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Interactional constraints on interpreters' action: the case of clinicians' comments about cultural differences

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Abstract

For a while now, interpreter-mediated talk has been analysed as a form of interaction under the lenses of approaches based on recorded and transcribed data. These studies converge on the idea that making sense of the participants' contributions puts constraints on the interpreters' activity, leading them to choices of action like explaining, clarifying, making explicit what is implicit. This paper focuses on sequences involving clinicians, migrant patients and intercultural mediators and deals with instances in which clinicians' contributions heavily limit the interpreters' choice of action. The cases in question are sequences where clinicians comment on patients' different behaviour or habits. Our analysis looks at four types of mediators' reaction that we found in the data, all showing the challenges these comments create for the mediators' choice of action. We conclude that rendering is hardly an option and that while non-rendition may serve the purpose of protecting the patients from possibly offensive talk, it also hinders their involvement in the interaction, or their possibility of replying.

Keywords

Interaction, mediation, rendering, stereotype, migrant inclusion, interactional constraints.

Introduction

Studies on interaction show that contributions coming first in the talk sequence project particular choices of action and may thus put constraints on the contributions of speakers coming next. The action-projection mechanism is a key notion in Conversation Analysis explaining systematic organization of some sequences in talk, for instance the question-answer sequence in medical talk (see e.g. Heritage/Robinson 2006; Heritage 2009). Mason (2006) has discussed the conversation analytic approach as applied to sequences of interpreter-mediated interaction. His discussion has mainly focused on *relevance*, i.e. the way in which interlocutors' contributions make particular responses relevant (or necessary) as well as the way in which particular interlocutors' contributions are made relevant (by other speakers) in subsequent talk. In the case of interpreting for instance, assigning a meaning to an interlocutor's contribution through rendition is a way of making that contribution's meaning relevant in the subsequent interaction. Mason describes the mechanism in terms of both projection of action and projection of expectations. In both cases, projection does not determine interpreters' responses, but often orients them to take particular actions in the interaction. These may include explanations, clarifications or making explicit what is implicit. It follows that, in responding to interactional requirements, interpreters make choices that may produce changes in the communication process (for instance when expansions are given for explicating implicit habits). It is these choices which allow for interpreters' coordination of the interaction (Wadensjö 1998). When interpreters' choices are change-producing (e.g. re-involving an interlocutor who was at risk of exclusion or making some habit understood by those who do not share it), they show interpreters' exercise of agency (Baraldi 2019).

This paper focuses on the work of so-called intercultural mediators, that is bilingual staff employed in Italian health care to provide an interpreting service. We concentrate on sequences in which problems related to patients' unusual behaviour, knowledge or expectations are raised by the clinicians during mediated interactions. Even though Italian mediators are specifically employed by the services to deal with intercultural problems (hence the name *intercultural mediators*), when clinicians offer comments about patients being 'different', mediators in our data are put under serious constraints, eventually preventing them from rendering these comments to the patients. Occurrences of clinicians' comments highlighting patients' cultural differences are luckily not at all frequent in our data. We however, find them worth considering because they systematically limit the mediators' choices of action. In particular, possibly treating these comments as potentially offensive, mediators never render them to the patient. We suggest that this systematic mediators' response provides for reflection about both the occurrence of these clinicians' comments in interaction with migrant patients and their treatment in rendition.

1. Theoretical overview: agency, mediation and intercultural issues

The concept of interpreters' agency in coordinating interactions is frequently associated with the idea that interpreting includes forms of mediation. While views of interpreters' agency vary (see Tipton 2008; Baraldi 2019), agency is in fact clearly visible when interpreters do something more than plainly repeat what was said in one language into another. The concept of interpreters' agency can thus be considered implicit to mediation and involves interpreters' choices that can change the course of the interaction (Baraldi 2019), with more or less effective consequences for the communicative exchange. Studies of naturally occurring interpreter-mediated conversations (see, among others, Angelelli 2004; Inghilleri 2005; Tipton 2008; Mason 2009; Mason/Ren 2012) have noted the interactional impact of the interlocutors' contributions on each other and have discussed ways in which interpreters may or may not achieve interlocutors' active participation and mutual understanding.

