Negotiating Renditions in and through Talk: Some Notes on the Contribution of Conversation Analysis to the Study of Interpreter-mediated Interaction

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Abstract

Conversation Analysis has shown that the system of turn-taking results in the construction of meaningful actions in conversation. Turns are not independent units; they both project new contributions and display reactions to previous ones. Contributions to talk are thus the result of complex mechanisms of negotiation and make sense in reference to each other. Davidson (2002) shows that the common difficulty in conversing through an interpreter consists in establishing reciprocity of understanding between the primary interlocutors and suggests that models need to be developed that take into account the necessity of constructing reciprocal understanding. On the basis of an analysis of audio-recorded and transcribed interpreter-mediated interactions in healthcare, this paper shows that interpreters' contributions are not free from the conversational system of turn-taking. Rather, the meaning of interpreters' actions (renditions or non-renditions) is achieved locally, in the turn-taking system and in reference to the goals that are interactionally established in and through the sequences.

Keywords: dialogue interpreting, interaction, mediation, triadic/dyadic talk, turn-taking.

1. Introduction

The concept of turn-taking (Sacks, Schegloff, and Jefferson 1974) was developed inside Conversation Analysis (CA) and accounts for participants'

systematic contribution to talk. In talk, the turn-chaining is such that participants, on the one hand, make evident what they expect from the next interlocutors' contributions (e.g. when asking questions), on the other hand, they react to previous interlocutors' utterances (e.g. responding). Individual contributions are thus clarified only in reference to the others. CA provides an attempt to describe conversation through the perspective of those engaged in talk by looking at their reactions and responses: it is assumed that such reactions and responses display the participants' understanding of what is going on in conversation, what they are making out of the communication event. It follows that talk is not explained in reference to expectations inherent to a particular context or setting; rather, conversation shows how possible expectations are understood and enacted (or not enacted) in the interaction. Participants in conversation are seen as mutually orienting to each other and collaborating in order to achieve communication. What they say, how and when is the result of this joint work.

In this paper, I suggest that since dialogue interpreting involves at least three participants taking turns to talk, it can be analysed as a form of turn-taking system. Looking at the ways in which participants design their contributions in reference to each other may be of help when considering much debated issues, such as those concerning the opportunity and even the legitimacy of the (occasional) engagement of interpreters in monolingual talk with one of the participants. My research is based on an analysis of audio-recorded and transcribed interpreter-mediated interactions in healthcare. It shows two sequential mechanisms, which seem to make up for participants' alignment to (a) triadic, (b) dyadic talk. In section 1, I briefly illustrate the debate on organizing models in dialogue interpreting; in section 2, I discuss the concept of coordination (Wadensjö 1998) and its importance in viewing dialogue interpreting as a form of interaction. In section 3, I describe my research project and my data, and in section 4, I illustrate two different mechanisms of turn-taking. Some concluding remarks will follow.

2. Organizing models in dialogue interpreting

Orienting models of dialogue interpreting have maintained that interpreters need to "interpret and translate truly and faithfully, to the best of one's ability, without anything to be added or omitted; summarizing only when requested" (Corsellis 2009, 43). Features of talk like interjections, feedback or hesitation have been recognised as meaningful items and interpreters'

guidelines have given increasing attention to their correct interpretation (see Hale 2007). The meaning that these functional items give to and take from the turn-chaining has however been largely overlooked. Turn-taking models provided for in interpreting codes suggest that interpreters ideally need to contribute their renditions after each of the other participants' turns, more or less independently of these turns' meanings and functions. While the meaning and function of turns affect the content and form of renditions, it is quite a clear assumption in interpreter guidelines that renditions should in any case be provided after each turn.

