Authentic Mediated Interactions for Training Healthcare Mediators

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ABSTRACT

This chapter concerns a model of training based on the discussion of authentic interactions involving cultural mediators, healthcare providers and migrant patients. The first section introduces interpreting as a form of dialogic interaction based on two main concepts, coordination and agency, which help explain how dialogue is built up in mediated interaction. The second section presents the type of materials that are used to exemplify interaction-based training and the methods used in this training; transcripts of authentic interactions will be analysed by highlighting types of actions which perform mediation in the achievement of communication in the two languages. The transcripts will be used as examples showing the type of analysis we expect the trainees to perform – in particular, we give orientations for observing actions like rendering (or non-rendering). We finally conclude with some considerations about learning from transcripts of authentic interactions.

Keywords: agency, coordination, mediation, interaction, renditions, negotiation

1 INTRODUCTION

This chapter presents a model of training based on interactions involving intercultural mediators, healthcare providers and migrant patients. The objective is to prepare immersion by familiarizing trainees with the analysis and discussion of authentic data, audio-recorded in healthcare services. The data show ways in which the bilingual encounters are mediated to make conversation possible. Mediation is thus looked at as a necessary component of interpreting and is explained by means of two concepts, *interpreter coordination* and *interpreter agency*, which are both discussed in the first part of this chapter. We then outline the materials (authentic interactions) which will be used to exemplify the way the interaction-based training should be carried out, and we describe the methods for analysing and discussing the data. Some general guidelines are provided to help trainers and trainees carry out competent observation of authentic interactions and learn from the "experiences" they suggest. Finally, some examples will be provided, whose aim is to guide the trainers to create and include similar activities in their training projects. Some concluding remarks close our work.

2 POSITIONING

As mentioned above, the chapter looks at the work of intercultural mediators who work as interpreters in Italian healthcare institutions. The Italian case has been widely debated in literature (e.g. Baraldi and Gavioli 2012; Falbo 2013, Pittarello 2009; Merlini 2009) and sometimes addressed as a case where the importance of managing potential intercultural conflicts was the main task of mediators (see Pöchhacker 2008). While the conception of the profile was definitely controversial and not without problems, at the moment of this writing, intercultural mediators in Italian healthcare services are employed for interpreting, not for managing conflicts. So, the training we are presenting here involves techniques for interpreting, rather than techniques for conflict management. In this respect, we believe it is worth using also with those professionals who in other countries are called "public service interpreters".

3 CONCEPTS: COORDINATION, AGENCY AND MEDIATION

Studies on healthcare interaction with migrant patients have highlighted that language barriers, as well as lack of competence of healthcare professionals in overcoming those barriers, increase the hierarchical distribution of authority in conversation, making migrant patients' participation difficult and calling for the necessity of removing linguistic obstacles (see e.g. Bischoff et al. 2003; Harmsen

et al. 2008; Rosse et al. 2016; Schinkel et al. 2018). Healthcare interpreting has been devised as a solution to these problems, including the intersection of two types of action: (1) providing renditions of participants' utterances, thus giving them "voice" (Baraldi and Gavioli 2014, 2016); (2) acknowledging different cultural orientations (Angelelli 2004, 2012) and ways of expressing (Penn and Watermeyer 2012) to enable their treatment in the interaction (Baraldi and Gavioli 2017). These two types of action have been explained in the literature through two main concepts: coordination and agency.

The idea of *coordination* was first introduced by Wadensjö (1998) and then increasingly explored in the literature (e.g. Baraldi and Gavioli 2012). The activity of interpreters as interactional coordinators consists in making sense of the participants' contributions in relation to each other, so as to make it clear that the participants are "responding" in the interaction in relevant ways. Interpreters' position in the conversation gives them access to knowledge expressed by the participants, including their emotions or those perspectives that each participant takes for granted. Interpreters also have the possibility to convey newly acquired knowledge via forms of rendition which involve not just textual reformulation of what was said in the other language, but also explanations and requests for clarification. Coordination may be accomplished implicitly, that is through adaptation of interpreted utterances to the context of the other language and to the (interpreted) expectations of the participants, and explicitly, with "authored" interpreters' contributions, e.g. checking participants' understanding of current talk, or solving misunderstandings.

Interpreters' *agency* is the possibility of interpreters to choose autonomously among a range of possible actions. While coordination has to do with interaction management, agency is, in a way, a pre-condition for this. It can be looked at as an interactional construction because interpreters can exercise agency if conditions for their exercise of agency are created in the interaction. To put it in simple words, interpreters can exercise agency if their competence, reliability and knowledge (e.g. understanding what is said in the two languages and making it clear) is acknowledged in the interaction. The acknowledgment of interpreters' agency, in the interaction, may facilitate mediation giving interpreters the possibility to choose how to (best) coordinate the conversation (Angelelli 2004; Baraldi 2019; Tipton 2008).

