

Interlinguistic and intercultural mediation in healthcare settings

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Abstract

The paper investigates the role of interlinguistic intercultural mediators in healthcare settings, where they act both as responders, affiliating with the patient in a two-party interaction, and as translators/coordinators, formulating the affective gist of the mediator-patient conversation for the doctor.

Introduction

When all is said and done, people and cultures are more similar than different, for the simple reason that all human beings are first and foremost human, and only secondly Eskimo or Bantu.
(G. Devereux, quoted in Goussot)

The paper deals with Community Interpreting in healthcare settings, which, differently from others (Angelelli 2004, Bowen 2000, Niska 2002, Hale 2007), we will call Interlinguistic Intercultural Mediation, with the term including all forms of oral translation that occur in healthcare settings as services offered to foreign residents who do not speak the language of the host country. The paper investigates the role of Mediation as a form of oral translation and its role in giving voice to cultural minorities (Baraldi/Gavioli 2007). Our assumption is that, despite the widespread use of English as a lingua franca, giving patients the opportunity to communicate with healthcare personnel in their native language is an expression of respect for their human rights (Russo 2004). Our study focuses

on women and children, who often find themselves at a disadvantage in communicating with healthcare personnel (Favaro 1997, 2001; Favaro/Fumagalli 2004) for cultural, linguistic and/or psychosocial motives (Lesi/Falhem 2008: 99). The paper investigates the role of interlinguistic intercultural mediators in healthcare settings, where they act both as “responders”, affiliating with the patient in a two-party interaction, and as “translators/coordinators”, formulating the affective gist of the mediator-patient conversation for the doctor.¹ The paper is divided into 2 sections: the first includes a theoretical framework on the role of interlinguistic and intercultural mediation as a form of oral translation across cultures (Moro 2005), along the lines established by Sybille de Pury Toumi (2005), Baraldi (2009) and Amato/Gavioli (2007). The second section contains transcriptions and analyses of a mediated interaction, highlighting the role of the Interlinguistic Intercultural Mediator (IIM) as intercultural coordinator² and promoter of the intercultural dialogue through affective support that is “functional for the achievement of the dialogic action” (Baraldi/Gavioli 2007). The assumption is that translation is not enough to promote reciprocal acceptance of cultural expressions (Baraldi/Gavioli 2007) but it is through the coordinating activity of the IIM that the intercultural dialogue is promoted.

1. Theoretical framework: an attempt to draw a multi-faceted profile

There have been numerous attempts to use a standard term in the literature, but rarely do these succeed in touching on the deeper essence of the mediation process: linguistic mediation, cultural mediation or intercultural linguistic mediation. In our view, none of these transmit the complex essence of mediation: each emphasises one or another aspect of the *gestalt* of mediation. For example, cultural mediation puts the accent on the cultural aspect, providing a closed and self-referential connotation that is totally inadequate, because mediation inherently tends to open up worlds, facilitating dialogue between different cultures in an atmosphere of reciprocity and mutual exchange. On the other hand, the term linguistic mediation is also limiting, for it places the emphasis on only one of the tasks the mediator is expected to perform: the mediator’s task cannot be limited to the carrying out of a linguistic trans-codification (Peronace 2007). In mediation, translation intended as a process of language trans-codification alone is not enough, because if the intention is to “read what is hidden between the lines” (Coppo 2003), an intercultural competence is necessary. Therefore, for the purpose of the present study, we shall adopt the term Interlinguistic Intercultural Mediator (IIM), in line with Unesco’s definition (Pignataro 2009:

- 1 We refer to “affective expectations” in the sense expressed by Baraldi (2006): “affective expectations are expectations that interlocutors expect, expressions of concern, and support in response to some previous interlocutor’s action” (quoted in Baraldi/Gavioli 2007:156).
- 2 The coordinating activity of the mediator is “aimed at making the interaction between the participants of different languages possible and successful [...], it also aims at the participant’s reciprocal understanding and sharing of information” (Baraldi/Gavioli 2007: 156).

