Interpreter-mediated interaction in healthcare settings: an analytical framework

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This presentation is about interaction, in healthcare settings, between speakers of different languages talking to each other with the help of a mediator/translator.
While this type of communication could be considered “intrinsically intercultural”, we pose two questions:

(1) in what way is this type of communication **in fact intercultural**?
(2) what is **culturally relevant** in this type of communication?
We observe:

1) the relationship between evidence of “cultures” in communication and facilitation of intercultural communication.

2) the relationship between mediation and translation.
The relationship between evidence of “cultures” in communication and facilitation of intercultural communication
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 social systems (Luhmann, 1984)
For example, in healthcare systems, cultural presuppositions of interaction are provided by: expectations about the value of patients’ health, the specific roles of doctors and patients, the need of medical treatments and patients’ adaptation.

Following this general cultural pattern, two main types of more specific cultural presuppositions have been observed in doctor-patient interactions.
1. Patients adapt to the “Voice of Medicine” (Mishler, 1984): they respond to doctors’ questions and accept doctor’s recommendations. There is a hierarchical relationship between doctors and patients based on difference in competence (doctor-centred medicine).

2. Doctors support the patients’ lifeworld (Barry et al., 2001). Patients are expected to be competent interlocutors and are encouraged to express their problems and needs in the interaction. There is an interpersonal relationship between doctors and patients based on attention for patients’ needs (patient-centred medicine).
1. In doctor-centred medicine, expectations are mainly cognitive (expectations of patients’ adaptation and doctors’ performance) and normative (hierarchical relationships).

2. In patient-centred medicine expectations are mainly affective (expectations of patients’ and doctors’ self-expressions in interpersonal relationships).
In the interaction, cultural presuppositions may be different and the differences between them may embody the differences between “cultures”.

These different cultural presuppositions 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 emergence in the interaction (the cues) of a difference between cultural presuppositions creates the conditions for intercultural communication.

**Intercultural communication** is a type of communication in which cultural diversity is observed and treated as a meaningful phenomenon.
In intercultural interactions, mediation may facilitate both:

(1) reproduction of the mainstream cultural presuppositions (cultural reproduction of a specific cultural system)

and

(2) cross-cultural adaptation (Kim, 2001) by which the parties can acknowledge their own expectations about cultural presuppositions
The relationship between mediation and translation
In healthcare systems, when the parties do not understand each other for linguistic reasons, intercultural mediation requires **translation** as a fundamental activity.
In these situations, translation is essential at least in:

(a) assuring common understanding and

(b) facilitating a direct communication between the parties.
This means that the very activity of translating is an activity of mediating.

Consequently, cultural presuppositions and intercultural meanings are produced through translation.
Here we suggest that:
Coordination of participants’ turns in interactions involving the provision of translation has consequences for the achievement of cultural reproduction or cross-cultural adaptation.
More precisely we suggest that:

1. Interpreters’ actions are projected by other actions, presenting the cultural presuppositions of a specific social system (e.g. medical treatments).

2. Interpreter-mediated interaction produces a re-interpretation or re-contextualisation (Baker, 2006) of these cultural presuppositions, promoting the participants’ understanding and responsibility for their actions.
To sum up:

1. Interpreter-mediated interaction is contextualized by a set of cultural presuppositions (e.g. forms of medical culture)

2. Such contextualization derives from embedding social systems relevant in society (e.g. healthcare system)

3. Interpreter-mediated interaction can possibly change these cultural presuppositions, that is it can re-contextualize the embedding system

4. Contextualization and re-contextualization are made evident through particular linguistic cues
Mediation/translation is not the mere result of the mediator’s actions.

The mediator’s and the other participants’ (doctor and patient) actions are always strictly coordinated.

The interplay among these three participants’ actions permits the interactional construction of cultural reproduction or intercultural contact.

We’ll see this better tomorrow, in Laura’s presentation.
In our research (Baraldi, 2006; Baraldi, Gavioli, 2007; Baraldi, Gavioli, in press; Gavioli, Baraldi, 2005), we have observed some forms of mediation.

In this presentation, I will introduce one “side” of our observation, while Laura Gavioli will present the other “side” tomorrow morning.

I will introduce three forms of re-contextualisation through mediation.
Mediation as assessment of We-Identities (normativeness expanded beyond medical culture; over-adaptation of the patients’ actions to the medical culture; non renditions of prescriptions)

Mediation as dyadic separation (instructions; questions; answers; responses; reduced translations; feedback channel; affective support)

Mediation as affective formulation (affective support combined to translation as formulation)
The data

