Healthcare across Languages in Italy: A Case Study

Eugenia Dal Fovo

ABSTRACT

This study aims at investigating healthcare interaction first and foremost as a form of institutional talk-in-interaction (Schegloff 1990), which, when interpreter-mediated, requires an adjustment of discourse practices and configuration (Pöch-hacker and Shlesinger 2007), with a shift in the distribution of powers in terms of turn allocation and interaction coordination (Baraldi and Gavioli 2012). Real-life data are collected in the "Healthcare Interpreting Quality 2014-2015 Corpus" (HCIQ.1415) compiled by Dal Fovo (forthcoming). By necessarily drawing on analytical frameworks such as Conversation Analysis (Sacks, Schegloff, and Jeffer-son 1974) and interactional sociolinguistics (Gumperz 1982), recurring phenomena in the examined interactions will be identified and studied from a functional point of view (Levinson 1983). In particular, the analysis focuses on episodes that highlight interpreters' choices promoting or excluding emotions (cf. Farini 2015), by tentatively applying Merlini and Gatti's (2015) theoretical framework to the data. Results shall ideally serve as orientation for professionals to deal with ELF-related issues that usually emerge in interpreter-mediated doctor-patient interactions, by considering such communication instances as a specific kind of discourse, rather than a mere deviation from the norm – i.e. monolingual doctor-patient interactions.

Keywords: access, dialogue interpreting, empathy, face-to-face interaction, healthcare interpreting.

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1. INTRODUCTION

The EU Commission *White Paper* of 2007 enshrines four principles envisaging access to healthcare as a universal right. The Paper (2007, 2) states that "Health is central in people's lives and needs to be supported by effec-

tive policies and actions in Member States". Italy may appear a forerunner in this field, as its national Constitution introduced the right to access to healthcare for all as far back as 1948. And yet, little (or nothing) has been done – then and now – to grant such access to foreign citizens, migrants, and non-Italian-speaking individuals in general. Legislation is still lacking in terms of definition of access for non-Italian-speaking individuals, as well as professionals supposed to grant such access. Draft bills have been presented to the Italian Parliament in the past decades (e.g. AA.VV. 2009a, b, c, d, e; AA.VV. 2010), but the identification of a professional figure satisfying law-related requirements and, at the same time, users' expectations, is still the object of a heated, ongoing debate, partially solved on a merely local level: indeed, specific regional authorities have been actively involved in the definition and acknowledgement of language- and culture-experts able to facilitate contact between foreign citizens and the hosting country's institutions, as well as access by the former to public and private services. According to the Friuli Venezia Giulia regional bill (AA.VV. 2006), such experts are defined as "cultural mediators", and are required to have an extensive knowledge of the local context, in which they live and work, as well as the culture and language of one or more countries of origin of the individuals they assist; they have to be able to direct and favour immigrants' access to local services, assisting them in the exercise of their fundamental rights and activation of their autonomous decision-making processes through listening and dialogue; they facilitate communication, information provision and cultural exchange between immigrant foreign citizens, locals and institutional service providers on the territory. As comprehensive as this definition might seem, the indication of who and how should train such professionals is (conveniently) missing.

This study investigates bilingual healthcare interaction first and foremost as a form of institutional talk-in-interaction (Schegloff 1990). Healthcare communication is a particular kind of professional discourse, expressed by the caregiver as the "voice of medicine", but also involving a non-professional party, namely the patient, or the "voice of the lifeworld" (E.G. Mishler [1984] in Bolden 2000, 395). When interpreter-mediated, the "voice of medicine" splits into two distinguished, and yet intertwined, professional voices: the one of the caregiver (medical profession) and the one of the interpreter (interpreting profession). This bipartite nature requires an adjustment of discourse practices and configuration (Pöch-hacker and Shlesinger 2007), with a shift in the distribution of powers in terms of turn allocation and interaction coordination (Baraldi and Gavioli 2012) with respect to monolingual communication. Real-life data are examined to identify recurring phenomena in interpreter-mediated doctor-