154). Sybille de Pury Toumi (2005) takes a very unambiguous position, explaining what mediation is not: it is *not* a “conciliatory procedure whose purpose is to reconcile the parties or reach an agreement”. It is quite odd to imagine the implications of a mediation whose only purpose is to create consensus or forge an agreement: mediation does not presuppose the imposition of a meeting, although it does require contact (de Pury Toumi 2005: 132). Mediation is defined as a process that produces results: actions, not observations (*ibid.*: 131). It is a process that implies dynamism (Pöchhacker 2008: 13), transformation, but also unpredictability. We never know where the mediation process will lead us: the outcomes will always remain unexpected and unpredictable:

during interactions the connections among actions or turns is not pre-determined [...], as each action projects another one into a wide variety of possible options. (Goodwin/Heritage, quoted in Baraldi 2009: 43)

Within the constantly changing flow of communication, the IIM promotes new exchanges. Starting with the difficulties encountered in translation, the original text is de-structured and the culturally determined expressions are specified. The outcome is a new text, belonging to widely differing cultures and languages, that is to say different worlds. The IIM is at the heart of the entire process, acting as its motor, fully responsible for what happens, because the translations s/he chooses will have an impact on the outcome of the exchange. In point of fact, as we can see from the examples of transcriptions, during meetings between doctors and patients, communication often proceeds in spurts, not because the participants wish it so, but because of the requirements of the mediation process itself. Intercultural Interlinguistic Mediation is a special and complex mode of communicating (Coccia 2004: 11) characterised by the fact that:

the two main participants in the exchange belong to different cultures and/or manifest a more or less accentuated cultural difference, and this constitutes a barrier to be overcome if one wishes to communicate. Adding an intercultural-interlinguistic mediator should help to overcome the barrier, but not eliminate it entirely: the mediator must favour a compromise between expectations and interests, sometimes in contrast with each other, with the awareness that these are not always translatable and/or do not always represent rights, nor can they be tackled solely through a mediated negotiation process (Castiglioni 1997, quoted in Coccia 2004: 119). [my translation]

Our field study data can be used to generate a multifaceted profile. The mediator becomes an *active participant* in a “real-time interaction” (Pöchhacker 2008: 13) in the triadic exchange and her social role as “institutional gatekeeper” (Davidson 2000) takes on primary importance in involving the other participants: the mediator contributes to creating a dyadic or triadic interaction, including or excluding the other participants, based on the translation strategies adopted (see turns 8-9) that go beyond the mere transposition of linguistic content. In fact, she does not limit herself to translating the “text”, but also translates the “interaction that accompanies what is said” (Zorzi/Gavioli 2009: 188). The mediator’s translation can take various forms (Amato/Gavioli 2007: 294) and make an active contribution to the conversational interaction: the mediator decides when to translate and when not to, when to expand the text in order to reassure a

participant (extract no. 10), co-constructing meanings (Davidson 2002), and promoting the participation of the speakers within the interaction. The IIM acts as a *coordinator* during the interaction (Pöchhacker 2008) with a doctor, as pointed out in Wadensjö's definition (1998):

the coordination aspect of the role of the interpreter derives from the interpreters' unique middle-position. Interpreters are establishing, promoting and controlling connections between primary parties in conversation. [...] Primary interlocutors will partly rely on the interpreter to mediate turn-organizational clues signalled in and by talk. (Wadensjö 1998: 148)

The IIM also plays a *creative role*: during the process of listening and re-phrasing the content, the use of specific medical terminology could compromise comprehension or lead to misunderstandings. The original text is dissected and the ambiguities are removed, to provide emotional reassurance to the patient; the result is a text that is completely different from the original, one that has its own identity (de Pury Toumi 2005: 133), within which lies a possible encounter with the Other. The IIM produces a text that takes into consideration the interests of the patient for whom s/he is working and with whom s/he probably shares a similar immigration experience. A text which is not the exact copy of the original one, but a new one, keeping in mind the patient's culture and cognition:

dans le cas de la médiation – une situation où doivent se rencontrer des locuteurs – il faut au contraire non pas trahir, mais *produire* un texte nouveau qui sera lieu de rencontre, participer à fracturer le texte de départ et non pas se borner à le reproduire ou à le dupliquer dans une autre langue. [...] En passant d'une langue à l'autre, les locuteurs font surgir des concepts différents. (de Pury Toumi 2005: 133)

