THE PRAGMATICS OF EMOTIONS IN INTERLINGUISTIC HEALTHCARE SETTINGS

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Abstract
Data-based studies on interlinguistic medical interaction show that frequently migrant patients encounter difficulties in expressing their emotions and concerns. Such difficulties are not always overcome through the intervention of an interpreter, as emotional expressions tend to "get missed" in translations which focus on problems and treatments in medical terms.

The main question addressed here is: what types of interpreters' actions cut out, or make relevant, migrant patients' emotions? Our data is based on a corpus of 300 interlinguistic medical interactions in Arabic, Mandarin Chinese and Italian in two public hospitals in Italy. The conversations involve one Italian healthcare provider, an interpreter and a migrant patient. The corpus is analyzed drawing upon Conversation Analysis, studies on Dialogue Interpreting and Intercultural Pragmatics.

Keywords: conversational analysis, medical interaction, pragmatics, emotion, intercultural communication

1. Introduction

Situations requiring interpreters are increasingly common in Western medical systems where healthcare providers encounter migrant patients. *Interpreter-mediated interaction*, that is, triadic interaction involving an interpreter as the third party in a communication process between individuals speaking a different language, is considered one of the most important practices used by institutions to encourage foreign patients to access public healthcare services.

Parallel to its increasing importance for healthcare institutions, interpreted-mediated interaction in public services has become the object of empirical studies from applied linguistics, with respect to collections and transcriptions of conversations (Cambridge, 1999; Pöchhacker and Kadric, 1999; Tebble, 1999; Angelelli, 2004; Baker, 2006; Baraldi and Gavioli, 2011).

In the same period, standards of conducts for healthcare professionals have been devoting more attention the development of an emotional sensitive rapport with patients. Research on different medical settings across the last fifteen years show that the treatment of emotions is now widely considered important for the successful outcome of medical treatment and care (Charles *et al.*, 1999; Epstein *et al.*, 2005; Mead and Bower, 2000; Zandbelt *et al.*, 2006). Patients' emotions and the doctors' affective involvement

in the interaction are now considered of primary importance in helping patients comply with treatment (Barry *et al*., 2001; Kiesler and Auerbach, 2003; Mangione-Smith *et al*., 2003; Heritage and Maynard, 2005; Robinson and Heritage, 2005). In this respect, healthcare providers are invited to observe illness through the patient's lens and *"treat the patient, rather than just the disease"* (Heritage and Maynard, 2006: 355).

However, with regard to interpreter-mediated medical interactions, some peculiar difficulties in handling emotional expressions have been observed in several studies; in particular, doubts have been raised about the effectiveness of interpreting in promoting balanced power relationships. Davidson's research (2000; 2001) suggest that in healthcare settings interpreters can act as *gatekeepers*, controlling what is passed between doctor and patient and fuelling asymmetric power relations between the two parties. In these situations, instead of relaying patients' concerns in full to doctors, interpreters tend to summarise what patients have said, focusing on medical problems and treatments; consequently, emotional expressions may be overlooked or omitted (Hsieh, 2010). Performing the role of gatekeeper, interpreters work as a pre-filter, evaluating the importance of the patient's contributions before translating them (Bolden, 2000).

Stimulated by empirical evidence of the difficulties encountered by migrant patients in presenting their case histories and concerns in interpreted-mediated interactions (Bolden, 2000; Davidson, 2001; Hsieh, 2010; Meyer and Bührig, 2004), this article discusses how interpreted-mediated interactions may empower, but also inhibit, migrant patients' participation in medical encounters.

The discussion is based on the analysis of medical interactions recorded in two public healthcare services in region Emilia-Romagna of Italy, the *Centro per la salute delle famiglie straniere* (Healthcare support centre for foreign families) in the sanitary district of Reggio Emilia and the *Consultorio* (Local centre for health and social services) in Vignola, a small town pertaining to the sanitary district of Modena.

2. Background

2.1 Interpreting as mediation

With regard to interpreted-mediated interactions in public services, it may be helpful to consider empirical studies from applied linguistics, with respect to collections and transcriptions of mediated conversations. Theses studies clarify that interpreting can be seen as a triadic interaction involving two primary participants (service provider and service user) and a third one (the interpreter), who has to allow the user to access the service by translating from the user's language to 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 (Mason, 2006).

In order to explain the type and amount of work that interpreters do in the interaction, Wadensjö (1998) suggests that interpreters play a double role in the conversation, they *translate* and they also *coordinate* the talk activity. Such coordinating activity is aimed at making the interaction between the participants of different languages possible and

successful and it is concerned with the promotion of their participation and understanding. Interpreters, therefore, need to consider the meanings and purposes that are achieved through a conversation; for this reason *interpreting may be understood as a form of mediation* and interpreter may be understood as mediators in interlinguistic and intercultural settings. According to Wadensjö (1998), the most important function of the interpreter-mediator (henceforth: the mediator) is not simply the faithful translation of what the participants say, but has to do with the promotion of a shared knowledge and with coordination. In other words, the mediator is an independent agent who must be seen as an active participant, influencing the orientation of the communication, the expectation towards the roles of doctor and patient and the meanings of healthcare (Baraldi, 2009).

2.2 Context and outline of the study

This article is based on a dataset collected within a research project undertaken in 2010 in two sanitary districts of Region Emilia Romagna: the Modena district and the Reggio Emilia district. The research project, titled *Interlinguistic and intercultural communication: analysis of interpretation as a form of mediation for the bilingual dialogue between foreign citizens and institutions* aimed to create a method of analysis of healthcare practices, drawing up specific criteria to identify good practices and developing guide-lines to be used in personnel training.

In the last fifteen years, the areas pertaining to the Modena and Reggio Emilia districts have been experiencing waves of migration from Northern and Western Africa and West Balkans. More recently, new migration waves have originated from China and Southern Asia. While in 2001 the migrants in both areas were less than 4% of the resident population, data from 2012 indicate that migrants in the area of the Modena district are 89,346, (12.7% of the resident population) and in the area of Reggio Emilia they amount to 69,060 (13% of the resident population). In both districts, the majority of migrants originate from Morocco and Albania. Modena also has a population of Tunisian migrants and Reggio Emilia has quite large Indian and the Chinese communities. Facing these demographic trends, a major challenge for healthcare services is to provide appropriate service for migrants. As a result, healthcare institutions have being encouraged to reorganize their services in innovative ways based on migrant-friendly models (Chiarenza, 2008, 2012).

