Assessing mediated interpreting in healthcare

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This presentation is about assessment of interpreter-mediated interaction, in healthcare settings, that is interaction between speakers of different languages talking to each other with the help of a third party, who is considered a mediator in some cultural traditions (e.g. Italy) and a community interpreter in many others (e.g. Sweden, USA).
Mediation/interpreting services in healthcare systems may be assessed for two main aspects:

1. Organisation (decision-making)

2. Practice (interaction)
Difference between assessment and evaluative research

1. Different functions: decision vs. analysis

2. Different actors: decision-makers vs. researchers

3. Different consequences: continuation/transformation/interruption vs. advices for improvement
Types of evaluative research on practice:

1. Analysis of customer satisfaction
2. Practitioners’ and mediators/interpreters’ reports
3. Analysis of conversations
4. Analysis of context
Reasons for choosing evaluative research (concerning the practice of mediation/interpreting):

1. Practice is communication in interactions
2. Satisfaction is not a cue for good practices
3. Reports are not cues for the interaction, they are their “social representations”
4. Context may be observed only in communication practices which reproduce it
While it is impossible to exclude the researcher as (second order) observer from evaluative research, direct, first-hand observation of practices, excluding other observers, may be useful.

Analyses of customer satisfaction and reports (social representations) may be useful to investigate how the participants observe the interaction, in order to enrich the basic and essential first-hand information about practices derived from direct analysis.
The clarification of methodological and theoretical assumptions of evaluative research of mediation/interpreting practices is the main task of this presentation.

Examples of empirical analysis were delivered in the last year presentations and are available (in English) in Baraldi-Gavioli 2007, 2008, and in Baraldi-Gavioli forthcoming.
My first assumption is that mediation/interpreting is a communication system and more specifically an interaction.

On the basis of this assumption, I observe the possible assessment of:

1. The specific function of translation as mediation in this system

2. The function of this system in the global healthcare system

3. The function of this system as facilitation of intercultural communication
Mediation/interpreting is a communication system/interaction in that:

1. Mediation/interpreting exists if and when there is a coordination of action and understanding
2. This coordination produces information for the participants
3. Action is visible in turn-taking in the interaction
4. Alternation of turn-taking displays understanding
5. Consequently the sequence of turns (actions) is fundamental to understand the system
6. The features of turns in the sequence and of the produced information are cues for the structure and the cultural orientation of the system.
Questions about mediation/interpreting as a communication system/interaction:

1. What are the features of function of translation, function in the healthcare system and function for intercultural communication?

2. In which conditions and with which range of variability?

3. With which frequency?

The following suggestions are based on provisional results of a research which is in progress and must be considered as a source for discussion and confrontation.
The specific function of translation as: 

mediation in interpreter-mediated communication systems
Translation is a reaction to translatable turns which projects different opportunities for interlocutors’ active participation in the interaction.

Translation:

(a) assures common understanding

(b) facilitates a direct communication between the parties

The very activity of translating is an activity of mediating.
Mediation/translation is the result of the coordination of the mediator’s and the other participants’ (doctor and patient) actions.

The interplay among these three participants’ actions permits the construction of interpreter-mediated interaction.
Variables for assessment. Translation as mediation:

1. After turn translation

1.1 Trivial machine/non person (?)
1.2 Types of rendition (zero, non, reduced, expanded)

2. Suspension (dyadic sequences)

2.1 Instructions
2.2 Questions
2.3 Direct answers
2.4 Requests for clarifications
2.5 Acknowledgment tokens
2.6 Continuers
2.7 Echoes

3. Formulation (after sequence translation)

3.1 “Summarized renditions”

4. Negotiation of translation relevance

4.1 Dislike for translation of a turn or a series-of-turns, signalled through direct reply or request of confirmation of correct understanding.
**Formulation**

Heritage defines formulation as “summarising, glossing, or developing the gist of an informant’s earlier statement” (1985: 100).

Formulation projects a *direction for subsequent turns* by inviting responses.

Two dimensions of after sequence translational formulations:

1. **Linguistic functions**
   - summarising
   - developing
   - glossing
   - Inferencing
   - making something explicit

2. **Formulated expectations concerning the gist of earlier statements**
   - Affective
   - Cognitive
   - Normative
Interpreters’ relevant actions in connecting dyadic suspensions and after-sequence translational formulations

1. Provision of feedback to allow patient/doctor expression

2. Stimulation of participants’ expressions by asking for more, encouraging to go on, providing feedback

3. Formulation of their understanding of dyadic interaction, distinguishing their contribution from the doctor’s
**Negotiation of translation relevance**

1. Doctors’ attempts to speak and display understanding of the patient’s language.

2. Patients’ opportunities to speak and display understanding of the native language.

3. Mediators/interpreters’ opportunities to encourage and help the doctor to speak the patient’s language and promote direct contact between doctor and patient.

