Languages (and cultures?) in contact. Interpreting and Intercultural Mediation in Italian healthcare settings

Federico Farini

University of Modena and Reggio Emilia

Abstract

A series of interpreted-mediated medical encounters is analysed in order to ascertain how interpreters coordinate doctor-patient interaction and to what extent they empower the "voice of patient" or promote patients' adaptation to the "voice of medicine".

1. Introduction: the state of the art

Intercultural Mediation (IM) is a practice primarily used by institutions to encourage foreign groups to access public facilities, especially those related to healthcare, social integration, education, justice and job assistance. IM is of growing interest to Italian public services, whose users now include an increasing number of migrants. The evidence for this interest is given by a significant number of studies, providing a description of IM's procedures and purposes with respect to public services.

Italian scientific literature analyses IM experiences from different perspectives: a pedagogical perspective, i.e. relating to intercultural education (Favaro 2001, Fiorucci 2000, Johnson/Nigris 2000), and anthropological (Castiglioni 1997) and sociological perspectives (Belpiede 1997, Ceccatelli Gurrieri 2003, Jabbar 2000). From these analyses we can borrow definitions of IM as applied to different social contexts. IM means finding a common view, coming to an agreement, favouring compromise. It is the creation of bridges and networks (cf. Ceccatelli Gurrieri

2003: 15); IM is a way of getting closer, facilitating contact, including, favouring interaction and exchange (cf. Favaro 2001: 10).

According to Johnson and Nigris (2000: 373-374), the demand for IM occurs in the following cases: when a) people belonging to different linguistic and cultural groups are involved in mutual communication; b) the interaction between these people takes place in institutional contexts lacking a balance of power between the parties involved. Thus, two contrasting functions of IM are observed: on the one hand, IM is used to connect individuals belonging to different cultures, on the other hand, IM is described as an action aimed at reducing the asymmetries of role and authority characterising institutions in the mainstream cultural background.

In the first case the mediator is viewed as a *referee* who gives voice to the questions, needs and thoughts of the service user, while at the same time clarifying the needs and functions of the institutional service. IM aims to support users so that they can better use the information they have been provided with, and use the most effective strategies to solve problems – thus reaching a higher level of independence in defending their position (empowerment).

In the second case the mediator is a sort of *advocate* who defends the interests of the service user, who is considered the weakest and most vulnerable party, due to her/his inability to independently formulate questions and obtain relevant replies. IM aims to defend the rights of those users experiencing discrimination and having difficulty getting others to recognise their needs.

According to the studies mentioned above, empowerment comes before advocacy: Belpiede (2002: 39) asserts that the mediator should first of all maintain an impartial position, not preferring any of the parties. Nevertheless, considering the disparity of the roles played by provider and user, the mediator should support the user's negotiation position, thus favouring empowerment. However, these studies have been based on reports from mediators' biographies and other experiences; in our opinion this data is only partially useful for the evaluation of mediation practices: the information appears overly categorised and often far from presenting the dynamics of IM practices. With some exceptions (Amato/Gavioli 2008, Baraldi 2006, Baraldi/Gavioli 2007 and 2008, Cirillo 2010, Merlini/Favaron 2007), Italian research on IM is lacking an empirical basis, and no clear proposal has so far been made to design a methodology for the evaluation of current IM procedures.

For this reason, this article presents a theoretical model and methodology developed around different approaches, particularly linguistic and sociological, to obtain a working definition of IM. To do that, the observation of communication processes involving institutional providers, migrants and a cultural mediator plays a crucial role.

2. A methodology for IM research

In order to help analyse IM-promoted communication forms between participants in an interaction, it may be helpful to consider empirical studies on

dialogue interpretation from applied linguistics, with respect to collections and transcriptions of mediated conversations (Davidson 2000, 2001 and 2002, Bolden 2000, Mason 1999 and 2001, Wadensjö 1998). They clarify that IM can be seen as a special kind of interaction defined as "interpreter-mediated" (Wadensjö 1998). Specifically, IM is considered as a triadic interaction (Mason 1999, 2001; Wadensjö 1998) involving two primary participants (service provider and service user) and a third one (the interpreter-mediator) who has to allow the user to access the service by translating from the user's language into the agent's language, making both aware of each other's differences, and also allows the service provider to provide the user with the service requested.

