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THE ROLE OF INTERCULTURAL MEDIATORS IN HEALTHCARE INTERACTIONS BETWEEN ENGLISH-SPEAKING PATIENTS AND ITALIAN CLINICIANS DURING ELECTRONIC DOCUMENTATION

FEDERICA CECCOLI*, DANIELE URLOTTI**, LAURA GAVIOLI**
*UNIVERSITÀ DI BOLOGNA
**UNIVERSITÀ DI MODENA E REGGIO-EMILIA

federica.ceccoli3@unibo.it
daniele.urlotti@unimore.it
laura.gavioli@unimore.it

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Abstract: Effective clinician–patient communication is fundamental to harmonious relationships and the success of care provided. With the increasing use of electronic medical records and the direct involvement of clinicians in dealing with them, concerns have been raised regarding the potential negative impact of digital parallel activities on the interactional construction (Crampton *et al.* 2016). The communication challenges are further exacerbated when patients come from migrant backgrounds and have limited linguistic proficiency. Extensive research in community interpreting has shown the crucial coordinating role interpreters play in healthcare settings, facilitating communication and improving the overall quality of care (Angelelli 2004; Gavioli and Merlini 2023). This study aims to explore an additional dimension of this issue by examining whether mediators can also contribute strategically to clinician-patient communication when clinicians are occupied with electronic documentation. Drawing on a corpus of 100 audio-recorded, interpreter-mediated encounters collected from health centers in two provinces of northern Italy with patients speaking English as a second language, this paper investigates how interpreter-mediated medical encounters unfold when clinicians direct their attention to computers to enter data. We specifically look at how participation is redistributed in these moments, focusing on the practices used by clinicians, mediators, and patients to manage typing episodes while ensuring both information accuracy and the relational quality of care.

Keywords: clinician–patient communication; interpreter-mediated encounters; healthcare mediation; electronic medical records (EMR); typing.

1. Introduction[1]

Effective communication between clinicians and patients is a cornerstone of quality care. It builds trust, enables accurate history-taking and diagnosis, and supports shared decision-making and adherence to treatment (Heritage and Maynard 2006). In contemporary medical settings, communication occurs alongside the routine use of electronic medical records (EMRs), which require clinicians to divide their attention between the patient and the screen. Previous studies have documented the benefits and risks of using EMRs: while EMRs can enhance capturing and sharing biomedical information, they may also reduce eye contact, disrupt the flow of conversation and limit opportunities for empathy if they are not carefully integrated into the consultation (Ventres and Frankel 2010; Crampton *et al.* 2016). These challenges are further exacerbated in intercultural consultations, where language, culture and health literacy can differ significantly, and where the involvement of interpreting services is often necessary to ensure mutual understanding (Angelelli 2004; Gavioli and Merlini 2023).

Although interpreting in the interaction involves much more than replacing text in one language with text in another language and studies have shown that coordinating turn-taking, negotiating meaning, and managing alignment is part and parcel of the provision of interpreting, empirical studies on how translating intersects with EMR use during consultations remain scarce. Little is known about what occurs at the precise moments when clinicians turn to the computer – how talk is organised while documentation proceeds and how participation is allocated. As typing episodes have become routine, they constitute predictable loci where interaction may depart from the projected sequential trajectory. This paper examines these dynamics through a conversation-analytic study of interpreter-mediated consultations in Northern Italy. The corpus comprises 311 audio-recorded encounters involving clinicians, English-speaking patients, and intercultural mediators providing interpreting service in Italian healthcare settings. The focus is on episodes in which clinicians direct their attention to the computer in order to enter data, and on how the interpreter-mediated medical encounter unfolds on these occasions.

The paper contributes to research on both healthcare and interpreted interactions by showing how EMR use intersects with linguistic and cultural mediation at the level of sequential organisation. By making visible how participation is redistributed during documentation, the study highlights the interactional practices through which clinicians, mediators, and patients manage typing episodes so as to safeguard both information accuracy and the relational quality of care. The structure of the article is as follows: the theoretical framework (Section 2) reviews work on clinician–patient communication, EMRs,

[1] This paper was jointly discussed, authored and edited, however Federica Ceccoli had the idea for this research first and was the training force for writing the paper. She is specifically responsible for sections 1, 2.1, 4.2 and 5. Daniele Urlotti is responsible for sections 2.2, 3 and 4.1 and for painstakingly revising the transcripts. Laura Gavioli provided the data, discussed the analysis and revised the paper extensively.