Coordination and agency are both observable through the analysis of authentic interactions and, quite clearly, they can be exercised either effectively or non-effectively. Data show that in coordinating mediated interactions interpreters' agency is effective when it succeeds in improving *equality* in the interactional distribution of participation, *empowering* providers' and patients' participation, and giving relevance to expressions of *affect and empathy* when this is relevant (Baraldi 2019). So effective exercise of agency results in masterly coordination of the interaction by making choices which enable participants to participate on

equal grounds, make themselves understood, possibly by re-wording their contributions in clearer ways with the help of the interpreter, and achieve reliability in their relationship. Masterly coordination is with no doubt related to the interpreters' competence, and that is what trainers train; however, the interpreters' competence can be displayed only if interactional conditions allow for the exercise of the interpreters' agency.

Under appropriate conditions, interpreters thus exercise their agency in order to make suitable coordinating choices. In this sense interpreters *mediate* the interaction. The idea of mediation has long been debated in the literature, particularly in reference to the risk that interpreters go beyond their areas of expertise. In the seminal paper by Franz Pöchhacker published in 2008 language and cultural mediation are treated as a single concept because it is not possible to render anything in another language without considering the "cultural" aspects which permeate language idiomaticity.

We believe that a look at authentic interactions may give a realistic idea of how language and cultural mediation takes place in Italian healthcare services, what the actions involved in rendering can or cannot do, what type(s) of mediation is achieved and what is more or less effective for equal participation, right of expression and rapport achievement.

4 INTERACTION-BASED TRAINING

Analyses of interpreter-mediated interactions help interpreters get familiar with the contingencies of interaction and mediate through such contingencies when they encounter them in their professional life, so that participants can participate on equal grounds. Thus, transcripts of authentic interpreter-mediated interactions can provide trainees with examples of "authentic experiences". We shall show transcripts of interactions that were collected in public healthcare hospitals and surgeries in the Italian areas of Modena and Reggio Emilia. 80% of these encounters were collected in gynaecological or maternity care, with the participation of doctors and nurses, both male and female, or midwives, all female. Interpreting staff is also all female and patients are prevalently women, who may be accompanied by their spouses. The staff involved in providing interpreting service is formed by trained intercultural mediators (see Chiarenza, this volume).

A crucial problem in interaction-based training is the availability of authentic recorded materials. Throughout the last 15 years we have recorded a large corpus of interactions including over 100 encounters, 4 language pairs (Italian + Arabic / Chinese / French / English) and 21 mediators. The availability of a large corpus of data is important for the possibility it offers to trainers of both observing and describing characteristics of interpreter-mediated interaction in a sort of lifelong learning, and of choosing data appropriate for training (see Baraldi 2016; Davitti

and Pasquandrea 2014; Zorzi 2008). Ample choice makes it: a) evident that there is a variety of options of action available for interpreters and mediators; b) less likely that the chosen materials are episodic and do not allow for generalisation.

While a large collection of data is clearly the best solution, there is also an easier way for trainers to get data, i.e. they can ask trainees to record themselves "on the job" (when possible and with the consent of the participants), and then analyse and discuss occurrences of interaction in which they were involved. This solution is a way to start and collect a corpus which will become larger and more diversified throughout the years. The use of these "locally-collected" materials show what interpreting or mediation means in the specific experiential context and allows for a participatory methodology in which trainees are very active. If it is impossible to collect local data, an alternative solution is to use data published in books and papers (this work provides some, but see more in "Further reading" below).

The training methodology involves reading the transcripts (possibly after playing the recordings) and discussing the actions carried out within the interactions, by taking, as far as possible, the perspective of the participants involved in the conversations. One of the risks in the analysis is to treat such transcripts as pre-fabricated scripts, like theatre or film dialogues, which they are not. Indeed, what is interesting in transcripts is precisely their "not being scripted" and the work of negotiation and adjustment the participants need to carry out to accomplish conversation. In this perspective, the trainer takes the role of a "facilitator" of the discussion among the trainees, someone who guides the trainees' reflection over the actions and contexts that are shown in the transcripts. The discussion may simply start from a comparison of the trainees' observations. Training may thus be carried out in four main phases:

Phase 1. Small group discussion about the proposed authentic materials in order to reflect on the strategies that can be adopted in dealing with specific conditions of participants' talk. The trainer briefly presents the materials and invites the trainees to focus on some questions (for more details, see below).

Phase 2. Plenary discussion (facilitated and monitored by the trainer) about the reports of the small groups' reflections, comparing opinions and expanding the discussion to other possible options about how the interaction might be coordinated in the situations represented in the transcripts.

Phase 3. Second phase of reflection in small groups based on the plenary discussion in phase 2; such second group work may focus on finding (and discussing) possible alternative strategies which interpreters (or healthcare providers) might adopt in the examined transcripts.