In a thorough reflection on models for the construction of conversation in interpreted discourse, Davidson (2002) highlights two foregrounding assumptions in talk: (1) participants, speaking or listening, are equally engaged in the ongoing process of constructing conversational meaning, and (2) in order to negotiate and capture the meaning of an utterance produced within an ongoing discourse, one must be a participant in the discourse itself. Davidson argues that the actual system of conversation is such that, in order for communication to take place, participants need to construct a shared ground which allows them to achieve reciprocal understanding. He shows that the common difficulty in conversing through an interpreter is based largely on establishing reciprocity of understanding between the primary interlocutors (Davidson 2002, 1274-1275). He thus proposes a more flexible model where rendition "after each participant's turn" may, on occasion, be interrupted by monolingual sequences involving the interpreter and one of the participants in clarification of the meanings and functions of contributions. This model thus accounts for the possibility that monolingual talk is used to secure mutual, reciprocal understanding. Davidson's model legitimizes interpreters to work on what participants 'are trying' to say, thus assuming that not all turns at talk are clear, precise and self-standing, and that capturing the meaning of what participants want to say may involve some conversational work.

Davidson's study accounts for experience emerging from work in public service interpreting. Metzger (1999), for instance notes that professionals working in the public service need, on occasion, to talk with participants individually to respond to their questions or solve their doubts. On these occasions interpreters' responses fulfil interactional requirements and non-responses "actually cause more interactional problems than do responses" (Metzger 1999, 158). In medical settings, it was found that patients' contributions are not always straightforward and interpreters need on occasion to interpret patients' hesitation or help them find the words to say what may be emotionally difficult to say (Englund Dimitrova 1997). The model proposed by Davidson then highlights: (a) that inter-

preters need to participate in talk as active responders; (b) that their participation is necessary to achieve reciprocal understanding.

While Davidson's idea conceptually accounts for talk dynamics characterizing interaction in interpreter-mediated bilingual talk, his actual model risks presenting interpreters' engagement in dyadic talk as 'unusual'. Although functional for the achievement of understanding, these dyadic sequences may be seen as a way to cope with 'accidents' in talk. So while they allow for spaces where reciprocal understanding can be accomplished, there is a risk that their function may be seen as simply that of dealing with current or potential misunderstanding, thus supporting the idea that the 'standard' model for turn-taking in interpreter-mediated interaction is turn-after-turn rendition. Here, I argue that while the remedial function is definitely one of the functions of dyadic sequences in interpreter-mediated interaction, it is not the only one and that relevant organizations of sequences, be they triadic or dyadic, are negotiated and shared by the participants in talk, in their attempt to accomplish what they understand to be the goals of the interaction.

3. Coordination

The idea of considering dialogue interpreting as a form of talk is not new in interpreting studies. Wadensjö's volume, published in 1998, offers, in fact, the first and most influential study which looked at dialogue interpreting as interaction. Wadensjö analyses recorded and transcribed conversations involving interpreters in Swedish institutions and provides a taxonomy of interpreters' contributions to talk, ranging from what she calls 'expanded' renditions (adding e.g. explanation or clarification to the original text) to 'zero' renditions (where no rendition is provided on the realization that the original text is already clear to the interlocutor). Although showing many functions of interpreters' contributions, Wadensjö's list can possibly be divided into two main groups: contributions that are *renditions* of previous talk, and those that are *non-renditions*. While renditions provide (modified) versions of original utterances in the other language, non-renditions account for interpreters' interventions such as requests (e.g. for clarification or for time to translate) or comments (e.g. to clarify the sense of talk).

Analysing the functions of renditions and non-renditions, Wadensjö distinguishes between two highly interdependent interpreters' activities in talk, translating and coordinating. While interpreters normally take

their turns to translate their interlocutors' utterances, such utterances need to be adjusted and explained in order to make their sense clear in communication. Renditions, even when modified and adapted, are often not enough to accomplish such tasks and interpreters need to engage in more explicit coordination activity. Coordination is thus the activity through which interpreters make the meaning of utterances clear in the interaction. In short, interpreters display their 'interpretation' of what is going on in talk and make it evident to the interlocutors.