patient interaction, particularly as regards interpreters' contributions that go beyond mere language transfer, while falling into the category of the healthcare interpreter's "typical role" (Goffman 1961; Wadensjö 1998). These phenomena are identified and studied from a functional point of view (Levinson 1983), by necessarily drawing on analytical frameworks such as Conversation Analysis (cf. *inter al.* Sacks, Schegloff, and Jefferson 1974) and interactional sociolinguistics (cf. *inter al.* Gumperz 1982). The aim is to analyse dialogue interpreters' (professional) discourse as interactional practice in the specific setting of healthcare, where effective communication is key to grant access to public services and ensure respect of fundamental rights. In doing so, the interpreter's role will be discussed, also in light of some recent contributions to the relevant literature (see Valero-Garcés and Martin 2008; Merlini 2009; Merlini and Gatti 2015). Indeed, an increasingly rigid classification of dialogue interpreters' role(s) into typologies of behaviour over time has been considered as the proverbial necessary evil in order to achieve a much-needed professionalisation of dialogue interpreting for the community; and yet, it may have led scholars astray, too deep into the realm of theory, which has little to do with real-life interpreting practice. More specifically, it may be argued that the very notion of role might be misleading when accounting for the multiple tasks interpreters have to take care of when co-constructing and co-negotiating conversation with their interlocutors in healthcare settings in conversation. A more flexible and dynamic interpretative framework could, instead, allow for a more comprehensive analysis of the interpreter's conversational behaviour and professional attitude, by setting aside the idea of role, and focussing instead on the interpreter's capacity to adopt a primary speaker's perspective – what Merlini and Gatti (2015, 155) identify as the dialogue interpreter's "empathic behaviour". According to the two authors, despite explicitly contradicting the traditional principle of interpreters' invisibility (Venuti 1995),

> empathy can be fruitfully used as a theoretical construct to highlight the complex interplay between the interpreters' inner dispositions, perceptions of situationally suitable behaviours, concrete interactional moves, and their effects on real-life conversations. [...] such an approach may help avoid the strictures and ambiguities of an external and essentially prescriptive point of view as is implied in the notion of role, with such categories as "advocate", "culture broker", and the highly equivocal "detached" and "involved translator".

A comprehensive account of the multiple theoretical and disciplinary descriptions of empathy is beyond the purpose of this study. As Merlini and Gatti (2015, 143) observe, scholars seem to have come to a consensual

definition as regards a series of attributes, which they summarise as follows:

> To conclude, considering our focus on (linguistically mediated) healthcare interactions, for the purposes of the present study empathy is conceived of here as a perspective-taking capability, entailing: awareness of both self and the other (and of self as distinct from the other); understanding of the other's situation; and a degree of concern for the other, communicated through a range of carefully selected affective displays in compliance with the aims and overall objective of the specific institutional activity.

The authors identify a series of "empathic communication cues" in the interpreters' output, distinguishing between three categories of actions, or "cues", that will be described in § 3 of this paper.

By applying Merlini and Gatti's (2015) trifocal model, in a combination of cognitive and interactional approaches to the data, this study's goal is to investigate dialogue interpreters' behaviour in their professional capacity and within the specific setting of healthcare, identifying and analysing instances in which their discourse displays traces of self-initiated perspective-taking activity. Results shall ideally serve as orientation for certifying institutions, providing for a set of guidelines to develop and/or update healthcare and public service interpreting profiles, that may bridge the gap between theoretical assumptions and real life, and serve as a basis for the compilation of a realistic code of ethics to guide professionals and clients in real-life interaction.

2. Dialogue interpreting

2.1. *Dialogue, interaction, interpreting and mediation*

Interlinguistic exchanges of various nature and in very diverse communication contexts of society have been increasing in frequency quite steadily in the past few decades, to the point that the interpreter's profession is no longer automatically associated with the cocoon-like world of high-level international conferences, but rather with the everyday-life world of social care, courts, schools, and healthcare. This interpreting dimension, where interpreters work face to face with their clients, has captured the interest of scholars in the past 30 years, leading to the formulation of many tentative identifications of a professional profile, corresponding to a broad range of

definitions (see Pöchhacker 2008, 19-22; Falbo 2013, 28-44). Despite their almost infant-like stage, Dialogue Interpreting studies today account for a significant body of research, which, however, appears quite 'scattered' and far from homogenous, considering the many denominations they have been published under, such as "liaison interpreting" (Gentile, Ozolins, and Vasilakakos 1996), "community interpreting" (e.g. Hale 2007; Hlavac 2010; Wadensjö 2011; Remael and Carroll 2015), and/or "public service interpreting" (e.g. Corsellis 2008; Hale 2011; Valero-Garcés 2014). Such denominations indicate a clear tendency to identify this kind of interpreting with the work setting in which it is performed; indeed, dialogue interpreters' (Mason 2009) behaviour is strongly dependent on the implication "of a basic option as to what [they] are there for" (Marzocchi 2005, 102). Definitions aside, there is consensus on the fact that dialogue interpreters [1] are as much an integral part of the ongoing face-to-face interaction as the other participants, and together they co-construct said interaction (Wadensjö 1998).