Phase 4. Final plenary discussion of the small groups' choices and the formulations of the conclusions that focus on: a) the strategies that were found "effective"

for interpreting/mediation in the transcripts; b) the strategies that may improve effectiveness of interpreting/mediation in similar situations.

In this type of training, trainees are encouraged to give voice to their opinions and doubts; only at the very beginning (phase 1, providing questions) and at the end (phase 4, orienting discussion and suggesting considerations) of the training, the trainer's role shifts from that of a facilitator to that of a "guide". This methodology is centred on the trainees and is based on the idea of experiential learning (Zorzi 2008), i.e. learning based on active trainees' participation (see also the chapter on tandem teaching in this volume).

5 INTERACTION-BASED TRAINING EXEMPLIFIED

The transcripts[1] that we show in this section concern two different sides of mediators' coordination and agency: a) mediators' renditions and b) what we call "negotiation of mediation". Mediators' renditions are observed either after participants' single contributions or after dyadic sequences involving the mediator and one of the participants. Negotiation of mediation has to do with constraints posed on mediation by one of the participants or both. In fact, in the interaction a particular mediating action may be sought for and encouraged by the other participants' actions – for instance, when doctors recommend that an explanation is

1 Transcriptions provide an attempt to represent authentic conversation.

The following transcription symbols are adopted:

DOC, PAT, MED	doctor, patient, mediator
f or m	male or female
(.)	barely noticeable pause
(n)	noticeable, timed pause (n = length in seconds)
text [text	overlapping talk.] indicates end of overlap (when audible)
text [text	
tex-	syllable cut short
te:xt	lengthening of previous sound or syllable
(text)	unclear audio or tentative description (due to unclear audio)
(?)	untranscribable audio
= text	latched to the preceding turn in transcript
<u>text</u>	stressed syllable or word
TEXT	high volume
°text°	low volume
.,?!	punctuation provides a guide to intonation, when intonation is unclear, no punctuation is provided
((sneezes))	non-verbal activity or transcriber's comments
testo *text*	intra-turn translation in italics

given extensively or when a patient first hesitates and then adds on details on her problems, which may change the initial description.

In what follows, we divide the training into two parts, with two different objectives: inviting the trainers (and eventually the trainees) to observe and reflect on the conditions of rendition (part 1) and on the conditions of negotiation (part 2). After a general presentation of the objective of the training, each transcript is first discussed in small groups, then discussed in a plenary session, then it is returned back to a second small group discussion and finally the transcript is discussed again in the second plenary discussion following the 4-phase procedure outlined above. Here, we provide examples of the role of the trainer in phase 1 and phase 4. For what concerns phase 1, we provide a brief presentation of each transcript and suggest some questions about possibly interesting features. For what concerns phase 4, we suggest possible items emerging from a discussion of the extract. Below we provide an example of the types of observations that may emerge from the use of authentic materials. It is worth noting that the discussion in phase 4 is related to the trainees' analyses in phases 1 to 3, which we cannot foresee in our examples.

5.1 TRAINING, PART 1. THE CONDITIONS OF MEDIATORS' RENDITIONS

Renditions are actions involving translation of previous talk. Renditions may occur after one participant's turn, as recommended in the traditional models of interpreting. However, since talk is a non-scripted extemporary construction, interlocutors may need to talk (normally briefly) with the mediator to make their contributions clear, so renditions often occur after dyadic sequences (Davidson 2002).

Renditions capture the meanings and purposes of the participants' contributions to talk. To do so, some changes may be necessary in relation to the "source" contribution. These changes involve text form and structure and are normally aimed at coordinating the interaction, i.e. making clear not only the contents, but also the entailed perspectives or assumptions, the purposes the participants' contributions accomplish within the talk (e.g. recommending, complaining). Changes include for instance: reduced or summarised renditions (focussing on the main point), expanded renditions (including or explicating some items) or multi-part renditions (where utterances are split to allow for feedback from the interlocutor). Expanded renditions in particular may make cultural perspectives (or differences) clear, they may explicate what is taken for granted (by a participant, or in that participant's perspective) or they may add contextualizing details which may provide for the primary participants' meanings and intentions. The choices mediators make in rendering (and consequently coordinating) communication show mediators' "interpreting" activity and their exercise of agency. Such choices may be fruitfully discussed by and with the trainees and alternatives considered.

EXTRACT 1

Phase 1

Presentation. Extract 1 shows an example where a male patient with symptoms of anxiety sees the doctor. The doctor invites the patient to describe his problem. The patient hesitates, but then starts describing how he feels with the help of the mediator.

Questions. Look at the transcript and respond to the following questions:

1) Which contributions are rendered by the mediator immediately after their completion and which are not?
2) What does the mediator do when she does not render the message into the target language? Is the mediator collaborative or not? Give reasons.
3) Look at turn 12 specifically: what is the function of this mediator's contribution?
4) What are the pros and cons of the mediator's actions in this extract?