For example, mediators have been appointed by the General Hospital Board and Local Health Board in Modena to help in reception, obstetrics, nursery, paediatrics, gynaecology, neonatology and the family advice bureau. For its part, Reggio Emilia Local Health Board uses intercultural mediators in the outpatients' departments and specialized units for the care of women and children.

2.3 Participants, data collection and analysis

Four doctors, four nurses and four interpreters took part in the research. All the healthcare professionals are of Italian origins and native speakers of Italian. The

interpreters, who comes from Tunisia and Jordan (Arab speaking) and Northern China (Chinese speaking) have been living in Italy for at least 6 years at the moment of the registration, undergoing formal training to enable them to work as intercultural mediators. Resolution 265 of the Regional Government of Emilia-Romagna (2005), establishes training standards for intercultural mediators. In order to be qualified as intercultural mediators in public services, it is necessary to follow courses organized by training centres validated by the regional authorities. The minimum duration of training course is 200 hours, including at least 40 hours of traineeship.

In the contexts of the research, mediation services are predominantly used in the nursery-infant and women areas; thus, most of the patients involved in the research are women (92%); in both districts migrant women represent the most delicate target for healthcare services: in accessing healthcare services they often encounter different and unfamiliar cultural constructions of health, disease, therapy, sexuality, motherhood which their husbands and fathers may not understand or approve and may, therefore, be a source of conflict.

With regard to the institutional goals of mediation services, Emilia Romagna Regional Law 5/2004, affirms that

> The Region promotes, also through the Local Health Units and Hospitals, the development of informational interventions aimed at immigrant foreign citizens, along with activities of intercultural mediation within the social-health field, finalized at ensuring appropriate cognitive elements, in order to facilitate access to health and social-health services

Hence, the research concerns medical encounters wherein the mediators are expected to promote the coordination between the principal interlocutors, preserving the functionality of the healthcare system.

The research on which this article is based originated the recording of 300 conversations involving migrants speaking Arabic, Chinese, Albanian, Russian, Igbo, Rumanian, Urdu, Hindi and other languages. For the sake of this article a subset of 57 conversation has been used, composed ofthe medical encounters involving Arabic and Chinese speaking women in two public healthcare services: the *Centro per la salute delle famiglie straniere* (Healthcare support centre for foreign families) in Reggio Emilia and the *Consultorio* (Local centre for health and social services) in Vignola (a small town in the sanitary district of Modena).

The conversations involve at least one Italian doctor (D), an Arabic-speaking or Chinese-speaking mediator (M) and an Arabic-speaking or Chinese-speaking patient (P).

Transcriptions of recorded conversation were carried out by researchers occasionally with the help of mediators who were not involved in the collection of data. The Arabic and Chinese turns of talk were transcribed in the Latin font type-set, as commonly used in international chat lines. Transcription of Arabic posed some problems because of the variety of dialects used by the patients. In some cases the transcriber understood the sense of the utterance but could not transcribe it precisely. In those cases an approximate translation of the turn is provided.

2.4 Ethical considerations

The project was reviewed and approved by a Management Coordination Committee, composed of the research coordinator and the coordinators of healthcare services in the two districts. The Management Coordination Committe was in charge of decision making on knowledge protection, ethical and legal issues.

Written information about the project was provided for doctors, interpreters and patients. This included a details of the aim of the project, request for permission to audio-record each conversation and how the results would be used. Written permission was requested from patients, interpreters and doctors. The privacy of participants was preserved according to the Italian Data Protection Act 675 (31.12.1996). Due to the sensitiveness of the situations, the research was authorised to collect audio, but not video, recordings, which did not allow observation of non-verbal action produced through gaze, gesture, facial expression, body posture, etc.

Before any encounter, participants were reminded about the aims of the research and their right to withdraw. Assurances about anonymity were important to avoid anyone being blamed or stigmatized as a result of taking part in the research. If removing or changing names was not enough to ensure anonymity, the ethical need for anonymity was prioritized over scientific considerations of documentation.

These ethical considerations are not, and cannot possibly, be exhaustive. Ethical research practice requires continuous reflexivity and coping with ethical problems as they arise. This requires dialogue on two levels: between researchers as a means of collectively sharing experience, and between researchers and participants in the ongoing research project.

2.5 Theoretical and methodological considerations

The theoretical and methodological premise of the present work is that language works to create meaning and to influence mutual behaviour, therefore language-in-interaction constitutes a unique object for a research motivated by an interest in the methods used by people to negotiate, in any social encounter, the meanings of roles, expectations and normative values (Schegloff, 2007). This article uses two methods for analyzing language-in-interaction: the first method follows the principles of Conversation Analysis, the second method derives from intercultural pragmatics.

Conversation Analysis (CA) is aimed at determining the methods and resources that the interactional participants use and rely on to produce interactional contributions and make sense of the contributions of others. Thus CA is designed to model the resources and methods, or *procedures*, by which participants in interactions perform their social identities and negotiate their relationships. In the last forty years, all basic interactional procedures have been subject of CA studies: the set of practices through which turns are allocated in conversation, the *turn-taking* (Sacks *et al.* 1974), the methods used by parties in conversation to deal with problems in speaking, hearing, or understanding. (Schegloff, *et al.* 1977), the preference in conversation for some types of actions (within sequences of action) over other actions. (Pomerantz 1984), the management of epistemic status (Heritage, 2012).

The object of CA as a method of sociological research is to discover how identities are generated in interaction while participants understand and respond to one another in conversation (Hutchby and Wooffitt, 1998; ten Have, 1999; Sidnell & Stivers, 2012), by means of practices that, behind the apparent contingency of conversation, constitutes the roots of human sociality (Enfield & Levinson, 2007).

The CA theoretical presupposition of the mutual influence of interaction and social order is explained by Mona Baker when she states:

> we perform our gender, we step in and out of professional and other roles numerous times during the course of a single conversation, and therefore whether a participant behaves and responds (…) at any moment depends on a variety of factors and can change during the course of a single interaction. (Baker, 2006: 326)

The second methods used in analyzing interaction is based on intercultural pragmatics (Gumperz, 1992; Koole and Ten Thjie 2001; Carbaugh 2005; Verschueren 2008: Tannen, 2009) and it is concerned with the influence of linguistic and interactional features in the negotiation of social relationships in medical encounters.

