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CLINICIANS' COLLABORATION IN SECURING PARTICIPATION OF VULNERABLE PATIENTS IN INTERPRETED INTERACTION: A TWO-CASE COMPARISON WITH MIGRANT WOMEN IN MATERNITY SETTINGS

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Abstract: While healthcare interpreting studies have extensively discussed the interactive work done by interpreters and intercultural mediators in providing interpreting, much less has been said about what clinicians can do to facilitate interpreting provision. In this paper, we draw on two extended maternity check-ups recorded in Italian hospitals, each involving a clinician, a migrant expectant mother and an intercultural mediator. The consultations were selected from a corpus of over 300 interactions recorded in similar contexts, with English-speaking patients from West Africa, India and the Philippines, because they lend themselves to a two-case comparison. In the first, with a Nigerian patient, the mediator receives considerable help from the clinician and, although the mediator is not particularly experienced, interpreting is carried out reasonably well. In the second consultation, with an Indian patient, the clinician's "doing" creates a number of obstacles to the mediator, who, although quite experienced, encounters various difficulties in the accomplishment of her interpreting work. We look at two types of sequences: a. question-answer sequences and b. clinician's uptake of patient's contributions. Our results indicate that certain clinicians' practices, although possibly well-meaning, may in fact inhibit smooth rendition and consequently patients' involvement in talk. Implications for training clinicians to work in interpreted settings are briefly discussed.

Keywords: interpreted interaction; healthcare; mediation; maternity settings; clinician-mediator collaboration.

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0. Introduction

Healthcare interpreting is generally viewed as the most effective way of removing obstacles hampering the participation of migrant patients in their interactions with clinicians. Enabling patients to contribute to the interaction in relevant ways, however, requires clinicians and interpreters to collaborate closely, especially when patients are in situations of particular vulnerability (Mason and Ren 2012).

Empirical studies have shown that interpreters attribute meaning not only on the basis of the "text" produced by their interlocutors, but also by drawing on discourse features generated in the context of the interaction (Wadensjö 1998). Interpreting in dialogic settings is a situated activity and orienting to what is made relevant by one's co-participants in the *hic et nunc* of interaction can thus be considered a form of interactional collaboration. However, while various studies on healthcare interpreting have detailed ways in which interpreters construct their renditions to make the intended meaning more explicit, reduce redundancies, split the propositional content up into more understandable units and the like, little attention has been directed to how such translation choices may reflect constraints put on their activity by the activity of the other participants, first and foremost the institutional operator.

This paper provides a contribution in this direction through a close analysis of two consultations extracted from a large corpus of interpreted interactions in health care. The consultations have been selected because, while in both cases the clinicians involved clearly wish to put the patient at ease, the interactional choices of the clinician in one consultation are particularly helpful, while those of the clinician in the other seem particularly unhelpful. In both cases the interpreting services are being provided by intercultural mediators. The concentration of facilitative vs. impeding practices on the part of the clinicians in the two consultations makes the interactional effects of their choices particularly salient, however, and the analysis thus provides insights that we argue are potentially valid for clinicians' participation in encounters interpreted both by mediators and interpreters.

1. Clinician-interpreter collaboration in dialogue interpreting

Scholarly work has highlighted a variety of collaborative practices in healthcare interpreting that characterize specific phases of the consultation and/or particular settings. In collecting details from patients in maternity check-ups, for instance, renditions of the clinicians' questions are systematically provided, while patients' answers – especially "yes/no" answers or answers containing technical lexis – are often directly accessed by clinicians (Gavioli and Wadensjö 2021); in dieticians' consultations, the legitimacy of patients' not knowing about medical issues is often made clear in rendering the dietician's contributions to the patient (Raymond 2014a; b); in eye examinations, interpreters' renditions of verbal instructions are coordinated so as to coincide with the assumption of

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certain positions on the part of patients and with clinicians' handling of the instruments used to examine them (Bolden 2018). There is evidence, moreover, that certain types of interpreting initiatives may be actively welcomed by clinicians. For instance, monolingual sequences of talk between the interpreter and the patient may help make medical requests clear (Angelelli 2012), facilitate clinicians in obtaining matching responses (Davidson 2002), support patients when they are hesitant to speak or narrate (Pasquandrea 2011; Gavioli 2012), incorporate relaxing small talk into the interaction (Penn and Watermeyer 2012), or help patients speak "freely" when a complaint is at stake (Merlini 2015).

At the same time, clinician-interpreter collaboration has been frequently perceived as anything but smooth, especially by interpreters. In studies based on interviews and focus groups, interpreters lament perceived reductionism in considering their activity as that of a conduit (see Roy 1993/2002 and also Wadensjö and Gavioli 2023: 2-3) and report experiencing tension between what clinicians expect them to do and what they consider professionally appropriate. This tension is mainly expressed in terms of a struggle between delivering accurate renditions and showing concern and empathy (Hsieh and Kramer 2012): Hsieh (2008), for example, reports interpreters complaining that if they want to keep their job, they need to act like "robots" (*ibid.*: 1371), ignoring patients' need for attention or reassurance.

Research focusing on clinicians' attitudes indicate that they typically equate higher professionalism in interpreting with lower interpreter agency (Li *et al.* 2018, Sturman *et al.* 2018), thus lending credence to the concerns expressed by interpreters. Clinicians have been reported to view word-for-word interpreting as reinforcing their relationship with patients (Hsieh 2008: 1371); they have also been reported to believe that expressions of emotions (e.g. angry tone and agitated movement) need not be relayed because such manifestations are directly accessible and hence universally understood (Hsieh and Nicodemus 2015: 1475).

