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

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Abstract

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

Introduction: the meaning of interpreted-mediated interaction

Research shows that differences concerning the meaning of health and illness or in the expectations towards the roles of doctor and patient may discourage people from linguistic and cultural minorities from accessing medical care (see American Psychiatric Association 2013). However, citizenship in late modern societies underpins the right of equal access to medical care. Moreover, if social groups are excluded from medical care, this may jeopardize strategies of sanitary control, blinding the “medical eye” which is a characteristic of European modernity (Foucault 1973). To help ward off this risk, resources are invested in developing instruments and pro-
cedures to support minority groups in accessing public facilities. Examples of such instruments are social advertising or the employment of health visitors. The focus of this contribution is on another instrument: interpreted-mediated interaction.

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

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

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

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

1. Methods

1.1 Context and outline of the study

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

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

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

the Region promotes, through institutions including Local Health Units and Hospitals, the development of informational channels aimed at immigrant foreign citizens,
along with activities of intercultural mediation within the social-health field, with the objective of ensuring appropriate knowledge, in order to facilitate access to health and social-health services (Translated by the author).

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

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

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

1.2 Methodology

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

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

A “three lines” format is used to transcribe the multilingual talk: the first line reproduces the transcribed talk in the original language, the second offers an English word-by-word gloss, and the third a functionally equivalent translation in idiomatic English.
The conversations are analysed using two sociolinguistic methodologies. The first is based on CA and focuses on how participants co-construct medical conversations through a coordinated system of turn-taking (Sacks et al. 1974). The second derives from studies on intercultural communication (Gudykunst 2005; Samovar/Porter 1997; Ting-Toomey/Kurogi 1998). In line with the perspective of intercultural communication studies, the aspect of whether the features of multilingual talk in the data either reproduced or tackled particular cultural aspects of the medical system is analysed, for instance, the marginalisation of emotional expressions.

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

2. Results

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

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

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

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

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

Excerpt 1

1D: adesso la pressione é a posto (.) martedì è sette, vero?
2M: _mmh, mmh_
3D: allora, gli dici di portare pazienza perché:
4 per le prime due settimane ci vedremo spesso
5M: ok, però l' orecchio-
6D: no, no, no adesso ci occupiamo dell' orecchio,
7 intanto digli che deve portare pazienza.
8M: ok (.) ní zhèigè yuè jínliàng duō,
9 xìà gè xīngqī ěr, qī hào, xiàwǔ liǎng
10 diǎn bàn lái zhělǐ,
11 wǒmen zài gěi nǐ zuò xuèyā jiǎnchá

now blood pressure is OK, next Tuesday, it is the 7th, right?
now tell him to be patient because in the first two weeks we'll meet very often
now tell him to be patient because in the first two weeks we'll meet very often
now tell him to be patient. 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.
ok, but the ear-
ok, but his ear-
now we work of the ear
now we'll take care of his ear, for the moment, tell him that he has to be patient.
now as much as possible this month
next Tuesday, the 7th, at 2:30
in the afternoon and come here
we give you to do blood pressure check
12 xīnzàng jiǎnchá
heart check

13 chī zhè ge yào, zhōngyào bù yào chī le
eat this medicine, traditional Chinese medicine must not eat
this I recommend you, next Tuesday, the 7th, at 2:30 you come here so that we check
your blood pressure, your heart. And take this medicine, don’t take the Chinese medicine
any longer.

14P: a:h zhōngyào 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
do not have to take don’t eat traditional medicine, don’t forget you come to Italy
don’t take, do you understand?

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

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

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

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

22P: zhè yào gěi Wǒba. "zhè yào" this medicine they give me. "this medicine"
they have given me this medicine

23M: zhè ge yào bù yào chī de, ok?
this medicine not to eat it, ok?
you do not have to take this medicine okay?

24 ((to D in Italian)) allora sto cercando di::
so I am trying of::
so I’m trying to

25P: bù shì yào zuò xùyā dema?
not to be medicine to do blood pressure?
bù yòng chī yào piàn?
need not to take medicine sheet?
aren't those medicines right for my blood pressure? Shouldn't I take the medicine sheet (of the Chinese medicine)?

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

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

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

There are three points worth highlighting in the analysis of the dyadic sequence. The first point concerns the way in which the patient resists the interpreter's instructions. In the turn following the interpreter's instruction (lines 15-17), the patient is expected to react either by accepting (the preferred action) or refusing the instruction. However, human interaction offers resources to avoid the constraints posed by a polar yes/no question. In this sequence, the patient produces a second question, asking for clarification, thus releasing himself from the pressure placed on him by the question (lines 18-19).

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

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

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

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

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

2.2 Interactions that promote emotional-sensitive healthcare

2.2.1 Dyadic interactions

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

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

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

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

113P alnmra btaa almhmol btaak btktbilihaha

number of your mobile, can you write for me
your phone number, can you write it for me?