It should be clear from the discussion above that coordination is a feature of turn-taking organization. In order to achieve reciprocity, in Davidson's terms (2002), participants need to display to each other the sense of the talk and how they understand it. In particular, by responding in turns participants 'tell' each other not only what is in the turn's content, but also what is relevant to say/do at that precise point in talk and what they expect the others to do. This provides for a system in which the participants not only achieve shared understanding but they also organize and establish what is relevant to do and thus legitimize appropriate actions in the interaction (see e.g. Heritage 2013). Insofar as the interpreter is the only interlocutor in the interaction who has access to both languages s/he may be the one invested with a particularly arduous coordinative function in communication.

As recently noted by Baraldi and Gavioli (2012), coordination can be considered as a form of 'communication on communication'. Studies in pragmatics and discourse show that meta-communicative activities play a fundamental role in communication and that a large amount of what we do in communicating consists of 'telling' each other what we are doing (for instance through text organization, discourse markers, invitations to talk, formulations, etc.). In this sense coordination is not a side activity, nor a remedial one, but is quite central to the construction of talk. Looking at coordination in interpreter-mediated interaction provides suggestions not only about how understanding is achieved, but also about those actions that are 'called for' and systematically pursued by the participants (together) in talk. This involves what is said in the turns, but also what is expected in and for the goals of the (institutional) interaction (see Mason 2006).

4. Project and data description

Interpreting for public institutions is a well-established service in North America, North Europe and Australia (Carr et al. 1997; Roberts et al.

2000; Hale 2007; Corsellis 2009). In countries with more recent immigration experience, such as Italy and Spain, the need to find a rapid response to an increasing demand for services in the public sector on the part of migrants has brought about, on the one hand, a search for cost-effective solutions, on the other, a major preoccupation with the need to ensure positive intercultural relationships. This combination of emergencies, possibly added to the necessity of interpreting in and from a variety of languages and dialects which are not traditionally taught in language or interpreting academic courses, has led institutions to rely on services of 'intercultural mediation' (see Martin and Martì 2008; Ortega and Foulquié 2008; Merlini 2009). Intercultural mediators are bilingual speakers, normally with a history of migration, who are employed and trained by the institutions to facilitate communication between institutional operators and migrant patients and although they are called 'mediators', they de facto provide interpreting service (see e.g. Baraldi, Barbieri, and Giarelli 2008; Luatti 2011).

The data examined in this study involve intercultural mediators and were collected in the course of a long-term research study based on a collaboration between academic researchers and local healthcare services, which are among the most advanced in Italy in their attention to migrants (see Chiarenza 2009). The study is carried out with the specific goal of providing suggestions to healthcare professionals and to the staff of mediators to ameliorate patients' participation and involvement. Its long-term research purpose is to develop guidelines and training programs for both medical staff and mediators.

The whole corpus consists of 300 interpreter-mediated consultations recorded in Italian healthcare services, most in maternity/gynaecological settings. The data involve three main groups of patients: Arabic-speaking patients from North Africa (about 80 interactions), Mandarin-Chinese speaking patients (about 70 interactions) and English-speaking patients (about 150 interactions). In this paper, I shall focus on the last-named set. The patients in this set are from English-speaking West Africa, mainly Ghana and Nigeria. The mediators involved are three, all women in their thirties, one from Ghana and two from Nigeria. They speak Italian and English well, have resided in Italy for over ten years and have worked for these services for over five years at the time of recording. In line with the convention adopted at their working place, I here will refer to them as 'mediators'.

To minimize the intrusiveness of data collection, the consultations are audio- not video-recorded. Transcription conventions are those commonly used in Conversation Analysis (Jefferson 1978; Psathas and Ander-

son 1990; and see also Niemants 2012). An English literal translation is provided in italics below each turn in Italian. All personal details have been altered in the transcriptions to protect participants' anonymity.

5. Two turn-taking mechanisms

As mentioned above, the organization of talk in dialogue interpreting has been lengthily debated in the literature. Engagement of mediators in dyadic talk with one of the participants has been considered risky for the inclusion of the other participant (see e.g. Keselman, Cederborg, and Linell 2010) and there might be a loss in the interpreters' role, shifting form that of 'interpreter' to that of a social assistant, cultural broker or advocate (see Leanza 2007 and also Buri 2012, 50). Intercultural mediators' requirements, in particular, have focused on the task of 'mediating between cultures' more overtly than interpreters' requirements, which suggested that those criteria of impartiality governing interpreters' work might not be attended to in so called 'mediation' (see e.g. Merlini 2009; Luatti 2011; Baraldi and Gavioli in press).