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and interpreting/mediation in healthcare. The methodology section (3) outlines the corpus and conversation-analytic approach. The analysis comprises two sections: (4.1) clinicians' EMR work aligned with mediator–patient dyads; (4.2) patients' initiatives during typing episodes. The paper's conclusions are presented in Section 5.

2. Theoretical framework

2.1. Clinician–patient communication and electronic medical records (EMRs)

Research on clinician–patient communication has consistently emphasised its pivotal role in establishing trust, eliciting accurate information, and ensuring adherence to treatment (Heritage and Maynard 2006). Patients seek information that is personally relevant and want to both "know and understand" and "feel known and understood" (Ong *et al.* 1995: 904). Thus, beyond exchanging biomedical facts, empathic patient-centred communication is essential if preferences and needs are to be taken into account (Levinson 2011).

At the same time, in recent years, the widespread introduction of electronic medical records (EMRs) has transformed the ecology of the medical consultation with the clinician's attention now caught between patient and screen (Crampton *et al.* 2016). Clinicians routinely use computers during visits to retrieve patient histories, document information, fill prescriptions, and arrange follow-up appointments. Records are treated as "objective" resources that complement patients' "subjective" accounts, enabling history-informed treatment and coordination with peers (Nielsen 2014; 2016). EMRs are not merely neutral repositories, but also additional participants in the care encounter contributing to shape gaze, turn-taking, and activity timing, and effectively turning a formerly dyadic encounter, when the encounter is monolingual, into a triadic one in which the record itself participates (Pearce *et al.* 2013). Several studies have highlighted both the benefits and challenges of EMRs. On the benefit side, EMRs reliably prompt, organise, and present biomedical data, improving capture, sharing, continuity, and safety (Graetz *et al.* 2014). On the cost side, documentation work – navigating menus, scrolling long lists, and keyboarding – can divert attention to the computer for extended stretches, which may reduce eye contact and empathic opportunities and make it harder to elicit psychosocial and emotional information. Physicians frequently report difficulty balancing accurate, comprehensive data entry with concurrent delivery of patient centred care (Ventres and Frankel 2010).

From a conversation analytic perspective, the use of EMRs raises issues of multiactivity, as clinicians must coordinate speaking and listening with record inspection and typing (Mondada 2011; 2012). Studies have revealed that this dual orientation can affect the consultation in two distinct ways: on the side of patients and on the side of clinicians. For patients, research has shown that they frequently adapt their talk to the rhythm of typing, sometimes pausing until the clinician finishes keying entries (Greatbatch *et al.* 1993; Heath and Luff 2000).

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Conversely, when clinicians read records while patients are presenting problems, patients' accounts may become hesitant and dysfluent (Heath 1986; Ruusuvuori 2001), underscoring the tension between being listened to and being registered. For clinicians, the challenge lies in managing this dual orientation, which ranges along a continuum of how explicitly they make their record use visible to patients (Nielsen 2014; 2016). At one end of the continuum, clinicians treat record reading as self-evident and proceed without explanation, relying on patients' implicit understanding of its medical relevance – though patients may sometimes resist the timing. In the middle, clinicians provide explicit explanations, framing record use as a purposeful but temporary departure from ongoing talk and as a way to confirm or challenge patients' accounts. At the other end, clinicians use alluding questions that both elicit patient responses and implicitly indicate what they are searching for in the record, allowing them to integrate reading with patient interaction. Overall, these practices show how the introduction of records shapes patients' participation while also requiring clinicians to manage the complex multiactivity of interacting with patients and the screen.

The timing of record use further structures the rhythm of consultations. Clinicians often pre-emptively close down talk before turning to records, creating a "free turn" that either party (clinician or patient) can use (Newman *et al.* 2010). Two preferred timeframes shape the continuation of talk: most conversations resume within 10 seconds, and topical continuity is most likely when pauses are shorter than 5 seconds. By contrast, longer pauses typically require restatement or a shift to a new topic. The use of records thus structures the rhythm of medical consultations, with observable timeframes shaping when and how conversations are resumed and whether the same topic is maintained (*ibid.*).

2.2. Linguistic and cultural mediation in healthcare

Within intercultural medical encounters, the communication challenges associated with EMRs intersect with those posed by linguistic and cultural diversity. Migrant patients may have limited proficiency in the local language and often bring culturally specific ways of narrating symptoms, understanding illness, and framing expectations of care. Particularly in light of these perceived differences, the Italian public health system often relies on "intercultural mediators" to ensure mutual understanding. Their role – explicitly defined in a document issued by the Italian National Council of Economy and Labour (CNEL 2009) – is to facilitate communication between clinicians and patients at both linguistic and cultural levels. In practice, intercultural mediators provide interpreting services in healthcare settings.