The perception that collaboration between interpreters and clinicians is not easy has inspired specific training programs for clinicians designed to highlight and address problems in communicating through interpreters (Felberg and Sagli 2023); projects in interprofessional training, in which interpreting students and medical students are given the opportunity to perform simulated interactions, have also been developed (e.g. Krystallidou 2023).While such training initiatives are helpful in familiarizing clinicians with the work of interpreters, little empirical work exists focusing on how clinicians' contributions actually hinder or facilitate interpreting. Some hindering practices have been highlighted in work by Wadensjö (2018), who notes that on occasion doctors totally refrain from showing empathy and that in such cases there is little that interpreters can do to alleviate the problem. The consequences of doctors' comments about what they see as patients' cultural features have been analyzed by Baraldi and Gavioli (2021), who note that such comments, even when delivered as playful, can present heavy challenges for interpreting since rendering them may be understood as potentially offensive or indeed uncaring. Facilitative practices by clinicians have instead gone relatively unnoticed, with, to the best of our knowledge, the single exception of a study on code-switching, in which doctors'

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shifting into the patient's language is shown to be a collaborative practice that displays attention and closeness (Anderson 2012).

This paper thus provides a contribution on an important but under-researched topic. To do so, it draws on a large corpus of doctor-patient interactions collected in Italian healthcare services where interpreting is provided by intercultural mediators, i.e. professionals (both trained or untrained in interpreting) employed in some Italian public services (e.g. education and healthcare) to facilitate communication in those situations in which language, cultural or religious diversity may impede smooth understanding (see CNEL 2009 for a definition of the job and Merlini 2009; Pittarello 2009; Falbo 2013 for a discussion of intercultural mediators as interpreters in Italian healthcare). From the corpus in question, we have selected two interactions which illustrate substantially different types of interactive practices that clinicians use in providing care to patients in mediated consultations. One set of practices seems to facilitate the mediator's provision of interpreting, while a second set of practices highly obstructs it. The reason for the selection of two entire consultations, rather than a series of examples from the corpus, is that they provide a more comprehensive picture not only of single practices that may facilitate or hinder the mediators' interpreting work, but also of the cumulative effect that repeated behavior of one or the other type may have on the consultation as a whole. It is worth noting that potentially neither of the two consultations is totally unproblematic. The mediator in consultation 1 is in fact quite inexperienced, yet, as we shall see, the clinician is so helpful that interpreting is carried out relatively smoothly. The mediator in consultation 2, instead, has considerable experience and there is evidence from the extended corpus that she normally does a good job in interpreting. In this encounter, however, she is put under heavy pressure by a clinician who, although probably not intentionally, creates a number of obstacles to the mediator's interpreting activity. Our purpose in analyzing practices that are typical, respectively, of these two cases is twofold: on the one hand, to highlight collaborative and non-collaborative practices on the part of clinicians that are particularly salient in the extracts and can be considered representative of facilitative/impeding practices used more extensively in the corpus; on the other, to provide empirical evidence of facilitative practices that may prove useful in situations where there is no other alternative to reliance on non- or pseudo-professional interpreting, as in the case of rare languages, recent migration groups or individual or humanitarian emergencies.

2. Identifying facilitative practices: methods and data

This study approaches clinicians' collaboration with the intercultural mediators in our data conceptually and methodologically through the lens of Conversation Analysis (CA). In the CA perspective, participants respond to previous contributions by showing their understanding of what has been said and reacting with new relevant contributions. This mechanism shapes the conversational encounter as mutually constructed and achieved and consequently situations are

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viewed as created, maintained, or altered through the actions by which they are constituted (Heritage and Clayman 2010: 21-22).

A core characteristic of interpreter-mediated interactions is that participants' contributions are largely responded to by interpreters (Wadensjö 1998), who, in their renditions, show their uptake of the previous participant's contributions – in other words how they "interpreted" that participant's contribution. Since interpreters must render their understanding of participants' talk in the other language, Mason (2006) notes that their performance provides "valuable evidence of take-up, of the sense they make of others' talk and how they respond to it" (2006: 365). As he perceptively highlights, this characteristic of interpreter-mediated talk makes it a window onto how sense-making takes place in conversation:

> For the valuable insight that such data provide into the interactive processing of talk, interpreter-mediated exchanges must surely be of interest to conversation analysts. Indeed, one could generalize from this point and suggest that the true potential contribution of translation/interpreting studies to the analysis of text and discourse lies in the analysis of translator behaviour as externalized evidence of an actual user response and, simultaneously, as audience design. (Mason, 2006: 365)

Our study explores the methodological implications of Mason's insight into the Janus-faced nature of renditions as simultaneously externalized evidence of listener response and instances of audience design. Taking as a working assumption that interpreters and intercultural mediators construct their renditions so as to make clear (i) the meaning they attribute to the preceding contribution and (ii) the relevance of this contribution for the interlocutor targeted, in the consultations selected we look at the intercultural mediators' renditions of clinicians' contributions in two types of sequences: a. clinician question – patient answer sequences and b. clinicians' responses to patients' concerns. Focusing on these two sequential contexts provides a more nuanced understanding of collaboration through the lens of mediator effort, operationalized in practical terms as: i. how much "re-design" is visible in mediators' renditions of clinicians' question turns for patients and ii. to what extent the way clinicians show receipt of and act on patients' contributions facilitates or complicates the mediator's task.

The data used to address these issues are two encounters taken from a large corpus of authentic mediator-interpreted interactions collected in public healthcare services in Italy, mainly in the area of women's health. The full corpus, assembled over a 20-year period, currently consists in over 100 hours of recordings (600 encounters) in 7 languages and involves 25 mediators (Baraldi and Gavioli 2012; see Niemants 2018 and Corradini *et al.* forthcoming for a description). The two encounters examined were selected from the English-Italian sub-set comprising 311 encounters). Both are maternity check-ups with English-speaking patients: the first, with a Nigerian patient, lasts 44 minutes; the second, with an Indian patient, lasts 56 minutes. The clinicians are both experienced midwives who have worked with the healthcare organization for

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over 5 years. The mediator in the second encounter (with the Indian patient) is experienced and has collaborated with the service for over 5 years. The mediator in the first encounter (with the Nigerian patient) had instead worked with the service for only 6 months at the time of recording and did not have prior experience in healthcare interpreting.