In what follows, I shall discuss two interactional mechanisms that have to do with this debate. The first type of mechanism involves a triadic organization and participants orient to a turn-after-turn rendition organization. This mechanism is interesting in that it shows that even though intercultural mediators are believed to avoid rendition after each turn, there are occasions where their alignment to this mechanism is quite strong. The second mechanism has to do with engagement in dyadic talk but, as will be shown, even this mechanism is interactional, and as such, not dependent on single individuals' initiative. What I suggest is that, looking at the interaction, notions like that of 'cultural broker' or 'advocate' actually blur over. As observed by Mason (2006), in participating in the interaction, interlocutors react to previous actions and project the next relevant actions. In adjusting their actions to each other's contributions, participants display their orientations to what they understand to be the meaning and goals of their encounter. Local turn organizations thus show the participants' understanding of the contextual system they are engaged in. The contribution of CA is that of highlighting these local organizations and their functions in the interaction.

5.1. *History-taking sequences and participants' orientation to triadic talk*

As shown in the literature on (monolingual) medical talk (see e.g. Heritage and Maynard 2006), medical encounters can be divided into steps or phases corresponding to different medical activities. One such activity is history-taking. That is the phase in the encounter where doctors ask patients about their medical history, e.g. symptoms, life habits, relevant diseases in their families and the like (see e.g. Heritage and Robinson 2006). This activity is fundamental in medical consultations; from the point of view of the doctors, it gives access to 'facts' concerning the patients' medical and social background which can provide a context for making a diagnosis; from the point of view of the patients, it provides an opportunity to give all those details which might have a bearing on the patients' medical condition (Boyd and Heritage 2006, 152). History-taking sequences are organized to set precise agendas (see Robinson 2006) and to maintain a focus on 'fact-finding' (Gill and Maynard 2006).

In my data, history-taking sequences are systematically organized according to a turn-after-turn rendition pattern. This is observable through two main features. The first is that history-taking doctors' questions are recurrently rendered immediately after their proffering. The second is that 'immediate' rendition of the patients' turn, when not given, is pursued (see also Gavioli in press a). Some examples will make the point. Extract 1 shows a case where rendition is provided by the mediator first after the doctor's turn, then after the patient's turn. The doctor acknowledges the patient's answer rendition with a short rephrasing and passes to her next history-taking question.

Extract 1. D = doctor; M = mediator; P = patient.

117. D: Mangiare, bere, norma – tutto norm[ale? Riesce?
Eating, drinking, norma – all normal? Can he?
118. M: [Do you: eat (.) normally?
119. P: Sometimes (I can't very –) (.) eat.
120. M: A volte non ha l'appeti[to.
Sometimes he doesn't have appetite.
121. D: [Non ha fame. da – sempre da due settimane?
He's not feeling hungry. fo – this too for two weeks?

Even though not necessarily *very* frequent, this pattern can be considered the one participants favour in history-taking sessions. This is suggested by the following recurrent variants. One variant is that, after rendering the doctor's question in the next turn, the mediator renders the patient's

answer even when there is no necessity to render it, e.g. because the content of the patient's answer is perfectly understandable to the doctor. In Extract 2 below, patient's answer "no" in turn 37 is simply repeated by the mediator in turn 38 and acknowledged by the doctor in turn 39; in Extract 3 the patient's answer in turn 61 is in Italian ("ceramica"), but is 'rendered' (that is, simply repeated) by the mediator in turn 62 and acknowledged by the doctor in turn 63.

Extract 2. D = doctor; M = mediator; P = patient.

35. D: Invece malaria ha mai avuto epis:odi?
Instead malaria has she had episodes?
36. M: Have you had any malaria before?
37. P: No.
38. M: No.
39. D: = No? occhei. (.) ha mai avuto interventi chirurgici?
= No? okay. (.) has she ever had any surgery?