The interpreter-mediator's actions, therefore, are fundamental to the result of the interaction: the interpreter, being the only participant who can be fully aware of the linguistic elements of the interaction, has a strong influence on the communicative process. According to Wadensjö (1998: 15), the most important function of the interpreter-mediator is not simply the faithful translation of what the participants say, but the promotion of shared knowledge and coordination of participants.

The interpreter-mediator is the only participant in the interaction able to understand everything the others say. Therefore the interpreter-mediator can define the context of the encounter, drawing attention to the production of shared topics, and managing misunderstandings. In this respect, we can see the interpreter-mediator as an active participant who builds intercultural communication through translation and coordination activities promoting the active participation of the people involved in the interaction.

In order to demonstrate the empirical value of the methodological premises mentioned so far, the next sections will present some sequences of mediated conversations that have been tape-recorded and transcribed. The analysis of these conversations will focus on: a) the forms of communication promoted by IM; b) the linguistic aspects of IM communication; and c) the consequences (be they explicit or not) characterising the relationship between the participants involved in the communication.

3.   Description of case studies and objectives of the research

The following collection of data is the result of a project called *Interlinguistic and intercultural communication: analysis of translation as a form of mediation for the bilingual dialogue between foreign citizens and institutions*, promoted by the University of Modena and Reggio Emilia.

Our analysis is based on 55 conversations in Arabic and Italian in two public healthcare services in Emilia Romagna: the *Centro per la salute delle famiglie straniere* (Healthcare support centre for foreign families, *CS* in the excerpts) in Reggio Emilia and the *Consultorio* (Local centre for health and social services, *CO* in the excerpts) in Vignola (province of Modena). All conversations have been tape-recorded and transcribed according to conversation analysis conventions (see Figure 1 below).

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

Figure 1: Transcription conventions (from Jefferson 2004)

The conversations involve at least one Italian healthcare provider (D), an Arabic-speaking mediator (M) and an Arabic-speaking patient (P). The object of our analysis consists of medical encounters with the presence of an interpreter who is expected not only to translate what the participants say, but also to promote the coordination between the principal interlocutors, preserving the functionality of the healthcare system. Thus, the interpreters in our data, play the role of interlinguistic *and* intercultural mediators (IIM). The analysis of the recorded conversations can be intended as an evaluation of IM processes in the contexts in question.

Previous research suggests that medical encounters consist of institutionalised activities in defined phases: opening, problem presentation, information gathering, diagnosis, treatment, closing (Robinson 1998 and 2003, Stivers 2002, Robinson/Heritage 2005). Although each of these phases represents a basic resource for treatment, very frequently migrant patients encounter severe difficulties in presenting their case histories, concerns and worries. As will be seen, such difficulties are not always overcome through the intervention of the IIM. Beyond the institutional purposes of IM, we will discuss in which ways it may empower or inhibit migrant patients' participation in medical encounters.

First, we will identify actions which exclude the *voice of patient* (Mishler 1984) from the medical encounter; second, we will identify actions which, in turn, promote its expression. Our research shows that the relevance of the patient's voice in medical encounters may be connected with the IIM's use of a specific conversational resource – *formulations*.

4.   The inhibition of patients' active participation in medical encounters
4.1   The exclusion of the patient's voice. Selectivity in translation: reduced and zero-renditions

The most common types of IIM action that exclude the *voice of patient* from the medical encounter are *reduced renditions or zero renditions* (Wadensjö 1998) of patient's and doctor's turns of talk, cutting out some of their content from the translation.

Excerpt CS13 offers an instance of zero rendition; in the course of the excerpt the patient, suffering from insomnia due to fear of having contracted HIV, makes three attempts to begin a narration about his personal experience of the disease (turns 3, 5 and 24). None of these attempts is successful. The first attempt (turn 3) is frustrated by the IIM, who begins to translate as the patient is reporting a

Federico Farini

symptom, thus overlapping with the patient's narration (turn 4). In turn 5, the patient tries again to initiate the narration, explicitly asking the IIM to take on the role of story-recipient. This second attempt is frustrated by the doctor who intervenes, relates to turn 4 of the IIM (turn 6), overlaps with the patient's narration, and thus blocks it. The doctor's intervention is a cue for the cultural presuppositions of a doctor-centred culture: as a technical expert the doctor tries to gather more precise symptoms, in this case exploring the physiological reason for insomnia (e.g. the patient "is not tired enough").

