("*ah, don't I?*") that indicates a change of state in his cognitive status about medical treatment (Heritage, 1984); the news-receipt token shows that the patient is now aware that he is asked to abandon Chinese medicine.

An examination of the extended dyadic sequence between the patient and the mediator, from which the doctor is excluded (lines 13-33) shows that the mediator's instructions in lines 14-15 and 19-20 are not immediately accepted by the patient (lines 17 then line 22).

Throughout the dyadic sequence in Chinese language, the patient defends the use of traditional Chinese medicine (lines 22, 26, 30-31) trying to resist to the mediator's instruction. Interestingly for the analysis of the impact of mediation on the medical interaction is that



none of those attempts reaches the doctor, because the mediator does not translate them.

The mediator systematically drops the translation by producing zero renditions and accessing the role of responder. Therefore, it is the mediator, and not the qualified medical expert, who manages the patient's reluctance to abandon Chinese medicine.

In excerpt 3, the mediator produces zero renditions of the patient's questions and accesses the role of responder, thus excluding the doctor from the interaction; a consequence of the mediator's choices is that the patient's personal and social reality, which includes the use of traditional Chinese medicine to treat blood pressure, is excluded from the medical encounter.

While it might be argued that reduced renditions and zero renditions make the medical encounter proceed faster, it might also be asked what kind of healthcare relationship is supported by these actions. Research suggests that these types of mediators' actions keep the interaction coherent, censoring a part of the medical discourse that might not be comprehensible or manageable by the patient, or a part of the patient's discourse which might be irrelevant to healthcare treatment (Leanza, 2010; Schouten et al., 2007). However, the same research argues that those types of mediators' actions hinder the trust building process between patients and healthcare providers. Reduced renditions and zero renditions, which often accompany the mediators' access to the role of responder, create more distance between the different language speaking participants. In this way, they 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).

#### **4. Interactions that promote emotional-sensitive healthcare**

#### 4.1 Dyadic interactions

Unlike the excerpts discussed previously, some interactions from the corpus suggest that doctors' and mediators' actions may encourage patients' expression of concerns, doubts, needs and requests in the medical encounter.

However, doctors' actions promoting patients' expression of emotions are rare, probably because the doctors' need for linguistic mediation limits their opportunity to communicate directly with the patients. Being native speakers of the patient's language, mediators have the concrete possibility to support patients in expressing their emotions.

In the corpus, mediators promote the expression of patients' emotions through different interactional practices, depending on dyadic (patient-mediator) or triadic (patient-mediator-doctor) nature of the interaction. Excerpt 4 presents a dyadic interaction in Arabic, where the mediator goes beyond the role of linguistic interpreter, and plays an active part in supporting the patient's expressions of emotions.

##### Excerpt 4

- 1 النمرة بتاع المحمول بتاعك بتكتيلياه P 1
- 2 *Your phone number, can you write it for me?*

- 3 M اه
- 4 Eh
- 5 P وعطوني شي حاجة ورقة مشان الفحص
- 6 I received the paper ((the invitation)) for an examination -
- 7 M اه (.) اه
- 8 Ah (.) ah
- 9 P كل ثلاث سنوات ادوز فحص للرحم
- 10 I pass the examination for the uterus every three years
- 11 M اه
- 12 Mmh
- 13 P جتني الورقة وما بغيت نمشي لان لازم نفهمهم اني عملت العملية
- 14 I received the paper and I don't want to go, because I would
- 15 have to explained I put the coil
- 16 M اه (.) فهمت عليك
- 17 A:h (.) I understand you
- 18 P كنت استنى اسال
- 19 I was waiting to ask it
- 20 M خفتي انك تيجي وتكوني-
- 21 You were afraid to come and being -
- 22 P اه انو يقلبوني ويحركو المكينة والة شي حاجة (..) فمن الاحسن انو يعطوني ورقة ويقولو
- 23 اني عملت العملية (.) بس انو يعني يقلبوني
- 24 Yes that they examine me and move the coil or whatever (..)
- 25 so it's better if you give me a paper saying I made the operation (.)
- 26 so they examine me (.) because they examine the uterus

The mediator promotes the patient's expression of personal emotions utilizing pragmatic resources such as feedback tokens used to display attentiveness and understanding of prior patient's turns ("Ah", line 7, "mmh", line 12, "Ah I understand you", line 17),

In line 21, the mediator suggests a possible justification for the patient's concerns. From an interactional point of view, the mediators' tentative statement works as a polar question, projecting acceptance or refusal in the subsequent turn. From a social-relational point of view, the mediator is helping the patient to express the reason for her concerns. Being empowered as an active participant, the patient is now confident enough to explain her concerns, and thus advances a request to the healthcare provider (lines 24-26).