Observing interpreters working *within* the interaction means taking into consideration variables usually neglected in conference interpreting settings: indeed, conferences represent clear-cut communication events, responding to their own traditional rituality and homogeneity of role and participation status; they display a relatively low interactivity degree, where speaking turns are mostly *monologue-* (i.e. individually managed) rather than *dialogue-like*. Interactions between institutions and foreign-language individuals, on the contrary, are marked by a high level of asymmetry between the parties involved, with foreign-language speakers frequently experiencing conditions of dire need. This has direct implications on the social management of the interaction, in terms of what interpreters should or should not do, and, consequently, on what distinguishes this kind of interpreting profession from that, much more familiar and codified, of conference interpreting. Casting a closer look at the set of professional tasks of dialogue interpreters, it is clear that interlinguistic transfer is only one component of their job, and that their activity and professional choices are extremely context-sensitive and recipient-oriented. These considerations may evoke Pöchhacker's (2008, 14) definition of mediation: the author distinguishes between "communicative mediation", further divided into "cultural/linguistic mediation" and "cognitive mediation"; and "contractual mediation", mainly aimed at solving "(intercultural)

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[1] The term "interpreter" here indicates individuals translating from one language-culture ("linguaculture": House 1997) to another, with no reference to their training or belonging to a given professional category.

conflicts or differences", on the other. As far as cognitive mediation is concerned, communication between interlocutors speaking different languages requires first and foremost comprehension and interpretation[2] of the message by the interpreter (Niemants 2015, 16). Moreover, the act of translation consists of a transposition of the message from one language-culture into another. Interpreters are therefore necessarily intercultural and interlinguistic mediators ("cultural/linguistic mediation"): indeed, as clearly stated by Gustafsson, Norström and Fioretos (2013, 189), "language is never culturally neutral", so interpreters could never interpret any verbal exchange irrespectively of the cultural component present in each communication act. Aside from studies framing cultural mediation as a set of practices and strategies aimed at promoting full integration of immigrants in their host society (at least in Italy, Luatti 2011), this paper is based on a concept of mediation closer to the one illustrated in the *Common European Framework of Reference for Language: Learning, Teaching, Assessment CEFR* (Council of Europe 2001). In that document, mediation is defined as any intra- or interlinguistic activity aimed at ensuring that individuals – who, for various and diverse reasons, cannot access written or spoken texts – understand what they read or listen to. In 2015 the Council of Europe highlighted the need to broaden the scope of categories making up mediation as "any procedure, arrangement or action designed to reduce the distance between two (or more) poles of otherness" (Panthier 2015, 1).

Furthermore, Dialogue Interpreting as a professional activity does not happen in a "social vacuum" (Wadensjö 1998, 8) and is inextricably linked to specific environments and their norms, demands and needs. In the newly published *Routledge Encyclopedia of Interpreting Studies*, probably the most up-to-date and authoritative point of reference for defining Interpreting Studies concepts so far, Merlini (2015) defines Dialogue Interpreting as fundamentally linked to the community and/or public service environment, with its sets of rules and conventionally accepted behaviours. As a result, Dialogue Interpreting varies greatly at national and geographical level, being subject to local as well as international factors (García-Beyaert *et al.* 2015; Remael and Carroll 2015). This paper is a case study on Dialogue Interpreting in Italy and, more specifically, in healthcare settings within the Friuli Venezia Giulia region.

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[2] Reference is here intended to hermeneutical studies, which clearly illustrate that every translating act (either spoken or written) necessarily requires interpreting – in a hermeneutical sense (see Cercel 2009).

2.2. *Dialogue interpreting studies: state of the art and cross-fertilisation*

Since 1998, when Wadensjö's *Interpreting as Interaction* was published, Dialogue Interpreting research has been advancing steadily, mainly thanks to studies carried out on real-life interpreter-mediated encounters. Availability of authentic Dialogue Interpreting data is however limited, due to technical and methodological concerns (cf. Dal Fovo and Niemants 2015a). As yet, therefore, there are only few comprehensive works overtly devoted to Dialogue Interpreting. Despite the current lack of Dialogue Interpreting large corpora, however, "[…] a number of independently conducted investigations are providing substantial evidence of *how* interpreters translate and of the reasons *why* they do it that way, showing the gap between 'professional ideology' and 'professional practice' (Merlini 2015)" (Dal Fovo and Niemants 2015b, VII).