However, the patient doesn't give up his attempt to talk about his personal experience and makes use of a problem in the IIM-doctor dyad to present his narration for a third time. In turn 24, the patient uses a presequence (Schegloff 1980) to inform the IIM he is about to start a narration. After the pre-sequence the next relevant action for the IIM is to accept or refuse the role of story-recipient.

In turn 25 the IIM encourages the patient's narration through a short turn working as a continuer ("mhmm", cf. Schegloff 1982), indicating that she has understood he is starting a narration, that she is attentive to that utterance and that she is passing up the opportunity to take a turn of her own during the course of the narration, thus accepting the role of listener to the story. In turn 26, the patient is in a position to start a narration which takes the form of *troubles-talk* (Jefferson/Lee 1981; Jefferson 1988), emphasising the troubles that insomnia produces in his everyday life, rather than providing *current symptoms* (Heritage 2008), i.e. objective symptoms in biomedical terms. When the patient completes the description of a first insomnia-related problem, different options are available for the IIM: she may translate the troubles-talk to the doctor, she may solicit the continuation of the troubles-talk by providing another continuer or she may request clarification.

However, she drops the narration producing a zero rendition (Wadensjö 1998); she doesn't translate the turn at all, remaining silent. Narratives in medical encounters are likely to be evaluated for the ways in which they contribute to a coherent explanation of disease: in this excerpt it seems that the IIM (not the doctor) evaluates the patient's troubles-talk as irrelevant to the diagnosis. The course of the interaction shows that the zero rendition was unexpected: the long silence shows that the patient was withholding his troubles-talk waiting for a contribution from the IIM (continuers, feedback etc.).

After 3 seconds of silence (turn 27), the doctor intervenes to move the encounter to the treatment phase; the patient has missed the opportunity to express the psychological experience and meaning of the perceived disease as continuing the troubles-talk would be inappropriate in the treatment phase. In the treatment phase, the patient is expected to listen to the doctor's instructions; he may ask clarifications but the opportunity to express his own personal feelings about his disease has passed.

Narrations are co-authored through interactional moves and activities between narrator and audience. They need to be collaboratively sustained by participants. Recipients influence the details that make up the story and the ways it is told through their participation. For instance, by using a story preface, when the speaker offers to tell a story, a recipient can accept a narration. Similarly a story can be encouraged by prompting the story through questions, by showing that

the end of the story has been recognised and, in some cases, by showing appreciation or by producing further stories (Monzoni/Drew 2009).

In this excerpt, the IIM accepts the role of narration-recipient only to quickly abdicate it, as she does not encourage the patient's troubles-talk. The IIM's zero rendition prevents an insomnia-related trouble, as experienced by the patient in his social world, from becoming relevant to the medical encounter. As the IIM evaluates the patient's troubles-talk to be of no value to the diagnosis, emotional expressions, the meaning of disease in the everyday life of the patient, and the social and personal relevance of his health problems are excluded from the interaction.

CS13

1	D	Di notte dormi?
2	M	*Can you sleep at night or?*
3	P	*No if I haven't worked during the day I [can't. I don't-*
4	M	[quando quando non è stanco non dorme
		When when he's not tired he can't sleep
5	P	واسمحوا لي أن أقول لك
		Posso di[re-
6	D	[Quando non è stanco e non lavora
		When he's not tired and doesn't work
7	M	Quando non è stanco e non ha lavorato
		When he's not tired and doesn't work
8	D	Quando non ha lavorato. Per questo-
		When he hasn't worked. For that –
9	M	Non riesce a dormire
		He can't sleep
10	M	إذا كنت لا تعب ، لا تنام؟
		If you are not tired, don't you sleep?
11	P	لا استطيع النوم حتى الصباح
		I can't sleep until the morning I
12	M	Cioè tutta la notte dice fino alla mattina
		Well he says all night long until morning
13	P	في العمل ، ولقد ترك لمدة ساعتين للنوم
		At work, I have to leave for two hours to sleep
14	M	E quando lavora deve per forza andare via per due orette per riposare
		And at work he has to take a break for two hours to sleep a bit
15	D	Ascolta vuoi che ti diamo qualcosina per riposare alla notte (.)Sempre (.) indipendentemente dal lavoro e non lavoro?
		Listen do you want we give you something to sleep at night (.) Either if you have to work or not?
16	M	بتقولك (.) تحب نديك حاجة , نديك دوة حاجة تنام بيها بالليل , تعبان مش تعبان (.) تنومك بالليل والة ؟
		He says (.) do you want we give you something to sleep at night? Tired or not helps you at night or-?
17	D	una compressina?
		a little tablet?
18	M	[حاجة عشان تنام بالليل ـ
		[something to sleep at night or-
19	D	((to the nurse)): [Dammi del
		[Gimme some
20	P	يا ريت
		I wish
21	M	Sì (.) sì (.) magari dice
		Yes (.) yes (.) I wish, he said