The reiteration of affective and promotional actions encourages the patient to express her doubts about the medical procedure, thus promoting the patient's active participation in the medical encounter. The mediator encourages the patient to express her concerns by making the patient's contributions relevant to the medical encounter. The patient's contributions then display the *person* with specific needs and worries, rather than an unspecific sick person expected to report physical symptoms.

#### **4.2 Turning dyadic sequences into triadic interaction**

The main difference between dyadic and triadic exchanges consists in the re-inclusion of the doctor in the interaction as an active participant, after monolingual dyads between the mediator and the patient. Basically, while dyadic sequences are almost inevitable in

mediated interactions, they may or may not be functional to promote triadic exchanges. In the data analysed, *formulations*, are the main conversational resource whereby mediators re-involve doctors in the interaction.

As an interactional object, formulations have been debated in CA research for the last three decades (Heritage, 1985; Antaki et al. 2005; Bolden, 2010). Formulations are described as summaries, or the gist, of what someone said in a previous turn or series of turns of talk. In a pragmatic sense, the function of formulations is to provide directions for subsequent turns by inviting responses in so far as they

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).

Formulations are not word-for-word renditions of contributions in prior dyadic sequences; rather, they are mediators' discursive initiatives. With regard to the medical settings of interest for the research, formulations are used by the mediators to: 1) provide an interpretation which highlights contents from prior sequences of turns; and 2) propose inferences about presuppositions or implications of the participants' contributions, including emotional stances (Baraldi, 2012; Baraldi & Gavioli, 2008, 2011).

*Affective formulation* (Beach & Dixon, 2001; Cirillo, 2010), are formulations concerned with the emotional aspect of turns. In interpreter-mediated medical settings, affective formulations are produced by mediators in order to offer the doctor the opportunity to get involved in the affective dimension of the medical encounter.

Affective formulations reveal the interpreter not as a neutral conduit, but as an active mediator of the preceding talk. Affective formulations provide for inclusion of emotional contents in the triadic sequence involving the doctor: they are coherent with the patient-centred approach, where patients assume a local identity that goes beyond a generalised social role.

Excerpt 6 offers an example of affective formulation. In this excerpt, the patient, who is a seven-month pregnant woman, complains about abdominal pain that forced her to go to the emergency room (line 2)

#### Excerpt 5

- 1 P مشيت عالمستشفى (.).جاني وجع في بطني  
 2 *I went to the emergency room (.). I had pain in my belly -*  
 3 M اه (.).رحتي عل -  
 4 *ehm (.). you went to -*  
 5 P حاد قوي وجع  
 6 *pain bad cramps*  
 7 M الاولادة؟ وجع (.). يعني وجع  
 8 *pains that is (.). did you have contractions?*  
 9 P اي  
 10 *yes*  
 11 M اه اه  
 12 *mmh mmh*  
 13 M è andata al pronto soccorso perché ha avuto del dolore –