The issue of interpreters' agency in mediating talk is rather controversial, particularly in medical encounters. Preliminary studies by Bolden (2000) and Davidson (2000) showed that interpreters exercising agency, for instance to modify laypeople's language into medical jargon, or to summarize patients' storytelling, in fact impeded access of clinicians to patients' provision of details which were often significant. Interpreters' engagement in talk with one of the interlocutors was found both critical, for the risk of excluding one of the interlocutors (Valero-Garcés 2007), and necessary for example for making contents clear (Davidson 2002), supporting patients when they hesitate to speak (Pasquandrea 2011; Gavioli 2012), or creating empathy (Penn/Watermeyer 2012; Merlini 2015). More recent studies show diverse ways in which interpreters exercise agency, by collaborating with doctors giving instructions (Bolden 2018), taking patients' histories (Gavioli/Wadensjö 2021) and even creating rapport (Wadensjö 2018).

While on the one hand, mediation involves interpreters' exercise of agency in clarifying issues, positions and rapport, on the other, it has traditionally been associated with a specific function of interpreting, that of translating so-called "cultural" differences. As Wadensjö (1998: 277-278) notes, interpreting "makes it possible to identify [...] non-linguistic differences between people – differences in world view – which make shared understanding between them difficult to achieve despite the interpreter's bridging of the language gap" and observes that, for this reason, interpreters "cannot avoid functioning as intercultural mediators" (Wadensjö 1998: 75). In his thorough reflection on interpreting as mediation, Pöchhacker (2008) similarly shows that there are different dimensions of mediation in interpreting, including intercultural bridging and adjustment of social imbalances. Intercultural mediation, he argues, "is necessarily a matter of social relations – an interpersonal interaction for which the interpreter is contracted to mediate" (2008: 16). Interpreting thus includes mediation inside the complex process of translating across languages and cultures.

The issue we address in this paper is related to the intercultural-mediation component of interpreting as described above and the case we make is related to explicit mentioning of cultural differences in the interaction, which defines

communication as intercultural in the proper sense. There are probably two ways to define intercultural communication in this perspective. On the one hand, intercultural communication can be viewed as the result of encounters between culturally different individuals (e.g. Spencer-Oatey/Franklin 2009; Samovar *et al.* 2013). Holliday has criticised this approach, which he sees as a form of cultural essentialism. This definition, he argues, presents "people's individual behaviour as entirely defined and constrained by the cultures in which they live so that the stereotype becomes the essence of who they are" (Holliday 2011: 4). An alternative, constructivist way of looking at intercultural communication is to regard it as mutual negotiation of cultural differences (Baraldi 2015). Holliday (2011) distinguishes between the two alternatives by describing the former as "big cultures" and the latter as "small cultures". While in an essentialist view big cultures are intended as predefined in some national or ethnical context, in a constructivist view the negotiation of cultural differences is produced at a small level, as contingent and negotiated inside specific groups or activities. In these negotiated constructs, cultures may be shaped in different ways, becoming either a block for the interaction (when constructed as big) or a thread for effective inclusion and understanding, when culture is constructed as part of personal being (Amadasi/Holliday 2017). The reproduction of essentialist assumptions in institutional interactions clearly blocks communication, since the interaction reproduces group stereotypes (referring to big cultures), thus impeding the participants' expression and negotiation of their personal trajectories in specific activities or small groups (e.g. in health care meetings).

Here we look at sequences where intercultural differences related to big cultures are raised by clinicians providing comments on the patients (their behaviour, habits or features), thus giving the mediators the task to deal with them in the small context of the encounter. While these occurrences are not frequent in our data, we will see that the constraints they put on interpreting are heavy and definitely not easy to mediate, leading to an interactional construction of stereotype. The occurrences are not many, but they are all consistent with Holliday's idea that reproduction of essentialist assumptions blocks communication and thus impedes negotiation of cultural differences as acceptable alternatives.

2. Intercultural mediation: the Italian case

In Italian healthcare services, interpreting is provided by so-called intercultural mediators. While the label on the one hand underlines the interest of healthcare services for the intercultural component of interpreting, on the other it minimizes the complexity of the interpreting work proper and for this reason the Italian choice has been widely debated in the literature (e.g. Pittarello 2009; Merlini 2009; Baraldi/Gavioli 2012a; Falbo 2013). In his study on mediation, Pöchhacker (2008) argues that such a suggested dichotomy between interpreters and mediators is highly undesirable, since it deprives both professionals of most fundamental skills, which are indeed to be trained jointly if the target is to have professionally prepared staff.

Pöchhacker's position (2008) is that interpreters should be trained to use mediation appropriately in that mediation is inextricably connected with interpreting: it is part of it, not a separate skill. The conception of intercultural mediators' professionalism, instead, is definitely more controversial (for a very critical approach, see Pokorn/Mikolic-Juznic 2020) and not without problems, the major one probably being the extreme variety of skills, education, and competence of Italian healthcare interpreting mediators. At present, however, Italian healthcare services are still working with mediators while training programmes have increasingly been launched to provide such staff with adequate competence (see Chiarenza 2020).