01 DOCf:	Allora dimmi adesso.
	Okay tell me now
02 MEDf:	So what's your problem now? (??)
03 PATm:	My heart is worrying me, my heart.
04 MEDf:	How is it worrying you?
05 PATm:	Ehm: (0.2) my heart is-
06 MEDf:	Beating faster?
07 PATm:	Yes, yes, beat fast (.) fast fast.
08 MEDf:	Or you feel pain?
09 PATm:	Ye-yes, I feel pain. (?As straight walk)
10 MEDf:	It beats faster?
11 PATm:	Yes.
12 MEDf:	Eh:: ha il cuore che batte forte. Ha anche dolore (.) dice.
	Eh:: his heart beats fast. He has pain too (.) he says.
13 DOCf:	Da quanto?
	How long?
14 MEDf:	Since when?

15 PATm: Almost two weeks (now)

16 MEDf: Da due settimane adesso.

For two weeks now

Phase 4

Discussion. The doctor starts the encounter with a general question inviting the patient to describe his reasons for coming: the doctor uses a routine request form in Italian, which is rendered by the mediator with an equivalent routine form in English. The patient starts his answer in turn 03 saying that he is worried about his heart but adding nothing else. From turn 04 to turn 11, we have a short dyadic sequence where the mediator asks questions which invite the patient to give precise details. All the details given by the patient are rendered in a summarized form in turn 12. The mediator's rendition in turn 12 enables the doctor to ask a more specific question which is rendered by the mediator after the completion of the patient's answer.

Considerations. As in many other occurrences in the data, the patient seems unable to provide a detailed description of his symptoms, so the mediator's exercise of agency can be seen in her opening a brief mediator-patient sequence with the function of helping the patient provide more details. While the mediator asks specific questions, they are not "doctor's questions", rather they can be regarded as clarification requests to allow for communication to proceed smoothly. The dyadic sequence is very short (few seconds) and the details collected are all rendered to the doctor, who is then in a position to ask "doctor's questions". Unluckily, what the patient says in turn 09: "Ye-yes, I feel pain. (?As straight walk)" is not fully clear in the transcript, the mediator does not render it and she did not ask the patient to repeat this utterance – which she might have.

EXTRACT 2

Phase 1

Presentation. Extract 2 shows an example where a pregnant patient complains that she cannot sleep at night. After examining her, the doctor establishes that there is nothing physically wrong with the patient's or her baby's body and concludes that the reason for the patient's insomnia is probably related to her concerns about becoming a mother, far from home and with little support.

Questions. Look at the transcript and respond to the following questions:

1) What is the mediator's reaction to the doctor's contributions in turns 1 and 3? Could you think of alternative mediator's contributions? If so, what effect might these alternative contributions have?

2) Does the mediator show that she has understood the doctor's point and is ready to render it? How does the mediator show (or not show) her understanding of the doctor's position?

3) What is added in the mediator's rendition to the patient? What is modified? Does the mediator's rendition capture the sense of the doctor's contribution?

01 GYNf	prova a spiegargli questa cosa che un po' i pensi[eri] sono
	try to explain her this thing that in some way thoughts are
02 MEDf	[mm]
03 GYNf	immagino i pensieri di essere in un paese: che non è il proprio
	di essere un po' [quindi alcune] preoccupazioni [più facilmente]
	I can imagine the thought of being in a country: that is not your own of being a bit [so some] worries may easily
04 MEDf	[mm] [mm mm]
05 GYNf	[poi a]ppunto quando (.) le luci si spengono posso[no venire]
	fuori
	[then] I mean when (.) lights switch off it m[ay come] out
06 MEDf	[mh] [sì]
	[yes]
07 MEDf	mm: that's maybe you know during the day you may be (ill) or since you may have some you know: thoughts you may be thinking you know because (.) ((tongue click)) you are here (.) eh e:h (.) in another country that is not your own far from home (.) you know without anybody (.) you may also be thinking about the pregnancy mm (.) yo: you know you are here pregnant in home in a far in a far place (.) you may also be thinking about the delivery all these all these things that you are thinking during the day
08 PATf	hm [hm]
09 MEDf	[th]at's when night comes and you lay down to sleep those things would be: you know: bombing your brain
10 PATf	yes
11 MEDf	[((laughter))]
12 PATf	[((laughter))]

Phase 4

Discussion: The extract shows two dyadic sequences. In the first sequence (turns 01-06), the doctor speaks to the mediator not only informing her that the patient's insomnia is probably due to her psychological state, but also that the doctor understands the patient's problem and sympathizes with her. In the second (turns 07-10), the mediator renders both the informative content and the empathic sense of the doctor's contribution to the patient. The mediator's expanded rendition provides both reassurance that there is nothing wrong (the patient is not physically ill, though probably in a difficult situation), and sympathy for the situation she is experiencing. The mediator exercises her agency by choosing how to describe the feelings of a woman who is about to become a mother and has no one to help her. The mediator also makes it explicit that the patient's concern may become strong at night "bombing her brain" and preventing her from sleeping, an idea that was only implicitly mentioned by the doctor. The mediator finally laughs with the patient (turns 11-12) possibly in an attempt to relax the patient a bit.