4. Levels and forms of linguistic coordination between mediators/interpreters and doctors (in turn-taking and used language). Claims and competition.
Doctor’s relevant actions of negotiation of translation relevance

1. Attempts to understand, even if the language is not theirs

2. Interruptions of long dyadic sequences involving the mediator and the patient

3. Direct questions about patients’ feelings and worries

4. Encouragements to patients and interpreters to express in their own terms
The function of interpreter-mediated interaction:

in the healthcare system
Interaction is based on **cultural presuppositions** (Gumperz 1992: 230): presuppositions the participants “must rely on to maintain conversational involvement and assess what is intended”

Cultural presuppositions may be conceived as **generalised expectations in the encapsulating social systems** (Luhmann 1984), eg. healthcare system
In healthcare systems, cultural presuppositions of interaction are expectations about:

1. Value of patients’ illness and health

2. Roles of doctors and patients

3. Recovering as interrelation of medical expertise and patients’ adaptation
Variables for assessment. Interpreter-mediated interactions may favour:

1. Doctor-centred communication:
   1.1. Patients adapt to medical expertise
   1.2. Patients respond to doctors’ questions and uncritically accept doctor’s recommendations
   1.3. Displayed expectations concern patients’ adaptation, doctors’ performance and hierarchical relationships based on difference in competence

2. Patient-centred communication:
   2.1. Doctors support patients’ emotional display (concerns, worries doubts)
   2.2. Patients are treated as competent interlocutors and are encouraged to express their problems and needs in the interaction
   2.3. Displayed expectations concern patients’ expressions and doctors’ display of sensitivity
Different cultural presuppositions (and forms of doctor-patient communication) may be observed in the interaction through specific contextualization cues, which are:

linguistic cues which highlight, foreground or make cultural presuppositions salient in communication (Gumperz 1992).
The function of interpreter-mediated system as:

facilitation of intercultural communication
**Intercultural communication** is a type of communication in which cultural diversity is observed and treated as a meaningful phenomenon.

Interpreter-mediated interactions may facilitate either:

1. Reproduction of specific cultural presuppositions (cultural coordination)

or

2. Cross-cultural adaptation between different presuppositions (intercultural coordination)
Variables for assessment. Mediation may mean:

1. Separation of the parties
   2.1 Non renditions of prescriptions
   2.2 Parties and their cultural identities substituted through mediators/interpreters’ initiatives.

2. Assessment of We-Identities
   1.1. Normative expectations expanded beyond medical culture
   1.2 Over-adaptation of patients’ actions to medical culture

3. Promotion of different narratives
   3.1 Affective expectations expanded beyond technical treatment
   3.2 Cross-cultural adaptation of patients’ and doctors’ actions
Assessing We-Identities

1. Mediators’ initiatives create shared normative or cognitive expectations with one party

2. Mediators’ translations project confirmations and enforcements of these expectations in the interaction with the other party

3. Shared cognitive and normative expectations with one party are confirmed and enforced in the interaction with the other party
Promoting narratives

1. Creating the conditions for the growth of alternative stories

2. Building these stories as incompatible with hierarchical forms of relationships

3. Opening space for shifts in participants’ discursive positioning (towards “positive” positioning)

4. Thickening alternative stories
Assessment of translation’s consequences for intercultural communication

1. Contextualisation (Gumperz 1992): projection of interpreters’ actions by the cultural presuppositions of healthcare system (forms of doctor-patient communication).

2. Re-contextualisation (Baker 2006): change of cultural presuppositions, promoting the participants’ understanding and responsibility for their actions.

3. Contextualization and re-contextualization are made evident through particular linguistic cues
An example. Interplay of formulation (translation) and narrative (mediation)

1. The mediator encourages the patient to express her/his worries which are eventually translated to the doctor through a formulation.

2. By formulating the patient’s worries to the doctor, the mediator promotes the patient’s need to be reassured by the doctor and the doctor’s care of the relationship with the patient.

3. Mediation as formulation can promote cross-cultural adaptation in medical settings.

4. This means promoting both patients’ expression and doctors’ involvement in the interaction.

5. That is: promoting a patient-centred approach in medical culture, which coincides with a culture-centred approach.
The three examined functions concerning systems of interpreter-mediated interactions (function of translation, function in healthcare system, function for intercultural communication) are clearly intertwined.

However, their analytical distinction is useful because it permits the evaluative analysis of differentiated components of the system.

This enhances the opportunities both to observe different aspects of the system and to assess separately these different aspects.

The reconnection of these aspects permits analysis and assessment of mediation in its complexity.