- 120 audio-recorded interactions involving Italian healthcare providers, an immigrant patient and a bilingual mediator.
- Patients are African English, Arabic and Chinese speakers.
- The mediators are, respectively, Nigerian/Ghanaian, Jordan/Moroccan, and Mandarin Chinese bilingual professionals.
- 40 interactions are examined per linguistic group.
Mediation as assessment of We-Identities (extract 1)
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<tbody>
<tr>
<td>1</td>
<td>D</td>
<td>Well, very well! Everything is all right, all okay. We saw before that it was all okay, didn’t we?</td>
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<tr>
<td>2</td>
<td>M</td>
<td>How many girls do you have? You have two, maybe the third one? Is okay eh?</td>
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<td>3</td>
<td>D</td>
<td>Has she got two?</td>
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<tr>
<td>4</td>
<td>M</td>
<td>Eh!</td>
<td></td>
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<tr>
<td>5</td>
<td>D</td>
<td>Two more?</td>
<td></td>
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<tr>
<td>6</td>
<td>M</td>
<td>Yes (.). No, this is number five!</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>D</td>
<td>Number five?</td>
<td></td>
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<tr>
<td>8</td>
<td>M</td>
<td>Yes! Is OK eh? You know this problem that you are talking to – If your husband is going to make love, go and buy condom or...((P smiles)) (?)</td>
<td></td>
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<tr>
<td>9</td>
<td>P</td>
<td>Yes!</td>
<td></td>
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<tr>
<td>10</td>
<td>M</td>
<td>You cannot face the baby. You have at this point, this problem eh? Or you want to pack the children and go to Ghana? Eh?</td>
<td></td>
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<tr>
<td>11</td>
<td>P</td>
<td>Ah! ((P sighs))</td>
<td></td>
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<tr>
<td>12</td>
<td>M</td>
<td>Ok! So if you don’t want to go and live in Ghana with these children, don’t stop (.). Go, come to via Padova and we’ll give you what you will be take in, so that you don’t get pregnant. If your husband, I know uses condom (.). I know Africans maybe don’t like condom. If he cannot use, there’s a pill that you can be taking or you come at this point. Do you understand? Don’t stay too long, eh?</td>
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Mediation as dyadic separation
(extracts 2 and 3)
55 P Why people have told me is not too much dangerous. So I want to try.

56 M Yes:, the coil eh?

57 P Yes.

58 M Yeah, it’s not dangerous.

59 P Before I was afraid about that.

60 M It needs that you normally come for control, that’s all.

61 P O:k.

62 M No, (sweat tone) don’t worry.
14 D: A hard job, isn’t it?
15 M: Yes yes yes.
   (8)
   ((D touches P’s hand))
17 P: °Ah:::
18 M: It’s painful eh? Mm.
19 D: °Don’t hurt me, he says.°
20 M: Eh yes he said he feels pain ((smiles)).
In these examples, mediation promotes self-referential cultural reproduction in the interaction, through:

1. Substitution of the parties and their cultural identities (**assessment of we-identities**)

2. Separation of the parties and their cultural identities (**dyadic separation**)
Mediators’ initiatives create shared normative or cognitive expectations with one party

Mediators’ translations project confirmations and enforcements of these expectations in the interaction with the other party
Mediation as affective formulation
(extract 4)

Heritage defines formulation as “summarising, glossing, or developing the gist of an informant’s earlier statement” (1985: 100).
17 D Now (.) if she’s alright (.) doesn’t have problems (.) her period is normal: -

18 M Mmh

19 D Normal (.) ok (.) we can also stop here

20 M Ok

21 D If instead she wants me to see her (.) ok (.) willingly (.) I have time I can control her

22 M she asks you now are you alright or you feel something? Because she says have you got any problem? Normally when one fixes a coil about every year they have a check up

23 D because alternativley it’s July August (.) I mean this summer

24 M Eh

25 D after a year
You wait for the seventh month to do the yearly control

Now –

Now –

I haven’t got anything

if everything is fine and your period is regular you don’t need doing any control

now it’s a month and I haven’t got it

a month and you haven’t got it

precisely a month

She says that pain (.) something strange – there isn’t any (.) she says she’s alright

That she hasn’t got her period yet this month (..) (smiling) and she’s a bit worried

So probably let’s do this (.) let’s do a pregnancy test

Ok
The mediator encourages the patient to express her worries (echoes, supporting feedback) which are eventually translated to the doctor through a formulation.

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.
Mediation as **affective formulation** can promote the parties’ participation allowing intercultural contact, in the form of cross-cultural adaptation:

(1) Mediators’ initiatives create affective expectations allowing one party to self-express

(2) Mediators’ translations as formulations give the opportunity to the other party to confirm and support this self-expression.
To sum up, the mediator’s initiatives, direct answers and formulations can create:
(1) shared cognitive and normative expectations with one party and then confirmation and enforcement of these expectations in the interaction with the other party (extracts 1, 2 and 3)

(2) affective expectations allowing one party to self-express and then the opportunity to the other party to confirm and support this self-expression (extract 4)
To answer the questions we posed at the beginning:

1. in what way is this type of communication in fact intercultural?
2. what is culturally relevant in this type of communication?
First

Mediation as translation may promote cross-cultural adaptation, if it makes culturally relevant:

(1) patients’ expression and (2) doctors’ involvement in the interaction promoting a patient-centred approach in medical culture.
This happens if translation promotes:

(a) a balanced distribution of participation in the interaction between patients and doctors

and

(b) an affectively sensitive relationship between patients and doctors.
Mediation as translation promotes the reproduction of the self-referential culture of the system, if it makes culturally relevant a doctor-centred medicine, allowing absent or scarce:

(1) doctors’ personal involvement
and
(2) patients’ personal expression