The choice of these two encounters is linked both to the profiles of the two patients and to internal characteristics of the encounters in question. The patient in the first encounter is a Nigerian migrant on her own in Italy, just arrived from a refugee camp, living at a local migrant reception centre and facing her first pregnancy - a patient whose vulnerability is clearly multiple and 'intersectional' in nature (Giritli-Nygren and Olofsson 2014; see also the introduction to this volume and Tipton 2023). The Indian patient in the second encounter resides in Italy with her husband and four-year-old daughter, lives in a proper house (not a reception centre) and is relatively at ease with her pregnancy, as it is her second one; she is also fluent in English. What is striking about the two encounters is that, counter to expectations, the encounter involving the more vulnerable patient and less experienced mediator is overall much smoother and more successful. In the encounter with the Indian patient, the clinician ironically complains about the healthcare service she is part of, rushes through the phases of the encounter, asks multiple questions and sometimes takes long turns. While the mediator arguably possesses – and indeed, manifests – some familiarity with this type of "doing", she often struggles in interpreting and is compelled to select, within tight time constraints, among the multiplicity of details requested or provided. In the encounter with the Nigerian patient, instead, the clinician makes a series of discursive choices that help maintain the focus – both interactionally and substantively – on the patient. Whatever the contextual reasons are that may account for the particular attention exercised by the clinician in ensuring smooth communication, the mediator's contributions provide evidence that the strategies adopted by the clinician were facilitative for her interpreting work. In section 3 we turn to a comparative analysis designed to highlight these interactional practices in more detail.

3. Analysis of the two consultations

In this section, we look at the impact of the clinician's contributions on the interpreting work of the mediator and, more specifically, show which practices are facilitative and which ones create obstacles. To do so, we will first examine the consultation with the Nigerian patient (3.1 and subsections), and then the consultation with the Indian patient (3.2. and subsections). For each interaction, we focus on the mediator's uptake of the clinician's contributions and on how she designs (or re-designs) the clinician's contributions in her rendition for the patients. The aim is not to evaluate whether the mediator interprets well or not: rather we are interested in the "amount of work" she has to carry out to produce a contextually-appropriate rendition (or non-rendition). As noted above, the analysis focuses on two types of sequences, corresponding to different phases of the consultations: clinician question – patient answer sequences and clinicians'

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uptake of patients' contributions. In the first type of sequence (respectively, sections 3.1.a and 3.2.a), we examine the renditions of the clinicians' questions for the patients and their interactional consequences. In the second type (respectively, sections 3.1.b and 3.2.b), we examine the renditions of the clinicians' uptake of patients' contributions and how the medical professionals build on patients' mediated contributions to provide medical responses and guidance.

3.1. Consultation 1

a. Question-answer sequences

Most if not all the clinician's questions in consultation 1 are very explicitly designed to address the patient as interlocutor, as shown by the frequent use of the patient's name and other turn-initial markers like "okay Claire" or "ti chiedo Claire", which project the question to follow. The clinician's questions are single, short questions followed by pauses of around 1 second. Although studies in conversational turn-taking organization reveal that pauses may invite the current speaker to re-select (Sacks *et al.* 1974), here the clinician never takes the floor again, thus leaving ample time to the mediator to render or to the patient – an Italian resident herself – to reply and possibly show her understanding.

(1)

0002 MIDf okay Claire (.) allora (2.5) .hh (0.5) ti chiedo intanto come stai ?
(0.9)
okay Claire (.) so (2.5) .hh (0.5) first I ask you how are you?

(2)

0043 MIDf ti chiedo Claire (.) se senti: che il bambino si muove
(0.7)
I ask you Claire (.) if you feel: the child moving

Both of the clinician's questions presented above are followed by mediator renditions (see 1a and 2a, below), and in both cases we can see that little re-design is needed: the mediator cuts the turn-initial marker "okay Claire"/"ti chiedo Claire" and addresses the patient directly by using the second person pronoun. In extract (1), the mediator repeats the question twice using two

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different forms; in (2), she acknowledges the patient's response with a final "hm" and the patient re-confirms more loudly in overlap:

(1a)

0002 MIDf	okay Claire (.) allora (2.5) .hh (0.5) ti chiedo intanto come stai ?
	(0.9)
	okay Claire (.) so (2.5) .hh (0.5) first I ask you how are you?
0003 MEDf	hm (.) how are you ? how you feeling?

(2a)

0043 MIDf	ti chiedo Claire (.) se senti: che il bambino si muove
	(0.7)
	I ask you Claire (.) if you feel: the child moving
0044 MEDf	do you [feel the mo]ve ? [hm]
0045 PATf	[°yes°] [yes]

The patient provides an answer with either no pause or a very short one, showing prompt understanding of the questions, and, in some cases, she responds in Italian. In extract (1b), see below, the patient's response in Italian is acknowledged by the clinician, while in example (2b) the patient's response in English is rendered by the mediator and followed by a further question on the clinician's part:

(1b)

0002 MIDf	okay Claire (.) allora (2.5) .hh (0.5) ti chiedo intanto come stai ?
	(0.9)
	okay Claire (.) so (2.5) .hh (0.5) first I ask you how are you?
0003 MEDf	hm (.) how are you ? how you feeling?
	(0.3)
0004 PATf	°bene (.) molto bene°
	°well (.) very well°
0005 MIDf	molto bene (.) okay
	very well (.) okay

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(2b)

0043 MIDf	ti chiedo Claire (.) se senti: che il bambino si muove
	(0.7)
	I ask you Claire (.) if you feel: the child moving
0044 MEDf	do you [feel the mo]ve ? [hm]
0045 PATf	[°yes°] [yes]
	(0.3)
0047 PATf	(??)
0048 MEDf	hm hm
	(0.1)
0049 MIDf	tante volte durante il gio:rno ?
	many times during the day?
	(0.6)

In conversational turn-taking, pauses are considered an element of disfluency and indeed the rhythm of the conversation in consultation 1 is slow. These pauses, however, give the mediator time to take the floor, render and monitor the patient's understanding, either by repeating the question twice (as in 1b) or by double checking the patient's answer (as in 2b). A recurrent conversational practice can thus be identified in this consultation consisting of: a. clinician's explicit address to the patient + short question, b. mediator's rendition and monitoring of patient's understanding, c. patient's response (in English or Italian), d. mediator's rendition when relevant and clinician's acknowledgment (explicit, as in 1b, or implicit, by moving to the next question, as in 2b).