At the end of the '90s, research into the social aspects of Dialogue Interpreting[3], such as the interpreter's coordinating activities, turned out to be essential to account for interpreters' utterances that have no counterpart in preceding "originals" ("non-renditions" in Wadensjö's terms), but visibly respond to some social or communicative goal that needs to be met (Davidson 2000, 380), and/or are inextricably intertwined with conversational face-related issues (e.g. Merlini and Falbo 2011). When applying this approach, any kind of (dialogue-interpreted) institutional interaction may entail the presence of many participation frameworks (cf. Schäffner, Kredens, and Fowler 2013, 3), all of them, albeit diverse, requiring some kind of face-work by all interlocutors, interpreters included (Merlini 2015). Alongside verbal components of discourse, supra-segmental elements (*ibidem*) play a crucial role in the co-constructed activity of sense making (*inter al.* Wadensjö 2001; Mason 2012). How, then, does day-to-day practice of Dialogue Interpreting relate to the principle of interpreters' invisibility? Echoing Metzger (1999) and her interpreter's paradox[4], Martínez-Gómez (2015) correctly observes that invisibility is traditionally linked to the perception of moral correctness rather than empirical evidence. Indeed, interpreters may find themselves in situations, where they are required to interrupt their translating task to play the role of mediators between cultures, e.g. to answer questions by the institutional

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[3] See the "sociological turn" in Interpreting Studies (Straniero Sergio and Falbo 2012; Angelelli 2014).

[4] The idea is that there are often discrepancies between the interpreter's invisible role, endorsed and enforced through training and professional ethics, and the actual behaviour of interpreters in practice.

representative on the foreign-language speaker's culture, and even to act as full-fledged ratified speakers e.g. to calm or convince a patient to be examined in their presence. Solomon (1997, 91), referring to the medical setting, states that interpreters' focus "should not be on maintaining a distant neutrality, but on building shared meaning", thus allowing for the provision of "additional context, to say more than the physician may have said, or to ask questions of the physician that the patient might not have asked". By further elaborating on this concept, Valero-Garcés and Martin (2008, 2) speak about "delicate, uncomfortable situations", where "wide cultural gaps, power imbalance, urgent communication needs, lack of resources, lack of professional profile" create a constellation of circumstances "in which it would be difficult for any human being to remain unperturbed". Furthermore, institutional settings require that at least one participant in the encounter be in charge of monitoring compliance with the pre-established rules conventionally associated with the institution at hand. In interpreter-mediated institutional encounters, institutional representatives share this responsibility with interpreters, whose task becomes twofold: indeed, linguistic transfer activities are combined with coordinating activities (*inter al.* Linell 1998, 74; Wadensjö 1998). When not implicit (Wadensjö 1998), coordination is explicit, namely "a meta-communicative activity, whose aim is to resolve communication problems by, for instance, clarifying, expanding, repairing, questioning, or formulating understanding of the meaning of conversational actions" (Merlini 2015, 106). Finally, there are other aspects involved in Dialogue Interpreting which can only be identified by extending the scope of the analysis beyond the interaction itself, to include the conversational history interpreters share with one or both interlocutors (institutional operators and foreign-language speakers), and interpreters' knowledge of rules and procedures of a given institution [5] (hospital, family counselling, police station, court, etc.). According to Merlini (2015, 106), mediation in this sense equates to a "double angle" kind of participation, with interpreters performing their professional tasks and, at the same time, becoming "fully involved in the interaction as social actors in their own right", whose involvement "may foster – or thwart – agency by primary participants".

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[5] Suffice it to mention instances in which operators give the interpreter mandate to act on their behalf (Angelelli 2004), or the cases of so-called "co-interviewing" (Davidson 2000, 388; Niemants 2015, 34, 82).

3. INTERPRETING IN INTERACTION

Examples in this section are taken from two interactions recorded at two different family counselling units in the city of Trieste, within the frame of a study on the quality of interpreting services provided by the association of linguistic and cultural mediators Interethnos Onlus. The study is currently being conducted on the resulting corpus, HCIQ.1415 ("Healthcare Interpreting Quality 2014-2015 Corpus"), which comprises both real-life interpreter-mediated doctor-patient interactions (HCIQ.1415_p) and classroom simulations of interpreter-mediated doctor-patient interactions (HCIQ.1415_s) that took place during the healthcare interpreting course offered at the Advanced School of Modern Languages for Interpreters and Translators (SSLMIT) - University of Trieste, during the same time period [6].

In the first encounter, the patient is a young woman who has recently moved to Italy from the Philippines to join her parents: she speaks very limited English, has given birth to a baby girl a few months prior to the consultation and has requested a gynaecological visit. The second encounter is a gynaecological visit as well, this time involving a Nigerian patient, who speaks English as her second language; in this case, the patient arrived in Italy as an illegal immigrant, but was immediately transferred by the Italian Ministry for Foreign Affairs to a local organisation providing accommodation and reception services in the city of Trieste, where she spent the eight months prior to the visit, and learned basic Italian. Both interactions involve a doctor (D), an interpreter (I), and a patient (P), although some of the excerpts only display portions of dyadic interactions between two of the three parties. Phenomena highlighted in the following sections have been classified using an integrated approach to the analysis, which combines traditional interactional observation elements (e.g. Angelelli 2004; Baraldi and Gavioli 2012 and 2016) and the cognitive approach – more specifically, Merlini and Gatti's (2015) trifocal model on empathic communication, as described in § 1 of this paper.