Against this controversial background, our research has observed interpreting work provided by experienced and trained intercultural mediators. Our assumption has been that observing their work through recorded and transcribed naturally-occurring interactions might reveal strong and weak points of their *doing interpreting* in a perspective where provision of cultural mediation is an explicit institutional requirement. In our studies up to now, we have mainly focused on encounters showing effective dynamics of language mediation, for three reasons. First, effective dynamics are the most frequent in our data and they represent what normally occurs in mediated interactions. Second, interpreting service is often the result of good team work (see e.g. Baraldi/Gavioli 2021), so looking at clinicians who have worked with some particular mediators for a while reveals good synchronization and effective interactional management. Finally, effective dynamics are interesting in a learning/training perspective, in that they show mediators (and interpreters and providers too) how successful interpreting including mediating components can be carried out (Baraldi/Gavioli 2016).

We cannot ignore however that there are sequences where doing interpreting can be hard for intercultural mediators (and possibly interpreters alike). In a previous paper (Baraldi/Gavioli 2017), we have analyzed the way in which a sense of cultural essentialism may be promoted by mediators positioning as authorities in producing knowledge of migrant patients' cultural needs and features, thus blocking rather than enhancing intercultural adaptation and understanding. Here, we shift our attention to the institutional providers and look at firstly, healthcare providers' stereotyping comments on patients' cultural features and secondly, their interactional consequences regarding two interconnected issues: first, the constraints on the mediators' choice of action; second, the obstacles to the rendition activity. Empirical research on medical interaction has reported significant communication barriers between healthcare providers and migrant patients (e.g. Meeuwesen *et al.* 2007; Rosse *et al.* 2016; Schinkel *et al.* 2018), but stereotyping is not included among those observed. While these studies reinforce the idea that the production of stereotypes is not frequent (or only indirect, see Baraldi/Luppi 2015) in medical interaction with migrants, they suggest that the description of even a minor number of occurrences may be of particular interest.

3. Data and methods

3.1. Data description

Our study is based on the audio-recording and transcription of authentic mediator-interpreted interactions, collected in public healthcare services in Italy in the last 15 years. It is based on a large corpus of data, gathering around 600 encounters (over 100 hours of recording), 7 languages and 25 mediators, who have worked in Italian health care for many years. The corpus was collected as part of a research project on interpreting in Italian public healthcare interaction (Baraldi/Gavioli 2012a; 2012b; see Niemants 2018 for an updated description), mainly in women's health areas.

In this paper, we focus on the Arabic and English sets of data, which make up 481 encounters (170 with Arabic and 311 with English) and 14 mediators (6 speakers of Arabic and 8 of English). The clinicians in these interactions are doctors and nurses (male and female), and midwives (all female). The patients are migrants from North African countries (Morocco and Tunisia) and West Africa (mainly Ghana and Nigeria). One encounter of over an hour (including an extract we will discuss below) occurs with an English-speaking patient from India and is interpreted by a Nigerian mediator. Since most of the encounters were recorded in gynaecological and maternity care, patients are prevalently women, who may be accompanied by their spouses. The mediators are all female.

The transcription conventions we adopted are largely derived from Conversation Analysis. The transcription method was devised on the basis of conversation in English and needs to be adapted when transcribing non-Latin alphabets (see Egbert *et al.* 2016). Transcribing interpreter-mediated data is no exception. Indeed, interpreter-mediated data pose the additional problem of combining transcriptions of languages with different alphabets in the same interaction. When transcribing interaction in Arabic and Italian, for instance, where the left-right direction of writing is not the same, overlaps can only be represented with difficulty, so a transliteration of Arabic into the Latin alphabet was adopted to accommodate these types of issues (Baraldi/Gavioli 2012b: 17-19). Names and identifying details have been changed to protect the privacy of individuals. A list of the conventions we use in our transcripts is included at the end of the paper.

3.2. Our methodological approach

Small culture construction in essentialist forms makes language mediation difficult and patients' involvement hardly possible. The problem we address in this paper is thus: how do mediators respond to blocks in communication posed by such constructs in their mediating activity? The main analytic concept we use comes from Conversation Analysis and is that of *action projection* mentioned in the first part of this paper. In brief, Conversation Analysis looks at systematic responses following particular turn types or actions and argues that response systematicity orients speakers' expectations for that response to be provided. Just to give some

examples, compliments are systematically downgraded in responses, greetings are normally reciprocated. This does not mean that no other response is possible. In fact, greetings may not be responded or compliments may be upgraded. In these cases, though, some extra-meaning or contextual cue is constructed. For instance, the interlocutor who received the greeting is upset or distracted; the interlocutor who boosts the compliment may do that for joking or because s/he is affectively related to the speaker who produced the compliment.