FEDERICO FARINI

22	D	Eh?
		Eh?
23	M	I wish
		magari
24	P	اقول.
		I will tell
25	M	اه –
		Eh –
26	P	الحاجة دي عمّالي زهق في حياتي , لما مبنام اروح للبالكونة وارجع –
		I can't sleep I go back and forth to the balcony
27	D	Allora lui viene mercoledì pomeriggio alle 2/2.30 che gli facciamo il prelievo (...) poi per l'Aids così abbiamo fatto tutto, eh?
		So he comes Wednesday afternoon at 2/2.30 and we take the blood sample (...) then everything will be done about Hiv, eh?

4.2 The exclusion of the patient's voice. IIM as a responder replacing the doctor

Another class of actions which weakens the patient's voice, limiting her/his capability to create a direct connection with the doctor, are those related to the IIM playing the role of *responder*, giving directly to the patient the information s/he requested from the doctor, thus avoiding the involvement of the doctor in the interaction.

In excerpt CS5, the patient produces two questions (turns 3 and 5) to understand if the doctor is going to treat her leg in the office. Instead of translating the patient's questions to the doctor, the IIM responds directly, thus hindering patient-doctor communication.

CS5

1	D	Allora signora (.) possiamo provare a dare (..) del Fastum gel in pomata (.) che però se lo deve comprare perché non ce l'abbiamo (.) due volte al giorno
		So madam (.) we can try (..) Fastum gel ointment (.) but she has to buy it herself because we don't have it (.) twice a day
2	M	بتعطيك (.) "بوماتا" تعمليها, لما تشتريها من "الفارماجيا" فهمتني
		She gives you (.) ointment you put it (.) buy it at the pharmacy
3	P	ما بتعطينيها؟
		Does she give it to me?
4	M	خاطر مش موجودة عندهم هنا فهمتني
		They do not have it
5	P	ما بدها تعطينيها؟
		Doesn't she want to give it to me?
6	M	هو مفيهوش حاجة غالية فهمتي
		معندهمش, معندهمش مش مشكل ايه..(تبتسم) كيف لو عندهم بيعطوك همة بنفسهم يعني (..) مش غالي
		That's not the issue ((smiling)) they don't have it (..) really don't have it

In turn 2, the IIM produces a reduced rendition of the doctor's contribution in the previous turn ("she gives you the ointment"), leaving out the information regarding the drug not being available at the doctor's office. This reduced rendition is a cue for a doctor-centred culture (Mishler 1984) where the patient is expected to follow the doctor's instructions, while the doctor doesn't have to account for his/her decisions. But this reduced rendition creates some concern for the patient, who, in the same turn (turn 3), is told that the doctor is treating

her leg with the ointment and she should buy the drug at the pharmacy. In fact, the interpreter uses "give" as a synonym of "prescribe" while the patient understands "gives you" as "treats you with the ointment".

The patient is uncertain about the doctor's intentions. Moreover, the patient doesn't know that the drug is not available (the IIM did not tell her in turn 2) and has no reason to believe that the doctor will not treat her leg in the office. Is the doctor treating her leg in the office? In order to solve this problem, the patient initiates a repair sequence in turn 3 ("Does she give it to me?"). The repair is completed by the IIM, who responds to the patient without translating the request to the doctor ("They do not have it", turn 4).

If this explanation is true, why didn't she offer it in turn 2? Since turn 1, the doctor hasn't said anything to justify the new piece of information added by the IIM in turn 4. The explanation arrives too late in the interaction; the patient understands it as a way to cover the fact that the doctor doesn't want to treat her.

The patient's reiteration of the question in a different format (turn 5) is evidence of her dissatisfaction with the IIM's response, as it includes the presupposition that the doctor doesn't want to treat her leg in the office, even if she could do it. This change in the format of the patient's question foregrounds her increasing disaffiliation. By acting as a responder, the IIM keeps the two parties distant, making the creation of a common ground between the doctor and the patient very unlikely.