During the translation process, ample room is left for the mediator's creative contribution and sensitivity as s/he adapts and creates the new text, which is re-shaped based on the needs of a culture of destination that is very different from the one of origin. The mediator clarifies and reassures, with gestures and smiles, promoting understanding and making communication possible. As we read in Baraldi (2009):

the key aspect of mediation is participation in the communication process, thereby favouring the possibility of acceptance of an action and comprehension. (Baraldi 2009: 43)

2. The data

The preliminary analysis focuses on a corpus of data (Bazzanella 1994, Setton 2000) consisting of transcribed conversations, recorded during empirical observations carried out in Italy, at the Istituti Ospedalieri of Cremona, in naturally-occurring bilingual bicultural encounters, involving an Indian female mediator and a female Indian patient in the neurology department³. The corpus

3 The study began in January 2010 and the recordings were made after 3 months of field observations. The study is currently in progress, in collaboration with Dr. Carmen Rauso and with the valuable contribution of the Indian mediator, Dr. Anisha Sharma,

of data was analysed in order to identify translation and coordinating activities (Baraldi/Gavioli 2007) of the IIM, particularly with respect to the notion of “emotional skills”⁴ for the construction of affective support, considered as a key factor in determining the success of the intercultural mediation (*ibid.*: 157). For the purposes of the present study, we shall only analyse the data recorded in a conversation that took place in the hospital’s department of neurology. The other conversations were recorded in the departments of obstetrics, gynaecology and paediatrics. As noted by Orletti (1991, 1994) one of the principal problems with empirical research is the effect a researcher has on the study data due to his presence. According to the authors, systematic observation of verbal behaviour automatically creates a formal situation, in which the speaker pays more attention than usual to his verbal production (Orletti/Testa 1991: 243). Aware of the risk involved, we attempted to remain as unobtrusive as possible, in order to avoid biasing the data and also to allow the patients, medical personnel and the IIM to work in as natural a manner as possible.

2.1 Case discussion

For the purpose of the present study, we focused on patient’s emotive expressions and on the affective support of the IIM during medical examinations. For an effective communication in a triadic interaction, mediators should ensure constant translation of the emotional expressions, involving the doctor and promoting a patient-centred medical interaction: intercultural dialogue is produced and becomes effective only if it is followed by the mediator’s formulations and renditions of the emotional expressions of the patients. As Baraldi and Gavioli (2007) suggest, the mediator’s affective support is very important and “functional for the achievement of the dialogic action”. The mediator’s renditions of the emotional expressions through formulations lead to the accomplishment of affective expectations and promote the reciprocal involvement of both patients and doctors, in a patient-centred perspective (*ibid.*: 172). Interpreters’ formulations through translation promote triadic affective interactions fulfilling two key functions in intercultural mediation, that of giving voice to the patients’ emotions and that of supporting a patient-centred medical interaction (*ibid.*: 172). As acknowledged in the literature (Baraldi/Gavioli 2007), in medical encounters IIMs contribute to dialogue management in two ways: 1) as responders, affiliating with the patient in a two-party interaction; 2) as translators/coordinators, affiliating with the patient and then formulating the affective gist of the interpreter-patient conversation for the doctor.

who carried out the translation and transcription of the conversations from the Punjabi language into Italian.

- 4 The topic of emotional involvement and emotional skills was addressed from the perspective presented in the studies by Amato/Gavioli (2007), Baraldi (2009), Zorzi/Gavioli (2009) and Caffi/Janney (1994).

