

Affective Formulations in Multilingual Healthcare Settings

Federico Farini

University Campus Suffolk

Abstract

This chapter discusses the results of a research on the treatment of emotions in medical interactions involving Italian healthcare providers and Arabic or Chinese speaking interpreters and patients. Findings suggest that the possibility for patient's emotions to become relevant in the medical encounter is affected by the activity of interpreters as mediators of the inter-linguistic interaction. While this contribution also considers examples of interpreters' choices excluding the emotions of the patients from the interaction, the discussion focuses on affective formulations of patient's expression of emotions, as an interactional resource to involve doctors in an affective framework previously developed within dyadic monolingual interactions. This study suggests that interpreters may effectively promote an emotion-sensitive healthcare, towards a patient-centred model of inter-linguistic medicine.

1. Introduction. Interpreting as interaction and the management of emotions in medical encounters

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* (Mishler, 1984), including their emotions, is now widely recognized as a key component leading to the successful outcome of medical treatment and care (Mead & Bower 2000; Zandbelt *et al.* 2006). Doctors' affective involvement in the interaction is considered of primary importance in helping patients comply with treatment (Barry *et al.* 2001; Heritage & Maynard 2005; 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).

Following the influential and pioneering contribution from Mishler (1984), this approach to doctor-patient relationship is defined *patient-centred*, as it takes into account the life-world and the lived experience of illness of the patients. However, numerous studies show that the

patient-centred approach encounters severe difficulties in case of multilingual medical interaction. Migrant patients struggle to express their emotions and to present their case histories and medical concerns (Angelelli 2004; Baker 2006; Baraldi & Gavioli 2011; Pöchhacker & Kadric 1999). This communicative difficulty can significantly impact the success of medical intervention as well as patients' motivations to follow a prescribed course of treatment (Davidson 2001; Hsieh 2010; Meyer & Bührig 2004).

One of the most important practices used by institutions to support migrant patients in accessing healthcare services is interpreter-mediated interaction. As an abstract model, interpreter-mediated interaction is a triadic interaction involving two primary interlocutors (service provider and service user) and a third party (interpreter), who is in charge of enabling the user to access the service by translating between the user's language and the agent's language (Mason 2006).

However, moving from an abstract model to the analysis of current practices, research demonstrates that interpreters play a dual interactional role: they not only translate utterances but also coordinate the talk activity (Wadensjö 1998: 145). According to Wadensjö, the most important function of the interpreter emerging from the analysis of practices is not to offer close renditions of turns of talk, but to coordinate and facilitate a shared understanding of the activity in which the speakers engaged (see also recent research by Baraldi and Gavioli 2014). For this reason, interpreting may be understood as a form of mediation in which the interpreter-mediator (henceforth, the mediator) is an active participant who constantly monitors and evaluates the communicative effects of her/his actions while facilitating the successful alignment of participants' interactional involvement with the institutional goals and constraints.

With regard to interpreted-mediated medical interactions, the difficulties of handling the expression of emotion have been observed in several studies. Davidson (2000) suggests that in healthcare settings, the interpreter can act as a *gatekeeper*, controlling what is passed between doctor and patient and fuelling asymmetric power relations between the two parties. As a gatekeeper, the interpreter works as a pre-filter that evaluates the importance of the patient's contributions before translating them (Bolden 2000). Rather than passing patients' expression of emotions to doctors, interpreters as gatekeepers edit what patients have said, focusing on medical problems and treatments while omitting emotional expressions (Hsieh 2010).

Taking up these issues, I have conducted an analysis of conversations between interpreters, migrant patients and doctors in Italian healthcare settings, in order to investigate how mediators empower or inhibit the migrant patients in expressing their emotions, doubts and concerns. The discussion presented in this contribution considers the linguistic aspects of interpreted-mediated interactions and the consequences (direct and indirect) for the transactional and interpersonal relations between the participants involved in this institutional encounter.

2. The study

2.1 Context and outline of the study

Last available statistics (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 districts, the majority of migrants comes from Morocco and Albania. Modena also has a population of Tunisian migrants; Reggio Emilia also has large Indian and Chinese communities. In the two districts, healthcare services are reorganizing their services towards migrant-friendly models, in particular for women who may encounter different and unfamiliar cultural constructions of health, disease, therapy, sexuality, and motherhood. Interpreters have been appointed by the General Hospital Board and Local Health Board in Modena to help in reception, obstetrics, nursery, paediatrics, gynaecology, neonatology. Reggio Emilia Local Health Board uses interpreters in the outpatient departments and specialized units for the care of women and children.

This contribution discusses the results of a research titled *Interlinguistic and intercultural communication: Analysis of interpretation as a form of mediation for the bilingual dialogue between foreign citizens and institutions*. The aims of the research were: (1) to create a method of analysis of healthcare practices, drawing up specific criteria to identify good practices; (2) to develop criteria to evaluate these practices, pointing out the indicators of effectiveness concerning their functionality, correspondence to patients' needs, and opportunities of access; (3) to develop instruments to monitor these models, with the goal of reducing inequalities and institutional and linguistic barriers; and (4) to develop guidelines to be used in personnel training.

