Interpreting and Intercultural Mediation in Italian Healthcare Settings

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Abstract

Sociolinguistic studies on dialogue interpretation suggest that the interpreters in healthcare settings play a double role: they interpret and coordinate communication: for this reason, interpreting is considered a form of intercultural mediation. Based on the analysis of 55 tape-recorded conversations in Arabic and Italian in public healthcare services in Italy, this article connects the forms of intercultural communication promoted by the mediators and the linguistic aspects of mediation, discussing how the relevance of the migrant patients' voices in medical encounters is connected with the use of specific conversational resources by the mediators. Starting from the observation of actual and naturally-occurring interactions in intercultural healthcare services, the article suggests how an analysis of intercultural mediation may provide an empirical-based route to create guidelines for effective mediation practices.

Keywords: *Migrants' Health; Interpreting; Intercultural Mediation; Italy; Arabic Language; Healthcare Services*

Introduction

Intercultural Mediation (IM) is a practice primarily used by institutions to encourage foreign groups to access public facilities, especially those related to healthcare, social integration, education, justice and job assistance. IM is of growing interest to Italian public services, whose users now include an increasing number of migrants.

Communication may be considered as the basic social process which gives meaning to either the interlocutors' "cultural reality" and their intercultural relationships (e.g. Carbaugh 2005; Koole and Ten Thjie 2001; Pearce 1989; Verschueren 2008). In this perspective, the cues of these meanings are observable in the interaction. Cultural differences are highlighted inside communication processes where the participants show and orient to different relevant values, different forms of contribution and different expectations about the results of communication. Any such difference in the medical system may, for instance, concern treatments of illnesses and expectations about both doctors' competent performances and patients' motivation to adapt to the doctor's suggestions.

Italian scientific literature analyses IM experiences from different perspectives: a pedagogical perspective, i.e. relating to intercultural education (Favaro, 2001; Fiorucci, 2000; Nigris, 2000), and anthropological (Castiglioni, 1997) and sociological perspectives (Ceccatelli Gurrieri, 2003; Jabbar, 2000). From these analyses we can borrow definitions of IM as applied to different social contexts. IM means "finding a common view, coming to an agreement, favouring compromise. It's the creation of bridges and networks" (Ceccatelli Gurrieri, 2003, p. 15), IM is "a way of getting closer, facilitating contact, including, favouring interaction and exchange" (Favaro, 2001, p. 10).

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

From this literature, we can draw narrations of mediators' biographies (Aluffi Pentini, 2004; Ceccatelli Gurrieri, 2003) and prescriptions on basic ethics and qualifications that a mediator should be provided with to produce an effective IM (Belpiede, 2002; Favaro and Fumagalli, 2004). The Italian literature on IM qualifies it as a pivotal strategy to favour the promotion of a multicultural citizenship in multinational societies (Kymlicka, 1995). As pointed out by Jabbar: "The presence of a cultural mediator is an essential executive moment, but most of all a valuable scheduling resource for all commissions promoting integration policies" (2000; p. 88).

However, these studies have been based on reports from mediators' biographies and other experiences; in our opinion this data is only partially useful for the evaluation of mediation practices: the information appears overly categorized and often far from presenting the dynamics of IM practices. With some exceptions, (Baraldi, 2006; Baraldi & Gavioli, 2008; Cirillo, 2010; Merlini & Favaron, 2007), Italian research on IM is lacking an empirical basis, and no clear proposal has so far been made to design a methodology for the evaluation of current IM procedures.

For this reason, this article presents a theoretical model and methodology developed around different approaches, particularly linguistic and sociological, to obtain a working definition of IM. To do that, the observation of communication processes involving institutional providers, migrants and a cultural mediator plays a crucial role. The development of conceptual tools and a methodological approach is as much a purpose of this research as the analysis of the conversations; in its final section, the article will discuss how an analysis of IM, starting from the observation of the interactions that take place within public services, may provide an empirical based route to create guidelines for effective mediation practices.

A methodology for IM research

In order to help analyse IM-promoted communication forms between participants in an interaction, it may be helpful to consider empirical studies on dialogue interpretation from applied linguistics, with respect to collections and transcriptions of mediated conversations (Davidson, 2000/2001; Bolden, 2000; Mason, 1999/2001; Wadensjö, 1998). They clarify that IM can be seen as a special kind of interaction defined as "interpreter-mediated" (Wadensjö, 1998). Specifically, IM is considered as a triadic interaction (Mason, 1999, 2001; Wadensjö, 1998) involving two primary participants (service provider and service user) and a third one (the interpreter-mediator), who has to allow the user to access the service by translating from the user's language 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.