In medical interaction, questions may be specifically designed as to project "no-problem" responses or presuppositions that a problem exists, thus discouraging a no-problem response (Heritage 2009) and this is a mechanism by which doctors make their diagnostic orientations clear to patients. A well-known study by Heritage/Robinson (2011) has shown that when asking the patients if they have further questions, doctors may use two forms "do you have *any* questions?" or "do you have *some* questions?" (our emphasis). It is shown that the latter is significantly more likely than the former to be followed by further requests by the patient, thus making a projection of expectations for more questions clear and the item *some* more encouraging for patients to ask.

This interactional mechanism is discussed in Mason (2006) in terms of what an action makes relevant as to following actions in the interaction and in terms of construction of interactional (shared) assumptions. In interpreter-mediated interaction, Mason (2006) argues that a provider's request for a detail makes relevant either a direct response by the interpreter or a rendition for the service seeker. In police office interrogations, however, providing a direct answer may not allow the defendants to show that they can appreciate the question and respond to it consequently, thus depriving them from the possibility of showing that they are reliable speakers, although speaking a different language. In other contexts (e.g. healthcare), this mechanism may instead optimize the conversational flux leading to better reciprocal understanding.

The action-projection mechanism, as described in Wadensjö (1998), is a crucial one for interpreter coordination activity because it gives interpreters access to expected actions or assumptions, as well as the possibility of rendering accordingly or explicating implicit meaning. In our previous work, we have shown that explication may be given as a response to other participants' projected requirements of, for example, showing attention, seeking compliance or conveying details in delicate or appropriate ways (see e.g. Baraldi/Gavioli 2016; Gavioli 2015).

Here we focus on sequences occurring inside or following the history-taking phase of the medical encounter, as defined in Heritage/Maynard (2006), that is after clinicians have collected (some) patients' details relevant for the current medical (mainly maternity) check-up. In these sequences, the providers comment on the patients' answers by highlighting the cultural differences involved in the clinicians' perspective. These comments concern food habits (e.g. rice vs. pasta), expected knowledge of personal details (e.g. knowledge concerning weight and height or dates of birth), health (common diseases in the patient's country, e.g. malaria), the value of life and wealth (life expectancy, life standards).

As mentioned above, these types of comments are not frequent in our data, giving us around 12 sequences in the whole corpus. After these 12 occurrences, the mediators deal with the providers' comments in one of the following four ways, leading to four different types of interactional construct.

Type 1. Mediators align to the provider's proffered expression of cultural essentialism supporting it, sometimes laughing together with the clinician.
Type 2. Mediators provide explanations of patient's behaviour as typical of the patients' community group.
Type 3. Mediators deny the provider's classified behaviour as typical of the patients' group and offer an alternative explanation.
Type 4. Mediators ignore the provider's proffered expression of cultural essentialism and go on with their rendering activity by selecting some other relevant item.

Our analysis below shows one example for each type. We will see that responding to the provider's stereotypical comment is not easy. The provider's comments are never rendered to the patients, making direct or even modified (e.g. mitigated) rendition not an option in our data. Indeed, the mediators have little escape from contributing towards shaping the stereotype. Levels of alignment are however different as we will see in the four examples.

4. Interactional constraints after clinician-produced stereotypes

In what follows, we show four examples, one for each of the types listed above. We will focus on the consequences of the providers' action and the constraints it poses as for blocking the mediators' rendition activity. We additionally discuss the mediators' exercise of agency and the changes produced in the interaction by their choosing different response options.

4.1. Type 1 - The meaning of life is completely different

Extract 1 comes from an encounter with a Nigerian patient, in particular from the first part of the encounter where the midwife is taking the patient's history. At the clinician's request about how the patient's mother died (rendered by the mediator in turn 08), the patient answers that her mum was sick, had a fever, went to hospital and died. Both the mediator (in turn 10) and the clinician (in turn 14), ask for more specific details about the cause of death, which the patient cannot provide. Either the fact that the patient does not know exactly how her mother died or that a young person can die from fever, prompts the midwife's comment in turn 19 and the mediator's response in turn 20 (both arrowed in the transcript).