According to intercultural pragmatics, in any social encounter participants rely on repertoires of cultural presuppositions to foreground the expectations of others, therefore being able to choose how to act, and to re-act to the actions of others. Cultural presuppositions are sets of expectations depending on socialization patterns, that concern role performances, actions and understanding of action. For instance, medical discourse, be it the discourse on healthcare (medicine) and discourses in healthcare (medical interaction), is permeated by cultural presuppositions concerning differentiated role performances and the interrelation of doctors' actions and patients' actions.

The cultural presuppositions of interaction are observable empirically if one focuses on the participants' management of *contextualization cues*. The analytical concept of contextualization cues was introduced in intercultural pragmatics by Gumperz, to refer to verbal and non-verbal signs which are selected by interlocutors to "relate what is said at any one time and in any one place to knowledge acquired through past experience" (Gumperz 1992: 230). Contextualization cues could be identified at any discursive level: prosody (intonation, pitch shift), paralinguistic signs (tempo, pausing and hesitation, latching or overlapping of speaking turns), code choice (style, language) and choice of lexical forms or formulaic expressions.

How contextualization cues are managed, that is, which linguistic and paralinguistic signs are identified by participants as contextualization cues depends on their knowledge and past experiences as much as on their expectations; the management of contextualization cues "highlight, foreground or make salient the cultural presuppositions of the interaction" (Gumperz 1992: 232), for the participants as well as for the analyst.

CA and intercultural pragmatics share the analytical principle that language, culture and social organization must be analyzed not as separate subfields but as integrated elements of coherent courses of action, allowing their combination: while CA has developed tools to analyze the basic units out of which turns are fashioned and the relations between turns in sequences of actions, interactional pragmatics has developed analytical tools to recognizes those units and those sequences as cues for the cultural

presuppositions of interaction from the perspective of participants' own reasoning and understanding about their circumstances and communication.

Based on the combination of CA and intercultural pragmatics, this article will discuss how linguistic and interactional features cooperate in constituting the *background* of interaction (Searle, 1992) in medical encounters mediated by an interpreter, establishing either the discrimination and the exclusion of the migrant patient or an emotional-sensitive healthcare, where the patient actively participates as a person, with his/her worries, doubts and concerns.

In the following sections two types of social situation will be discussed: those where mediation creates the conditions for the exclusion of patients' worries, doubts, concerns and emotions from the medical encounter and those where mediation succeeds in making patients' emotions relevant in the interaction. All conversations were transcribed according to Conversation Analysis (CA) 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 between inverted commas is used for *English translations*

Figure 1: Transcription conventions. (from: Jefferson G. Glossary of transcript symbols with an introduction. In: Lerner G, ed. Conversation Analysis: studies from the first generation Philadelphia: John Benjamins, 2004; 13-23.

3. Interactions that exclude or inhibit patients: Non-renditions and zero-renditions

Data show that the situations where mediation creates the condition for the marginalization of patients' emotions, concerns and social worlds from the medical encounter are often characterized by the presence of two types of mediators' action: *non-renditions* and *zero renditions* of both patient's and doctor's turns of talk (both concepts derives from Wadensjö, 1998).

Non-renditions are "text which are analysable as an interpreter's initiative or response which does not correspond (as translation) to a prior 'original' utterance" (Wadensjo, 1998: 108). In zero-renditions originals are left untranslated, that is, "one or more element(s) produced by one of the primary participants lacks a correspondent in the production of the interpreter" (Wadjenso, 1998: 108).

In the first place, the discussion will focus on the form and consequences of *non-renditions* that, according to data gathered in the context of the research, occur when the mediator passes information from the patient to the doctor and vice versa.

Excerpt 1 has been recorder in an emergency room; the patient, who is a young Arab-speaking woman from Northern Africa, has suffered a leg injury at home. As the woman

shows limited skills in the Italian language, the doctor calls for the mediation service, which is available 24 hours a day, 7 days a week, in that hospital.

The crucial section of the excerpt consist in the dyadic sequence in Arabic, where the patient advances two questions (lines 6 and 8) to find out if the doctor is treating her leg in the office while the mediator, instead of translating the patient's questions, responds directly with non-renditions.

(1)
1D: *Allora signora (.) possiamo provare a dare (.) del*
So madame (.) can try to give (.) of

2 *Fastum gel in pomata (.) che però se lo deve comprare*
Fastum gel of ointment (.) that but it must buy

3 *perché non ce l'abbiamo(.) due volte al giorno*
because not it have (.) two times to day
"So madam (.) we can try (.) Fastum gel ointment(.) but she has to buy it herself because we don't have it (.) twice a day"

4M: *pomata Fastum gel, lma tshtriha mn alvarmajia*
ointment Fastum gel, what buy in pharmacy

5 *fhmtni*
she gives
"She gives you (.)the ointment you put it (.) buy it at the pharmacy"

6P: *fhl iatiha li?*
she give me it?
"does she give it to me?"

7M: *msh mojoda andhm hna fhmtni*
not here do not she gives
"It is not available here she's not giving it to you"

8P: *bdha tatiniha ma?*
not want give me?
"Doesn't she wants to give it to me?"

9M: *andhmsh, mandhmsh msh mshkl aih. kif lo andhm*
that that's not the problem. they it in them

10 *£ biatok hma bnfshm iani (.) msh ghali*
means don't have (.) not really

11 *homfihosh haja ghalia fhmti*
need you understand don't give
"£ That's not the problem they don't have it (.) really don't have it"

In lines 4-5, the mediator produces a *non-rendition* of the doctor's previous turn *("she gives you the ointment")*, excluding the information that concern the unavailability of the ointment. The *non-rendition* is a cue for the cultural presuppositions of a doctor-centred

culture (Barry *et al.*, 2001), where the patient is expected to follow doctor's instructions, while the doctor is not excepted to justify them. The sequential order of actions shows that the *non-rendition* is hindering mutual understanding: in the same turn the patient is told that the doctor is treating her leg with the ointment and that she needs to buy the ointment at the pharmacy; the interaction is entrapped in a paradox, which is a consequence of mediator's use of "*give"* as a substitute for "*prescribe",* so that the patient understands "*gives you*" as "put *the ointment on your leg".*

The patient is not able to give meaning to doctor's action, as they are reported by the mediator's non-renditions. She is not aware that the ointment is not available because the mediator cut out this piece of information in the non-rendition. Without knowing that the ointment is not available, the patient can still expect the doctor to treat her leg in the office. In order to overcome the uncertainty, the patient initiates a repair sequence in line 6: "*Does she give it to me?"*. Instead of translating the question to the doctor, the interpreter completes the repair sequence, responding to the patient with a second non-rendition: "*It is not available here she's not giving it to you*" (line 7). Also that second non-rendition is a cue for the cultural presuppositions of a doctor-centred culture: as the doctor has already said that is not treating the patient at the office, the continuation of the topic prompted by the translation of the patient's question would unnecessary slowdown the encounter.