Considerations. The mediator exercises her agency twice: first in providing listening feedback to the doctor then in providing an expanded explanation of the doctor's contribution to the patient. This, on the one hand, enables the doctor to carry out and conclude a contribution which includes both reassurance and empathy, and, on the other hand, helps the mediator to make both the meaning and the purpose of the doctor's contribution clear to the patient, choosing appropriate words and explicating what was implicit in the doctor's talk. The reaction of the patient in turns 10-12, where she laughs with the mediator, shows that the doctor's (mediated) words have probably reached the objective of relaxing the patient. A problem that may be raised by looking at this sequence is whether, after this "relaxing" explanation, the patient is given some help, e.g. some (mild) therapy for sleeping or someone to contact for help with her maternity – or whether she is given the possibility to ask questions to the doctor.

EXTRACT 3

Phase 1

Presentation. Extract 3 shows an example of a pregnancy check-up. It is the first visit in which the doctor explains the organization of the screening throughout the nine months. In particular she focuses on three scan tests, the period in which they are taken and the purpose of each of these tests. The mediator renders the explanation to the patient, who is accompanied by her husband. The voice that is mainly heard in receiving the mediator's explanation is the voice of the patient's husband.

Questions. Look at the transcript and note:

1) You can probably see that the extract is divided into two parts, in the first one the mediator listens to the doctor's explanation, and in the second one the mediator renders the doctor's explanation to the patient. Check the differences and similarities between these two parts and underline them on the transcript. Can you give reasons for such differences and similarities?

2) How would you consider the mediator's reaction to the doctor's talk in the first part? Is the mediator inviting the doctor to provide a long and detailed explanation of the three tests or does she think that such detailed explanation is not necessary? Give reasons.

3) Does the interlocutor in the second part of the extract (the patient's husband) seem to understand the mediated explanation? Give evidence for your answer.

01. DOCf allora adesso le dobbiamo spiegare le tre ecografie

So now we have to tell her about the three ultrasound tests

02. MEDf oka:y

03. DOCf allora la prima che la facciamo al primo trimestre la seconda è la più [importante] però si vedono solo le cose fisiche –

now we do the first one in the first trimester, the second one is the most important but we see only the physical features

04. MEDf [certo]

[absolutely]

05. MEDf =Sì

=Yes

06. DOCf la terza che vediamo quanto è cre[sciuto]

the third one when we check how much it ((the baby)) has grown.

07. MEDf [okay] okay. (.)

I bit ullak, halla' ihna khilal elhaml (..) fi Italia, bini'mil thalath talfazat (..). 'thalfaza aloula 'lli bitin'iml hadi nghul fi 'shahr 'thani 'shahr 'thalith taqriban, 'lli tutbit 'nu mawjud alhaml w 'tifl dakhil 'rahim w kulshi mzian (.) 'talfaza 'thaniya 'lli bitin'imil taqriban fi 'shahr alkhamis aw bayn 'rabi' wa alkhamis, hadi tbayin ennu 'tifl kamil ala'daa'.

[Okay.] Okay. (.)

She says about your pregnancy (..) in Italy we have three ultrasound tests (..) the first one is in the second third month about this shows that the pregnancy has started and that the foetus is in the right position and that everything is alright (.) the second one is taken during the fifth - between the fourth and the fifth month this shows that the baby's body is complete in all its parts

08. HUSm Ah

Yes

09. MEDf idih w (.) rjlih w 'ra's w lbatn w l ma'ida.

her feet (.) her hands and all the rest

10. HUSm Ah

Yes

11. MEDf ya'ni kul haja mawjuda fi aljism.

That everything is in place

12. HUSm aywa.

Yes

13. MEDf w 'thalfaza al ukhra 'lli 'ala ishahr (.) nghul bayn 'sabi' w akhir 'sabi' w awwal 'thamin taqriban akthar had.

The third one is taken between the (.) beginning of the seventh and the eighth month maximum

14. HUSm Ah

Yes

Phase 4

Discussion. The extract is divided into two dyadic sequences, the first one between the doctor and the mediator, and the second one between the mediator and the patient and her husband. The second sequence includes also the mediator's expansion of the details and her anticipation of the patient/husband to confirm that they follow and understand what has been said. The mediator coordinates the interaction in two ways, in both cases differently from what we have seen in Extract 2. In the first part of the extract she shows understanding of what the doctor says and provides feedback for her to complete her contribution, but clearly stops her from expanding – there is a difference to be noted between the feedback the mediator provides here ("okay" turn 02, "absolutely" turn 04, "yes" turn 05) and the "continuer" feedback ("mhm") of the mediator in Extract 2. In the second part of the extract, the mediator shows her competence and knowledge in explaining the details of the three scan tests by expanding them as to

include the peculiarities of the Italian system ("In Italy we normally have three ultrasound tests") in reference to possibly different expectations. Her rendition is split in different parts so as to allow feedback from the interlocutor(s).