2.2 Ethical considerations

The research project was reviewed by a Management Coordination Committee, composed of the research coordinator and the coordinators of healthcare services who are in charge of decision making on ethical and legal issues. Written information about the project was provided to doctors, mediators and patients. The consent form offered information about the aim of the project, request for permission to audio-tape conversations, and explanation of how the results would be used. Written permission was requested from patients, interpreters and doctors. The privacy of participants was preserved according to the Italian Data Protection Act 675.

Before any medical encounter, participants were reminded about the aims of the research and their right to withdraw, and reassured about the anonymization of data. However, removing or changing any personal reference was not always enough to ensure complete anonymity. In such cases the ethical need for anonymity was prioritized over scientific considerations of documentation. These ethical considerations are not, and cannot possibly, be exhaustive. Ethical research practice requires continuous reflexivity and addressing ethical problems as they arise. This requires dialogue on two levels: among the scholarly community and between researchers and participants in the ongoing research project.

2.3 Participants

Four doctors, four nurses and four mediators cooperated to the research. All the healthcare professionals are native speakers of Italian. Two mediators are Arabic speakers (one from Tunisia and one from Jordan) and two mediators are Mandarin Chinese speakers (from Northern China). All the mediators had lived in Italy for more than 5 years at the time of data collection. In accomplishment of Resolution 265 of the Regional Government of Emilia-Romagna (2005), which establishes training standards, all mediators had followed formal training. resolution 265 establishes that in order to be registered as intercultural mediators in public services, it is necessary to complete training validated by the regional authorities. The minimum duration of the training course is 200 hours, including at least 40 hours of supervised traineeship. In both Modena and Reggio Emilia districts, mediation services are used predominantly in the Maternity and Neonatal Wards and Obstetrics Gynaecology; therefore most of the patients involved in the research were women. With regard to the corpus of data discussed in this study, 51 patients (92.72%) are women, and 5 (7.28%) are men.

2.5 Data collection and analysis

The analysis presented here is based on 55 multilingual medical encounters in Arabic-Italian or Chinese-Italian, audio-taped in two public healthcare services in region Emilia Romagna of Italy: the *Centro per la salute delle famiglie straniere* (Healthcare support centre for foreign families) in Reggio Emilia and the *Consultorio* (Local centre for health and social services) in Vignola (Province of Modena). Most of the encounter concern obstetrics, nursery, paediatrics, gynaecology and neonatology (47 cases, 85,4%). Emilia Romagna Regional Law 5/2004, commits the Region to promote

the development of informational interventions aimed at immigrant foreign citizens, along with activities of intercultural mediation within the social-health field, finalized at ensuring appropriate cognitive elements, in order to facilitate access to health and social-health services.¹

Therefore, in light of the Regional guidelines the interpreters involved in this research are not only requested to translate what participants say but to also act as mediators, promoting the coordination between healthcare professionals and patients to support the functionality of the healthcare system. A number of studies (for instance Baraldi & Gavioli 2014, Hsieh & Hong 2010, Niemants 2013) highlight that the attention for the emotions of the patient is necessary for the achievement of effective coordination, evidencing the impact of mediators' actions on the construction of affectivity in medical interactions. Research suggests that mediators' questions may encourage the production of personal narratives by the patients, while expansions, feedback on patients' turns and follow up comments may promote more complex stories, co-authored by patients and mediators, who have the opportunity to engage healthcare providers in such narrations. The impact of mediators' actions on the development of a patient-centred healthcare is now widely acknowledged in the field of interpreting studies, as shown by the contributions to a recent collection (Pochhacker 2015).

In the following sections I will discuss two types of interaction: those in which the mediator excludes or inhibits patients from communicating their emotions, doubts, and concerns to the doctor, and those in which mediation supports emotion-sensitive triadic interactions. All interactions in the corpus, involve at least one Italian healthcare provider of the institution (D),

an Arabic-speaking or Chinese-speaking mediator (M), and an Arabic-speaking or Chinese-speaking patient (P). All conversations were audio-recorded, and transcribed according to the conventions of Conversation Analysis. The researcher carried out transcription with the assistance of the translators (not involved in the medical encounters). The Arabic and Chinese languages were transcribed using the Latin font type-set. Transcription of Arabic posed some problems because of the variety of dialects used by the patients. In some cases the transcriber understood the sense of the utterance but could not transcribe it precisely. In those cases an approximate translation of the turn is provided.

All personal details that are mentioned in the talk have been altered in the transcription to protect participants' anonymity. Due to the sensitive nature of the data and interaction, only audio recordings were authorized, which did not allow observation of gesture, gaze, facial expression, body posture, or other non-verbal behaviour.