2.2 Affective communication for an effective interaction

Whenever we speak, [...] we are called upon to choose the most effective ways of expressing our ideas and feelings; and our feelings come first. (Caffi/Janney 1994: 326)

Caffi and Janney maintain that all native speakers possess an “emotive capacity: that is a basic, conventional, learned, affective-relational communicative skill” (Caffi/Janney 1994: 327) that helps them interact smoothly, negotiate potential interpersonal conflicts and achieve different goals in speech. These skills are related to linguistic performances and other activities that can be interpreted broadly as “signs of affect [...]” (*ibid.*: 327) and in order to have a successful interaction a good mastery of these conventional skills is of the essence (Caffi 1994). In a medical context, we expect doctors to formulate accurate diagnoses and propose effective treatment, whereas patients are expected to accept the proposed treatment and follow the doctor’s indications (Zorzi/Gavioli 2009). Little or no space is left for the expression of affective expectations (*ibid.*: 183) or the expressions of feelings of doubt and worries. In our corpus, this view is not confirmed. In our data the IIM shows affiliative responses to the patient’s expression of feelings and this “seems relevant in carrying out the affective sequences in medical interpreter-mediated interactions” (Baraldi/Gavioli 2007: 164) above all when the affective contribution is rendered through translation, involving the doctor and promoting a triadic dialogue. As postulated by Zorzi/Gavioli (2009), managing affective actions during encounters is not always easy, above all when three dyads are involved: doctor-patient, mediator-patient, and doctor-mediator (*ibid.*: 180). In our data, unlike the observations made in Davidson (2000), expressions related to the emotional sphere are neither eliminated nor attenuated through translation.

2.3 Coordination of dialogue and affective support

The following sequences are taken from an encounter among a neurologist (D) (male), an Indian patient (P) (female) and the Indian IIM (M) (female). The doctor explains that the Indian woman has neurological problems due to circulatory disorders and asks the IIM to explain that an exam will have to be carried out. The IIM wants to be sure that the patient understands what is said and starts a sequence of questions, encouraging the patient to express her preoccupations. The IIM displays *affective support*, speaking directly to the patient: her concern is that the patient is unable to comprehend, due to the circulatory problems (turn 4: “do you understand me well?”). The IIM introduces a projection of affective reassurance, and finally the patient’s worries and doubts are assuaged by the doctor’s support (“tell her that it won’t hurt”). As Baraldi maintains, “the provision of affective support encourages patients to further express their emotions and worries and eventually leads to reassurance” (Baraldi 2007: 163). This attitude is of particular importance for the interaction, as acknowledged in the literature (Gavioli/Zorzi 2008), above all when the question is translated to the doctor (i.e. in 05: “She said that now she is fine and that she understood perfectly. She also told me that she understands what I am saying and that she can communicate”),

contributing to giving voice to the patient's emotions and worries; by promoting the doctor involvement, a triadic interaction is created, with the affective support passing through translation (turn 05: see above).

Example 1:

04 M. qUhwnUM myrI glbwq pUrI qrHw smJ Aw rhI hY?

English Gloss *Do you understand me well?*

05 M. She said that now she is fine and that she understood perfectly. She also told me that she understands what I am saying and that she can communicate.

This attitude is also evident in example no. 2. where the IIM encourages the patient to express her doubts. In sequence 09 the patient looks tired and sleepy, and the IIM again asks for confirmation providing reassurance ("Did you understand well what I told you? If you did not understand tell me. Do not be afraid if you do not understand").

Example 2:

09 M. qUhwnUM smJ Aw igAw jO mY ikhw? Agr qUhwnUM koel gl nhI smJ

Aw rhI qw swnUM ds dyvo. Agr qUhwnUM fr hY ik myrI glbwq nhI smJ
AweI qw qUsI GbrwAo nw

English Gloss *Did you understand well what I told you? If you did not, then say so, don't be afraid if you don't understand.*

In the following example, the doctor wants to explain to the patient that an exam has to be performed (turn 6), in order to rule out any cardiac complications. In turn 7 the IIM explains to the patient the type of exam ("They will take you to another department and perform this exam to see whether you are fine, if circulation is normal"), without mentioning the name of the exam ("trans-esophageal ultrasound"), because the medical terminology ("thrombus"; "cardiac valve") would have presumably troubled and worried the patient. At the end of sequence 07 the IIM provides emotive support with the addition: "He says that he wants to dispel all doubts. He wants to explain you everything because he doesn't want you to get scared when they will insert the tubing into the throat"

Example 3:

06 D.

English Gloss *Well, we have to tell her that this morning she will be called by the cardiologist to perform an exam called trans-esophageal ultrasound. Let me explain: it is an exam to visualise the heart, to rule out the presence of a thrombus in the heart or in the cardiac valve. Since the view is obstructed by the bones of the sternum and ribs, they will have to introduce a tube into the esophagus so that the probe can see the heart from the rear, without the interference of the bones. You should explain that they will introduce a tube in the mouth, only a small portion will be introduced, only down to the heart, we do not need to see the stomach.*

07 M. ieh ikh rhy hn ik Aj iehnw ny qUhwfw iek tyst krxw hY ies leI ik ieh pqw
krxw cwhMUdy hn ik qUhwnUM ieh iSkwieq ikau hoel. Agy ieh
qUhwfy idl dw cYk Ap vI krxw cwhUMdy hn smJx leI ik ieh iSkwieq
qUhwnUM aus krky nw hoel hovy. idl ivc koel pRoblm krky ho skdw hY
ik ies dw Asr quhwfy isr qy ho igAw hovy. ies krky iehnw ny qUhwnUM
aus ivBwg vl lY ky jwxw hy ijs ivc idl dw tyst krdy hn. ieh ikh rhy hn ik
ieh tyst bwhro nhI ikqw jw skdw ikauik swfy PyPiVAw dIAw hfIAw krky
AMdr cMgI qrHw idsdw hnI ik idl iks qrHw hY. ies leI auhnw ny
quhwfy AMdr iek tlaub pwky dyKxw hY ijdw iehnw ny qUhwfy mUMh

rwhI iek tIaub AMdr pwauxI hY Aqy auhnw ny dyKxw hY ik AMdrO
 swrw kUC TIK hY jw nhI. mqlb ik Agr Kun TIK FMg nwl Gumdw hY, jw
 iPr idl TIK FMg nwl kMm kr irhw hY ik ausnUM koeI pRoblm qw nhI
 hYgI. ikhMdy ik iehnw ny isrP Awpxw Sk kFwx hY. ieh qUhwUM ies
 lel smJw rhy hn ik qUsI fr nw jwieAo, jdo ieh qUhwfy mUMh ivc tIaub
 nUM pwaux.

English Gloss *He is saying that today they will ask you to perform an exam to understand the cause of this problem. They want to do this test because they want to understand if the two problems are related. Due to some cardiac problems, the brain might have suffered. They will take you to another department and perform this exam to see whether you are fine, if circulation is normal. He says that he wants to dispel all doubts. He wants to explain you everything because he doesn't want you to get scared when they will insert the tubing into the throat.*

In turn 08, the doctor realises that after the explanation of the medical exam the patient looks anxious and he affiliates providing indirect reassurance (“She doesn’t look convinced, tell her it won’t hurt”). This attitude stresses the importance of emotive support in a triadic interaction that has to pass through translation.⁵

Example 4

08 D. Non mi sembra convinta...eh? Ma non fa male, le dica che non fa male.

English Gloss *She doesn't look convinced...eh? But tell her that it won't hurt.*

The dyadic sequences between the IIM and the patient are the longest (from turn 24 to turn 27), translation to the doctor is provided only after 4 sequences, in turn 28 (“She asked me why she sometimes feels strange and forgets things”). These are the turns when the patient speaks directly to the mediator (from 24 to 28 and from 45 to 46) providing emotional reassurance. In these instances the worries and the negotiation of the problem is evident (i.e. in 24: “What’s happening?”) (Zorzi/Gavioli 2009): the IIM emotionally reassures and encourages the patient’s self-expression in a long dyadic affective structure (from 24 to 28) shared with the doctor (e.g. in 05 and in 28). A triadic interaction is created: the worries of the patient are not cut out but conveyed through translation; the doctor is not excluded from the triad, thanks to the full renditions by the IIM. This is a form of dialogue coordination (Pearce/Pearce 2003, quoted in Baraldi 2009: 71), where dialogue is defined as “a form of communication in which all the participants can act or interact; dialogue is a way to promote participation”.