Extract 1

08. MEDf	what happened to her? (.) before (she died)?
09. PATf	she just (.) she is sick
	(0.6)
10. MEDf	what's the kind of sickness (she) has we want to know (you) know [((laughter))]
((laughter))	
11. PATf	[((laughter))]
	(0.7)
12. PATf	just fever just ehm before you get to hospital just fever (??)
13. MEDf	ha avuto un po' di febbre quando è arrivata in ospedale (.) però (??)
	she had a little fever when she arrived at the hospital (.) but (??)
	(0.5)
14. OBSf	ha avuto la- la malaria probabilmente? ((mobile rings))
	she had the- the malaria probably?
15. MEDf	no no ha detto che ha [avuto] [solo febbre]
	no no she's said she has [had] [only fever]
16. PATf	[hello?]
17. OBSf	[ma era giovane]
	[but was she young]
18. PATf	((??)) [((??)) the hospital]
19. → OBSf	[dio bò (.) il] senso della vita è tutto diverso [(eh)]
	[good lord (.) the] meaning of life is totally different [(eh)]
20. → MEDf	[per] fortuna che non ha detto il malocchio ((laughter)) (1.5) alcuni dicono eh
	[fortunatelly] she didn't say the evil eye ((laughter)) (1.5) some people say eh
	(2.8)
21. OBSf	quanti anni aveva la mamma quando è deceduta?
	how old was mum when she passed away?
	(0.8)
22. MEDf	(beside) ho- how old was she?
	(0.4)
23. PATf	thirty-eight

It may be observed that the midwife's comment is started in overlap with the patient speaking briefly on the phone; a distraction of the patient which might have prompted the midwife to speak more freely with the mediator. The actual midwife's comment, however, does not overlap with anyone else's talk and it

can be assumed that the patient could hear it. In turn 20, the mediator aligns to the midwife's comment adding a further, exaggerated, stereotype, about what other patients sometimes mention as possible causes of death. The mediator's comment is accompanied by laughter, possibly inviting the midwife to treat occurrences of weird responses by patients as laughable or not serious (see Jefferson *et al.* 1987 on the function of laughter for inviting interlocutors to share views on topics). Silence follows both this invitation to laugh and the completion of the mediator's comment. So, while possibly intended as a suggestion to appreciate this patient's response (compared to others'), the mediator's reaction *de facto* supports the clinician's comment, reinforcing the idea that the patient's cultural group has strange ideas about health and death. Thus, small culture as a shared stereotype about migrants' meaning of life is constructed in the interaction.

It is interesting to note that the mediator's alignment closes the sequence: the clinician does not comment further and the stereotyping comment is not rendered to the patient. Rather, history-taking goes on and the detail about the mother's age at death is provided. The mediator's alignment thus apparently blocks the clinician's stereotype by offering another upgraded one. However, the clinician's comment heavily limits the mediator's action. On the one hand, her possibly mitigating proposal of treating these patients' responses as not too serious is not taken up in the interaction, on the other hand, rendition of the exchange as it is, may be considered (by the mediator) a highly undesirable, potentially offensive option. This option is in fact completely discarded in the encounter, protecting the patient but leaving her with no access to what the mediator and the clinician were talking and laughing about in turns 19-20. The mediator's exercise of agency is thus severely limited, as neither mitigation nor rendition are achieved in the sequence.

4.2. Type 2 - Do you know anything Viviana?

Extract 2 comes again from a history-taking sequence, this time with a Ghanaian patient (fictitiously called Viviana in the transcript). In the first part of the consultation (not shown here), the doctor asked Viviana her weight and the date of her previous delivery; Viviana answered she does not know. When the extract shown below starts, a further question is asked about Viviana's height (turn 01, rendered by the mediator in turn 02) and she again answers she does not know (turn 03). The doctor negatively comments the patient's lack of knowledge in turn 05 (arrowed): "do you know anything Viviana?". Similarly, to what we have seen in Extract 1, the mediator laughs at the doctor's question, thus inviting the doctor to treat the patient's contribution as laughable. The doctor takes the patient's height and then comments on the patient's (non) knowledge: "questa è bella" ("this is weird", turn 20, arrowed). The doctor's comment in this case underlines the unusual nature of the patient's behaviour without ascribing it to a stereotype. It is the mediator who, in her attempt at explaining Viviana's response as not so weird, ascribes it to a stereotype: weight

and height details are not important in African cultures (turn 21). While, in this case too, the explanation may be interpreted as to offer a benevolent eye on Viviana’s behaviour, it reinforces the idea that not just this lady but all African people have poor knowledge of relevant body measures. Thus, small culture as a stereotyped group identity of Africans is proposed by the mediator, possibly in order to defend the migrant’s individual identity.