All transcripts have been analysed conversation analysis (CA) as a methodology to interpret the corpus data. In the most general terms, the object of CA is to discover the procedures which allows a certain degree of predictability in the way in which social actors understand and respond to one another. CA looks at the mechanisms employed by participants in interaction to achieve understanding, to manage their access to the roles of speaker and listener, and to connect to previous turns of talk (Schegloff 1980; Pomerantz 1984; Sacks et al. 1974).

Interactionist studies of emotions in medical interactions (Angelelli 2004; Baraldi & Gavioli 2007; Cirillo 2010; Zandbelt et al. 2006) demonstrate that interpreters may facilitate or inhibit expressions of personal interest, active listening and appreciation of the participants' contributions. Interpreters can thus help in promoting distribution of active participation, addressing participants' interests and needs. Baraldi and Gavioli (2007) demonstrate that also in the frame of patient-centred medicine, where support and appreciation are expressed by interlocutors towards each other's actions and experiences, a failure to translate such support and appreciation leads to construction of distance between doctor and patient.

In analysing the data I have tried to identify how patients' display of emotions is promoted or marginalized by mediators' actions; the most procedure for analysis that I have utilized is the 'next turn proof procedure', inspecting turns at talk to see how the current speaker is treating what has been uttered before. The core analytical concept of CA is that people's understanding of each other's actions can unfold as sequences of talk unfold. According to Schegloff (2006), any next

turn in a sequence displays the understanding of the prior turn; “responses to contributions are very important in explaining how each participant orients to the activity and how they achieve a shared understanding of the business at hand” (Mason 2006: 364). Consistently with the approach adopted by CA, I have explored how the relevance of emotions is “talked into being” (Heritage 1984: 290), rather than connecting it to social or psychological traits of the participants. I have approached the importance of patients’ emotions in the medical interactions as interactively ‘co-constructed’ by participants turn after turn, towards their promotion or exclusion.

The extracts discussed in this contribution are representative of data-set in terms of participants involved, expression of emotions (or attention to emotion) by doctors, patients and mediators, and the treatment of such expression in the interactions, especially with regard to the actions of interpreters.

3. Interactions that exclude or inhibit patients’ expression of emotions: zero and -reduced renditions

The most common types of mediators’ actions that exclude patients’ expressions of emotions from the medical encounter consist of *reduced renditions* or *zero renditions* (Wadensjö 1998) of both patient’s and doctor’s turns of talk. In these situations, the mediator either cuts out some (reduced renditions) or all (zero renditions) contents of utterances from the translated material. Reduced or zero renditions usually occur when the mediator passes medical information from the patient to the doctor and vice versa, but they may also involve the expression of emotions.

Excerpt 1 (taken from one of the few encounters involving a male patient) is utilized to illustrate occurrences of zero renditions. The patient is lamenting a persistent insomnia and in this phase of the medical encounter he has already expressed his concerned about having contracted HIV. In the course of the excerpt the patients makes three attempts to start a narration of his personal experience of insomnia (lines 3, 6 and 31, 33-34) but such attempts are not supported by the mediators, who operate to exclude patient’s emotions from the medical encounter.

(1 Arabic-Italian)

1 D Di notte dormi?
At night sleep?
Can you sleep at night

CH8_FARINI_AFFECTIVE FORMULATIONS

Submission to John Benjamins

- 2 M yemkenk alenwem fey alelyel a::w?
Can sleep you night o::r?
Can you sleep at night or
- 3 P la eda lem tekn qed 'emelt khelal alenhar (.)
Not if have worked not during the day (.)
- 4 la asetting'e. [ana la
I can not. [I do not
No if I haven't worked during the day I can't [I don't
- 5 M [quando quando non è stanco non dorme=
[when when not is tired not sleep=
When when he's not tired he can't sleep
- 6 P =wasemhewa ley an [aqewl lek
=Some let me to [tell you
Can I say something
- 7 D [Quando non è stanco e non
[When not is tired and not
- 8 lavora,
work,
When he's not tired and hasn't worked
- 9 M Quando non è stanco e non ha lavorato
When not is tired and not has worked
When he's not tired and hasn't worked
- 10 D Quando non ha lavorato. Per questo=
When not has worked. For that=
When he hasn't worked. For that
- 11 M =Non riesce a dormire
=Not can to sleep
He can't sleep
- 12 M eda kent la t'eb la tenam?
when tired you not you not sleep?
When you are not tired, don't you sleep?
- 13 P la asetting' alenwem heta alesbah la:: I
cannot sleep until morning I::
I can't sleep until morning I
- 14 M >Cioè tutta la notte dice fino alla
>That is all the night says until to the
 15 *mattina<*
morning<
So, he says all night long until morning
- 16 P fey al'emel welqed terk lemdh sa'eteyn lelnewm
At work and leave for two hours to sleep
At work, I have to leave for two hours to sleep
- 18 M E quando lavora deve per forza andare via per due
And when works must by force go away for two