14 *she went to the emergency room because of the pain in the*  
15 *belly –*

16 D ah un'altra volta?

17 *ah again?*

18 M sì

19 yes

20 D ti volevo chiedere (.) come mai hai la faccia così sofferente?

21 *I wanted to ask (.) why does your face look so suffering?*

22 M عليكي؟ باين يعني تعبان وجهك ليش

23 *why does your face look so tired?*

24 P -الوجع شوي

25 *because of that pain-*

26 P الغبرة مثل عطاني

27 *((he/she)) gave me that powder*

28 M اه (..) ايه

29 *ehm (.) ah*

30 P عادية حاجة قالولي

31 *((he/she)) told that was normal*

32 M الله شاء ان خير

33 *let's hope everything will be fine*

34 P شوي احسن

35 *a bit better*

36 M احسن

- 37            *better*
- 38    M    معينة مشكلة (.) البيت في مضايقتك يعني حاجة فيه (.) مضايقتك معينة حاجة فيه  
39    والة؟
- 40            *is there something wrong (.) something that worries you at*  
41            *home (.) any problem or?*
- 42    P    خايفة شوية (.) لا P
- 43            *no (.) I am bit scared*
- 44    D    no (.) mi sembra a me che abbia la faccia sofferente
- 45            *no (.) it seems to me that her face looks suffering*
- 46    M    ((sorridente)) un po' spaventata perché diciamo per la pancia  
47            *((smiling voice)) a bit scared because let's say of the belly*
- 48    D    e:h ma è bellissima la tua pancia!
- 49            *e:h but her belly is beautiful!*
- 50    M    مشكلة اية فيه ما بتقلك طبيعي كلشي
- 51            *it's alright, he says everything is OK*

The patient's complain in line 2 is followed by an immediate engagement of the mediator in the narration of medical symptoms. The active contribution of the mediator consists in her interactional work to co-construct a more precise symptom with the patient (“*did you have contractions?*”, line 8). In line 12 the mediator displays her understanding of the patient’s narration (“*mmh mmh*”, line 12) before translating it for the doctor. After the mediator’s translation, the doctor displays her concern for the patient’s story by acknowledging its rendition with a news-receipt item (“*ah again?*”, line 16).



In line 20 the doctor expresses concern for the patient (*“why you look so suffering?”*). This is followed by a monolingual dyadic sequence (lines 21-42) between the mediator and the patient, where the mediator first translates the doctor’s question, substituting “suffering” with “tired”, then empathizes with the patient’s expression of fear and concern, thus consolidating the affective framework of the encounter.

In the course of the dyadic interaction, the mediator uses short conversational markers to manifest attentiveness and involvement in the patients’ contributions. These actions consist of feedback tokens that express the relevance of the patient’s prior narration (*“Ah”*, line 28), explicit affiliation to the patient (line 32) and echoing of the patient’s prior turn (line 36).

In line 43, the doctor interrupts the dyadic sequence to downgrade the seriousness of the symptom reported (see Caffi, 2001, for the pragmatics of mitigation in medical encounters). However, she keeps the patient’s emotional status at the centre of the interaction, in the spirit of a medicine sensitive to the emotions of the patient.

At this point in the sequence, the mediator produces a reduced rendition to formulate her understanding of the patient’s concerns (*“a bit frightened because, let’s say for her belly”*, line 46). This rendition projects a form of affective reassurance by the doctor in the subsequent turn.

The reduced rendition in line 46 is an affective formulation offering the doctor the opportunity to tune in to the emotional status of the patient. By producing the affective formulation, the mediator develops and emphasises the emotional expression of the patient, and transform it into an object for subsequent interaction. In line 47, the doctor affiliates to the expectations of emotional support for the patient, providing indirect reassurance. Finally, in the last part of the excerpt, the mediator translates the doctor’s reassurance and provides further support to the patient’s emotional status (line 50).

## 5. Discussion and conclusion

This contribution has focused on the crucial dual role of interpreter-mediator to enable migrant patients to have their emotions heard in medical encounters. In the first section of the analysis, the discussion has considered how mediators accessing the role of responders or producing zero/reduced renditions exclude patient's emotions from the conversation.

In the second section of the analysis, the focus has moved on *affective formulations* and the opportunity that they offer doctors to tune in to the emotions of the patients. While highlighting the emotions of the patients, affective formulations involve the doctors in the development of affective relations. Affective formulations select what in the prior talk permits to infer the patients' emotions, thus allowing their treatment in the doctors' subsequent turn.

This paper argues that the possibility for the patients' emotions to become relevant in medical encounters is influenced not only by the mediator's technical skills but also by the interactional roles the mediator accesses. It is therefore suggested that the complexity of the mediators' task needs to be acknowledged within both professional practice and interpreters' training.

In triadic interactions the mediators are the only participants who can effectively understand all the contributions of the other participants. This implies that mediators are never neutral conduits and that linguistic misunderstanding and errors in translation are not the only issue. Mediators necessarily co-ordinate the contingent and changeable construction of common ground between participants in

the multilingual interaction, and the corresponding distribution of communicative resources through their translation activity.

Therefore, it is suggested that guidelines for practice and training programmes should contemplate the potentialities of an emotion-sensitive mediation in order to support the healthcare personnel to access the many facets of the patient's situation at both a personal and cultural level.

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