While they may or may not have academic training, intercultural mediators are typically individuals with a migrant background and proficiency in both Italian and one or more other languages – often including languages of lesser diffusion, which is arguably one of the main reasons services rely on them (Pokorn *et al.* 2020). The use of intercultural mediators instead of professional interpreters has long been debated, and the emphasis placed by public services on addressing "cultural issues" has not been without problems (see Baraldi 2023; Skaaden 2023). Nonetheless, the dual aim of creating a welcoming environment

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and managing the wide variety of languages and dialects spoken by migrant communities has made this choice a consolidated practice in Italy. More recently, Italian services have also started investing in training: in the region where our data were collected, intercultural mediators take part in dedicated programs designed to equip them with the skills and competences needed to perform their role effectively (Chiarenza 2020).

Our study is based on naturally occurring interactions that were recorded and transcribed, and it sits within a wider trend of studies examining what participants do while talking. One major issue possibly emerging from this body of work is that, in triadic exchanges, interpreters' actions extend beyond translation to the coordination of interaction, making continuous reference to the participants' activity as a "situated" one (Wadensjö 1998). These coordination activities have included the study of question–answer sequences (Baraldi 2015), the design of non-literal renditions to produce positive communicative outcomes (Baraldi and Gavioli 2014), and the ways in which mediators sustain direct communication between patients and clinicians (Gavioli and Wadensjö 2021). Other studies have highlighted how coordination practices are adapted when interacting with patients with limited proficiency in English: mediators may simplify the medical language (Watermeyer et al. 2021), expand their rendition to explain the efficacy of treatments more clearly (Madlon-Kay and Smith 2019), distribute the content of complex utterances over multiple shorter renditions (Urlotti 2023; 2024) or rely on repetitions to secure mutual understanding with the patients (Urlotti forthcoming).

Of interest to our purposes here, a recent study by Bolden (2019) has explored how medical instruments intersect with the dynamics of interpreter-mediated conversation. The paper analyses an optometrist examination in which the patient's eye pressure is measured using an instrument called a tonometer. While the clinician instructs the patient on how to position her head in relation to the tonometer, the Russian–English interpreter plays a pivotal role in managing the boundaries of the examination by moving around the room and providing instructions to the patient at precisely the moment she needs to adjust her position for the examination to proceed correctly. Thus, this study shows how the tonometer becomes 'a participant' in the interaction, and how the interpreting activity incorporates the instrument, as well as the clinician's actions in operating it, to successfully coordinate the examination.

Building on this line of research, our analysis investigates how EMRs intersect with the linguistic and cultural mediation activity of intercultural mediators in a local Italian healthcare setting. Focusing on how clinicians, patients, and mediators manage moments in which EMR use temporarily reorganises participation, the analysis contributes to a deeper understanding of how healthcare communication is negotiated in interpreter-mediated encounters.

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3. Methodology and data

The data analysed in this study are drawn from a corpus of 311 audio-recorded interpreter-mediated medical encounters collected between 2004 and 2024 in hospitals and surgeries located in two provinces of northern Italy (Corradini *et al.* 2024) and dealing mainly with women's health. All recordings were anonymised or pseudonymised, and informed consent was obtained from clinicians, patients, and mediators prior to data collection. Transcriptions were produced following Conversation Analysis conventions (Hepburn and Bolden 2017) in order to accurately represent the spoken language used during these interactions.

Although the data were audio recorded, which may pose a significant problem for research focusing on the integration of verbal and non-verbal actions, the recordings reproduce background sounds with considerable accuracy. In addition, field notes taken by the researchers present during data collection provide further detail on sounds heard in the environment. Thus, while we lack access to gaze and posture, the audio track was sufficiently accurate to allow us to complement our transcripts with some of the conventions used in multimodal transcription (Mondada 2018). This made it possible to capture the phenomena related to EMR use, including typing, mouse clicks, and other sounds produced by the use of pens or staplers. Mouse clicks, in particular, were treated as a key cue for identifying when clinicians who were not typing were nevertheless engaged in EMR activities. Given that one of the aims of the study was to achieve precise alignment between EMR activity and participants' speech, and given the rapid nature of mouse clicks (which usually correspond to a maximum of one or two uttered syllables), these were consistently annotated with the abbreviation "*m.c.*" in order to minimise space in the transcripts (further details on transcription conventions are provided in the Appendix).