The IIM notices the patient's increasingly dissatisfaction and tries to mitigate it; however, she doesn't translate the question to the doctor but provides a direct response (turn 6) and again she increases the distance between the two principal interlocutors. We can imagine the attitude the patient will have towards medical prescriptions if she believes that the doctor is not interested in her health.

Mediator actions such as zero and reduced renditions, interruption of the patient's turn and the substitution of the principal interlocutors make medical encounters proceed faster towards the diagnosis and prescriptions phases, thus apparently supporting the functionality of the system. However, we may ask what kind of system's functionality is supported by these actions. Recent research by Leanza *et al.* (2010) and Schouten *et al.* (2007) confirm 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 mediator action hinder the trust-building process between patient and healthcare provider. Since they create more distance between the principal participants, zero renditions, interruptions and substitutions of the parties 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).

5. The promotion of active participation in the medical encounters
5.1 The support of the voice of patient in dyadic sequences

Our data offers instances where mediators' actions encourage patients' self-expression, giving voice to their concerns, doubts, needs and requests, thus promoting their active involvement in the medical encounter. Mediators may promote patients' active participation through different interactional practices, depending on the nature of the interaction: either dyadic (patient-mediator) or triadic (patient-mediator-doctor).

In dyadic interactions, the mediator supports the voice of the patient through *backchannelling* (Schegloff 1982; Schiffrin 1999), using short conversational markers such as feedback tokens and continuers, or echoing, to manifest attentiveness to and involvement in, prior patient turns and contributions.

In excerpt CO1, the mediator expresses her attentiveness and understanding through feedback tokens ("Ah", "mmh", "Ah I understand you"). In turn 122, the mediator encourages the patient to express her concerns, making her participation relevant to the medical encounter, as a person with specific needs and worries rather than a generic sick person expected to provide current symptoms. In this excerpt, the mediator systematically encourages the patient to express her doubts about the therapy, thus promoting her participation in the medical encounter. Being empowered as an active participant, the patient is confident enough to finally advance a request for clarification (turn 123).

CO1

115	P	وعطوني شي حاجة ورقة مشان الفحص
		(I had to say) I received the paper ((the invitation)) for an examination –
116	M	اه (.) اه
		Ah (.) ah
117	P	كل ثلاث سنوات ادوز فحص للرحم
		I pass the examination for the uterus every three years
118	M	اه
		Mmh
119	P	جتني الورقة وما بغيت نمشي لان لازم نفهمهم اني عملت العملية
		I received the paper and I don't want to go, because I would have to explain I put the coil
120	M	اه (.) فهمت عليكي
		A:h (.) I understand you
121	P	كنت استنى اسأل
		I was waiting to ask it
122	M	خفتي أنك تيجي وتكوني-
		You were afraid to come and being –
123	P	ه انو يقلبوني ويحركو المكينة والة شي حاجة (..) فمن الاحسن انو يعطوني ورقة ويقولو اني عملت العملية (.) بس انو يعني يقلبوني
		Yes 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

5.2 Informative and affective formulations that re-include the doctor in the interaction

The main difference between dyadic and triadic interactions consists in the way in which the doctor re-enters the interaction, which in turn depends on the mediator's actions. The main conversational resource whereby mediators may involve doctors in the interactions are *formulations* of patient contributions.

According to Heritage (1985: 100), we define "formulation" as a specific interactional move "summarising, glossing, or developing the gist of an informant's earlier statement". Formulations project a direction for subsequent turns by inviting responses insofar 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).

Mediator formulations consist of translations which follow patient-mediator dyadic sequences, adapting their contents for the benefit of the doctors. Through formulations, mediators build, expand, and recreate the meanings of prior dyadic sequences according to presuppositions and orientations for which they are responsible. Formulations are not word-for-word translations of contributions in prior dyadic sequences, but they rely on the mediator's discursive initiative and willingness to create a common ground between patients and doctors. In this way, the mediator acts as a coordinator of the medical encounter.

Specifically, formulations are conversational resources available to the mediator in order to: a) provide a translation which highlights content from prior sequences of turns; b) make explicit what is thought to be implicit or not clear in the prior turns of talk; c) propose inferences about presuppositions or implications of the participant's contributions (Baraldi/Gavioli 2008). Formulations are "informational" when they elicit explanations from doctors which patients are somehow inhibited from requesting; formulations are "affective" when they bring patients' emotions, doubts and concerns into the medical encounter.