Extract 3. D = doctor; M = mediator; P = patient.

59. D: Che lavoro fa lui?
What job does he do?
60. M: What type of work do you do?
61. P: (.) Mhm:, ceramica.
Ceramics.
62. M: Ceramica.
Ceramics.
63. D: Mm. E ci riesce a andare e fare tutto quello che deve fa[re?
And does he manage to go there and do everything he is required to do?
64. M: [You:: you: manage

In Extract 2 and 3 above, then, the transparency of the patients' answers, using words that are the same in English and Italian or using Italian simply, could, but does not, prompt the doctor to intervene immediately.

A second variant is that the doctor does intervene after the patient's 'transparent' answer and displays that the answer does not necessitate rendition. In these cases, the doctors do not wait for a rendition by the mediator, but either propose one themselves or show that they can understand what was said by the patients. Here, we have an example of both cases. In Extract 4, the patient's answer in turn 40 is 'rendered' by the doctor in turn 41, while in Extract 5, the patient's answer in turn 346 is repeated, in English, by the doctor, in turn 347, displaying that the doctor knows what the disease mentioned by the patient is. See the highlighted turns below.

Extract 4. D = doctor; M = mediator; P = patient.

038. D: E l'ultima mestruazione?
And last menstruation?
039. M: Your last menstruation
040. P: (0.1) Twen – eh eh:: (0.2) six
041. D: **Sei?**
Six?
042. P: Six.
043. M: Sei [six of when
Six
044. P: [Sei
Six
045. D: Sei f – marzo?
Six f – March?

Extract 5. D = doctor; M = mediator; P = patient.

344. D: Malattie eredita:rie?
Hereditary diseases?
345. M: Is there any inheredited (sick –) sickness in the family? (0.5) like: eh: [(?)?
346. P: [(There is only) my daughter, (0.5) my uncle's daughter she: (0.6) she's born with a cleft li[ps.
347. D: **[Cleft [(.) lips! okey [okey okey!**
348. M: [O:kay o:kay (0.1) okay.

In both cases, and apparently independently of the intonation used, doctors' turns are followed by a confirmation by the mediator that the doctors' understanding is correct (see turn 43 in Extract 4 and turn 348 in Extract 5).

A third pattern suggesting participants' orientation to a turn-after-turn organization in history-taking sequences is the following. Here, as in the extracts above, the doctor's question is rendered immediately after the doctor's turn. The patient's answer in English is instead responded by the mediator in English. In these cases, doctors intervene, interrupting the 'dyad'. This is recurrently done by doctors displaying understanding of what the mediator and the patient are saying and the interruption is accepted by the mediators who systematically confirm doctors' understanding. Let us see two examples.

In Extract 6, the patient's answer in turn 27 is responded by the mediator in turn 28 with a partial repetition ("eight of") and a completion of the patient's answer in English ("March"). The patient confirms that the mediator's understanding is correct in turn 29 and the doctor

intervenes in turn 30 suggesting a rendition for the the patient's last menstruation date: "otto marzo". The doctor's contribution is confirmed by the mediator in turn 33 ("sì otto di marzo") and the question-answer sequence is closed here.

Extract 6. D = doctor; M = mediator; P = patient.

25. D: Allora. ultima mestruazione lei quando l'ha avu[ta
So. Last menstruation when did she have it
26. M: [Your last menstruation when did you see it.
27. P: I told you before. on the: eight (.) .hh
28. M: **Eight of (.) March.**
29. P: Mhm
30. D: **Otto [marzo**
Eight of march
31. M: [It was regular?
32. P: Yes
33. M: °Sì (.) otto di marzo°
Yes eight of march

Similarly, in Extract 7, the patient's answer in turn 12 ("condom") is responded to by the mediator with a request for confirmation. An intervention by the doctor follows in turn 14, displaying understanding of what was said in the patient-mediator turn-sequence (9-13). After this doctor's intervention ("utilizzava il condom?"), we have a subsequent history-taking question ("gli si è rotto?"). The mediator in turn 15 begins to render the latter question and then stops and confirms the doctor's understanding about the patient's use of condoms (the mediator's "sì" in turn 15 answers the first part of the doctor's question in turn 14 ("utilizzava il condom?"). See highlighted talk below:

Extract 7. D = doctor; M = mediator; P = patient.