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- 19 orette per riposare
small hours to rest
And at work he has to take a break for two hours
to rest
- 20 D Ascolta vuoi che ti diamo qualcosina
Listen want that you give something
- 21 per riposare alla notte (.) Sempre (.)
to rest at night (.) always (.)
- 22 indipendentemente dal lavoro e:: non lavoro?
independently from work and:: not work?
Listen do you want us to give you something to sleep
at night (.) whether you have to work or not?
- 23 M betqewlek (.) theb nedyek hajh nedyek dewh
says (.) want make you some make you sleep
- 24 hajh tenam beyha balelyel? t'eban mesh t'eban (.)
some makes sleep at night ired not tired
- 25 tenwemk balelyel walh?
helps you at night or?
He says (.) do you want us to give you something to sleep at night?
That helps you at night whether you are tired or not?
- 26 D una compressina, (.) ((to the nurse)) dammi del::
a little tablet,(.) ((to the nurse)) give me some::
- 27 P areyd
°I would like°
- 28 M Sì (.) sì (.) >magari dice<
yes (.) yes (.) >if only says<
- 29 D Eh?
Eh?
- 30 M re::yd
Wo::uld like
- 31 P aqewl-
I say-
- 32 M ʔ?
mmh?
- 33 P ala astty'e= alnwm adhb dhaba
I can't sleep=I go to balcony
- 34 weyaba ela alshrfh
forth and back
I can't sleep I go back and forth to the balcony
- 35 (3.0)

- 36 D Allora:: lui viene mercoledì pomeriggio
So:: he comes Wednesday afternoon
- 37 alle due:: due=e mezza che gli facciamo
at two:: two=and half that to him we make
- 38 il prelievo poi per l'Aids così abbiamo
sample taking then for HIV so we have
- 39 fatto tutto (.) eh?
done everything (.) eh?
So he comes Wednesday afternoon at 2, 2:30
for the sample taking then everything will
be done about HIV, eh?

The patient's initial attempt to describe his experience of insomnia (lines 3-4) is halted by the mediator, who overlaps patient's turn with an early translation. The application of the next turn proof procedure to patient's turn in line 6 ('Can I say something?') suggests that he sees the early translation as an interruption. In line 6, the patient access the role of speaker without being prompted by any question and without waiting for doctor's reaction to the translation; there is something to be accomplished (the narration) and in order to do that, he explicitly requests the mediator to align with the role of recipient.

However, a second overlapping utterance deprives the patient of the status of current speaker. In this occasion is the doctor who intervenes summarizing the mediator's translation (lines 7-8). From an institutional point of view, the doctor is performing his role of technical expert, who explore possible physiological reasons for insomnia (e.g., the patient "is not tired enough"). From an interaction point of view, the early translation produced by the mediator assigns to the doctor the role of next speaker, who is expected to react to the information passed. The doctor intervenes because the translation signals that the patient's account as 'complete'.

The patient tries a third time to express his personal experience of the disease, when a dyadic interaction between the mediator and the doctor encounters some problems. The doctor, who is engaged in two different lines of conversation (the second one with a nurse, line 26), misses a turn of the mediator, therefore initiates a repair sequence to recover a minimum level of mutual understanding (line 29). This instability offers an opportunity for the patient, who produces a *preliminary turn* (Schegloff 1980) to signal he is accessing the role of speaker (line 31). After the preliminary turn, the next relevant action for the mediator is to either accept or refuse to take on the role recipient of patient's telling. In line 32, the mediator encourages the

patient's with a short turn ("mmh?") which indicates that she is accepting the role of recipient. Therefore, the patient is now in the sequential position to initiate a *troubles-telling* (Jefferson & Lee 1981; Jefferson 1988). Rather than providing details of his *objectified symptoms* in biomedical terms (Heritage 2008), the patient offers an account emphasizing his personal experience with the difficulties that insomnia produces in his everyday home life. In lines 33-34 the patient is speaking his *disease*, rather than providing a description of his *illness* (Mishler 1984). The completion of a first account of the troubles caused by insomnia creates a *transition-relevance place* (Sacks, Schegloff & Jefferson 1974), making possible a transition between speakers. After patient's turn, there are different available options for the mediator. The mediator may translate to the doctor, may support the continuation of the troubles-talk by providing another continuer, or she may request clarifications. However, the mediator remains silent (line 35), producing a zero rendition (Wadensjö, 1998). By applying the turn proof procedure, the long pause in line 35 suggests the zero rendition was unexpected; the patient does not take the turn of talk, waiting for a mediator's action. After a three-second silence, the doctor intervenes to advance the interaction to the treatment phase (lines 36-39). In this phase of the medical encounter it is difficult for the patient to express his personal experience of the disease. In the treatment phase, and in the following prescriptions phase, it is inappropriate for the patient to pursue the completion of his trouble talk, being the doctor is the only ratified active participant in this phase (Heritage & Maynard 2006). Rather, in the course of the treatment and prescription phase the patient is expected to listen to the doctor's instructions.