These studies suggest that the interpreters' activities can be seen as primarily oriented to the joint construction of meaning through interpreting both what is said and what is implied. Interpreters, therefore, need to consider the meanings and purposes that are achieved through a conversation and, thus, play a double role: they *interpret* and *coordinate* communication. For this reason interpreting may be understood as a form of mediation. The interpreter-mediator is the only participant in the interaction who is able to understand everything that the others in the conversation say. Therefore, s/he can define the context of the encounter, draw attention to the production of shared topics, and manage misunderstandings.

According to Wadensjö (1998), the most important function of the interpreter-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. Davidson (2000) suggests that in healthcare settings, the interpreter can act as a gatekeeper, i.e. a pre-filter that evaluates the importance of the patient's contributions before translating them. In other words, the interpreter is not a "linguistic parrot", but an

independent agent, responsible of a flow of information and medical evaluations. In fact, the interpreter is involved in a preliminary diagnostic process. In this respect, we can see the mediator as an active participant and evaluate the effects that her/his action determines on the orientation of the communication. To simplify, in intercultural terms we can hypothesise that through translation and coordination activities the mediator builds intercultural communications, promoting the active participation of the people involved in the interaction, while at the same time gatekeeping, i.e. acting as a filter in the information flow.

This paper focuses on the dual role of IM, as interpreter and as mediator, as it emerged from analysis of conversations between interpreters, patients and doctors in an Italian setting. The analysis will focus on: a) the forms of communication promoted by IM; b) the linguistic aspects of IM communication, and the consequences (be they explicit or not) characterizing the relationship between the participants involved in the communication.

Description of case studies and objectives of the research

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

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

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

Figure 1: *Transcription conventions. (from: Jefferson, Gail. 2004. "Glossary of transcript symbols with an introduction". In Conversation Analysis: studies from the first generation, Gene Learner (ed.), 13-23. Philadelphia: John Benjamins)*

The conversations involve at least one Italian healthcare provider of the institution (D), an Arabic speaking mediator (M) and an Arabic-speaking patient (P).

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". With regard to women the Law 5/2004 makes another reference to mediation by affirming that "Immigrant women are guaranteed treatment equal to that offered to Italian women, as well as social welfare, in compliance with the legislation relevant to family consultories, promoting and sustaining social-health services that are attentive to cultural differences. The guardianship of minors, under the age of 18, is also guaranteed, in compliance with the principles established by the Convention on the rights of children, held in New York on November 20th, 1989 and ratified with Law n. 176, dated May 27th, 1991".

Thus, the object of our analysis consists of medical encounters with the presence of an interpreter who is expected not only to translate what the participants say, but also to promote the coordination between the principal interlocutors, preserving the functionality of the healthcare system. Therefore, the interpreters in our data, play the role of interlinguistic *and* intercultural mediator (IIM) and the analysis of the recorded conversations can be intended as an evaluation of IM processes in the contexts in question.

The extracts which are discussed in this article were chosen for their clarity; however they respect the prevalent organizations of sequences in the whole corpus of data. They represent the main type of discourse organization in the interactions and they can be considered fully representative of the kind of IM processes observed in the collection of data. The extracts which are used in the following discussion can thus provide an idea of the sequences of talk that are found in the data.

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

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

The inhibition of patients' active participation in medical encounters

Selectivity in the translation: zero-renditions

The most common types of IIM action that exclude the *voice of patient* from the medical encounter are *reduced renditions* or *zero renditions* (Wadensjö, 1998) of patient's and doctor's turns of talk, cutting out some (reduced renditions) or all (zero renditions) of their contents from the translation. Excerpt CS13 offers an instance of zero rendition.

CS13

1. **D:** Di notte dormi?
2. **M:** Can you sleep at night or?
3. **P:** No if I haven't worked during the day I [can't. I don't-