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[6] Both corpora were collected by the author, who is also the trainer responsible for the above-mentioned course.

3.1. *Expanded renditions and reformulations*

In the first excerpt (example [1]) [7] the doctor (D) asks the patient (P) about the delivery of her baby, and the interpreter (I) translates the question into English immediately afterwards.

ExAMPLE (1) D = Doctor; I = Interpreter

231	D	il parto com'è stato?
		the delivery how was it?
232	I	how was the: the delivery the birth? was it
233		long? was it ehm uneventful? was it natural?

I's translation is much more articulate compared to D's brief, open question. I formulates a series of clarifying questions aimed at circumscribing the object of interest and explaining the first translated version ("how was the: the delivery the birth?" line 232) by making its sense more explicit. The use of both the technical term "delivery" and the layman version "birth" seems to corroborate such a hypothesis, which points to the ultimate goal of obtaining the exact pieces of information D intends to elicit. The reason behind I's expanded rendition (Wadensjö 1998) may be due to the fact that I appreciates the need to make D's synthetic formulation more explicit, given the conversational history between them: indeed, D and I have been working together for at least three years at the moment the exchange was recorded, making it unnecessary for D to spell out her questions for I, who knows what is and is not relevant for D perfectly well. Moreover, I is aware of P's production and comprehension difficulties in English, as the two have met before, during an encounter between P and a social assistant.

In example (2), again, I seems to believe that a close rendition of D's question (line 90) would not project the answer D wishes for: therefore, after a moment of hesitation, I reformulates D's request with another expanded rendition (lines 91-93).

ExAMPLE (2) D = Doctor; I = Interpreter; P = Patient

90	D	che scuole ha fatto?
		what schools did she attend?
91	I	eh what school did you go to? ehm what's your eh
92		degree right now? did you have just high school
93		<o:r universi>ty as well?

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[7] Examples are taken from the transcripts of the two encounters described in § 3. Transcription conventions are illustrated at the end of the paper. Turns uttered in Italian are followed by their English gloss in italics on a sentence-by-sentence basis.

94	P	<yes high school>	high school
95	I	high school la maturità	
		high school degree	

These examples show I's attention and concern for the communication process: she is constantly ensuring mutual understanding, in order to reach the overarching goal of the ongoing interaction, namely obtaining P's case history. I then concludes her dyadic exchange with P, repeating her last utterance, thereby showing that she is fully focused on her interlocutor and signalling her understanding of P's answer; she then turns to D, providing the second item of the adjacency pair that was initiated on line 90. The "liminal turn" (Davidson 2002) on line 95 indicates that I is fully aware of the relationships between her and both D and P.

3.2. *Mandate*

I's reformulation (line 102) in example (3) not only responds to the needs expressed so far, but is also I's reaction to D's mandate [8] on lines 100-101.

EXAMPLE (3) D = Doctor; I = Interpreter; P = Patient

100	D		<ah> senti malattie nella
			<ah> look diseases in
101		famiglia sua **le solite**	
		*her family **the usual ones***	
102	I	mh mh are there any important diseases in your	
103		family? are there members of your family I don't	
104		know your grandparents that suffered from any	
105		particular disease	
106	P	my grandfather eh	
107	D	non piange per niente	
		she doesn't cry at all	
108	I	<SMILES>	
		<SMILES>	
109	P	<SMILES> heart	
		<SMILES>	
110	I	heart attack?	
111	P	yes	
112	I	suo: nonno è morto d'infarto	
		her grandfather died of a heart attack	
113	D	quale nonno?	
		which grandfather?	
114	I	eh the father of your father? or your or the	

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[8] In bold in the transcript.

115		father of <your mo>ther?
116	P	<mother>
117	I	<il: nonno mate>rno
		her mother's father
118	D	<madre> [...]
		mother

D addresses I with her initial words on line 101 ("<ah> senti" [ah look]), selecting her as both interlocutor and collaborator. The following utterance ("malattie nella famiglia sua le solite" [diseases in her family the usual ones]) is formulated just like a regular mandate: D does not ask I to 'say' something, but rather to 'do' something. This hypothesis is corroborated by the use of the third person singular to address I, turning her into D's primary interlocutor. Diseases are referred to as "le solite" (the usual ones). Such use of a noun adjective in its plural form indicates D's assumption, possibly even certainty, that I is familiar with the context and the tasks to be carried out. In other words, D transfers part of her competence as healthcare provider (see Angelelli 2004) to the interpreter, who accepts, thus turning into "co-interviewer".