Troubles tellings are co-authored through interactional moves and activities between teller and recipient(s). Therefore they need to be collaboratively sustained by all participants. Recipients influence the details that make up the telling, and the ways it is told, through their contributions, for instance by producing a go-ahead response when the speaker offers a pre-telling, prompting the telling through questions, displaying they have recognized the end of the telling, and in some cases producing related tellings (see Monzoni & Drew 2009).

In the context of medical encounters, the patient's troubles tellings are likely to be supported only if they contribute to the explanation of the disease. In Excerpt 1, the mediator (but not the doctor) assesses the irrelevance of the patient's troubles telling for the treatment. Although the mediator accesses the role of recipient when prompted by the patient, she subsequently fails to support the patient's trouble telling. The mediator's zero rendition prevents

the personal experience of the disease as narrated by the patient to reach the medical expert, who should promote an emotional-sensitive healthcare. The personal and social meaning of the disease for the patient are thus excluded from the medical encounter.

Excerpt 2 represents an example of a dyadic sequence involving the mediator and the patient, which is prompted by a translation provided in summarized form. The patient is a Chinese woman who complains about a ringing sound in her ears (tinnitus). While the patient believes to have an ear infection, for which she is taking traditional remedies, the doctor relates the tinnitus to high blood pressure.

(2 Mandarin Chinese-Italian)

- 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, is it 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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Submission to John Benjamins

- 12 xīnzàng jiǎnchá
heart check
- 13 chī zhège yào, zhōngyào bù yào chī le
eat this medicine, traditional Chinese medicine must not eat
Next Tuesday, the 7th, at 2:30, come here so that we check
your blood pressure and your heart. And take this medicine.
Don't take the Chinese medicine any longer.
- 14P: a:h zhōngyào bù yào chī le?
a:h traditional chinese medicine, must not eat?
ah, I don't take chinese medicine?
- 15M: zhōngyào yīgài bù yào chī le,
traditional Chinese medicine must not eat,
- 16 bù yào wàng le, dào Yìdàlì lái bù yào chī le,
must not to forget, to Italy to come must not eat
- 17 tīngdǒng le méiyǒu?
to understand not to have?
No, remember this, you have come to Italy so you
must not take traditional medicine, don't
forget you have come to Italy, don't take it, 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? qīngchū le? hái yǒu méiyǒu
can't eat:: ok? to understand? still to have or
- 21 bù qīngchū 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 ōba. °zhège yào°
this medicine they give me. °this medicine°
They have given me this medicine. °This medicine°
- 23M: zhège yào bù yào chīde, ok?
this medicine not to eat it, ok?
Do not 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?
- 26 bù yòng chī yào piàn?
need not to take medicine tablet?

*aren't those medicines right for my blood
pressure? Shouldn't I take the Chinese pills?*

27M: bù yòng chī yào piàn
*need not to take medicine tablet
no, you don't have to take the pills*

In this excerpt, we can see an exchange between the doctor and the interpreter (lines 1-7), followed by the interpreter's rendition in a summarized form (lines 8-13). Already at this stage, the idealized model of accurate renditions borrowed from conference interpreting is abandoned in the reality of the medical encounter.

In line 14, the patient responds to the last statement in the interpreter's translation with a question preceded a *change of state token* (Heritage 1984), indicating a shift in her understanding ("*ah, I don't have to take Chinese medicine?*"). This action inaugurates a dyadic sequence in Chinese language, where the mediator and the patient negotiate the meaning of "not taking Chinese medicine" and the relationship between Chinese medicine and Western therapy.

There are two points to be noted here: the first is that the instruction to discontinue traditional therapy is given by the mediator, not by the doctor. In this encounter the mediator accesses the role of representative of the western medicine. The application of the next turn proof procedure suggests that the mediator understand patient's question in line 14 as a cue for her reluctance to dismiss traditional therapies. In line 15-17, the mediator does not offer any justification for her instruction but simply reiterates that the patient must abandon the traditional therapy remedy. The meaning of traditional medicine in the personal and social dimensions of the patient is not explored, and cannot reach the doctor.

As the rationale of the medical instruction is not explained, the patient tentatively advances a possible justification for the need to dismiss traditional medicine: 'it's not good so I can't take it?' (line 19). However, the mediator does not produce the action made relevant by the question. She does not provide an answer, but simply repeats the instruction, without offering any feedback to the patient's statement. By repeatedly asking the patient if the instruction is 'clear' (line 21), the mediator presents it as an order, rather than a prescription. Across the whole dyadic sequence, the patient will seek an explanation, but without any success.

The second point regards a tension between the dyadic sequence in Chinese language and the re-inclusion of the doctor. The medical expert is largely excluded from the medical encounter, because the mediator engages with the patient rather than translating her turns. Only

after many turns, in line 24, the interpreter includes the doctor, perhaps to inform him of the resistance opposed by the patient. However, this interpretation is speculative, as the sequence turns back to a dyad in Chinese language as the patient addresses the mediator in line 25.