Excerpt CO23 below offers an instance of informational formulation. In the course of the examination of a pregnant woman, it turns out that the foetus is not yet in the appropriate cephalic position. In turn 59 the doctor reassures the patient about this issue, and in turn 60, the mediator offers reassurance and further suggestions to the patient. The doctor is re-involved in the interaction in turn 63, through an informational formulation which is introduced by the mediator to obtain therapeutic recommendations for the patient's benefit. In CO23, the informational formulation is an initiative motivated by the mediator's interpretation of the patient's stance as refraining from uttering a request for recommendations.

CO23

59 D ((sorridendo)) Ma dai che si gira!
((smiling)) come on, he will turn!

60 M – تحركي وتمشي وان شاء الله
Exercise and take long walks and God willing

61	P	وان تحركت ومشيت -
		If I exercise and take long walks-
62	M	بيساعد
		It would help -
63	M	C'è qualche cosa particolare che aiuta a girare? (.) camminare (.) fare delle -
		Is there something that helps to turn (.) walking (.) do some -
64	D	No
		No
65	M	Della ginnastica particolare delle cose?
		Exercises of some kind whatever?
66	D	No (.) he will turn by himself
		No (.) si gira da solo
67	M	بدو يدور بدور ما بدو يدور بيظلو قاعد هيك بتقلك هاي شغلة ما فينا نقول انك تعملي مشي او تتحركي او تلعبي رياضة هاي طبيعي هوة من راسو
		He says that in this case we cannot say it is useful (.) walking or exercising or making specific movements, it will happen spontaneously, he will turn by himself or will stay like this

Affective formulations may be understood as discursive initiatives undertaken by the IIM to give voice to patients' emotions, which in most cases manifest themselves implicitly. Patients rarely talk about their emotions directly and without prompting. Instead, patients provide interlocutors with clues for their feelings, thus providing "potential empathic opportunities" (Beach/Dixson 2001). Affective formulations focus on the emotional point of patients' utterances, giving the doctor the possibility to share and get involved in the affective dimension of interaction. In this way, doctors are made aware of patients' concerns, and patients assume a local identity that goes beyond the generic social role of being sick.

In excerpt CO11 below, the patient reports a delay in her menstrual period, but mitigates the relevance of this information by assuming she will get her period within the following few days. Through affective formulations, the IIM brings to the fore the patient's emotions, which have remained implicit up to that moment, making them a topic for communication and a concern for the doctor. The IIM's discursive initiative capitalises the potential emphatic opportunity offered by the patient.

The IIM's formulation in turn 65 ("she's a bit worried") is affective because, while making current symptoms available to the doctor, it highlights the patient's emotional stance, which could otherwise have gone unnoticed by the doctor in prior turns. The IIM's formulation of affective understanding involves the doctor in the affective exchange and promotes a shift form a two-party to a three-party interaction.

CO11

55	M	*When you had your period last?*
56	P	جتني تلاتعش من شهر عشرة
		It was the thirteenth in the month of October
57	M	تلاتعش عشرة؟
		Thirteenth October?
58	P	اي
		Yes
59	M	L'ultima mestruazione è il 13 ottobre
		The latest menstrual period is the thirteenth of October

60	D	Mmh
		Mmh
61	M	Ora siamo al 13 novembre
		Now it's November thirteenth
62	P	كانت تهبط علي كل شهر نيشة (.) الدم ما هبط صار شهر لليوم
		It comes each month exactly, now it's a month that it's not coming (.) a month today
63	M	اه
		Mmh
64	P	استنى تلات ايام والة اربع ايام بش مش عارفة اذا تجي
		will wait three days or four, maybe it will come
65	M(to D):	Ah (.) può darsi che tra 4 o 5 giorni al massimo (.) arriva (.) però (.) lei è un po' preoccupata
		Ah (.) maybe in four or five days at latest (.) it will come (.) however (.) she's a bit worried

The IIM's affective formulation offers the doctor the ability to tune in to the emotional status of the patient, reassuring her as needed. Affective formulations are inclusive because, while highlighting the emotions of the patient, they involve the doctor in the formation of affective relations. By producing an affective formulation, the IIM develops and emphasises an implicit emotional expression, thus representing the emotional gist of the report in conversation so that topicalisation and elaboration can take place in the doctor's subsequent turn, and possibly in the subsequent interaction.