Extract 2

01. DOCf	quant’è alta la signora? (.)
	how tall is the lady?
02. MEDf	do you know your height?
03. PATf	no.
04. MEDf	((laughs))
05. →DOCf	SAI QUALCOSA VIVIANA:?
	DO YOU KNOW ANYTHING VIVIANA:?
06. MEDf	((laughter))
	((13 turns omitted in which the patient is measured))
20. → DOCf	(questa è be:lla)
	(this is weird)
21. MEDf	((laughs)) eh eh (.) no:: nessuno guarda questo in Africa. quanto è alta:, quanto pesi, [no nessuno mai
	((laughs)) eh eh (.) No:: nobody looks at this in Africa how tall she is:, your weight, no nobody ever.
22. DOCf	[eh: lo so: però ((ride)) ah ah
	[eh: I know: but ((laughs)) ah ah
23. DOCf	PERÒ È IMPORTA:NTE [per vedere se è in sovrappe:[so
	BUT IT IS IMPORTA:NT [to see if she is overwei:[ght
24 MEDf	[sì: [sì: sì certo eh
	[yes: [yes: yes sure eh
25. DOCf	perché- u-un peso può essere dive- in base all’altezza: può avere un significato dive:rso=
	because- a-a weight can be diff- depending on height: weight may have a differ:rent meaning=
26. MEDf	=sì
	=yes
27. DOCf	io però non riesco a capire questo fatto che è dimagrita, non mi va giù sinceramente
	I however cannot understand the fact that she has lost weight, I cannot figure out frankly

28. MEDf	no *no*
29. DOCf	che in tutta la gravidanza lei è dimagri[ta di: *that for the duration of her pregnancy she has lo[st:*
30. MEDf	[sì, sempre così (.) sempre *[yes, always like that (.) always*
	(0.2)
31. DOCf	allora (.) anche nell'altra gravidanza era dimagrita::? *so (.) did she lose weight even in her other pregnancy?*
32. MEDf	when you were pregnant of the other baby were you like this, this situation you are now?

Rather than dropping the topic, as was the case in Extract 1, here the doctor accepts the invitation to laughter (turn 22) but, immediately after, explains emphatically the reasons why knowing body measures is relevant from a clinical point of view and relates her request to the case in question: Viviana, who is six months pregnant, is apparently losing, rather than gaining, weight. Neither the doctor's comment nor the reasons she provides for asking are rendered to the patient. Rendition starts again after the doctor gets back to history-taking in turn 31. It is clearly impossible to say, from the data, whether the mediator's choice to provide no rendition is due to an attempt to protect the patient from what may be understood as possibly offensive or to seek a possibility to negotiate, with the doctor, a medical and thus more translatable explanation of the doctor's comment. In any case, the clinician's negative comment poses the mediator with the challenge of whether and how to render it, in this case blocking her rendition activity or delaying it up to the point that a new question is introduced (and rendered).

4.3. Type 3 - All Indian women have hypothyroidism

Extract 3, with an Indian patient, involves a Nigerian mediator (fictitiously called Tery), our intern student (STUf, participating to collect the data) and a midwife. During the first part of the history-taking phase (not shown here) the patient said that she suffers from hypothyroidism, a detail that was not taken up in the conversation. So, the patient repeats the detail more clearly in turn 01 below and it is the midwife who shows understanding in turn 02, checks her understanding with the mediator, and receives confirmation in turn 03. The detail provided by the patient prompts the midwife's comment in turn 04 (arrowed) that all Indian women are affected by hypothyroidism. While the comment does not, strictly speaking, point to a stereotype, it still treats the patient's problem as a group problem, regarding all Indian women.

In the sequence that follows (turns 05-10, all arrowed), the mediator, also

supported by the student in turn 07, criticises the midwife's generalisation, stressing that it cannot be applied to such a huge country as India. Within the sequence, a we/them comparison is developed between Italy and India, going from the national dimension to the distance of inland from the sea; the mediator provides an explanation of how this distance explains the illness better than cultural belonging.