In the course of the sequence represented in excerpt 2, the patient makes four attempts to find out why traditional Chinese medicine for the ear cannot be used in tandem with Western medicine for high blood pressure. However, none of these attempts reaches the doctor, because the mediator does not translate them. The mediator systematically produces zero renditions, replying directly to the patient instead of translating to the doctor. In this excerpt the mediator (not the doctor) constructs the patient's reluctance to abandon Chinese medicine as a problem for the medical treatment and, without involving the doctor, enforces the institutional recommendations by seeking to persuade the patient to adhere to the recommended medical instructions.

In all types of interpreted interactions, including medical interactions, the participation framework is necessarily co-constructed through interactional moves and activities between all the speakers involved. In this excerpt, the mediator's zero rendition prevents the personal and social worlds of the patient, which include the self-diagnosis of ear infection and the use of traditional medicine, to be acknowledged in the consultation.

Analysis of interpreter-mediated health care encounters show that zero renditions enable the medical consultations to proceed faster, thus supporting the functionality of the system. However, we may ask what kind of functionality is supported by these actions. Research by Leanza et al. (2010) confirms the efficacy of this type of mediator action in keeping the interaction coherent, for instance by 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. But the same research shows that these types of mediators' actions hinder the trust-building process between patient and the healthcare provider. Because they can create more distance between the doctor and the patient, zero and reduced renditions pose risks to the therapeutic process and, paradoxically, compromise the core values (e.g., self-determination and informed decision-making) of the Western medical system (Hsieh 2010).

4. Interactions that promote emotion-sensitive healthcare

4.1 Supporting patient's expressions in dyadic sequences

Mediators' actions can promote patients' in expressing their emotions within monolingual dyadic sequences (patient-mediator) or in the triadic dimension of the multilingual interaction (patient-mediator-doctor). In interactions organized as dyadic exchanges, the mediator supports the voice of the patient through *recipient tokens* (Gardner 2001). Recipient tokens are short conversational markers which in the corpus are used to signal that the stated information has been received (*acknowledgment tokens*, e.g. yeah, OK) or to maintain the flow of conversation and offering the current speaker an opportunity to keep this interactional position (*continuers*, e.g. hmmm, mhm). An example of mediator supporting the patient in expressing her emotions is presented in Excerpt 3. At the end of her first medical visit in the district, while the doctor is moving the encounter towards its conclusion, the patient expresses her worries about a recently received invitation to an uterus check.

(3 Arabic-Italian):

- 113P alnmra btaa almhmol btaak btktbiliaha
Number of your mobile, can you write for me
Your cell phone number, can you write it for me?
- 114M هـ
Eh
- 115P .hhh °oatoni shi haja orqa mshan alfhs°
.hhh °I have received the paper examination°
I have received a letter saying I should come in for a check-up
- 116M هـ (.) هـ
Ah (.) ah
- 117P kl thlath snoa:t adoz alfhs llrh
Every three year:s pass the examination uterus
I have to have a uterus check-up every three years
- 118M هـ
Mmh

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119P .hh jtni alorqa oma bghit nmshi lan laz
*.hh received paper and don't go want because I would
nfhamham ani amlt alamlia
have explained I had the operation
I received the letter and I don't want to go, because I would have
to explain I had an *operation*

120M ah (.) fhmt aliki
*ah (.) understood you
ah (.) I understand you*

121P knt astna
*You waiting to ask
I was waiting to ask you*

122M °khfti° .hh ank tiji otkoni,
°Afraid° .hh were come and being,
so you were afraid to go and being

123P ah ano iqlboni almkina oala shi alamlia (.) alahsn
yes me examine machine and move the operation (.) 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 injure the part where I had an
operation done before so it's better if you give me a letter
saying I had the operation so they examine me
because they examine the uterus*

*Note: The precise nature of the previous operation or surgery is not specified.

The mediator responds to the patient's announcement (line 115) with a news receipt (line 116) and to the patient's subsequent account (117) with a continuer (line 118). In this way, the

mediator constructs as role in the interaction as the one of recipient, encouraging the patient to proceed with her telling.

When the patient expresses her concerns (line 119), the mediator react with an explicit formulation of empathy (Heritage & Lindström 2012), which supports the patient to further express her emotions (line 121). In line 122, the mediator advances her understanding of patient's fears by producing an *upshot formulation* (Antaki *et al.* 2005). Upshot formulations include speaker's interpretation and reconstruction of possible implicit meaning of previous turn. In this interaction, the upshot formulation is used to support a reticent patient to express the reason for her concerns, and makes relevant the expression of either agreement or disagreement by the patient in the following turn. In both cases, the upshot formulation brings more knowledge about the patient's emotions.

The upshot formulation is not a close rendition; rather it is a discursive initiative taken by the mediator, which successfully promotes the patient in expressing her emotions and concerns. In lines 123-125, the patient confirms the mediator's upshot formulation, by asking for doctor's support.