This practice remains the same in basically all question-answer sequences in consultation 1, even when the clinician's exploration of the patient's situation becomes more complex and the details to be collected more technical. This can be seen in the continuation of the second example, reproduced below (2c). Here the clinician's questions focus on how many times a day the patient feels the baby moving in her womb. She is clearly not seeking a precise number, but a rough number that will give an idea of the baby's liveliness. Still, the clinician does not explain here (she will, later on) that an approximate number may help, but continues to ask one short question after another, each coordinated as previously shown: pause, rendition, patient's response, rendition of patient's response and new question.

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(2c)

0049 MIDf	tante volte durante il gio:rno ?
	many times during the day?
	(0.6)
0050 MEDf	((tongue click)) many times in a day ?
	(0.4)
0051 PATf	yes
	(0.1)
0052 MEDf	hm
0053 MIDf	quante volte secondo te ?
	how many times do you think?
	(1.2)
0054 MEDf	hm (.) how many times ?
	(0.2)
0055 MEDf	((nose sniffing))
	(0.3)
0056 MEDf	[do you think]
0057 PATf	[hm:] I can't even know
	(0.7)
0058 PATf	I can't I can't list my hand on how many times but all I know is that it's moves [so] where you go
0059 MEDf	[hm]
	(0.9)
0060 MEDf	hm hm
	(0.4)
0061 MEDf	non lo sa (.) però sa che: si muove si
	she doesn't know (.) but she knows it moves yes
0062 MEDf	((nose sniffing))
	(0.2)
0063 MEDf	si muove:
	it moves
	(1.1)
0064 MIDf	al mattino si muove: ?
	in the morning it moves?

As can be noted, the mediator's uptake exemplifies a characteristic format: a short pause followed by "hm" or "hm hm". "Hm hm" seems to work here both as a rendition of the patient's "yeses" and as a continuer inviting the patient to go on and add more details, a function which seems confirmed by the pauses following the mediator's "hms". Since the patient does not provide a quantification of the baby's movements inside her womb, not even an approximate one, the clinician re-designs her questions in different ways. The mediator's uptake of this design (possibly eliciting more specific details on the patient's part) is evident from the mediator's contributions: she does not actually translate the "yes" responses, which are already clear to the clinician, but provides continuation feedback and pauses after each of the patient's contributions. When no patient continuation is forthcoming, we find a new question on the clinician's part (e.g. turns 49, 53). When some continuation is provided, we have the mediator's rendition to the clinician (e.g. turns 61-62) and the clinician's uptake.

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This practice facilitates the mediator, both by making clear to her that what is being pursued is a full, detailed description of the baby's movement and by giving her enough but not too much material to render. Although connected to each other, the midwife's questions are short and clear, and a new question is provided when little or no response has been collected from the patient after the previous one. The dynamic interacted by the clinician and the mediator also seems facilitative in leading the patient, step by step, to provide more and more details about her baby's movement: the pauses and mediator's "hms" after the patient's answers invite the patient to go on, and when she does not, the clinician intervenes with a short and more specific question. This pattern is repeated several times in the next part of the sequence (not shown), which lasts until turn 126, and it allows the patient to provide an extensive narrative about the movements inside her uterus, e.g. that she feels the baby move more when she is hungry or that the baby seems to dislike when she lies down in certain positions.

b. Clinician's uptake of patient's contributions

In interpreted interaction, uptake of patients' contributions by clinicians normally takes place through uptake of the interpreters' renditions of the turns in question - even though direct display of clinician understanding is not rare (as also noted in Meyer 2012 and Anderson 2012). In both consultations examined here, the midwives show interest in addressing concerns raised by the patients (through the mediators) and in encouraging their participation. One mechanism used by clinicians to show interest and readiness to respond is to ask what is going on when a rendition is occasionally suspended. Extract (3a) below provides an example from consultation 1. Here the patient presents a problem in turn 152, the mediator provides continuation feedback (turns 153-4) and then stops and shows she is ready to render. There is a long pause, which may be due to the midwife's compiling the patient's check-up record, followed by an invitation to render: "volevi dirmi qualcosa?". The following short sequence (turns 157-8) elicits and then explicitly provides a sequential slot for the rendition to come.

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(3a)

0152 PATf	((tongue click)) (please) what will I use for my stomach (the thing) used to scratch me so much eve:n: (0.5) the breast anyway (0.4) what will I use I don't know
0153 MEDf	hm
	(0.7)
0154 MEDf	hm hm
	(0.1)
0155 MEDf	let's say to her
	(5.0)
0156 MIDf	volevi dirmi qualcosa ?
	did you want to say something?
	(0.1)
0157 MEDf	sì
	(0.5)
0158 MIDf	dimmi
	tell me
	(0.3)

Extract (3b), below, presents the rendition sequence that follows. Here, the mediator renders the patient's problem by means of a multi-part rendition (Wadensjö 1998), that is, by spreading out the contents over several turns. The clinician shows her uptake of the patient's problem in turn 160 ("prurito") and also provides continuation feedback (turn 162). A number of pauses allow the mediator to provide further details. No more details appear to be forthcoming after the mediator's turn 164, so the midwife self-selects in turn 165 by asking a specific question.

(3b)

0159 MEDf	m'ha detto che: sente purito
	She told me she feels itchy
	(0.8)
0160 MIDf	prurito
	itch
0161 MEDf	sulla ma si (.) sulla pan:cia e anche i seni
	on the ha- yes (.) on her belly and also her breasts
	(0.7)
0162 MIDf	hm
	(0.1)
0163 MEDf	hm il corpo così
	hm so her body
	(0.4)
0164 MEDf	che le eh le fa purito
	that is eh itchy
	(0.2)
0165 MIDf	da quanto tempo è cominciato ?
	how long ago did it start?
0166 MEDf	for how long ? when did it start ?