Considerations. The mediator exercises her agency in showing her knowledge to both the doctor ("yes" and "absolutely" show that she knows what the doctor is talking about) and to the patient, by providing further details. Her longish rendition probably reassures the doctor that everything that needs to be said has in fact been said: the doctor does not check with the mediator and apparently trusts her. The patient's husband seems very compliant and shows understanding repeatedly. What is not fully clear is the reason why the patient participates so little – which may be a fruitful discussion topic.

5.2 TRAINING, PART 2. NEGOTIATION OF MEDIATION

We hope we have made it clear that interpreter-mediated encounters are largely interactional products where participants' actions affect each other in a number of ways. The mediators understand both languages spoken in the conversation and are thus in a position to help the interlocutors reach each other. However, there is clearly a lot of coordinating and mediating work that they have to do which requires that the other participants in the interaction acknowledge the mediator's right to exercise agency. It may be added that this acknowledgment involves, in turn, the mediators' competence to make choices appropriately in order to render talk in a contextualised way, and trust on the part of the other participants that the mediators have such competence (see Mason 2006). Indeed, mediators are not alone in the interaction and their mediating action may be solicited by other participants' actions. In this second part of our interaction-based training, we will look at examples which show how such interlocutors' constraints are posed on the mediator's action and how mediators deal with these constraints. As mentioned above, constraints may be posed by doctors or patients. We will deal with doctors' constraints briefly and will then show two extracts, posing two different types of constraints, both by the patients.

The constraints posed by the doctors can be noted in both Extract 2 and Extract 3. Both extracts start with a dyadic sequence involving the doctor and the mediator where the two interlocutors define not only the contents but also the pragmatic meaning of the doctor's contribution. In particular, it is clear, in the chain of turns, that the doctor in Extract 2 aims to convey reassurance and empathy and that in Extract 3 she is referring to a routine procedure ("the three ultrasound tests" meaning "the usual ones"). In both cases the doctor uses an introductory verb by which she gives instructions to the mediator and also authorizes her to report the doctor's contribution in a particular way.

EXTRACT 2

01 GYNf	prova a spiegargli questa cosa che un po' i pensi[eri] sono
	try to explain her this thing that in some way thoughts are
02 MEDf	[mm]
03 GYNf	immagino i pensieri di essere in un paese: che non è il proprio di essere un po' [quindi alcune] preoccupazioni [più facilmente]
	I can imagine the thought of being in a country: that is not your own of being a bit [so some] worries may easily

EXTRACT 3

01. DOCf	allora adesso le dobbiamo spiegare le tre ecografie
	So now we have to tell her about the three ultrasound tests
02. MEDf	oka:y

Even though differently translated in the italicized line, the verb used by the doctors is the same, "spiegare" (explain), a verb used in Italian to underline that the message is important and needs to be clarified in all its aspects including the relational ones (see Gavioli 2015). This form of talk authorises the mediator to choose appropriate ways to convey the doctor's message. It thus creates conditions for the exercise of her agency, but also puts constraints on the mediator to choose an appropriate rendition for the doctor's intended meaning – something that the mediator does in both cases. So, adding an accurate explanation conveying empathy in the first case and clarifying the different steps of a pregnancy screening in Italy in the second is not a totally deliberate choice of the mediator, rather it is negotiated and agreed with the doctor, who, within such negotiation, makes clear what she wants to say and contemporaneously acknowledges the mediator's authority to choose how to say it, in the other language.

Let us now look at the two extracts showing constraints posed by the patients' actions.

EXTRACT 4

Phase 1

Presentation. Extract 4 shows an example of a doctor's question which is a routine one and highly recurrent in our data, that is the request for the date of the patient's last period (turn 01). In the case in question, the date that the patient provides (24 February) is almost a month and a half before the current encounter, it may thus suggest that the patient's menses are late.

Questions. Look at the transcript and note:

1) What type of rendition follows the doctor's turn?
2) The patient's answer is not rendered immediately. What does the mediator do instead? Can you give reasons for this choice?
3) Is the patient's answer rendered eventually?
4) What are the consequences of this mediator's choice in the interaction? Is the doctor excluded?