4. **M:** [quando quando non è stanco non dorme
   When when he's not tired he can't sleep
5. **P:** واسمحوا لي أن أقول لك
   Posso di[re-
6. **D:** [Quando non è stanco e non lavora
   When he's not tired and doesn't work
7. **M:** Quando non è stanco e non ha lavorato
   When he's not tired and doesn't work
8. **D:** Quando non ha lavorato. Per questo-
   When he hasn't worked. For that -
9. **M:** Non riesce a dormire
   He can't sleep
10. **M:** إذا كنت لا تعب ، لا تنام؟
    If you are not tired, don't you sleep?
11. **P:** لا استطيع النوم حتى الصباح
    I can't sleep until the morning I
12. **M:** Cioè tutta la notte dice fino alla mattina
    Well he says all night long until morning
13. **P:** في العمل ، ولقد ترك لمدة ساعتين للنوم
    At work, I have to leave for two hours to sleep
14. **M:** E quando lavora deve per forza andare via per due orette per riposare
    And at work he has to take a break for two hours to sleep a bit
15. **D:** Ascolta vuoi che ti diamo qualcosina per riposare alla notte (.) Sempre (.) indipendentemente dal lavoro e non lavoro?
    Listen do you want we give you something to sleep at night (.)Either if you have to work or not?
16. **M:** بتقولك (.) تحب نديك حاجة , نديك دوة حاجة تنام بيها بالليل , تعبان مش تعبان (.) تنومك بالليل والة ؟
    He says (.) do you want we give you something to sleep a night? Tired or not helps you at night or-?
17. **D:** una compressina?
    a little tablet?
18. **M:** *[* حاجة عشان تنام بالليل -
    [something to sleep at night or-
19. **D ((to the nurse)):** [Dammi del
    [Gimmie some
20. **P:** يا ريت
    I wish
21. **M:** Sì (.) sì (.) magari dice
    Yes (.) yes (.) I wish, he said
22. **D:** Eh?
    Eh?
23. **M:** I wish
    magari
24. **P:** اقول-
    I will tell -
25. **M:** اه –
    Eh -
26. **P:** الحاجة دي عملالي زهق في حياتي , لما مبنام اروح للبالكونة وارجع –
    I can't sleep I go back and forth to the balcony - (3.0)
27. **D:** Allora lui viene mercoledì pomeriggio alle 2/2.30 che gli facciamo il prelievo (…) poi per l'Aids così abbiamo fatto tutto, eh?
    So he comes Wednesday afternoon at 2/2.30 and we take the blood sample (...) then everything will be done about Hiv,eh?

In the course of the excerpt the patient, suffering from insomnia due to fear of having contracted HIV, makes three attempts to begin a narration about his personal experience of the disease, (turn 3, 5 and 24). None of these attempts is successful. The first attempt (turn 3) is frustrated by the IIM, who begins to translate as the patient offers a relevant symptom in biomedical terms, overlapping with the incipient patient's narration (turn 4). In turn 5, the patient tries again to initiate the narration, explicitly asking the IIM to take on the role of story-recipient. This second attempt is frustrated by the doctor who intervenes, relates to turn 4 of the IIM (turn 6), overlaps with the patient's narration, and thus blocks it. The doctor's intervention is a cue for the cultural presuppositions of a doctor-centred culture: as a technical expert the doctor tries to gather more precise symptoms, in this case exploring the physiological reason for insomnia (e.g. the patient "is not tired enough").

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

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

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

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

Narrations are co-authored through interactional moves and activities between narrator and audience. They need to be collaboratively sustained by participants. Recipients influence the details that make up the story and the ways it is told through their participation. For instance, by using a story preface, when the speaker offers to tell a story, a recipient can accept a narration. Similarly a story can be encouraged by prompting the story through questions, showing they have recognized the end of the story and in some cases by showing appreciation or by producing further stories (Monzoni & Drew, 2009).

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

Mediator actions such as zero renditions make medical encounter proceed faster toward the diagnosis and prescriptions phases, thus apparently supporting the functionality of the system. However, we may ask what kind of system's functionality is supported by these actions. Recent research by Leanza, Boivin & Rosenberg (2010) and Schouten et al. (2007) confirm the efficacy of this type of mediator 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 shows that these types of mediator action hinder the trust building process between patient and healthcare provider. Since they create more distance between the principal participants, zero and reduced renditions pose risks to the therapeutic process and, paradoxically, compromise the core values (e.g., self-determinism and informed decision-making) of the Western medical system (Hsieh, 2010).

The promotion of active participation in the medical encounters

The support of the voice of patient in dyadic sequences

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

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

In excerpt CO1, the mediator expresses her attentiveness and understanding through feedback tokens ("Ah", "mmh", "Ah I understand you").

CO1

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

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

Affective formulations that re-include the doctor in the interaction

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

According to Heritage (1985: 100), we define "formulation" as a specific interactional move "summarising, glossing, or developing the gist of an informant's earlier statement". Formulations project a direction for subsequent turns by inviting responses insofar as they "advance the prior report by finding a point in the prior utterance and thus shifting its focus, redeveloping its gist, making something explicit that was previously implicit in the prior utterance, or by making inferences about its presuppositions or implications" (Heritage, 1985: 104).