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This question in turn 165 initiates a series of specific exploratory questions (not shown in the extract), each rendered by the mediator and organized in the same way as the question-answer sequences seen in section 3.1.a above. This practice will allow the midwife to collect more details and eventually lead to the decision to examine the patient's skin.

Extract (4a), below, shows another example of this midwife's uptake of a patient contribution. Here, the patient's complaint is presented as one of a series of problems already partially brought up before: the patient is experiencing headaches almost every day. These headaches (this is the newly-introduced problem) prevent her from sleeping well (turn 463). The problem is immediately taken up by the midwife in turn 452 by showing understanding of the word "headache". The patient confirms, in turn 453, that she would like to talk about her headache. She presents the problem by referring back to a series of issues she mentioned earlier in the consultation: "so: wh what about the headache" (turn 450), "you know now headache" (turn 453). The midwife checks her understanding in turn 452 ("il mal di testa ?"); the mediator replies to the midwife in turn 454 and then renders for her explicitly in turn 455.

(4a)

0450 PATf	so: [wh what about th]e headache ?
0451 MEDf	[this is all the:]
	(0.4)
0452 MIDf	il mal di testa ?
	the headache?
0453 PATf	you know now headache
	(0.5)
0454 MEDf	sì
	yes
	(0.4)
0455 MEDf	il mal di testa
	the headache
	(0.6)
0456 MIDf	sì .h ehm:
	yes .h ehm:
	(1.5)
0457 MIDf	ti chiedo questo Claire (.) se in queste (.) ultime due o tre settimane il mal di testa era uguale: a
	I ask you this Claire (.) if in these (.) last two or three weeks your headache has been the same: as
	(0.8)
0458 MIDf	e:h mm (.) il periodo prima
	e:hmm (.) before

The clinician's uptake (turn 456) shows acceptance to talk about the problem raised by the patient and she immediately redirects the discussion by formulating a clear question, explicitly directed to the patient. Sequence (4b), below, which immediately follows (4a), shows a similar structure. The mediator renders by using a multi-part rendition (turns 460-462) and reformulating the clinician's question twice: "is it the same?" The patient answers (in turn 463) that her headache never stops and does not allow her to sleep even at night but does not

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say whether it is the same as before. Thus the question “is it the same or not?” is asked again by the mediator (turn 464) and subsequently the patient’s complete answer is rendered in turn 468.

(4b)

0459 MEDf	mm
	(0.4)
0460 MEDf	e:h this er:n (.) er last two: weeks
	(0.1)
0461 MEDf	is it the same thing ?
	(0.4)
0462 MEDf	how is (.) uhm (.) the ehm the pai- the headache ? [is it the] same [(would it)]
0463 PATf	[the headache?] [i:t's al]most
	every day I can't even sleep in the night
	(0.6)
0464 MEDf	ehm but is the same with erm: when it started anew ? (.) mm:
0465 PATf	yes
	(0.4)
0466 MEDf	m:h (.) [this last] time
0467 PATf	[°(two weeks) °] (.) vee just bit it's stopping me just like that uf:::
	(0.7)
0468 MEDf	((nose sniffing)) mi ha detto si (.) però: che non riesce a dormire
	she told me it’s the same (.) but: that she can’t sleep
	(0.4)
0469 GYNf	ecco (.) per[ché]=
	well (.) because
0470 MEDf	[beh]
0471 GYNf	=infatti (.) l'altra cosa te che che ti avrei chiesto è se riuscivi (.) a dormire [hm] (.) quindi fai,
	indeed (.) the other thing I was going to ask you is if you could (.) sleep [hm] (.) so you can
0472 MEDf	[hm]
	(0.8)
0473 GYNf	quante ore (.) puoi dormire in una notte ?
	how many hours (.) a night can you sleep?

Again, in this case, the clinician readily takes up the patient’s problem in turn 471 by introducing another question. It is interesting to note that the clinician introduces the question as a conclusive statement (“quindi fai,”) which would project a yes/no answer, but stops and re-plans her question in turn 473 as an explicit request for details about how long the patient actually manages to sleep per night.

The extracts also reveal that the clinician is attentively monitoring the patient’s and the mediator’s contributions. In extract (3a), she notes the feedback of the mediator to the patient and the following silence so she intervenes (“volevi dirmi qualcosa?” “*did you want to say something?*”), giving the floor to the mediator to render; in extract (4a), she takes up the patient’s complaint immediately and asks the mediator for confirmation, thus again passing the floor to the latter for rendering. Doing so allows the mediator to render the patient’s contributions in two or more turns, sometimes helped by the midwife who provides continuation feedback. In both extracts, the midwife treats the patient’s contributions, rendered by the mediator, as relevant contributions and addresses them by providing short questions, clearly focused on the collection of specific details (“da quanto tempo è cominciato” *“how long ago did it start?”*, “il mal di

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testa è uguale a prima?" *"has your headache been the same as before?"*). The mediator's renditions show little effort: the mediator repeats the question in English in one or more parts, thus involving the patient in showing her understanding and then providing her response. Time for clarification with the patient is allowed for before the clinician solicits a rendition, as shown in extract (4b). In conclusion, the clinician in consultation 1 clearly shows her orientation towards "being translated" and towards receiving the mediator's rendition, not only by designing her contributions to be delivered "as they are", but also by systematically inviting the mediator to render and then allowing her time to further explicate in her renditions and to elicit the patient's contribution by providing continuation feedback or clarification requests. This sequential organization seems highly facilitative to providing an adequate rendition, even though the mediator is not expert.

3.2. Consultation 2

a. Question-answer sequences

In the second maternity check-up examined (in this case, with the Indian patient), the question-answer sequences show overall very different patterns. Most if not all the clinician's questions in this consultation are addressed to the mediator, with the patient referred to in third person. The clinician's questions, moreover, are rarely separate, free-standing questions. They consist instead in "packed" questioning turns that contain either several questions or a question accompanied by other, sometimes extraneous, contents. In extract (5) below, for instance, the clinician is reading the patient's record and commenting on her appointments. The latter comment is relevant for the patient since, as will become clear later in the consultation, this is the patient's first check-up and, as such, needs to be organized according to particular standards (e.g. personal details need to be collected and the patient's history taken); this fact is not explained, however, in extract (5). The clinician's question comes immediately after this comment and is introduced by an attention seeker ("ascolta") directed to the mediator.