01.DOCf	Ultima mestruazione quando è stata?
	Last menstruation when was it?
02. MEDf	Akhir marra jatk fiha l 'ada shahriya?
	Last time you had your period?
03. PATf	Rab'awa'ishrin (.) f sh'har juj
	Twenty-fourth (.) in the month of February.
	(0.2)
04. MEDf	Fsh'har juj?
	In February?
05. PATf	Ah, rab'awa'ishrin (.) f sh'har juj.
	Yes, twenty-fourth of February
06. MEDf	F sh'har- f had sh'har ma jatksh?
	In the month- in this month you didn't have it?
07. PATf	Majatnish, yallah jatni, ghlt lik dart liya retard tis' ayyam.
	I didn't have, I have just had it, I told you I had a nine-day delay.
08. MEDf	Yallah jatk?
	You've just had it?
09. PATf	Ah.
	Yes.
10. MEDf	Imta jatk?
	When did you have it?
11. PATf	Jatni:: el bareh.
	I had it yesterday.

12. MEDf	Ehm, ya'ni les regles tsamma dyal l bareh mush-
	Ehm so yesterday menstruation don't-
13. PATf	Ah, ghlt dyal bareh, mashi lli ghlt dak sh'har
	Yes I said yesterday, not that from last month.
14. MEDf	Eh, no, akher marra. ma'natha nti daba haid?
	Well no, last time. So you're having your period now?
15. PATf	Ah.
	Yes
16. MEDf	Allora, attualmente è mestruata. (.) Le sono venute ieri.
	Well, she's having her period now (.) It came yesterday.
17. DOCf	ah! Allora bisogna che torni ((laughs))
	ah! so she needs to come back
18. MEDf	infatti, adesso-
	that's right, now-

Phase 4

Discussion. The mediator in turn 02 renders the doctor's question to the patient using an Arabic turn structure that is similar to the one used by the doctor in Italian. The patient's answer, however, refers to a month and a half before the encounter so the mediator stops rendering and talks with the patient to check whether her menses are late. The clarification sequence covers turns 04-15. In fact, the sequence shows that there is a misunderstanding: since the patient already said that she was having her menses currently, the date she provided after the doctor's request is that of the menstruation before the current one. In turn 16, the mediator renders the correct date to the doctor, with the consequence that the pap-test which the patient was supposed to take on that day gets postponed.

Considerations. The mediator coordinates the interaction in a way as to solve the misunderstanding and render to the doctor the detail she asked about at the beginning of the sequence. The mediator exercises her agency in choosing not to render the patient's answer immediately as she understands there is something unclear about it. So, the patient's understanding of the doctor's request (which is made clear in her answer) poses constraints on the mediator as to decide whether to render or solve a possible misunderstanding. The mediator decides for the latter solution and what she renders to the doctor is "the solution", i.e. the patient's answer that is relevant for the current medical check-up. The interaction proceeds smoothly, even though the doctor is not informed about the misunderstanding.

EXTRACT 5

Phase 1

Presentation. Extract 5 is collected in the context of a gynaecological check-up. The problem that is posed is that the patient has heavy menstrual pain before and during her period and that the pain was particularly strong during her recent 9-day delay.

Questions. Look at the transcript and note:

1) Is there a difference in the organization of rendition in the first (turns 01-04) and the second (turns 05-08) part of the encounter? Give possible reasons.
2) How does the patient's contribution in turn 05 change the course of interaction? And how does this affect the mediator's rendition in turns 09-11?
3) What about the doctor's reaction in turn 13? How do you interpret it in relation to what comes before?

01 DOCf	ha dei fastidi::? Qualche proble:ma? O sta bene?
	Has she got any disturbance? Any problem? Or is she alright?
02 MEDf	'ndk shi mushkil? Ya'ni shi haja ka tqlqk binisba l-
	Have you got any problem? I mean something that hurts you for-
03 PATf	=la, ghir mn lli ka tjini dm ka tjini bl wj', [safi.
	No, only when I have my period I have pain, that's all.
04 MEDf	[sì. No, i soliti dolori
	mestruali, niente di particolare.
	[*Yes. No, it's usual*
	menstrual pain, nothing peculiar.
05 PATf	htta had tis'at ayam lli dart liya retard, kan ka ijini l wj' bzaf,
nhar	'la nhar
	Also in these nine days delay, I had frequent pain, day after day
06 MEDf	Mh.
07 PATf	w bqit bhal hakkak [htta jatni
	And it was like that until it came ((the period)).
08 MEDf	[htta jatk.
	until it came.

09 MEDf ma che: soprattutto in questi nove giorni di ritardo ha avuto molti dolori.

but that particularly during this nine-day delay she had frequent pain.

10 DOCf Mh.

11 MEDf =finché [sono arrivate le:

until she had the

12 DOCf [mh.

13 DOCf va bene, la visito

okay, I shall examine her

Phase 4

Discussion. The mediator renders the doctor's and the patient's contributions closely from turn 01 to turn 04. The patient's spontaneous intervention in turn 05 changes the meaning and purpose of her initial contribution: she did not mean that "everything is normal", as initially suggested, rather she wanted to say that she had particularly strong pain before her last menses. This puts constraints on the mediator and prompts her to explore the problem with the patient briefly before rendering the patient's contribution to the doctor.