In the corpus of data, turn-by-turn rendition are intermingled with other actions which are relevant for the achievement of the interactional goals. Frequently, following a translatable contribution the mediator produces items (e.g., acknowledgment tokens, continuers, requests for clarification or direct replies) which transcend and suspend the turn by turn translation model. A rendition of the whole dyadic sequence is often provided in summarized form, later on in the conversation, when the interaction is moved to a *triadic* format with the inclusion of the doctor.

4.2 Giving voice to patients' emotions in triadic interactions: affective formulations

In the movement from dyadic to triadic interaction, the crucial aspect is the way in which the doctor re-enters the interaction. In the data analysed, the main conversational resource whereby mediators involve doctors in the interactions is *gist formulations* of patient contributions. *Gist formulations* are often summaries of what someone has said and 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)

In medical mediated interaction, mediators' formulations consist of renditions of patient-mediator dyadic sequences. Formulations are not close renditions, they are an interaction resource used by the mediator to: (1) provide an interpretation that highlights content from prior sequences; (2) make explicit what is thought to be implicit, or unclear, in prior turns of talk (3) propose inferences about presuppositions or implications of the participants' contributions (Baraldi & Gavioli 2008). As a specific type of formulations, *affective formulations* may be understood as discursive initiatives undertaken by the mediator to give voice to patients' emotions when they manifest themselves implicitly. Patients rarely talk about their emotions directly and without prompting; more frequently, they provide clues about their feelings, thus providing health professionals and mediators with *potential empathic opportunities* (Beach & Dixon 2001: 39), as shown in Excerpt 3.

Affective formulations focus on the emotional aspects of patients' utterances, offering the doctor an opportunity to understand and participate in the affective dimension of the interaction. In this way, doctors are made aware of patients' concerns, and patients assume an identity that goes beyond their standardized role within the medical institutions. In Excerpt 4, the patient, who is in her seventh month of pregnancy, complains about abdominal pain which forced her to go to the emergency room (line 1)

(4 Arabic-Italian)

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 cramps,
((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,

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- 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 (.) why do
 you look like you are suffering?
- 11M: lesh uigihik hek tabaan bain aleki
 why face your tired is much
 why is your face so tired?
- 12P: .hhh °((Arabic untranscribable))°
 .hhh °((Partly for 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
 for her belly
- 20D: fe:h ma è belli(H)ssima la tua panciaf!

*fe:h but is beauty(H)ful the your bellyf!
e:h but your belly, it's beautiful!*

21M: btul shitabii btiilik fma tilaiif
all normal everything you fis finef
she tells you that everything is
normal, everything is fine

The patient's complain is followed by a complex turn, with a translation as the first turn unit, and a question as the second unit (line 3: 'did you have contractions?'). The question at the end of the turn makes relevant an answer from the patient, confirming a possible physiological reason of her disease. In line 4 the patient confirms mediator's hypothesis, and in line 6 the mediator contributes to the co-construction of a narration of patient's experience by an acknowledgment token (*mmh mmh*), translating that narration to the doctor in the second part of the turn. By doing this, the mediator addresses the doctor's epistemic authority in this matter, avoiding to claim the role of medical co-expert as discussed with regard to excerpt 2.

The doctor's acknowledgement in line 7 comes as a news-receipt marker (*ah again?*), displaying that the information made a difference in her cognitive status. In lines 9-10, the doctor displays her interest in the patient's personal discomfort ('why do you look like you are suffering?'), in form of a question that makes relevant a translation by the mediator and further explanations from the patient. The doctor's question is followed by a short dyadic sequence (lines 11-15) between the mediator and the patient. The mediator translates the doctor's question, substituting "suffering" with "tired", and then affiliates n with the patient's expression of emotional stress, asking for other possible reasons behind the her complain.

The doctor then interrupts the dyadic sequence in Arabic (line 16-17) to express her concern for the patient, albeit in a downgraded form. The doctor's turn is not translated by the interpreter, who formulates her own understanding of the patient's worries in Italian (lines 18-19: 'a bit frightened because, let's say for her belly'), making relevant the doctor's reassurance in the following turn (line 20). Finally, the interpreter translates the doctor's reassurance and provides support to the patient's emotional status (line 21).

In Excerpt 5, the patient reports a delay in her period, but mitigates the relevance of this information by assuming she will pass it in the following days.

(5 Arabic-Italian)

1D: quando é stata l'ultima mestruazione?