(5)

001 MIDf	questo è l'appuntamento questo è l'unico appuntamento che lei ha (.) ascolta l'acido folico lo prende?
	this is the appointment this is the only appointment you have (.) listen do you take folic acid?
002 MEDf	my dear (.) are you taking [folid acid ?]
003 PATf	[yes]
004 MEDf	hm sì
	hm yes

The mediator's uptake shows that the clinician's comment about the patient's first appointment has been cut in her rendition and only the question following it has been rendered. The mediator, moreover, re-designs the clinician's question, directing it explicitly (and affectively) to the patient ("my dear"). While both of

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these choices on the mediator's part seem interactionally effective (a relevant answer is immediately given by the patient and rendered by the mediator), the clinician's opening turn has arguably required the mediator to make several split-second decisions. First, she decides to treat the comment as non-relevant for the patient. Typically the first maternity check-up is much longer and more complex than the others, a feature that is often explained to patients in our data. But both the fact that the clinician does not state this explicitly and the fact that she asks a question immediately following the comment suggests she is treating the comment as not really relevant (or, at any rate, not relevant now), which is in fact the interpretation opted for by the mediator. As for the mediator's welcoming and affective turn design, i.e. her decision to address the patient (explicitly) with "my dear", this may have been occasioned by the lack of any explicit address of the patient on the clinician's part – a choice which is effective in involving the patient's involvement but clearly puts an extra burden on the mediator in terms of redesign.

A further example of a "packed" clinician questioning turn can be seen in extract (6). Here the midwife makes reference to a number of issues in the same turn. First, she alerts the mediator to the fact that the encounter is not over because the patient's record has not yet been compiled; second, she mentions that she has heard the patient utter the word "thyroid"; third, after a self-repaired false start, she asks two questions: a. if the patient suffers from thyroid-related diseases; b. if she has consulted a specialist (an endocrinologist).

The clinician's contribution here can be considered well-meaning. Her "stop everyone, we are far from finished" implies a joking attitude towards an institutional setup that perhaps requires too much data collection; in picking up the word "thyroid" in English, she shows that she is monitoring the patient's contribution; finally, her questions are apparently aimed at exploring the aforementioned thyroid disorder further. We have, however, a "crowded" floor moment, when the interlocutors all speak at the same time and deprive the mediator of her interpreting space. The midwife in particular does not let the mediator translate because she has heard a word she seemingly understands ("thyroid", lines not shown here), the patient interjects "oh what is this" (turn 381) and the mediator tries to restore some conversational order by explaining to the patient the activity at hand so that the patient understands what contributions can be accepted as relevant (turns 382-384). The burden this series of contributions poses on the mediator is evident both in her hesitating attempt to take the turn (see turn 382) and in the difficulty she shows in continuing (turn 384), even though the patient has shown that she is attending to what is being said (turns 381, 383). A further contribution on the clinician's part ("now she explains it all", turn 386) ratifies the mediator's initiative to restore order, but again stops the mediator in her tracks. Here the clinician may also be alluding playfully to the fact that since the patient mentioned the word "thyroid" she will now be compelled to answer more questions – a joke that is taken up with laughter by the mediator in turn 387 but not explained to the patient. Again, the mediator's rendition displays uneasiness, as evidenced by hesitations, self-correction and overlap (turns 387-391).

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(6)

378 MIDf	allora fermi tutti perché dobbiamo ancora fare la cartella non è mica fi[nita]
	hang on then because we still have to fill in the medical record it is not fi[nished] at all
379 MEDf	[d'accordo]
	[okay]
380 MIDf	hai detto una cosa che ho capito che hai detto tiroide [tu (.)] prendi delle malat- aspet- fermati (.) soffri di malattie della tiroide? chiedile se è seguita da un endocrinologo
	you said something I understood that you said thyroid [you (.)] take some disea- wai- stop (.) do you suffer from thyroid disorders? ask her if she is taken care of by an endocrinologist
381 PATf	[oh what (is this)]
382 MEDf	s::o (.) now (.) we are going to do the file
383 PATf	okay
384 MEDf	and to see has
	(0.4)
385 PATf	okay
386 MIDf	adesso ti spiega tut[to okay hai] sparato tiroide poi ci hai lasciati lì così [dobbiam capire] se va da un endocrinologo
	now she will explain everythi[ng okay you] said thyroid and you left it at that [we must understand] if she sees an endocrinologist
387 MEDf	[so the other] [((laughter))]
	(0.3)
388 PATf	o[kay]
389 MEDf	[ehm] she is going to ask you (.) hm ? (1.3) ho- (1.9) how are you do you have any sickness you
	(0.3)
390 PATf	no only thyroid

The mediator's rendition is eventually provided in the form of two short dyadic sequences, first with the patient and then with the clinician, in which the details required (that the patient suffers from thyroid disease; that she has seen an endocrinologist) are given (data not shown). Overall, the amount of work the mediator needs to carry out in consultation 2 (in terms of selecting which details to render and in which order to render them) is considerably greater. It is interesting to notice that the teasing attitude of the clinician, which is taken up by the mediator with laughter at least after the clinician's second contribution (turns 386-388), is completely omitted from her rendition, which focuses only on the medical details. While it may be argued that mediators should render each and every meaning present in the interaction (in this case, including the clinician's teasing comments), contextualising these comments so that they can be appreciated by the patient would not have been easy for the mediator as they do not appear to be specifically designed "for the patient". Packed questions and teasing put a clear burden on the mediator's rendition activity, the former possibly leading the mediator to select, the latter necessitating some time to contextualize what is amusing (see also Straniero Sergio 2012 on possible failure in rendering amusement).