However, from the patient's perspective, the doctor didn't say anything about the unavailability of the ointment. If one applies the CA method, considering the sequential order of actions positioning herself as a participant in the interaction, what emerges is that the second non-rendition, that conveys the information of the unavailability of the ointment, comes only after a patient's question, whereas the first non-rendition didn't mention that unavailability. The sequential order of the interaction motivates the patient in understanding the second non-rendition as a strategy to deny the fact that the doctor does not want to treat her.

The patient's reiteration of the question (line 8) displays her dissatisfaction: the question has an interrogative-negative format, that CA research connects to questions designed to claim a knowledgeable position for the questioner (Heritage, 2001; Koshik, 2002; Stivers and Makoto 2010), seeking confirmation for information that is already in play.

For the patient, the order of mediator's non-renditions is a cue for the doctor's decision not to treat her leg in the office, a decision which the patient considers as a matter fact; the function of the interrogative-negative question is not to ask for information but to express dissatisfaction. The trajectory of the interaction suggests that such function is understood by the interpreter, who tries to mitigate the patient's dissatisfaction; however, she does so with a third non-rendition, without translating the patient's question to the doctor question but providing a direct response to the patient (lines 9-11).

In excerpt 1, the systematic use of non-renditions is a cue for the cultural presuppositions of a doctor-centred culture, in the first place for a hierarchy of differentiated social roles where the doubts and concerns of the patients are excluded if considered irrelevant for illness treatment. However, doubts about the functionality of a medical communication only concerned with physical symptoms have been raised, as a number of studies suggests that the treatment of emotions is important for the successful

outcome of medical treatment and care (Charles *et al.*, 1999; Mead and Bower, 2000; Barry *et al*., 2001; Epstein *et al.*, 2005; Zandbelt *et al.*, 2006), and the doctors' affective involvement in the interaction is of primary importance in helping patients comply with treatment (Stivers, 2002; Kiesler and Auerbach, 2003; Mangione-Smith *et al*., 2003; Heritage and Maynard, 2005; Robinson and Heritage, 2005). We can imagine the attitude of the patient towards medical prescriptions if she believes that the doctor is not interested in her health.

In excerpt 2 a dyadic sequence involving the interpreter and the patient is prompted by a non-rendition that offers a summarized translation of doctor's contributions.
The patient is a Chinese man in his fifties, who has been living in Italy for the last two years, without developing adequate skills in the Italian language. The patient has been diagnosed with high blood pressure and put under medical control. The excerpt is taken from a programmed examination, with the presence of the mediator.

(2)
1D: *martedì è sette, vero?*
Tuesday is seven, true?
"next tuesday, is it the seventh, right?"

2M: *mmh, mmh*

3D: *allora gli dici di portare pazienza perché*
so to her tell f bring patience because

4 *per le prime due settimane ci vedremo spesso*
for the first two weeks us see often
"now tell him to be patient because in the first two weeks we'll meet very often"

5M: *ok, però l' orecchio -*
ok, but the ear -
"ok, but his ear -"

6D: *no, no, no. adesso ci occupiamo dell' orecchio,*
no, no,no. now we work of the ear

7 intanto digli che deve portare pazienza.
for now tell him that must bring patience.
"no, no, no. now we'll take care of his ear, for the moment, tell him that he has to be patient"

8M: *ok (.)nǐ zhèigè yuè jǐnliàng duō,*
as much as possible this month

9 *xià gè xīngqī èr, Qī hào, Xiàwǔ liǎng*
next Tuesday, the 7th, at 2:30

10 *diǎn bàn lái zhèli,*
in the afternoon and come here

11 *wǒmen zài gěi nǐ zuò xuèyā jiǎnchá*
we give you to do blood pressure check

12 *xīnzàng jiǎnchá*
heart check

13 *chī zhège yào, zhōngyào bùyào 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 bùyào chī le?*
a:h traditional chinese medicine, must not eat?
"ah, I don't have to take chinese medicine?"

15M: *zhōngyào yīgài bùyào chī le,*
traditional Chinese medicine must not eat

16 *bùyào wàng le, dào Yìdàlì lái bùyào 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 those medicines more, do you understand?"

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

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

20M: bù *néng chīde, 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 W ǒba. zhège yào.*
this medicine they give me. this medicine.
"they have given me this medicine"

23M: *zhège yào bù yào chīde， 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*
((to D in Italian)) so I am trying of
((to D in Italian)) "so I'm trying to"

25P: *bù shì yào zuò xuèyā dema?*
not to be medicine to do blood pressure?

26 *bù yòng chī yào piàn?*
need not to take medicine sheet?
"aren't those medicines right for my blood pressure? Shouldn't I take the medicine sheet ((of the Chinese medicine))?"

27M: *bù yòng chī yào piàn*
need not to take medicine sheet
"no, I don't have to take it"

A dyadic sequence in Italian language between the doctor and the mediator (lines 1-7) is followed by a dyadic sequence in Chinese language involving the mediator and the patient (lines 8-13), which is prompted by a mediator's non-rendition.

In the non-rendition, the mediator adds a recommendation, to avoid traditional Chinese medicine, which was included in the doctor's contribution. By producing the non-rendition the mediator is performing the role of representative of the medical system, making relevant the distinction between scientific medicine and tradition, non-scientific, potentially harming medicine.

In turn 14, the patient responds to the recommendation with a question *("ah, I don't have to take chinese medicine?")* where the initial token *"ah"*, indicates of a change of state his understanding (Heritage, 1984), that is, that the recommendation to avoid traditional medicine makes a difference for the patient. The rest of the dyadic sequence provides negotiation of understanding of such change of state.

Two points need to be noticed. The first point is that mediator's confirmation of the referent of the change of state, that Chinese medicine must be avoided (lines 15-17) is not immediately accepted by the patient (lines 18-19), who insist on the possibility of re-establishing the validity of Chinese medicine (lines 22 and 25-26), while the mediator insists on the need to abandon it (lines 20-21, 23 and 27). The second point concerns the tension between what the development of the dyadic sequence in Chinese language and the inclusion of the third participant, the doctor, in the interaction. For instance, the mediator attempts to involve the doctor in the interaction (line 24), but is immediately re-engaged in the conversation with the patient by the lacking of patient's alignment to the recommendation to give up Chinese medicine.