Affective formulation reveals the IIM not as a neutral conduit but as an active interpreter of the preceding talk. In particular, the IIM's active participation concerns the patient's implicit, difficult, and embarrassed emotional expressions, providing a way for inclusion of such expression in the triadic sequence and for its treatment in a patient-centred interaction involving the doctor (Baraldi/ Gavioli 2007).

6. Conclusion

The Italian studies on IM we have examined are in agreement with respect to the final objective of IM: the construction of "bridges" between cultures through the promotion of intercultural dialogue. Italian literature considers IM a pivotal strategy of a multicultural society (Colombo 2002) to be employed to cope with difficulties connected with transnational, migrational differences (Melotti 2004; Zanfrini 2004). By facilitating the access to, and use of, public services, IM should create the prerequisites for the migrant's integration into the new society, thus developing multicultural citizenship for a multicultural society (Kymlicka 1995).

The kind of IM described in Italian literature involves facilitating communication and understanding between people belonging to different cultures and eliminating misunderstandings between the migrant and the social agent mostly caused by different cultural codes and values. In summary, the ultimate purpose of IM is to allow every party involved in communication to access the other party's "cultural imagination" (Fiorucci 2000).

The works we have analysed for the purposes of the present paper are based on lists of principles that the mediator is supposed to comply with. From these analyses we can draw prescriptions on basic ethics and qualifications that a

mediator should be provided with to produce an effective IM (Belpiede 2002). However, these studies do not provide the mediators with any practical working input on how to reach the presumed goals of communication.

From our point of view, the functions of IM should be analysed on the basis of empirical data, starting from the observation of the interactions that take place within public services. Our data suggests that the possibility for the voice of patient to become relevant in medical encounters largely depends on the IIM's actions. On the one hand, we have observed how IIM-reduced renditions, zero renditions and the substitution of the principal interlocutors may exclude the patient or the doctor from relevant healthcare information. On the other hand, we have seen how translating patient's turns of talk including their interpretation of implicit content (primarily emotions) improved the emotional rapport between patients and doctors, thus taking the medical encounter well beyond a mere exchange based on standardised roles.

In particular, our data shows that a specific conversational resource, *affective formulations*, is effective in capitalising potential empathic opportunities offered by the patient in the course of dyadic sequences, bringing to the fore his/her voice. By producing affective formulations, IIMs 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 at both a personal and cultural level.

References

Amato A. / Gavioli L. (2008) "Il ruolo dell'interprete-mediatore nella comunicazione istituzionale medico-paziente: un'analisi dei contributi traduttivi", in C. Bosisio / B. Cambiaghi / M. E. Piemontese / F. Santulli (eds) *Atti del 7° Congresso dell'Associazione Italiana di Linguistica Applicata. Aspetti linguistici della comunicazione pubblica e istituzionale*, Perugia, Guerra Edizioni, 293-319.

Baraldi C. (2006) "Diversity and adaptation in intercultural mediation", in D. Busch (ed.) *Interkulturelle Mediation. Eine theoretische Grundlegung triadischer Konfliktbearbeitung in interkulturell bedingten Kontexten*, Frankfurt, Peter Lang, 225-250.

Baraldi C. / Gavioli L. (2007) "Dialogue interpreting as intercultural mediation. An analysis in healthcare multicultural settings", in M. Grein / E. Weigand (eds) *Dialogue and Culture*, Amsterdam/Philadelphia, John Benjamins, 155-175.

Baraldi C. / Gavioli L. (2008) "Cultural presuppositions and re-contextualisation of medical systems in interpreter-mediated interactions", *Curare. Journal of Medical Anthropology* 31/2-3, 193-203.

Beach W. A. / Dixson C. N. (2001) "Revealing moments: formulating understandings of adverse experiences in a health appraisal interview", *Social Science and Medicine* 52, 25-44.

Belpiede A. (ed.) (2002) *Mediazione culturale. Esperienze e percorsi formativi*, Torino, UTET.

Bolden G. B. (2000) "Toward understanding practices of medical interpreting: interpreters' involvement in history taking", *Discourse Studies* 4/2, 387-419.

Castiglioni M. (1997) *La mediazione linguistico-culturale. Principi, strategie, esperienze*, Milano, FrancoAngeli.