Extract 3

01. PATf	erm (.) I told her I'm having thyroid (.) I'm having] thyroid (.) I'm taking tablets every day for it
02. OBSf	ha problemi di tiroide?
	does she have thyroid problems?
03. MEDf	eh sì
	oh yes
	(0.1)
04. → OBSf	(??) .hh (1) eh ma ha problemi di tiroide e::: st- è seguita da un- °tutte le indiane ci fai caso? (.) son tutte tiroid- ipotiroidee° (.) .hh ascolta (.) °perché secondo me° (2.5) chissà lei se abita in una zona dove c'è [(.) c'è poco iodio c'è il ma- c'è il mare] però eh
	but she has problems with her thyroid e::: sh- she is treated by a- °all Indian women have you noted that? (.) they have all got thyroid- hypothyroidism° (.) hh listen (.) °because I think° (2.5) who knows she may live in an area with [(.) with little iodine there's the se- there's the sea there though
05. → MEDf	[hm non lo so (.) è come noi (qui)]
	[hm I don't know (.) it's like us (here)]
	(0.8)
06. → MEDf	eh dipende da dove abita [(.) ehm se] se abita all'interno
	eh it depends on where she lives [(.) erm if] she lives inland
07. → STUf	[dipende (.) è:: (è grande)]
	[it depends (.) it:: (it's big)]
	(0.4)
08. → OBSf	vabbè anche qua però in Italia (0.6) ci son di quelli che abitano all'interno [ma tanti che]
	okay but here in Italy too (0.6) there are those who live inland [but many who]
09. → MEDf	[eh ma voi]
	(.)
	l'Italia è fatta in un modo che [il mare (??) l'inter] no proprio non è così lontano dal mare
	[yeah but you] (.) Italy is shaped in a way that [the sea (??) the inlan]d is not so far from the sea

10. → OBSf		[eh (.) c'è lo stivale]
		[eh (.) it's a boot shape]
	(0.1)	
11. OBSf	e invece- ah può essere! (.) .hh ascolta di- una cosa adesso adesso Tery ti spiega tutto	
	while instead- ah maybe! (.) .hh listen to- one thing now now Tery is going to explain everything to you	
12. MEDf	okay so	

In this case, the midwife's reaction in turns 10 and 11 shows acceptance of the mediator's (and the student's) explanation and it is the midwife, this time, that projects the rendition of the sequence about hypothyroidism in India as not relevant for the continuation of the encounter, immediately proposing a new topic (the "tutto"/"everything" mentioned by the midwife refers to routine treatment of pregnant women with hypothyroidism, usually including an endocrinological check-up).

Even though there is no explicit criticism, the provider's essentialist positioning regarding the patient as belonging to a group excludes the patient as a person (e.g. the patient is not invited to give her opinion on the spread of hypothyroidism in India). The mediator's action discourages the stereotyped identity, by opposing an alternative explanation to the illness, but her position as a rendition provider is blocked and her choices of action highly limited. In this case, too, no rendition of the discussion is given to the patient and history-taking is taken up again and carried on.

4.4. Type 4 - The problem is that they get lost

Extract 4 comes from the same consultation as Extract 1, involving a Nigerian patient, the mediator, the midwife and a colleague of the midwife (COLf, fictionally called Elisabetta) who participates for the duration of the second half of the encounter. While telling her history, the patient mentions that she comes from a family of ten children; the participants then discuss the topic of big families, which are noted as typical of African culture (data not shown). The extract shown below starts with the midwife's colleague commenting on families with many children. The comment (how can you take proper care of so many children?) is followed by two comments by the midwife, one in turn 02 (about the different meaning of life in the country the patient comes from) and one in turn 06 (about migrants' inability to cope with Western life-style). The pause between turns 02 and 03 shows that the mediator does not take up either of the clinician's comments in turns 01-02, and instead the mediator intervenes only for translating a new history-taking question (asked in turn 03 and rendered in turn 04). The same occurs after the midwife's turn 06, where the mediator's response is in fact the translation of the patient's turn 05.

Extract 4

01. →COLf	come fai a mantenerli poi?
	how can you take care of them then?
	(0.7)
02. → OBSf	sì ma:: ti ho detto il senso della vita Elisabetta è tutto diverso
	yes but as I told you the meaning of life Elisabetta is totally different
	(1.0)
03. OBSf	.h allora la mamma (0.9) lei e suo marito non sono consaguinei?
	. h so mummy (0.9) you and your husband are not blood relatives?
	(0.8)
04. MEDf	you and your husband? (.) do you come from the same family?
05. PATf	[hh no ((laughter))]
06. →OBSf	[il problema è che qua si] perdono
	[the problem is that here they] get lost
07. MEDf	((rendering PATf turn 05)) no no no
08. OBSf	allora la madre ((OBSf utters words at very low volume (inaudible) while typing on computer))
	so her mother