08. D: Allora lei non ha mai utilizzato metodi contraccettivi?
So has she ever used contraceptive methods?
09. M: You've never used eh contraceptive or (.) something to prevent you From getting pregnant
10. P: Yeah
11. M: So what do you normally use? (.) for prevention
12. P: (?) condom
13. M: Condoms?
14. D: **Utilizzava il condom?** gli si è rotto?
Did she use condoms? did it break?
15. M: It broke – **sì**
Yes

In short, the set of extracts above shows one type of turn organization orienting interpreter-mediated history-taking sequences. Rendition is provided after each doctor's or patient's turn. Moreover, doctors recurrently anticipate the mediators by displaying understanding of what the patients said or interrupt mediator-patient dyadic sequences, even when very short, showing that they are participating in the triad. This organization seems functional to doctors' collection of details: doctors' questions are rendered immediately and patients' answers are captured by either an immediate rendition or by direct engagement of doctors in talk with the patients. As in monolingual conversation, history-taking questions are focused and project close answers ("yes"/"no", dates of birth, patients' job). Close answers provide details that, at least in English, are understandable to the doctors. Orientation to rendition 'after each turn' seems thus functional to maintaining a focus on these details and on 'fact-finding', apparently the main function in history-taking sequences.

5.2. *Participants' orientation to dyadic talk and the treatment of criticalities*

In doctor-patient interaction, the presentation and discussion of critical issues – that is issues which are delicate, problematic or very important for the patient's health – are not rare, and the ways in which such issues are dealt with in talk has been discussed to some extent in the literature (see e.g. Maynard's seminal work 1991). Silvermann and Peräkylä (1990) show that in interviews with HIV positive patients, delicate matters like sex or the prospect of death are recurrently introduced and accompanied by what they call 'perturbation', that is pauses or hesitations or other markers of talk signaling caution.

In my data, critical (or possibly critical) issues seem to be recurrently signaled by the doctors, who invite the mediators to intervene in talk and 'explain' such issues to the patients. That is to say, recurrently in my data, there are occasions when doctors 'call mediators in' and ask them to relay to the patients. Such 'calls' by doctors are systematically positioned at the beginning of the turn or the part of the turn that needs to be rendered. They take two forms. The first is an explicit invitation to the mediator to 'explain' or 'tell' the patient something, (e.g. "le spieghi"); the second, is a first person imperative, like "glielo diciamo" or "glielo spieghiamo". Extract 8 shows one example of the first form; extract 9 shows an example of the second.

Extract 8. D = doctor.

01. D: **Le spieghi** che adesso la mestruazione dovrebbe arrivare verso il venti venticinque di questo mese (.) potrebbe essere una mestruazione anche più abbondante del solito (.) ma di non preoccuparsi perché si deve svuotare a modo. Se ha molto male viene e ce lo dice.
Explain to her that *now her menstruation should come around twenty twenty-five of this month (.) it could be a more abundant menstruation than usual (.) but she doesn't have to worry as she has to discharge completely. If she feels a lot of pain, she comes back here and tells us.*

Extract 9. D = doctor.