114M eh

115P .hhh °oatoni shi haja orqa mshan alfhs°
.hhh °I have received the paper examination°
I have received the invitation for an examination

116M ah (. ) ah

117P kl thlath snoa:t adoz alfhs llrhm

every three years pass the examination uterus
I pass the examination for the uterus every three years

118M °Mmh

119P .hh jtni alorqa oma bghit nmshi lan lazr
.hh received paper and don’t go want because I
would nfhamham ani amlt alamlia
have explained I put the coil
I received the paper and I don’t want to go, because I would have to explain I put the coil

120M ah (. ) fhmt aliki

ah (. ) understood you
ah (. ) I understand you

121P knt astna

You waiting to ask
I was waiting for you to ask

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

123P ah ano iglboni almkina oala shi alamlia (. ) alahsn

yes me examine machine and move the coil (. ) I need

124 Ano itni orqa oigolo ani mshan alml (. ) bs ano iani

Me better you give me paper says (. ) I did the

125 iglboni

operation
yes that they examine me and move the coil or whatever so it’s better if you give me a paper saying I made the operation so they examine me because they examine the uterus

In line 116, the interpreter uses a feedback token to support the incipient narration of the patient, which is further promoted by the continuer in line 118.
When the patient expresses her concern (line 119), the interpreter produces the acknowledgement token to display her understanding of the patient’s emotions. In line 122, the interpreter encourages the patient to express her concerns; this is accomplished by producing an upshot that advances an interpretation of the patient’s emotional stance (Antaki et al. 2005). The interpreter’s upshot makes the expression of either agreement or disagreement by the patient relevant in the following turn. In both cases further knowledge about the patient’s emotions and concerns will be produced. The interpreter’s upshot is not a translation; rather, it is a discursive initiative taken by the interpreter that elicits more contribution from the patient.

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

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

2.2.2 Triadic interactions

The main difference between dyadic and triadic interactions is the inclusion of the doctor in the interaction, which in turn depends on the interpreter’s actions. The most important interactional resource used to involve doctors in patients’ emotional contributions is affective formulations. Formulations are a conversational object recognized and analysed by Conversation Analysis (Antaki et al. 2005; Bolden 2010; Heritage 1985). Formulations are summaries of previous turns, which provide directions for subsequent turns by inviting a reaction from the recipients. Formulations advance the prior report by finding a point in the prior utterance and thus shifting its focus, redeveloping its gist, making something explicit that was previously implicit in the prior utterance, or by making inferences about its presuppositions or implications (Heritage 1985: 104).

In the data reported on here, interpreters’ formulations are interpretations following patient-interpreter dyadic sequences, with adaptations in order to build, expand and recreate the meanings of the dyadic sequences. Formulations, therefore, are not word-for-word translations of contributions in prior dyadic sequences; rather, they rely on the interpreter’s discursive initiative and willingness to create common ground between patients and doctors (Cirillo 2010). Specifically, interpreters use formulations as conversational resources that (a) provide an interpretation which highlights content from dyadic monolingual
sequences; and (b) propose inferences about presuppositions or implications of patients’ contributions (Baraldi/Gavioli 2008).

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

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

Excerpt 3

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

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

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

4P: mhm uagiaa
   mhm yes

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

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

7D: ah un’ altra volta?
   ah one other time?
   ah, again?

8M: sì
   yes

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

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

11M: lesh uigihik hek tabaan bain aleki
   why face your tired is much
   why do you look so tired?
The patient’s complaint is followed by a complex turn; the first unit of the turn is a translation, while the second unit of the turn is a question. The question projects an expectation of confirmation/disconfirmation of a possible cause of pain (line 3, did you have contractions?). Following the patient’s confirmation, the interpreter acknowledges receipt of the information (line 5, mmh mmh). The doctor’s acknowledgement in line 7 is expressed as a news-receipt marker (ah again?), displaying the relevance of the information. In lines 9-10, the doctor displays her interest in the patient’s situation with a question (why you look so suffering?), which opens the way for a translation by the interpreter and further explanations by the patient.

The doctor’s question is followed by a short dyadic sequence in Arabic (lines 11-15) between the interpreter and the patient. The interpreter translates the doctor’s question (replacing “suffering” with “tired”) and subsequently displays interest in the patient’s emotions.
The doctor interrupts the dyadic sequence to re-express her concern for the patient (line 16-17); however, the doctor’s contribution is not translated by the interpreter, who formulates her own understanding of the patient’s worry (“a bit frightened because, let’s say for her belly”, lines 18-19). The interpreter’s initiative makes some form of reassurance by the doctor relevant in the following turn (line 20). Finally, the interpreter translates the doctor’s reassurance and provides further support to the patient (line 21).

3. Discussion and Conclusion

3.1 Discussion

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

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

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

3.2 Conclusion

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

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

In particular, the data show that a conversational resource, affective formulations, is effective in maximising potential empathic opportunities offered by
the patient in the course of dyadic sequences. Through affective formulations, interpreters introduce patients’ emotions, doubts and concerns to doctors, making it possible for healthcare personnel to access the many facets of the patient’s situation on both the personal and the cultural levels.

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

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

Statement

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

References