The mediator thus ignores the expressions of cultural essentialism that are raised in the interaction treating it as private talk between the midwife and her colleague so that nothing is passed to the patient. While it may be argued that the mediator does not feel entitled to render what may be considered aside conversation, explicitly not intended for the patient, it needs to be considered that: a. what the clinician says is perfectly audible to everyone in the interaction, b. there are other cases in the data in which a second clinician participates in the interaction and their contributions are made relevant for the patient too. Thus, the very choice of the mediator to treat the clinicians' comments as not relevant for rendition cancels the stereotyped identity by non-rendering the issue in the interaction. So, constraints are put on the mediator's activity and she eventually focuses on the medical part of the check-up, cutting herself (and the patient) out of the chit-chatting that is taking place in the encounter. In this way she does take active action in constructing small culture, but still contributes in it by ignoring, protecting and excluding.

5. Conclusion

The analysed sequences show that clinicians' comments on patients' diversity introduce cultural essentialism in interactions and make mediators' actions very

problematic. First, these comments can hardly be passed to the patients as they are, in that choosing to render may reveal potential insults. This seriously hinders the mediators' rendering activity and makes it very difficult for the mediators to include the patients in the interaction. Second, these clinicians' comments put constraints on mediators' responses in that the alternative choices they have enhance their contribution to shape stereotyped cultural features. Either sharing, proposing, discouraging, and even ignoring stereotyped identities in fact produces construction of group culture as an interactional result.

In previous work of ours (e.g. Baraldi/Gavioli 2016), we have argued that, since mediators (and interpreters) participate in the interaction to make bilingual communication possible through forms of interpreting, their action refers to the communication process and the way in which the communication process is produced. We have called this interpreters'/mediators' action "reflexive coordination", following Wadensjö's concept of interpreters' coordination (1998: 145-152). Reflexive coordination focuses on the ways in which the communication process is produced, for instance by working on participants' understanding of information, explication of the expectations of actions, covering or clarifying imbalances in knowledge and contributing in creating collaborative or trustworthy relationships. Reflexive coordination is achieved in the interaction, with the contribution of the other participants. This implies that the interaction may not create the conditions for interpreters to work effectively on the communication process.

In the cases analysed here, reflexive coordination is constrained by healthcare providers' actions. In the extracts shown, rather than fulfilling medical tasks, clinicians' comments position them as authors of cultural assessments, thus displacing usual forms of reflexive coordination, based on explication of (medical) information or on assumptions that what is said is functional to provide care. In the interactions we have examined, where cultural mediators participate, clinicians' cultural comments are dealt with as cultural assessments, producing either problematic acceptance of stereotypes (extracts 1 and 2) or potentially conflictive rejection (extracts 3 and 4). Accepting the clinicians' projected action as expression of essentialism rather than care is definitely limiting for cultural mediators, whose choices can barely go beyond zero rendition, protecting the patients, but excluding them from participating.

While the choices of the mediators participating in our data may be debatable, they are placed in the awkward position of choosing between either rendering a stereotype to the patient or accepting/dissenting with the clinicians, all alternatives which might be avoided if clinicians who work with migrants were trained to refrain from proffering expressions of cultural essentialism and negative evaluations of patients' personal identity *tout court*. Even when they are jokingly or occasionally expressed, they may put heavy burdens and obstacles on interpreter-mediated talk. In our data, such occurrences are rare and in fact restricted to three clinicians in the whole corpus, but their interactional consequences are clear.

By way of a final consideration, it has probably been noted that all of the extracts we showed are from the English, not the Arabic set of data. This is not

a choice of ours, but is triggered by the results of our analysis. We have in fact found no occurrences of clinicians' stereotyping comments in our 170 Arabic-Italian encounters. While we have no explanation for this (non-) occurrence at present, it definitely provides interesting data to be explored, like observing whether some pre-emptive mechanisms are used by Arab mediators to prevent clinicians from expressing stereotypes. If this were the case, suggestions could be made not only for clinicians to refrain carefully from commenting on cultural differences, but also for mediators (and interpreters) to act pre-emptively on this interactional construction.

Transcription conventions

(.)	barely noticeable pause
(2)	noticeable, timed pause (n = length in seconds)
A text [text B [text	square brackets aligned across adjacent lines denote the start of overlapping talk
tex-	syllable cut short
te:xt	lengthening of previous sound or syllable
(?)	untranscribable audio or tentative transcription
=text	latched to the preceding turn in transcript
TEXT	loud volume
°text°	low volume
.,?!	punctuation provides a guide to intonation
((*sneezes*))	transcriber's comments
translation	translation of Italian turns is in italics

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