Example 5:

24 M. ikdw kwqy hUMdw hY.

English Gloss *What's happening?*

25 P. ik keI vvrI mynUM pqw nhI lgdw?

English Gloss *Sometimes I don't understand.*

26 M. iks qrHw pqw nhI lgdw?

English Gloss *What do you mean, you don't understand?*

27 P. Aydw kwqy hUMdw hY ik cyqw Bul jwdw hY mY.

English Gloss *Why do I sometimes forget things?*

28 M. *She asked me why she sometimes feels strange and forgets things.*

5 “Affective expectations in a triadic sequence create the condition for a non-ethnocentric form of mediation” (Baraldi 2009: 65). For a detailed description of ethnocentric mediation see Baraldi (2009).

In turns 44, 45 and 46 the IIM is encouraging the patient's self expression and actively coordinates dialogue. The IIM understands the patient's uncertainties and worries from her face expressions and encourages her to express herself (44. M. "would you like to ask the doctor anything else?"). After a brief hesitation (45. P. "No, that's all right"), the patient intervenes and expresses her doubts (46. P. "Sometimes I get these headaches"):

Example 6:

44. M. qUsI fwktr nUM hor kUC qw nhI pUCxw?
English Gloss *Would you like to ask the doctor anything else?*
45. P. nhI, Tik hY.
English Gloss *No, that's all right.*
46. P. myrw isr iek dMm drd hox lg pYdw hY.
English Gloss *Sometimes I get these headaches.*

This is a form of dialogue that promotes a fair distribution of participation with a strong focus on the participants' self-expression (Baraldi 2009: 71) (44. M. "Would you like to ask the doctor anything else?"). In our corpus of data this is the most typical organisation of talk: a long dyadic affective sequence (from turn 25 to turn 28), with the patient's emotional expressions followed by the mediator's affective reassurance (26. M. "What do you mean you don't understand?"); the doctor is not excluded from the dialogue, thanks to the translation of the IIM (28 M "she asked me why she sometimes feels strange and forgets things").

Our data suggest that the affiliative responses to the patient's expressions are relevant in the interaction because:

- 1) they contribute to the patient's reassurance (Baraldi/ Gavioli 2007) and
- 2) they encourage the patient's self-expression.

In conclusion, though data in the literature (Davidson 2000) seem to confirm that "the expression of patients' feelings and attitudes is problematic in doctor-patient mediated talk and that the mediator acts as a gatekeeper preventing the understanding and the sharing of emotional expressions in talk" (Baraldi/Gavioli 2007:164), in our data we observed that the IIM is not "cutting out" the patient's affective contributions in the rendition: the patient's expressions of worries are treated as relevant in the interaction, and the emotional contribution of the patient is fully rendered through translation and shared with the doctor, thus promoting the doctor-patient contact. The IIM repeatedly encourages the patient's self-expression and involves the doctor in translating the patient's turns.

3. An attempt to draw conclusions

At present, the limited amount of data doesn't justify any general conclusions but some preliminary considerations can be made on the multi-faceted role of the Interlinguistic Intercultural Mediator in healthcare settings. The IIM contributes to coordinate and promote patient's participation and involvement in the mediated dialogue, by emotionally reassuring and encouraging the patient's self-expression, and promoting a doctor-patient contact. Triadic interactions are

allowed thanks to the translations of the mediator, though not on a turn-by-turn basis. As Baraldi and Gavioli (2007) maintain, the forms of translation adopted generate a dyadic or triadic interaction, preventing or promoting the inclusion or exclusion of the participants. Undoubtedly, IIMs contribute to giving a voice to cultural minorities through their cultural competence and translating activity, and they play an active role in coordinating dialogue, providing affective support to the patients. An affective form of mediation through translation is a necessary prerequisite for the production of a triadic sequence, with the promotion of self-expression by each participant (Baraldi 2009). Therefore the IIM is a co-constructor of meaning, an active and visible participant, a bridge between distant worlds. Though some of them may be completely unaware of the extremely important role they play for the institutions and society in general, Universities should become more active and develop specific programmes to train new professionals in Interlinguistic and Intercultural Mediation. My fondest hope is that this study will contribute to increasing our awareness of the importance of the role played by Interlinguistic Intercultural Mediators.

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