01. D: Allora (.) volevo chiedere una cosa (.) lei eh::m (0.3) **glielo diciamo** anche se poi è molto molto limitata questa cosa = l'età non gl – non gl – non le dà le garanzie per potere fare (.) eh: qualcosa di (.) diciamo di accertamento genetico (.) però lei un – una: mh amniocentesi avrebbe ancora il <u>tempo</u> di farla (.) nell'eventualità (.) quindi –
So (.) I'd like to ask one thing (.) she er::m (0.3) ***let's tell her*** *even though there are many limits in this = her age is not such as to give her – indications to take anything (.) er: anything (.) let's say any genetic check-up (.) however she a – a: mh she may take an amniocentesis she is still in <u>time</u> to take it (.) just in case (.) so –*

Here, rather than simply speaking and stopping in order to allow for the mediator to intervene, as we saw in 4.1 above, doctors explicitly invite mediators to 'explain' or 'tell' the patients something. These doctors' invitations recurrently introduce a topic which is not a 'routine' one and in fact is critical or more complex than usual. This is clear in extract 8, where the doctor explains to the patient that her next menstruation, following abortion, may be particularly heavy and painful, and in extract 9, where the doctor's suggestion to have amniocentesis is given to a woman who is under the age normally indicated for this test. These doctors' turns are designed as invitations to the mediator to engage in telling the patient about a matter that may not be so 'smooth' and that may need to be treated with caution; they thus project the possibility for the mediators to engage in dyadic sequences with the patients to deal with the critical topic.

Possible uptakes of this doctor 'invitation' by the mediators are many and I have described them in detail elsewhere (Gavioli in press b). Here I shall illustrate just two of them. The first is when the mediator accepts the doctor's invitation and engages in talk with the patient. The second is when the mediator declines such invitation. I shall look at two extracts, one showing the first type of uptake and one showing the second type.

In Extract 10, below, the patient has insisted on medicine for a stomach ache. After examining her, the doctor decides to prescribe some, but alerts the patient that she should not overindulge in these pills since, in heavy quantities, they can damage her stomach seriously. The doctor then introduces her recommendation to the patient, with "diglielo" ("tell her", turn 1). The mediator takes up the doctor's recommendation and delivers it to the patient alerting her that this medicine needs to be taken carefully and in small quantities and she gives instructions about how to take the pills appropriately (one, after eating). The mediator finally reassures the patient that the doctors want her to heal ("they want the stomach pain stop and stop"); she underlines, in other words, that the doctor's advice to use the medicine sparingly is intended to benefit the patient (and not, e.g., to save medicines, as some patients seem to think).

Extract 10. D = doctor; M = mediator; P = patient.

01. D: Eh però anche lì, **diglielo** eh di prenderle poco perch[é dopo fa male lo stomaco eh cioè –
Eh even here, ***tell her*** *mh to take few of them beca[use then they hurt her stomach mh I mean –*
02. M: [The tablets she's giving you. You have to take it- you have to use them sparingly, you have to be very careful (.) because it will:: (.) ruin your stomach
03. D: [(??
04. M: [This tablet, so use it after eating, (if you want the stomach pain stop.) Then you go home,
05. P: Mm.
06. M: You eat, you take <u>one</u>. (.) (??) they want the stomach pain stop, and stop and stop and stop.
07. P: Ok, Thank you.
08. M: You're welcome.
09. P: Grazie.
Thanks.

The second type of uptake is when the mediator declines to provide extended explanation and basically limits her/himself to a rendition of the doctor's turn. There are just three instances of this type of uptake in my data but, interestingly, in all of them the doctor intervenes, in English, after the mediator's turn, to provide further comments, explanation and reassurance. Extract 11 below shows the doctor's contribution we have seen in Extract 8 and its continuation. It was noted above that, in this contribution, the doctor alerts the patient about something possibly unusual about her next menstruation: it may be more painful and heavier,

but this should not cause her to worry. The doctors' turn is opened with "le spieghi". The mediator's rendition provides a repetition of the doctor's words. Although nothing seems to be missing in this rendition, the doctor intervenes, in English, after the mediator. He provides further recommendation about how to avoid pregnancy and sexually-related diseases, and repeats that if the patient feels alright she needs no further assistance, otherwise she can get back to the medical service (see turns 3 and 5, below).

Extract 11 (*Extract 8* + continuation). D = doctor; M = mediator; P = patient.