Comparing the extracts we have seen in section 3.1.a. with the current ones, we can see that in the consultation with the Indian patient timing also creates a number of obstacles in rendering question-answer sequences. Extract (7) shows the mediator's rendition of a previous answer by the patient (turn 10), followed by a comment by the clinician in turn 11 and by the clinician pre-announcing

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the next step in turn 12. The mediator renders clinician's turn 11 to the patient in turn 13. The patient's reply (uttered as a false start in turn 14) is ignored (and interrupted) by a new clinician's question in turn 15:

(7)

010 MEDf	o:kay (.) a volte li prende dopo: [colazione e a volte dopo]
	o:kay (.) sometimes she takes them after: [breakfast sometimes after]
011 MIDf	[bene bene (.)] l'importante è che tu ne prendi uno al giorno
	[very well (.)] what matters is that you take one every day
012 MIDf	(.) .hh [allora]
	(.) .hh [so]
013 MEDf	[it's very important] you take (that) one a day
014 PATf	ah [(.) the]
015 MIDf	[numero di telefono] (.) [intanto (poi cominciamo)] è il primo figlio questo ?
	[telephone number] (.) [for now (then let's start)] is this the first baby?
016 MEDf	[please your telephone number]
017 MEDf	is this your first pregnancy ?
018 PATf	no no second
019 MEDf	no [(??)]
020 PATf	[I have a] (.) four and a half years old daughter

The question is again 'packed', as it is composed of three units: two questions ("numero di telefono" and "è il primo figlio questo?") and an organizational comment ("intanto poi cominciamo"). The mediator keeps track and renders the first question in turn 16, in overlap with the clinician, and the second question in turn 17, leaving the organizational comment aside. Some simultaneity is not unusual in interpreting, even in dialogue interpreting, but the fast clip at which the interaction is proceeding in this consultation hampers the mediator's work and consequently the patient's participation. In turns 18-20, for instance, the patient answers the rendered question that did not overlap with the clinician's talk ("is this your first pregnancy?"), but not the one that did ("your telephone number"). Some turns below (data not shown), she will have to be reminded to provide her phone number, which she could not provide when originally asked to do so.

b. Clinician's uptake of patient's contributions

Like the clinician in consultation 1, in the second consultation the clinician monitors the patient's contributions, showing that she is listening and occasionally capturing what the patient in saying in English. In extract (6) discussed above, for instance, the clinician heard the word "thyroid" and asked the patient to tell her more.

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Generally speaking, however, the uptake of the patient's contributions is less smooth. In extract (8) below, for instance, the patient's request for information in turn 263 is followed by a two-second pause during which no rendition is provided. As in extract (3a) from consultation 1 (see section 3.1.b, above), it is the clinician's uptake in turn 264 that makes the patient's contribution relevant. Here, though, the clinician addresses the mediator (Mary) explicitly, asking her to relay the patient's contribution. A close rendition is provided immediately in turn 265. As in the other parts of this interaction, the clinician self-selects and starts talking in overlap with the mediator's rendition twice: in turn 266, where "hhhh sì" is uttered in overlap with the mediator's "è presto/*it is early*" (turn 265) and in turn 268, where "è un po' prestino/ *it is a bit early*" is produced in overlap with mediator's "cosa co- come funziona qua/*what ho- how it works here*" (turn 267).

(8a)

263 PATf	((tongue click)) erm I mean it's too early but I also would like to know the hospitalization options after delivery
	(2.2)
264 MIDf	che c'è Mary ?
	What's the question Mary?
	(0.5)
265 MEDf	vuole sapere cosa farà (.) è hm sa che è pre- è presto (.) [è presto]
	she wants to know what she will do (.) is hm she knows it is ear- is early (.) [it is early]
266 MIDf	[hhhh (.) sì]
267 MEDf	ma vuol sapere [cosa co- come funziona qua] quando è ora di partorire
	but she wants to know [what wh- how it works here] when it is time to give birth
268 MIDf	[è un po' prestino]
	[it is a bit early]
269 MIDf	a meno che tu non fai tutto (in due o tre giorni) comunque non ti preoccup[are (adesso)
	unless you do it all in (two or three days) anyway don't wor[ry] (now)
270 MEDf	[you don't worry (??) when we are going on=
271 MIDf	=quando sei alla fine della gravidanza
	= when you are towards the end [of your pregnancy

Two aspects of these clinician's contributions are in our view worthy of note. First, since they are produced in overlap with the mediator's rendition of the patient's answer, they put constraints on the mediator about whether to go on with the current rendition or start a new one. Secondly, the playful attitude of the clinician, particularly in turn 269 ("a meno che tu non fai tutto in due o tre giorni/ *unless you do it all in two or three days*"), together with her pooling a lot of information into one single utterance, creates a burden on the mediator. The mediator renders "non ti preoccupare" ("you don't worry"), cutting the joke and starts to explain that information will come later (turn 270). Again the midwife self-selects in turn 271, confirming that more information will be given later. Here a misunderstanding is generated (and solved by the mediator), as shown in extract (8b).

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(8b)

271	MIDf	=quando sei alla fine [della gravidanza
		= when you are towards the end [of your pregnancy
272	PATf	[I (??) it's too early ((laughter))] [(during) the last week
273	MEDf	[oh no it's not the last week
274	PATf	after delivery
275	MEDf	(that's ehm)
276	MIDf	l'ultimo mese la mandiamo in [ospedale]
		the last month we'll send her to the [hospital]
277	MEDf	[that's ehm] on the around the seventh month
278	PATf	ah okay okay okay=
279	MEDf	=we'll talk about it ((laughter)) okay ((laughter)) (not last) week

This time it is the patient who self-selects in turn 272, possibly showing that she was aware that her request has been made too far in advance ("it's too early ((laughter))") and adding her interpretation of either the midwife's words in Italian or of what might be the correct moment to ask for information about delivery and post-delivery. By uttering her interpretation, the patient shows she has understood what is going on. The mediator thus provides an explicit repair in turn 273, then hesitates and the midwife comes in with more accurate information, which is rendered with an explanation in turns 277 and 279, and acknowledged by the patient in turn 278.