Example (4) is an excerpt from the second consultation, namely the one involving the Nigerian patient, and contains a mandate in P's turn at line 139.

EXAMPLE (4) D = Doctor; I = Interpreter; P = Patient

139	P	**can you tell her about** XXX
140	I	yes I'm going to tell her ehm in particolare aveva anche una
		in particular she also had a
141		preoccupazione più recente nel senso che in questi giorni è successo
		more recent concern in the sense that in the past few days it happened
142		sia la settimana scorsa che l'altro ieri eh: al mattino ha visto che
		both last week and the day before yesterday in the morning she saw that
143		sanguinava però non era un sangue da mestruazioni era un sangue molto
		she was bleeding but it was not menstruation blood it was very
144		denso e: aveva male all'altezza dei fianchi non è stato neanche un
		thick and she was hurting in her hip area also it was not
145		sanguinamento continuo nel senso che (.) andava così a episodi però
		continuous bleeding either in the sense that it came in episodes but
146		questo proprio sangue denso (.) viscoso quasi
		this very thick blood almost viscous
147	P	the day before yesterday
148	I	eh esatto l'altro ieri
		exactly the day before yesterday

P addresses I directly, lowering the tone of her voice, and asking her to tell D about something unintelligible ("xxx" in the transcript) they prob-

ably discussed while waiting for the visit (line 139). This hypothesis is corroborated by the fact that I immediately accepts the mandate, thereby showing that she knows what P is talking about ("yes I'm going to tell her" line 140), and turning to D immediately afterwards.

3.3. *Empathic communication cues*

Example (5), too, is an excerpt from the second consultation. I constantly reformulates D's words in order to clarify her suggestions, by using simpler words and metaphors. I's attitude corresponds to what Merlini and Gatti (2015, 146) call *perspective-taking cue*. Among the general group of "empathic communication cues", *perspective-taking cues* indicate all those instances in which interpreters check "understanding through requests for clarification, reformulation of speaker's utterances, elicitation of listener's questions; expressing understanding/approval of the other's point of view, reassuring, encouraging, offering advice" (Merlini and Gatti 2015, 146-147).

EXAMPLE (5) D = Doctor; I = Interpreter; P = Patient

248	D	lei ha una buona copertura antibiotica eh quindi non dovrebbe
		she has a good antibiotic coverage so she should not
249		avere preoccupazioni di questo tipo però (.) misurare la febbre bere
		have this kind of concerns but take her own temperature drink
250		molta acqua adesso
		a lot of water now
251	I	mh mh
252	D	molta acqua un litro e mezzo al giorno è poco (.) urinare tanto
		a lot of water one and a half litre a day is too little urinate a lot
253		per pulire l'urina eccetera
		to clean her urine etcetera
254	P	my urine is colour yellow
255	I	la ecco le urine sono molto gialle dice
		the actually her urine is very yellow she says
256	D	eh ma quanto beve
		uh but how much does she drink?
257	I	ah did you do you drink a lot of water
258	P	I can't remember but not too much
259	D	<eh:>
260	I	<well you should drink a lot> one litre and a half **one big bottle**
261		**and one small bottle** at least <every day>
262	D	<le urine
		concentrate> quando si aiuta un'infezione bisogna stare
		her urine

		concentrated when you help an infection you must pay
263		attenti eh perché vedi e vanno solo diluite con l'acqua per quello hanno
		attention uh because you see and they can only be diluted through water this is why they have
264		quel colore forte giallo
		that intense yellow colour
265	I	because there was an infection and now everything all this waste
266		is being expelled through your urine but you have to help it by diluting
267		it with water so drink a lot of water that could be the cause you know
268		that could be because and also check your fever every time you think
269		you have to check it because it is important to know if your body is
270		fighting against an infection or not

D explains dehydration to P, telling her that an infection could result in a higher concentration of urine, which must therefore be diluted by increasing P's water intake (lines 248-253 and 262-264). D's explanation is strictly clinical, whereas I's rendition is more instruction-like: she focuses on the operative aspects of D's turn, by adding the "bottle of water" metaphor (lines 260-261). Such addition ensures that P has all the necessary elements to change her incorrect behaviour and starts hydrating properly, thanks to the explicit quantification of the correct water intake ("one big bottle and one small bottle at least everyday"). Furthermore, when translating D's following turn (lines 262-264), I produces a *perspective-taking cue*: while retrieving the previously omitted content (line 268), she adds a further explanation to D's words, suggesting that P's weakness (which she mentioned previously) is probably due to the fact that she does not drink enough water, thereby providing further motivational elements that should encourage P to correct her behaviour (lines 265-270).