01. D: **Le spieghi** che adesso la mestruazione dovrebbe arrivare verso il venti venticinque di questo mese (.) potrebbe essere una mestruazione anche più abbondante del solito (.) ma di non preoccuparsi perché si deve svuotare a modo. Se ha molto male viene e ce lo dice.
Explain to her *that now her menstruation should come around twenty twenty-five of this month (.) it could be a more abundant menstruation than usual (.) but she doesn't have to worry as she has to discharge completely. If she feels a lot of pain, she comes back here and tells us.*
02. M: The menstruation probably comes to twenty twenty-five of this month (..) you see a lot of blood but it's ok, it empties of everything. If you are not feeling well come back –
03. D: And use always condom, you know that now there is no kind of diseases, no HIV, no any other infection, but: you must be careful in order to avoid it in the future
04. P: Ok.
05. D: If you are right, if you don't feel any pain, we are going to see after a year.

The data shown above thus suggest that "le spieghi" or "le spieghiamo" may work as a device to signal that what is talked about may be more complex or problematic than usual and that the mediator may be required to contribute with 'more effort' and engagement in order to explain to the patient an issue which has been presented by the doctor as a possibly critical one. While in history-taking sequences, interruption of dyadic and alignment to triadic organisation seems to be systematically pursued, in the extracts we have seen here, we can observe quite the opposite orientation. Mediators are invited to talk with patients about possible criticalities introduced by the doctors and when they do not do that, doctors eventually engage in talk in English with the patients, displaying that a little more than just rendition may be relevant in these particular cases.

6. Conclusion

While obviously not conclusive, the data above suggest that talk organization displays participants' orientations to what they are doing in the interaction, in their accomplishment of particular goals. In history-taking sequences, which are aimed to collect patients' details with a focus on fact-finding, the organization of interpreted talk is such as to make rendition relevant more or less after each participant's turn. Mediators provide renditions systematically after their interlocutors' turns and the doctors intervene to anticipate mediators' renditions, showing understanding of what was said by the patients or attempting to render it. Dyadic sequences between the mediators and the patients are normally immediately interrupted and rendition of each detail is pursued in the interaction.

There are, however, occasions where other types of organization are sought and eventually achieved. Here we have seen one possible device by which doctors call for a mediator's contribution that is 'more than' the mediator's turn rendition. Doctors' "le spieghi(amo)" normally introduces lengthy explanations by the doctors which mediators are possibly invited to render to the patients "appropriately'. In these cases, engagement of mediators in dyadic talk with the patients is allowed and possibly sought by the doctors, who (a) do not interrupt mediator-patient talk and, (b) in those cases where mediators do not expand the doctor's turn content, provide further explanation and reassurance in English.

The analysis I illustrated above suggests that alignment to triadic or dyadic talk in interpreter-mediated interaction is probably related to more complex dynamics than those discussed in the existing literature on interpreting studies. While Davidson's observation that participants may occasionally engage in dyadic talk with interpreters to achieve reciprocity is supported by my analysis, a closer look at the data suggests that engagement in triadic or dyadic talk has a meaning that is attached to the specific function accomplished in the medical interaction, i.e. collecting details of patients' history or providing explication and reassurance on critical issues.

It can also be noted that dyadic talk sequences do not seem to be dependent on the role of mediators as compared to that of interpreters. Mediators in my data provide rendition after each turn or lengthier explanations (speaking with the patient only), according to a specific (and interactionally established) talk purpose. This suggests that the type of turn-taking organization participants adopt has functions affecting the types and contents of the mediators' renditions; in other words, alignment to triadic or dyadic talk is not an individual speaker's (or role's) achievement.

A feature of context which, however, seems to affect the interactional dynamics shown here is that the language used by the patients is English. Since English is a language Italian doctors are usually quite familiar with, language shift by the doctors (showing understanding of or speaking English) is used to make particular actions relevant. An interesting issue for further analysis may thus concern the actions used to construct history-taking or medical criticalities when other, less familiar languages are involved.

In conclusion, it seems to me that analysis of turn-taking in interpreter-mediated interaction may throw light on issues that have been debated as key ones in the literature on dialogue interpreting. These are concerned with interpreters' local participation in the interaction and the significance of their contribution in the accomplishment of medical assistance.

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