Ceccatelli Gurrieri C. (2003) *Mediare culture. Nuove professioni tra comunicazione e intervento*, Roma, Carocci.

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

Colombo E. (2002) *Le società multiculturali*, Roma, Carocci.

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

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

Davidson B. (2002) "A model for the construction of conversational common ground in interpreted discourse", *Journal of Pragmatics* 34/9, 1273-1300.

Favaro G. (2001) *I mediatori linguistici e culturali nella scuola*, Bologna, EMI.

Fiorucci M. (2000) *La mediazione culturale*, Roma, Armando.

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

Heritage J. (2008) "Negotiating the legitimacy of medical problems: a multi-phase concern for patients and doctors", in D. Brashers / D. Goldsmith (eds), *Communicating to Manage Health and Illness*, London/New York, Routledge, 147-164.

Hsieh E. (2010) "Provider–interpreter collaboration in bilingual health care: competitions of control over interpreter-mediated interactions", *Patient Education and Counseling* 78, 154-159.

Jabbar A. (2000) "Mediazione socioculturale e percorsi di cittadinanza", *Animazione sociale* 10/2000, 82-88.

Jefferson G. (1988) "On the sequential organization of troubles talk in ordinary conversation", *Social Problems* 35, 418-41.

Jefferson G. (2004) "Glossary of transcript symbols with an introduction", in G. H. Lerner (ed.) *Conversation Analysis: Studies from the first generation*, Amsterdam/Philadelphia, John Benjamins, 13-31.

Jefferson G. / Lee J. R. E. (1981) "The rejection of advice: managing the problematic convergence of a 'troubles-telling' and a 'service encounter'", *Journal of Pragmatics* 5, 399-422.

Johnson P. / Nigris, E. (2000) "Le figure della mediazione culturale in contesti educativi", in E. Nigris (ed.) *Educazione interculturale*, Milano, Bruno Mondadori.

Kymlicka W. (1995) *La cittadinanza multiculturale*, Bologna, Il Mulino.

Leanza Y. / Boivin I. / Rosenberg E. (2010) "Interruptions and resistance: a comparison of medical consultations with family and trained interpreters", *Social Science and Medicine* 70, 1888-1895.

Mason I. (ed.) (1999) *Dialogue Interpreting*, Special Issue of *The Translator* 5/2.

Mason I. (ed.) (2001) *Triadic Exchanges. Studies in Dialogue Interpreting*, Manchester, St. Jerome.

Melotti U. (2004) *Migrazioni internazionali*, Milano, Bruno Mondadori.

Merlini R. / Favaron R. (2007) "Examining the 'voice of interpreting' in speech pathology", in F. Pöchhacker / M. Shlesinger (eds) *Healthcare Interpreting*, Amsterdam/Philadelphia, John Benjamins, 101-137.

Mishler E. G. (1984) *The Discourse of Medicine: Dialectics of Medical Interviews*, Norwood, Ablex.

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

Robinson J. D. (1998) "Getting down to business: talk, gaze, and body orientation during openings of doctor–patient consultations", *Human Communication Research* 25/1, 97-123.

Robinson J. D. (2003) "An interactional structure of medical activities during acute visits and its implications for patients' participation", *Health Communication* 15, 27-57.

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

Schegloff E. A. (1980) "Preliminaries to preliminaries: 'Can I ask you a question'", *Sociological Inquiry* 50/3-4, 104-152.

Schegloff E. A. (1982) "Discourse as an interactional achievement: some uses of 'uh huh' and other things that come between sentences", in D. Tannen (ed.) *Georgetown University Roundtable on Languages and Linguistics l981. Analyzing Discourse: Text and Talk*, Washington DC, Georgetown University Press, 71-93.

Schiffrin D. (1999) "'Oh' as a marker of information management", in A. Jaworski / N. Coupland (eds) *The Discourse Reader*, London/New York, Routledge, 275-288.

Schouten B. C. / Meeuwesen L. / Tromp F. / Harmsen H. A. M. (2007) "Cultural diversity in patient participation: the influence of patients' characteristics and doctors' communicative behaviour", *Patient Education and Counselling* 67, 214–223.

Stivers T. (2002) "'Symptoms only' and 'candidate diagnoses': presenting the problem in pediatric encounters", *Health Communication* 14/3, 299-338.

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

Zanfrini L. (2004) *Sociologia delle migrazioni*, Roma/Bari, Laterza.