Considerations. Patient's turn 05 clearly changes the course of interaction by turning a routine check-up into one which needs to consider a particular problem. The patient's contribution in turn 05 throws new light on her contribution in turn 03, which can now be interpreted just as the beginning of what the patient wants to say. Under this constraint, which changes the meaning of the patient's contribution, the mediator exercises her agency in choosing to stop her rendition and get back to the patient to explore the problem better. The mediator does not ask any question but simply provides listening feedback which prompts the patient to go on with her telling and complete it. The completed narrative is then rendered to the doctor. The doctor clearly attributes the problem medical relevance and decides to examine the patient.

6 CONCLUDING REMARKS

Our examples show three important aspects of mediation which may be useful to highlight in training. First, mediators' summarized, expanded, and multipart renditions are quite common, as well as dyadic sequences with providers or patients. Second, mediators' contributions are interactionally achieved and pursued in the interaction. Both doctors and patients call for mediators' attention

and expertise in rendering agreed information, in listening to more details, in adjusting contents in ways that the mediator finds appropriate for the other interlocutor to understand. Third, mediators contribute as agents in the selection of items among a range of choices made available to them. These three points can be considered by the trainers in encouraging trainees' reflection and to "guide" the trainees throughout the discussion in phase 4. The proposed training addresses a view of interpreting/mediation that puts quite a lot of responsibility on the interpreter/mediator in that it shows that mediating actions in interpreting are displayed through the mediator's choice of action. The training shows that the mediators' choices display the mediators' "interpretation" of what is going on and can promote participants' relevant contributions on equal grounds by empowering their right to say what they want to say and their achievement of an interpersonal relationship (as e.g. in Extract 2). The training also makes evident that cultural issues are relevant in mediated interactions (as seen in Extract 3), but mediation is not attached to cultural items alone. The training shows that mediation seems to be the result of a double operation: 1) giving meaning to what may not be clear for (some) interlocutors and 2) opening interlocutors' choices about which meanings are possibly attributed to particular items. Moreover, the proposed training highlights trainees' agency and coordination in finding and discussing their own interpretations of the examples. In fact, this training is in itself a way of showing what trainees intend as interpreting/mediation and how they coordinate and exercise agency during the training in phases 1, 2 and 3. Finally, one of the major objectives of the training is to suggest that coordination and agency fulfil the function of mediation, by transforming facilitation of understanding into the promotion of equity and empowerment of participation (and affect/empathy). Exercising agency in effective ways, by avoiding misinterpretations or inappropriate substitution of interlocutors in talk, involves a high professional competence, particularly in choosing among a high number of alternative actions that are dealt with in phases 1, 2 and 3. It also involves the trainers' competence in coordinating and exercising their agency through training, by activating ideas and considerations (phase 1), facilitating discussion (phase 2) and guiding the trainers towards possible solutions (phase 4).

7 ACTIVITIES

Discuss in pairs: is it better to study transcripts with trained or untrained interpreters? What are the benefits of one or the other option?

Compare the interactions in the transcripts with recommendations from the codes of conduct with which you are familiar. To what extent do they diverge? Discuss in pairs: Does this divergence suggest: a. that there needs to be an accommodation of interpreter behaviour to the codes of conduct or b. that codes

of conduct should be reinterpreted or adjusted in light of authentic interaction contingencies?

Discuss the issue of "trust", particularly in the relationship between service providers and interpreters in the interactions presented above. How can you achieve trust in such a relationship?

8 FURTHER READING

Cirillo, Letizia, and Natacha Niemants, eds. 2017. *Teaching dialogue interpreting.* Amsterdam: John Benjamins.

The volume collects studies applying the interactional approach to interpreting teaching and training. It provides examples of authentic interpreter-mediated encounters in many settings and suggests teaching/training activities based on authentic interaction.

Davitti, Elena, and Sergio Pasquandrea, eds. 2014. *Dialogue Interpreting in practice: bridging the gap between empirical research and interpreter education. The Interpreter and Translator Trainer,* Volume 8/3. Special issue.

The volume was the first study providing an application of Conversation Analysis to interpreting teaching and training. It provides a number of examples of practices occurring in an interpreter-mediated interaction and is a good guide to learn how to analyse an interpreter-mediated interaction.

Tipton, Rebecca, and Olga Furmanek. 2016. *Dialogue Interpreting: A Guide in Public Services and the Community*. London: Routledge.

This book is an excellent introduction to the study of dialogue interpreting and provides a thorough explanation and discussion of dialogue interpreting in the main settings in which it nowadays occurs.

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