In the course of the excerpt the patient makes four attempts to defend the use of traditional Chinese medicine; what is of the greatest importance for an analysis of the functions of mediation is that none of these attempts is translated to the doctor, because the mediator systematically drops the translation producing *zero renditions*. Instead of translating for the doctor, the mediator respond directly to the patient. Throughout the course of the interaction, mediator's zero renditions are cues for the presuppositions of a culture centred on the primacy of the expectations and the values of scientific medicine which are observed in opposition to traditional medicine, with the latter considered as a potential risk for the treatment, that must be abandoned.

By producing zero renditions, the mediator accesses the role of representative of the institution, substituting the doctor. It is the mediator, not the doctor, who manages the patient's reluctance to abandon Chinese medicine. Mediator's zero renditions are cues foregrounding: 1) trust in the western medicine, 2) distrust in traditional medicine, 3) expectations of the patient's resistance, that is, a set of cultural presuppositions feeding the idea of an unavoidable cultural conflict. In the context of the ongoing interaction, from the perspective of the mediator, who is concerned with the functionality of the medical encounter, that conflict must be solved in the shortest time, without involving the doctor, as it would be an unnecessary waste of the expert's time.

In all types of interactions, including mediated interactions, the participation framework is necessarily co-authored through interactional moves and activities between principal speakers and the mediator. In excerpt 2, the mediator doesn't cooperate in making patient's participation relevant in the medical encounter; her zero renditions prevent patient's concerns and social world, that includes the use of traditional Chinese medicine to treat blood pressure, to become relevant in the medical encounter.

By producing zero-renditions, the mediator substitutes the doctor in evaluating the relevance of patient's contributions, as the contributions that don't have corresponding translations are thus excluded from the medical encounter.

It is true that in excerpt 2, as in other excerpts, mediator's zero renditions make the medical encounter proceed faster, thus apparently supporting the functionality of the system. However, we may ask what kind of system's functionality is supported by those actions. Research by Leanza et al. (2010) and Schouten et al. (2007) confirm the efficacy of this type of mediators' action in keeping the interaction coherent, for instance, 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 show that these types of mediator's action hinder the trust building process between patient and healthcare provider. Creating more distance between the principal participants, zero- and non-renditions pose risks to the therapeutic process and, paradoxically, compromise the same values (e.g., self-determinism and informed decision-making) of the Western medical system (Hsieh, 2010).

4. Interactions that promote an emotional-sensitive healthcare: formulations

4.1 Informative formulations

Data show that mediator's actions could also promote the development of an emotional-sensitive healthcare, where the patient participates actively, expressing his/her worries, concerns and social worlds. The analysis of the structure of the interactions where mediation succeeds in promoting patients' participation shows that patients' emotions are made relevant in the medical encounter through a movement between dyadic interactions (patient-mediator) and triadic interactions (patient-mediator-doctor).

Dyadic interaction is the context where the mediators may express interest and involvement in patients' contributions, including the expression of emotions and concerns. Most of the actions used to promote patients' emotional expression can be included under the CA category of *backchannelling* (Schiffrin, 1999). Backchannelling refers to the existence of two channels of conversation operating simultaneously: the channel of the speaker who directs primary speech flow and the backchannel of the listener which functions to define the listener's comprehension or interest.

In the conversation analyzed, some elements of backchannel are cues for the cultural presuppositions of a patient-centred culture that values the importance of patient's participation, also with regard to the expression of emotions. In dyadic sequences, trhe mediators promote patients' expression of emotions through backchannel elements such as *acknowledgment tokens* expressing that the stated information has been received (e.g. yeah, OK), *continuers* (e.g. hmmm, ah-ha) maintaining the flow of conversation and supporting the current speaker in continuing his turn and *echoing*, providing feedback that attention is paid to what is being uttered.

Data show that most of the dyadic sequences are generated when, instead of translating a contribution, the mediator respond to the patient with backchannelling, producing acknowledgment tokens, continuers, echoing (but also more substantive backchannel as requests for clarification or direct replies). By responding with backchannel elements mediators align to patients' expression of worries or doubts, embarrassment or want for reassurance as *responders* (Wadensjö, 1998), that is, as listeners who are responsible for responding to patients' contribution, going beyond the role of reporters of patients' contribution to the doctors. It is only by accessing the role of responder that the mediators have the opportunity to check and echo the patients' perceptions and emotions, providing positive feedback and expressing personal concern for them.

When the mediator performs the role of responder, the translation activity is suspended; a rendition of the whole dyadic sequence is then provided in summarized form, moving the interaction towards a *triadic* format where all participants, patient, mediator and doctor, are involved.

In the conversations analyzed, *formulations* are the main conversational resource used by mediators to involve doctors in the interaction. According to CA definition, formulations are turns of talk used to

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)

Mediators' *formulations* follow patient-mediator dyadic sequences, with adaptations to accommodate the doctor. With *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 interpretations of contributions in prior dyadic sequences, but rely on mediator's discursive initiative and willingness to create a common ground between patients and doctors. Specifically, *formulations* are conversational resources available to the mediator in order to a) provide an interpretation which highlights content from prior sequences; b) make what is thought to be implicit or unclear, in prior turns of talk, explicit; c) propose inferences about presuppositions or implications of the participants' contributions (Baraldi & Gavioli, 2008). Data allows to make a distinction between two types of formulations, informational formulations and affective formulations. *Formulations* are *informational* when they elicit explanations from doctors, which patients are somehow inhibited from requesting and *affective* when they bring patients' emotions, doubts and concerns into the conversation.

Excerpt 3 includes *informational formulations*. The examination of a pregnant woman in her twenties, who is carrying her first pregnancy, shows that the foetus is not yet in the appropriate position.

(Excerpt 3)
1D: *£Ma dai che si gira!*
£come on, that himself turn!
"come on, he will turn by himself!"

2M: *thrki otmshi oan shaa allh*
move and walk and willing God
"Move, take walks and with the God's will"

3P: *oan thrkt omshit-*
and if move and I walk-
"So, if I move and take walks-"

4M: *bisaad*
help
"that would help"

5M: *dicevamo c'è qualche cosa particolare che (.)* we said is there something particular that (.)

6 *aiuta a girare? camminare (.) fare delle–*
helps to turn? walk (.) do some-
"Is there something that helps to turn (.)
walking (.) do some-"

7D: *no*
no

8M: *della ginnastica particolare (.) delle cose?*
some exercise particular (.) something?
"exercises of some kind, whatever?"