Example (6) is a case of *non-verbal cue* (Merlini and Gatti 2015, 147), namely the empathic communication cue expressed through "eye contact, facial pleasantness, smiling, laughing, head nods, frequent and open hand gestures, touching". I uses her laughter to mitigate P's embarrassment and sense of awkwardness resulting from the discussion of her bodily functions. P is not a native speaker of English and appears to be unfamiliar with the verb "evacuate" (line 633), which I uses to specify the kind of bodily function she is referring to when talking about going "to the bathroom" (line 632). I therefore chooses to clarify her question by using the colloquial English "pee" (pipi) and the referent "B" (line 639) to replace the word "faeces"; she then repeats the question replacing "pee" with "A" ("A or B" line 641) and combining her words with a deictic, pointing at the body parts responsible for each function, respectively. This strategy not only removes the elements causing embarrassment and threatening P's

positive face, but also reduces the distance between I and P, establishing a kind of complicity between the two, while facilitating communication and eliciting the desired piece of information.

EXAMPLE (6) D = Doctor; I = Interpreter; P = Patient

632	I	ehm can you when you go to the bathroom do you go regularly like
633		do you evacuate regularly
634	P	XXX toilet
635	I	yeah toilet
636	P	like today I XXX twice today
637	I	twice
638	P	yeah XXX
639	I	(.) to do (.) pee or B
640	P	XXX LAUGHS
641	I	A (POINTING AT HER FRONTAL GENITAL AREA) or B (POINTING AT THE CHAIR SHE IS SITTING ON AND SLIGHTLY TURNING HER BACK)
642	P	LAUGHS
643	I	LAUGHS
644	P	LAUGHS B
645	I	B (.) no no va regolarmente addirittura oggi è andata due volte di *B no no she evacuates regularly today she even had to*
646		corpo *evacuate twice*
647	P	LAUGHS

Finally, example (7) effectively illustrates the third kind of empathic communication cues: the *attentive listening cues*, namely I's turns "confirming understanding through feedback tokens (mhm, yes, right, etc.) to invite the speaker to continue" (Merlini and Gatti 2015, 146).

EXAMPLE (7) D = Doctor; I = Interpreter; P = Patient

392	P	XXX is it normal someone get a bleeding I don't know if someone
393		is pregnant XXX I was pregnant I had no sign of pregnancy yet <XXX>
394	I	<yes yes I remember I remember>
395	P	some things is it possible that someone's pregnant without
396		those signs of pregnancy
397	I	and you still have the bleeding
398	P	bleeding
399	I	siccome ehm era già rimasta incinta in passato e aveva abortito *since she was already pregnant once in the past and she had an abortion*
400		ehm però quella volta diciamo aveva avuto dei sintomi molto chiari le si era irrigidito il ventre le *but then let's say she had very clear symptoms her belly became rigid she*

401		si erano <gonfiati>
		had swollen
402	D	<sì>
		yes
403	I	i seni eccetera
		breasts etcetera

Once again, P refers to her past, relying on I's previous knowledge of her clinical history, to provide a basis for her question ("is it normal someone get a bleeding" line 392; "is it possible that someone's pregnant without those signs of pregnancy" lines 395-396). I immediately reacts by providing positive feedback through her *attentive listening cue* "yes yes I remember I remember" (line 394) and, subsequently, completing P's turn by making her question more explicit ("and you still have the bleeding" line 397). Once I obtains P's confirmation, with the latter echoing her wording ("bleeding" line 398), she turns to D and explains the origin of P's doubts by providing additional details regarding P's past (lines 399-401).

4. Concluding remarks

Despite the limited set of examples presented here, some tentative conclusions may be drawn.

Bilingual healthcare interaction as a form of institutional talk-in-interaction does appear to include a series of procedures, arrangements and actions "designed to reduce the distance between two (or more) poles of otherness" (Panthier 2015, 1), and that are by no means limited to inter-linguistic transfer. Data shown here seem to corroborate the idea that language, formerly downgraded to mere code, has a greater value, which emerges in dialogue as verbal exchange between human beings, whose talk expresses language as well as culture (cf. Sapir [1931] 1972); as a result, many traits that could be linked to the act of (Dialogue) Interpreting and that have been rejected in the past as irrelevant, owing to a limited perspective on language, are actually an integral part of the dialogue interpreter's day-to-day practice and, more importantly, are essential to achieve efficient communication. This may be a consequence of the previously mentioned bipartite nature of professional discourse in interpreter-mediated healthcare communication. I's renditions clearly demonstrate that interpreting instances cannot be avulsed from the communicative situation it originates from (e.g. Wadensjö 1998; Angelelli 2008). Expanded renditions and reformulations (examples [1] and [5]), for instance, alongside every aspect

pertaining to coordination, depend on the very interaction the interpreter takes part in, and within which she acts on various levels of intervention according to the interlocutors' moves (cf. Katan 2011).