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- When is been the last menstruation?
when was her last period?*
- 2M: bandma kan aakhr dora shhria lk?
*when was your last period?
when did you have your last period?*
- 3P: .h jtni tlatash:: mn shhr ashra
*.h was thirtee::n in month ten
It was October thirteen*
- 4M: tlatash ashra?
*Thirteen ten?
October thirteen?*
- 5P: °ai°
°yes°
- 6M: l' ultima mestruazione è il tredici ottobre
The last period is October thirteen
- 7D: °mmh°
°mmh°
- 8M: ora siamo: al tredici novembre
*now we are: to thirteen november
now it's November thirteen*
- 9P: °kant thbt ali kl shhr nisha (.)
°arrive here each month exact (.)
- 10 aldma hbt sar shhr lliom°
*blood not felt month today°
It comes each month exactly (.) now it's a month
today that it's not*
- 11M: mhm
mmh
- 12P: .hhh astna tlat aiam oala arba aiam aiati rbma
*.hhh wait three days or four days, .hh comes maybe
I will wait three or four days, may it .hh will come*
- 13M: ((to D)) ah (.) può darsi che tra quattro o cinque
ah (.) can be that in four or five
- 14 giorni al massimo (.) arriva (.) però (.) lei è un
days at most (.) comes (.) but (.) she is a
- 15 po' preoccupata
*bit worried
Ah (.) maybe in four or five days at the latest (.)
it will come (.) however (.) she's a bit worried*

Affective formulations are a resource for the mediator to bring the patient's emotions to the fore, when they have remained implicit, thus promoting them a topic for the medical encounter. The mediator's affective formulation in line 13-15 ('she's a bit worried') makes current symptoms available to the doctor but also highlights the patient's emotional state, which may have been overlooked. The mediator's formulation successfully involves the doctor in the affective exchange and promotes a shift from a dyadic to a triadic interaction.

The mediator's affective formulation is inclusive because while highlighting the emotions of the patient it also includes the doctor in the formation of affective relations. By producing an affective formulation, the mediator develops and emphasizes an implicit emotional expression as a topic for subsequent interaction. Affective formulation reveals the interpreter not as a neutral communicative conduit, but as an active mediator who supports the patient in expressing her emotions, at the same time providing a way for inclusion of such expression in the triadic sequence towards a patient-centred healthcare (Farini & Barbieri 2009).

5. Conclusion

This study reinforces previous researches' in observing that the dual function of interpreter and mediator can make positive contributions to patient-centred care and treatment. When the interpreter acts effectively as a mediator, otherwise hidden factors such as patients' emotional expressions can be reported to the doctor thus creating opportunities for him/her to respond within an affective frame.

Pöchhacker and Liu (2014) have recently suggested that training for interpreters might improve their attitudes toward the emotional dimension of the interaction, quality of care and patient safety, in this way confirming pioneering (Wadensjö 1998; Angelelli 2004) and more recent (Flores *et al.* 2012) research. While I agree with the importance of professional training for interpreters, I also argue that the complexity of the interpreting as mediation needs to be acknowledged. In triadic interactions the interpreters are never neutral conduits and errors are not the only issue: interpreter as mediators co-ordinate the contingent and changeable construction of affective involvement in medical interactions.

Analysis of data suggests that the dual role of interpreter-mediators is crucial in enabling patients to make their voices and emotions heard in medical encounters. I have observed how *reduced* and *zero renditions* may exclude the patient or the doctor from the conversation. For

instance, the patient may be prevented from understanding the rationale of the medical procedure, or the doctor may be deprived of relevant information about the emotional status of the patient. In the subsequent part of the contribution, I have discussed situations when *affective formulations* improve the emotional rapport between patients and doctors, taking the medical encounter well beyond an exchange merely based on normative institutional roles.

In the data discussed, the mediators support the patients in expressing their emotions accessing two different roles: *responders* in dyadic interactions, *coordinators* when they involve the doctors in triadic interactions. As *responders*, mediators check and echo the patients' perceptions and emotions, providing positive feedback. However, the interpreters' affective support needs to be made relevant in the medical encounter. By accessing the role of coordinators, the mediators transform dyadic sequences in triadic sequences. As coordinators, mediators capitalize potential empathic opportunities offered by the patient in the course of dyadic sequences. In particular, interpreters access the role of coordinators producing *affective formulations*. In the data analysed, mediator's renditions of emotional expressions through formulations promote reciprocal involvement between the patient and the doctor, in a patient-centred perspective.

These results support previous research on the interactional functions of formulations in mundane settings (Bolden 2010), in monolingual medical contexts (Antaki et al. 2005; Beach & Dixon, 2001) and in multilingual medical interactions involving languages different from the ones included in the corpora analysed (Baraldi & Gavioli 2008; Cirillo 2010). By producing affective formulations, mediators introduce patients' emotions, doubts and concerns to doctors, producing an emotion-sensitive translation that provides the healthcare personnel with the possibility of accessing the many facets of the patient's situation.

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ⁱ "La Regione promuove, anche attraverso le Unità Sanitarie Locali e gli Ospedali, lo sviluppo di interventi informativi rivolti ai cittadini stranieri, a fianco di attività di mediazione interculturale all'interno del campo socio-sanitario, finalizzati ad assicurare elementi cognitivi appropriati, per facilitare l'accesso ai servizi sanitari e socio-sanitari"