9D: *no (.) si gira da solo*
no (.) himself turns by alone
"no, he will turn by himself"

10M: *btqlk hai shghla ma fina nqol ank tamli (.)*
Says here can we no say it is useful(.)

11 *otmshi ao tthrki ao tlabi riadha hai tbiai*
walk or exercise or play sport in much

12 *hoa mn raso bdo idor bdor*
there is natural turn will turn
"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"

In line 1, the doctor reassures the patient about the foetus' position; the mediator's action in line 2 is a non-rendition, including a reference to physical exercise that was not included in doctor's quite generic reassurance. The mediator performs the role of medical expert first by producing the non-rendition, then by confirming her suggestion (line 4) in response to patient's echoing (line 3) that advanced a request for clarification.

The mediator involves the doctor in lines 5-6 through an informational formulation. If one focuses on their position in the sequential order of interaction, formulations are non-renditions; for instance, the informative formulation in lines 5-6 is a non-rendition as it advances a request to the doctor that was not included in the dyadic sequence, eliciting her opinion on the usefulness of physical exercise. After doctor's response in turn 9, the mediator produces an informational formulation to pass to the patient the gist of the previous dyadic sequence in Italian language, which object is obscure for the patient, as the dyadic sequences has been prompted by a mediator's initiative (line 10-12). The informational formulation adds some contents to doctor's generic and uninformative contribution. Those contents, without being relevant in strict medical terms, aim at offering a more effective psychological support to the patients.

Non-renditions (including formulations) may either exclude, as in excerpts 1-2, or give relevance to patients' personal expressions, as in excerpt 3. In the latter case, non-renditions are cues for the cultural presuppositions of a patient-centred culture, where patients' emotional status and the treatment of their concerns are considered as important.

4.2 Affective formulations

Affective formulations may be understood as discursive initiatives undertaken by the mediator to give voice to patients' emotions which, in most cases, manifest themselves implicitly. Patients rarely talk about their emotions directly and without prompting; instead, they provide clues about their feelings, thus providing health professionals and mediators with *potential emphatic opportunities* (Beach and Dixson, 2001: 39).

Affective formulations focus on the emotional gist of patients' contributions, giving the doctor the chance to share and get involved in the affective dimension of the interaction. In this way, doctors are made aware of patients' concerns, and patients assume an identity that goes beyond the generic social role of being sick.

In excerpt 4, the patient, who is a pregnant woman from the Middle East, complains about a pain in her belly that has forced her to go to the emergency room (line 1). Because of her limited skills in the Italian language, the doctor requests the help of a mediator.

(4)
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 (.)
"ehm, she had a lot of pain with cramps"

3 *((to P)) igiaki iluagiaa?*
((to P))contractions did you have?
"((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 P)) to you wanted ask (.)

10 *come mai hai la faccia così sofferente?*
why have the face so suffering?
"((to P)) I wanted to ask you (.) why you look so suffering?"

11M:*lesh uigihik hek tabaan bain aleki*
why face your tired is much
"why is your face so tired?"

12P:*((Arabic untranscribable))*
((Partly for this pain))

13M: *fi hagia muaiana mdaiktk*
is there something wrong

14 *uiani mdaiik blbit mushkila?*
in your house that you worries?
"Is there anything wrong that worries you at home?"

15P: lha (.) [khaifa
No (.) [frightened
"No (.) [I'm frightened"

16D: *[no mi sembra a me che abbia*
[no to me seems to me that has

17 *la faccia sofferente*
the face suffering
"[No it seems to me that she has a suffering face"

18M: *hh un po' spaventata perché diciamo per*
hh a bit frightened because we say for

19 *la pancia*
the belly
"hh a bit frightened because let's sayfor her belly"

20D: *e:h ma è bellissima la tua pancia!*
e:h but is beautiful the your belly!
"e:h but your belly, it's beautiful!"

21M: *btul shitabii btiilik ma tilaii*
all normal everyting you is fine
"she tells you that everything is normal, everything is fine"

After patient's complains in line 1, the mediator first translate this turn (line 2), then produces a non-rendition to ask the patient about the type of pain she complains about *("did you have contractions?"*, line 3). The first component of line 5, "*mmh mmh"*, is an acknowledgment token, expressing that the information has been received and understood. Both actions, the question in turn 3 and the acknowledgment tolen in line 5, are non-renditions in the context of a dyadic sequence, which is transformed in a triadic

sequence involving the doctor in line 5-6, with a translation of the patient's complaint that is acknowledged by the doctor with a news-receipt (*"ah again?"*, line 7).

In lines 9-10, the doctor expresses concern for the patient (*"why you look so suffering?"*). This is followed by a dyadic sequence involving the mediator and the patient (lines 11-15), where the mediator first translates the doctor's question, albeit mitigating the original term "suffering" in "tired", then affiliates to the patient's expression of fear, checking her motives and consolidating affective expectations. Mediator's questions in the dyadic sequence are cues for the cultural presuppositions of a patient-centred culture, where patient's emotions and concerns are treated as relevant in the interaction.

The doctor interrupts the dyadic sequence to rebate her concerns, calling for the mediator's attention, in the spirit of a medicine sensitive to the emotional status of the patient (line 16-17). In the following turn, the mediator formulates her own understanding of the patient's concern, through a non-rendition which also introduces a projection of affective reassurance (*"a bit frightened because, let's say for her belly"*, lines 18-19). The doctor affiliates with the mediator's initiative, providing an indirect reassurance (line 20) then, finally, the mediator translates the doctor's reassurance and provides support to the patient's emotional status (line 21).

In excerpt 5, the patient, who is a woman in her thirties from Northern Africa, reports a delay in her menstrual period in the course of a programmed gynaecological examination, but mitigates the relevance of this information by assuming she will get her period within the following few days.

(5)
1M: *bandma kan aakhr dora shhria lk?*
when was your last period?
"when you have your period for the last time?"

2P: *jtni tlatash mn shhr ashra*
was thirteen in month ten
"It was the thirteen of october"

3M: *tlatash ashra?*
Thirteen ten?
"Thirteen of october?"

4P: *ai*
"yes"

5M: *l' ultima mestruazione è il tredici ottobre*
"the latest menstruation is the thirteen october"

6D: *mmh*
mmh

7M: *ora siamo al tredici novembre*
now we are to thirteen november
"now it's the thirteen of november"

8P: *kant thbt ali kl shhr nisha (.)*
arrive here each month exact (.)