Although understanding seems achieved by the end of sequence (8b), coordination between the clinician and mediator appears compromised. The clinician is clearly monitoring the conversation and responds relevantly to the patient's misunderstanding with a clarification (last month, not last week). The mediator's rendition in turn 277 is however completely redesigned. In addition to specifying the time of pregnancy in which patients are normally informed about delivery and post-delivery organization (which appears more precise than the timing indicated by the clinician), the turn contains a substituted rendition: rather than translating literally as "we'll send you to hospital", the mediator renders as "we'll talk about it". Although in the end the patient receives an adequate response (as shown by her response "okay okay okay", turn 278), the remedial work stemming from the clinician's overlapping, packed and playful response, and consequent failure to focus on the uptake of the patient's query has considerably complicated the interaction.

4. Conclusion

The two consultations analysed in this contribution were selected specifically to show behaviours by clinicians that facilitate or hamper the mediator's task, so they are clearly very different. A granular analysis has shown that the differences observed can be linked to specific clinician behaviours that are recurrent in the

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two encounters and that have an impact on key sequences such as questioning and answering and clinicians' uptake of patients' contributions.

In the first consultation, the clinician's questions are explicitly directed to the patient, they are clearly designed as single-turn questions, and turn-transition time is slow, all characteristics that taken together make it possible, for the mediator, even if not experienced, to render and for the patient to respond. The clinician's uptake of the patient's contributions is provided systematically after the mediator's renditions and consists in short, clear turns that are explicitly directed to the patient. While this interactional organization may appear a bit slow and indeed even plodding, the uptake on the mediator's part shows that she clearly identifies what needs to be rendered and how. Her coordinating activity is evident, both from the continuation feedback she provides to the patient and from her splitting the clinician's longer turns into several parts when rendering them to the patient. Overall, however, there is little re-designing of the clinician's contributions (almost translatable "as they are") and basically no work on timing (e.g. management of overlaps). The two professionals appear fully concentrated on the patient's participation, both in terms of eliciting talk from her and in making contents clear to her.

In the second consultation, the mediator's uptake shows that although she captures the meaning and relevance of the clinician's contributions, rendering them is not a smooth task. The clinician's contributions are frequently multifold and not directly oriented towards the patient, leaving to the mediator the task of redesigning them for the patient. While in our data mediators sometimes redesign clinician's turns in their renditions, this is nonetheless a complex activity that requires time, time that in this case the mediator is not given. The clinician's playful attitude adds a further burden to the mediator's task: her sarcasm about the complexity of the details to collect, for example, or her joke about the patient's haste to conclude her pregnancy are not easily rendered, and indeed are left out in favour of "clinical content", like history-taking questions or the provision of reassurance.

As mentioned earlier in this paper, the mediator in consultation 1 is less experienced than the one in consultation 2 and less familiar with the clinicians working in this setting. This is visible from some of her renditions, both in this and other interactions, which are sometimes not fluent or contain too many or overly long pauses. The clinicians' contributions are however helpful and collaborative, as she not only shares what needs to be said to the patient, but also how to say it. The mediator in the second consultation is more experienced and has worked with the midwife in question on other occasions, which undoubtedly facilitates her understanding and handling of the interaction. This familiarity is visible in her almost immediate uptake of the midwife's jokes and in her ability to select from the clinician's "packed" turns which items are most relevant to render. Collaboration between the mediator and the clinician is nonetheless not easily achieved. The mediator's work is made difficult in several respects: she has little time to render complex items, e.g. how to render the sense of jokes; she needs to select which parts of the clinician's contributions are in fact "for the patient"; she needs to re-design the turns so that they are acceptable and understandable for the patient. She is clearly under considerable pressure,

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to the extent that at a certain point in the consultation she will understand the word "thyroid", as produced by the patient, "as "tired" and consequently misinterprets.

We have dedicated relatively limited attention in this analysis to the facets of the two patient's lifeworld and trajectories that contribute to positioning them as more or less vulnerable. This is not to deny or underestimate the importance of such determinants but, more simply because – as is also the case for the medical professionals involved – these are often inaccessible to the analyst and, even where known, can be notoriously difficult to pin down in the *hic et nunc* of interaction. This said, it is commonly recognised that situations of vulnerability are widespread whenever interpreted interaction is involved, particularly in health care. A recent meta-analysis of scholarly work on the concept of vulnerability as applied to women on the childbearing spectrum (Colgiago et al, 2020) shows that immigration and, with sporadic exceptions, language barriers are characteristics shared by members of all of the social groups identified by researchers as potentially vulnerable. Moreover, aspects of patients' experience that make them more vulnerable may emerge or at any rate become visible only during the interaction itself: for instance, that the Nigerian patient in consultation 1 is clearly frightened and hesitant to speak up or that the Indian patient in consultation 2 is potentially at risk due to a pre-existing health condition. Our analysis highlights that much can be done to facilitate interaction in cases in which patients are emotionally fragile and not easy to involve. Just as importantly, it illustrates that involving patients can be achieved even when the mediators may not be optimal professionals, as is the case of the mediator in consultation 1, who is just starting out, or may occur in emergency situations where trained interpreting staff may not be available.

Interpreting Studies have long forwarded the view that, in order to work smoothly with interpreters, institutional staff should speak to the patients and allow interpreters time to render (see Felberg and Sagli 2023 for a recent discussion). Besides confirming that there is some truth to these general guidelines, our analysis supports the need for clinicians to receive procedural training to become more effective when speaking through interpreters or mediators. It provides evidence that the activity of translating is made relevant *jointly* in the interaction and cannot be treated as an activity that is the sole responsibility of the interpreter or mediator. The clinician's orientation in the first interaction towards "being translated" and towards presenting items as they might be presented to the patient, show a systematic orientation towards translation as an ongoing activity that is helpful to the mediator and, we would argue, often crucial to carrying out multilingual mediated medical consultations successfully with vulnerable patients.

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