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

Specifically, formulations are conversational resources available to the mediator in order to: a) provide a translation which highlights content from prior sequences of turns; b) make what is thought to be implicit or not clear in the prior turns of talk explicit; c) propose inferences about presuppositions or implications of the participant's contributions (Baraldi & Gavioli, 2008).

We focus on a type of formulations, *affective formulations*, which may be understood as discursive initiatives undertaken by the IIM to give voice to patients' emotions, which in most cases manifest themselves implicitly. Patients rarely talk about their emotions directly and without prompting. Instead, patients provide interlocutors with clues for their feelings, thus providing "potential emphatic opportunities" (Beach & Dixson, 2000). Affective formulations focus on the

emotional point of patients' utterances, giving the possibility to the doctor to share and get involved in the affective dimension of interaction. In this way, doctors are made aware of patients' concerns, and patients assume a local identity that goes beyond the generic social role of being sick.

In excerpt CO11 below, the patient reports a delay in her menstrual period, but mitigates the relevance of this information by assuming she will get her period within the following few days.

CO11

55. **M:** *When you had your period last?*
56. **P:** جتني تلاتعش من شهر عشرة
    It was the thirteen in the month of October
57. **M:** تلاتعش عشرة؟
    Thirteen October?
58. **P:** اي
    Yes
59. **M:** L'ultima mestruazione è il 13 ottobre
    The latest menstrual period is the thirteen October
60. **D:** Mmh
    Mmh
61. **M:** Ora siamo al 13 novembre
    Now it's November thirteen
62. **P:** كانت تهبط علي كل شهر نيشة (.) الدم ما هبط صار شهر لليوم
    It comes each month exactly, now it's a month that it's not coming (.) a month today
63. **M:** اه
    Mmh
64. **P:** استنى تلات ايام والة اربع ايام بش مش عارفة اذا تجي
    will wait three days or four, maybe it will come
65. **M(to D):** Ah (.) può darsi che tra 4 o 5 giorni al massimo (.) arriva (.) però (.) lei è un po' preoccupata
    Ah (.) maybe in four or five days at latest (.) it will come (.) however (.) she's a bit worried

Through affective formulations, the IIM brings to the fore the patient's emotions, which have remained implicit up to that moment, making them a topic for communication and a concern for the doctor. The IIM's discursive initiative capitalises the potential emphatic opportunity offered by the patient.

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

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

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

A direct consequence of the active participation of the IIM is that there seems to be an overlap between *interculturally* and *interpersonally* oriented communication. This narrative is very popular also in the patient-centred approach in medical systems (Heritage and Maynard 2006; Mead and Bower 2000, Zandbelt et al. 2005), because "both quantitative and qualitative studies show that when physicians listen fully, exhibit care and compassion, and engage in other pro-social behaviours, patients' psychological status, physiological symptoms, and functional outcomes all improve" (Heritage and Maynard, 2006: 354). Patient-centred interaction should make the voice of patients' "lifeworld" emerge (Barry et al. 2001, Mishler 1984). Effective third-party coordination produced by IM promotes effective interpersonal communication enhancing personal expressions. In other words, intercultural coordination is not necessarily, and very often not at all, related to the emergence of cultural differences in the interaction. Our data suggest that third-party coordination is intercultural if and when it promotes both opportunities to express perspectives and emotions and sensitivity for these perspectives and emotions (Baraldi and Gavioli, 2008). Thus, a coincidence maybe suggested between effective translation and effective intercultural coordination.

Conclusion

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

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

The works we have analyzed for the purposes of the present paper are based on lists of principles that the mediator is supposed to comply with. From these analyses we can draw prescriptions on basic ethics and qualifications that a mediator should be provided with to produce an effective IM (Belpiede, 2002; Favaro and Fumagalli, 2004). However, these studies don't provide the mediators with any practical working input on how to reach the presumed goals of communication.

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

In particular, our data shows that a specific conversational resource, *affective formulations*, is effective in capitalizing potential emphatic opportunities offered by the patient in the course of dyadic sequences, bringing to the fore his/her voice. By producing affective formulations, IIMs introduce patients' emotions, doubts and concerns to doctors, producing an emotion-sensitive translation that provides the healthcare personnel with the possibility of accessing the many facets of the patient's situation at both a personal and cultural level.

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