9 *aldma hbt sar shhr lliom*
blood not felt month today
"It comes each month exactly (.) now it's a month today that it's not"

10M: *mhm*
"mmh"

11P: *astna tlat aiam oala arba aiam aiati rbma*
wait three days or four days, comes maybe
"I will wait three or four days,may it will come"

12M: *((to D)) ah (.) può darsi che tra quattro o cinque*
((to D)) ah (.) can be that in four or five

13 *giorni al massimo (.) arriva (.) però (.) lei è un*
days at most (.) comes (.) but (.) she is a

14 *po' preoccupata*
bit worried
"£Ah (.) maybe in four or five days at latest (.)
it will come (.) however (.) she's a bit worried£"

In excerpt 5, the mediator uses *affective formulations* to brings patient's emotions to the fore , making them a topic in the medical encounter. The mediator's formulation, in line 13-14, ("but she's a bit worried") is affective because, while making current symptoms available to the doctor, highlights the patient's emotional situation which could otherwise have gone unnoticed in prior turns. The mediator's formulation of affective understanding involves the doctor in the affective exchange and promotes a shift from a dyadic to a triadic interaction.

The *affective formulation* offers the doctor the opportunity 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 development of affective relations. By producing the *affective formulation*, the mediator develops and emphasizes an implicit emotional expression as a basis for subsequent interaction.

Affective formulations reveal the mediators not as a neutral conduits, but as active participants, who provide a way to include patients' implicit, difficult, and embarrassed emotional expressions in the triadic sequence, to be treated in a patient-centred interaction involving the doctor (Farini & Barbieri, 2009).

5. Conclusion

The dual function of interpreter and mediator can make positive contributions to a patient-centred care and treatment. We focused on how these two functions are intertwined and how they affect doctor-patient communication. When mediators act effectively as mediators, otherwise hidden factors, such as patients' emotional expressions, can be relayed to the doctors thus creating opportunities for them to respond.

Analysis of emergency visits in two large paediatric departments in the USA (Flores *et al.* 2012) suggests an association between previous hours of interpreter training and error numbers, types, and potential consequences in English-Spanish mediated interactions. 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 might have a major impact on reducing interpreter errors and their consequences in health care while improving quality of care and patient safety.

While we agree with the importance of professional training for interpreters, we also argue that the complexity of the interpreters' task, the fact that they cannot avoid the role of mediator between the principal participants, needs to be acknowledged. In triadic interactions the interpreters as mediators are the only participants who can effectively understand all the content and the intentions of the other participants; errors in translations are not the only issue: mediators necessarily co-ordinate the contingent and changeable management of sometimes diverging cultural presuppositions and the corresponding distribution of communicative resources, through their translation activity in intercultural contexts.

Data suggest that the dual role of interpreter and mediator is crucial to make patients' voices and their wishes heard in medical encounters. On the one hand, this article has discussed how non-renditions and zero renditions may exclude the patient or the doctor from the conversation. On the other hand, examples of a successful mediation have been discussed; in particular, the discussion has focused on a two-phases process where backchannelling promotes patient's participation in dyadic sequences then and a specific form of non-rendition, formulations, involve the doctor in the emotional situation of the patient, thus improving the emotional rapport between them and taking the medical encounter well beyond a mere exchange based on standardized roles.

When mediation succeeds in promoting an emotional-sensitive healthcare, mediators contribute to dialogue management in two ways: as *responders,* affiliating with the patient in dyadic interactions and as *coordinators*, translating patients' turns of talk including their interpretation of implicit contents (primarily emotions).

In particular, data suggest the effectiveness of *affective formulations* in capitalizing potential emphatic opportunities offered by the patients in the course of dyadic sequences. By producing affective formulations, mediators introduce patients' emotions, doubts and concerns to doctors, providing them with the possibility of accessing the many facets of the patient's situation at both a personal and cultural level.

References

Angelelli, Claudia V. (2004). *Medical Interpreting and Cross-cultural Communication*. Cambridge: Cambridge University Press.

Baker, Mona (2006). "Contextualization in translator- and interpreter-mediated events". *Journal of Pragmatics,* 38, 321-337.

Baraldi, Claudio (2009). "Forms of mediation: the case of interpreter-mediated interactions in medical systems". *Language And Intercultural Communication*, 9 (2), 120-137.

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

Baraldi, Claudio & Laura Gavioli (2011). "Interpreter-mediated interaction in healthcare and legal settings: talk organization, context and the achievement of intercultural communication". *Interpreting,* 13 (2), 205 - 233.

Barry, Christine A., Fiona A. Stevenson, Nicky Britten, Nick Barber & Colin P. Bradley (2001). "Giving Voice to the Lifeworld. More Human, More Effective Medical Care? A Qualitative Study of Doctor-Patient Communication in General Practice". *Social Science & Medicine* 53, 487-505.

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

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

Cambridge, Jan (1999) "Information Loss in Bilingual Medical Interviews through an Untrained Interpreter. *The Translator* 5, 2: 201-219

Carbaugh, Donal (2005). *Cultures in Conversation*. New York and London: Lawrence Erlbaum.

Charles, Cathy, Amiran Gafni & Tim Whelan (1999). "Decision-making in the doctor-patient encounter: revisiting the shared treatment decision-making mode"l. *Social Science and Medicine* 49, 651-661.

Chiarenza, Antonio (2008). "Towards the development of health systems sensitive to social and cultural diversity". In *Health and Migration in the EU* (167-176). Lisboa: Ministry of Health of the Republic of Portugal.

Chiarenza, Antonio (2012). Developments in the concept of cultural competence. In:D. Ingleby, A., Chiarenza, W. Devillé, and I. Kotsioni (Eds.), *Inequalities in health care for migrants and ethnic minorities* (66-81). Antwerp: Garant.

Clift, Rebecca, Paul Drew & Ian Hutchby (2009). "Conversation analysis". In S. D'hondt, J.O. Östman and J. Verschueren (Eds.), *The Pragmatics of Interaction* (40–54) Amsterdam: John Benjamins.

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

Epstein, Ronald M., Peter Franks, Kevin Fiscella *et al*. (2005). "Measuring patient-centered communication in patient-doctor consultations: theoretical and practical issues". *Social Science and Medicine* 61, 1516-1528.