Examples also show the tendency by the interlocutors to assign institutional tasks to the interpreter, identifying her almost as a member of staff. Mandates may be considered the way interlocutors renounce direct interaction with each other, or their refusal to constantly repeat instructions and explanations to the interpreter, who already knows what she has to do. This tendency confirms that interpreters are perceived by institutional operators as fully-fledged and active participants, especially as far as each single task is performed, e.g. collecting a patient's case history. There are also cases where it is the foreign-language speaker who addresses the interpreter directly, treating her as a consultant or confidant (Merlini 2009), in other words, asking her to act as someone else. This understanding is the ultimate litmus test for the delusional idea of "faithful translation" based on literality, and its opposite, namely what Hale (2007) calls "pragmatic translation", for instance. Moreover, it points to the need of considering Dialogue Interpreting as first and foremost a social activity (Straniero Sergio and Falbo 2012; Angelelli 2014), whereby the fundamental right to access to public services – in this case, healthcare – is granted to all, efficiently and effectively.

Selected examples also point to the interpreter's awareness of her interlocutors – who they are, what their goal is, and why her presence within the interaction is necessary. This is reflected in I's translation, which may be considered accurate *and* adequate to the exchange, precisely *because of* the specific communicative situation it fits into. It entails cultural elements, such as the illustration of possible schools attended in order to elicit P's answer about her degree (example [2]), or I's familiarity with the case-history procedures (example [3]). Moreover, the interpreter's awareness and her recipient-designed turns include instances of self-initiated perspective-taking activity: she reformulates the patient's utterances, establishing intertextual links that provide for further motivational elements that should encourage the patient to correct her behaviour (example [5] *perspective-taking cue*); she uses laughter to mitigate the patient's embarrassment and sense of awkwardness resulting from the discussion of her bodily functions, combining her words with a deictic, pointing at the body parts responsible for each function (example [6] *non-verbal cue*); and she provides positive feedback, confirming her understanding of the patient's questions and references, subsequently completing the patient's turn by making her question more explicit (example [7] *attentive listening cue*).

The tentative application of Merlini and Gatti's (2015) theoretical framework for the observation of empathic communication seem to confirm the authors' hypothesis:

> [...] cognitive perspective-taking capability, entailing an understanding of the other's situation, along with a degree of other-oriented concern communicated through carefully selected affective displays. These do not include sympathetic moves of experience sharing which, in the institutional context under study, would shift the focus away from both the recipient of medical care and the problem-solving task. [...] Thus qualified, empathy is seen as beneficial for professional relations in healthcare encounters, as it contributes to the achievement of their ultimate goal, namely the well-being of the patient. (Merlini and Gatti 2015, 154)

This study hopefully provides corroborating evidence of the benefits of accurately analysing actual occurrences of interaction that see dialogue interpreters at work (cf. Dal Fovo and Niemants 2015a), to describe the reality of the profession through actual discourse practices, with the aim of bridging the gap between theoretical assumptions and the real-life world.

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APPENDIX

Transcription conventions

Capital initial	Proper names of people, institutions places, ...
(.)	Silent pause. According to the analysis requirements, pauses may be quantified by replacing "." with the relevant duration in seconds
wor-	Truncated word
X	Unintelligible syllable
XXX	Unintelligible word
(wo)rd	Unintelligible phonemes, which do not, however, prevent the intelligibility of the entire word uttered
Word.word.word	Syncopated, "robotic" rhythm
CAPITAL	Throat-clearing sounds, swallowing sounds, laughter, heavy breathing, cough, applause, interpreter's comments, microphone noises ...
Eh, ah, ehm	Vocalized hesitations and filled pauses
Number	Numbers are transcribed in letters
a: word: word:::	Vowel or consonant lengthening
/variation 1, variation 2/	Ambiguous segment (multi-transcription)
((gesture))	Proxemic elements
→word word←	Fast(er) elocution rhythm
←word word→	Slow(er) elocution rhythm
(?) Ex: word (?)	Metathesis, anticipation, transposition and possible typographical errors
A: dgjioegj <dghdjk> B: <jkgkfg>	Speech overlap
Name (pronunciation: ------)	Incorrect pronunciation of proper names: the standard orthographic indication is followed by the altered one in brackets