Farini, Federico & Viola Barbieri (2009). "Mediated doctor-patient interaction. An Italian case study". In D. Busch, C.H. Mayer & C.Boness (Eds.), *International and Regional Perspectives on Cross-Cultural Mediation* (195-214). Berlin: Peter Lang Verlag,

Flores, Glenn, Milagros Abreu, Cara Pizzo Barone *et al.* (2012). Errors of Medical Interpretation and Their Potential Clinical Consequences: A Comparison of Professional Versus Ad Hoc Versus No Interpreters. *Annals of Emergency Medicine,* 60 (5), 545-553.

Gumperz, J. Jan (1992). “Contextualization and understanding”. In A. Duranti & C. Goodwin (Eds.), *Rethinking Context: Language as an Interactive Phenomenon* (229-253). Cambridge: Cambridge University Press.

Heritage, John (1984). "A change-of-state token and aspects of its sequential placement". In J. Heritage & J.M.Atkinson (Eds). *Structures of Social Action*. Cambridge: Cambridge University Press, 299-345.

Heritage, John. (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, John (2002). “The limits of questioning: negative interrogatives and hostile question content”. *Journal of Pragmatics* 34. 1427-1446.

Heritage, John (2012). “Epistemics in Action: Action Formation, and Territories of Knowledge”. *Research On Language And Social Interaction*, 45, 1: 1–29.

Heritage, John & Douglas Maynard (Eds.) (2005). *Communication in Medical Care: Interactions between Primary Care Doctors and Patients.* Cambridge: Cambridge University Press.

Heritage, John & Douglas, Maynard (2006). "Problems and prospects in the study of doctor-patient interaction: 30 years of research". *Annual Review of Sociology* 32, 351-374.

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

Hutchby, Ian, Wooffitt, Robin (1998). *Conversation Analysis*. London: Polity

Kiesler, D.J., Auerbach, S.M. (2003). Integrating measurement of control and affiliation in studies of doctor-patient interaction: the interpersonal circumplex. *Social Science and Medicine* 57: 1707-1722.

Koole, Tom & Jan, D. ten Thjie (2001). "The reconstruction of intercultural discourse: Methodological considerations". *Journal of Pragmatics* 33, 571-587.

Koshik, Irene (2002). “A conversation analytic study of yes/no questions which convey reversed polarity assertions”. *Journal of Pragmatics* 24: 1851-1877.

Leanza, Yvan, Isabelle Boivin & Ellen Rosenberg (2010). "Interruptions and resistance: A comparison of medical consultations with family and trained interpreters". *Social Science and Medicine,* 70, 1888-1895.

Mangione-Smith, Rita, Tanya Stivers, Marc Elliot *et al.* (2003). "Online commentaries during the physical examination: a communication tool for avoiding inappropriate antibiotic prescribing?" *Social Science and Medicine*, 56, 313-320.

Mead, Nicola & Peter Bower (2000). "Patient centredness: a conceptual framework and review of the empirical literature". *Social Science and Medicine* 51, 1087-1110.

Meyer, Bernd & Kristine Bührig (2004). "*Ad hoc*-interpreting and the achievement of communicative purposes in doctor-patient-communication". In J.House & J.Rehbein (Eds.). *Multilingual communication* (43-62). Amsterdam: John Benjamins

Pöchhacker, Franz & Mira Kadric (1999). "The hospital cleaner as healthcare interpreter: A case study". In I.Mason (Ed.) *Dialogue Interpreting. The Translator,* 5(2): 161-178.

Pomerantz, Anita (1984). "Pursuing a response". In J.Heritage & J.M. Atkinson (Eds.), Structures of Social Action (152-163). Cambridge: Cambridge University Press.

Raymond, Geoffrey (2003). "Grammar and social organization: Yes/no interrogatives and the structure of responding". *American Sociological Review* 68, 939-967.

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

Sacks, Harvey Emmanuel A. Schegloff &Gail Jefferson (1974). "A Simplest Systematics for the Organization of Turn-taking for Conversation". *Language,* 50, 696-735.

Schegloff, Emmanuel A (2007). "Interaction: the infrastructure for social institutions, the natural ecological niche for language, and the arena in which culture is enacted". In Enfield, N.J., S.C. Levinson (Eds.) *Roots of human sociality. Culture, cognition and interaction* (70-93). Oxford-New York: Berg.

Schegloff, Emanuel A., Gail, Jefferson & Harvey, Sacks (1977). "The Preference for Self-Correction in the Organisation of Repair in Conversation". *Language* 53, 361-382.

Schiffrin, Deborah (1999). "'Oh' as a marker of information management". In A. Jaworski & N.Coupland (Eds.) *The Discourse Reader* (275–288). London-New York: Routledge.

Schouten, Barbara C., Ludwien Meeuwesen, Fred Tromp *et al.* (2007). "Cultural diversity in patient participation: The influence of patients' characteristics and doctors' communicative behaviour". *Patient Education and Counselling* 67, 214–223.

Searle, John (1992). "Conversation". In John Searle et. al (Eds.) *Searle on conversation* (7-29). Amsterdam & Philadelphia: John Benjamins.

Sidnell, Jack & Tanya Stivers (Eds.) (2012). *Handbook of Conversation Analysis.* Boston: Wiley-Blackwell.

Stivers, Tanya (2002). "Participating in decision about treatment: overt patient pressure for antibiotics medication in pediatric encounters". *Social Science and Medicine,* 54, 1111-1130.

Stivers, Tanya & Makoto, Hayashi (2010). "Transformative answers: one way to resist a question's constraints". *Language in Society* 39, 1–25.

Tannen, Deborah (2009). "Interactional Sociolinguistics as a Resource for Intercultural Pragmatics". *Journal of Intercultural Pragmatics.* Accessed through: http://www9.georgetown.edu/faculty/tannend/pdfs/interactional_socioling_as_a_reource_for_intercultyral_interaction.pdf

Tebble, Helen (1999). "The tenor of consultant doctors: Implications for medical interpreting". In I. Mason (Ed.). *Dialogue Interpreting. The Translator* 5 (2): 179-200.

Ten Have, Paul (2007). *Doing Conversation Analysis: A Practical Guide*. London: Sage.

Verschueren, Jan. (2008). "Intercultural Communication and the Challenges of Migration". *Language and Intercultural Communication,* 1(8): 21-35.

Wadensjö, Cecilia. (1998). *Interpreting as interaction*. London: Longman.

Zandbelt, Linda C., Ellen M, Smets, Frans J. Oort *et al.* (2006). "Determinants of doctor's patient-centred behaviour in the medical specialist encounter". *Social Science and Medicine,* 63, 899-910.

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