The encounters involved three main groups of participants: i) clinicians, primarily gynaecologists and midwives; ii) patients, most of whom were migrants with varying degrees of proficiency in English used as a second language or a lingua franca; iii) linguistic and cultural mediators, with experience in healthcare settings, who provided interpreting in the public services. On the topic of linguistic variation, the patients in the recordings were mostly from Western Africa (Ghana and Nigeria in particular) or from India and the Philippine islands. In these countries, despite being an official language, English is widely spoken as a lingua franca, often in the form of a pidgin or other non-standard variety. This explains why in the extracts below it is not unlikely uncommon to find instances of non-standard English, which however does not impede mutual understanding between the mediators and the patients.

The analysis adopts the methodological framework of Conversation Analysis (CA). CA provides tools to examine how participants organise talk sequentially, negotiate meaning, and manage turn-taking in real time, in authentic interactions (Sacks *et al.* 1974; Heritage 2008). As mentioned above, our focus is placed on moments in which clinicians direct their attention to the computer for data entry, thereby reducing their availability as conversational participants, and

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on how mediators and patients coordinate their turns-at-talk in relation to the clinicians' undertaking of EMR activities.

While the analysis clearly concerns only verbal behaviour and nothing can be said on the role of gaze or posture in turn-exchanges, the data provide enough cues to investigate verbal work related to (1) how clinicians organise EMR work by orienting to the mediator–patient dyad as an interactional space and how mediators act during clinicians' typing; (2) how patients take the initiative during clinicians' typing (e.g., asking questions, introducing topics) and how these moves are made accountable. Sections 4.1–4.2 address these foci in turn – first clinicians' EMR work during mediator–patient exchanges, then patients' initiatives when clinicians' availability is reduced during typing. Each section presents short extracts followed by a micro-analytic commentary on the management of talk when EMR use is in play.

4. Analysis

4.1. Clinicians' EMR work during mediator–patient dyad

A recurrent phenomenon observed in the corpus is the temporal correlation between EMR documentation by the clinician and mediator-patient dyads. In the context of history-taking, for instance, once the clinician has formulated a question in Italian, the mediator and patient often engage in a dyadic exchange that temporarily sustains the consultation. This arrangement enables the clinician to turn to the computer and type without disrupting the overall progressivity of the anamnesis. Extract 1 part 1 illustrates this practice in detail.

The clinician initiates a history-taking sequence about the patient's food habits by addressing the patient in Italian (*"raccontami che cosa mangi in un giorno/tell me what you eat in a day"*), which the mediator renders with a general question in English for the patient (*"what do you eat?"*). The mediator's rendition triggers a request for clarification by the patient in line 907: "this morning?". The mediator then clarifies that the request refers to a typical day, in overlap with the clinician, who rephrases her question to ask about what the patient eats in the morning. In lines 910 and 912, the mediator renders both the first and second versions of the clinician's questions, to which the patient responds by stating what she eats in the morning in line 913. The clinician starts her EMR activities by typing in overlap with the beginning of the patient's response, while other EMR activities can be heard both at the beginning of line 914, where the patient simply repeats "in the morning", and in line 915 during a gap of silence, after which the mediator can be heard producing a single feedback token ("*mh*"). It is interesting to note that the mediator's feedback is immediately followed by the patient providing more details on what she eats in the afternoon (lines 917–918), while EMR activities continue at times, both in lines 917 and 918, and during the 0.4 second gap in line 919. In line 920, the mediator provides further continuation feedback, but this does not prompt the patient to resume her narrative, which she stops in line 921 with a suspended "so:" produced in overlap with the clinician's typing. This first part of the extract clearly shows that: a. the

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clinician is not asking questions, providing clarifications or feedback since she is engaged in EMR activities; b. the patient may be finding it difficult to carry on with her narrative without a responder as shown by some interactional disfluencies ("let me see" line 917; the suspended "so:" line 921); c. the mediator hesitates to align as a responder and only provides minimum feedback.

Extract 1 (part 1) [GYNf = gynaecologist; MEDf = mediator; PATf = patient]

```
901  GYNf   prova solo a (0.5) raccontarmi che cosa mangi (.)
            just try to           tell me what you eat
902         [in un g]iorno
             in a day
903  MEDf   [ . h h ]
904  MEDf   hm
905         (0.6)
906  MEDf   what do you eat?
907  PATf   this morning?
908  MEDf   [[in a day e:h]
909  GYNf   [[come comincia] la mattina?
              how does your morning begin?
910  MEDf   in [a day]  what do you eat?
911  PATf      [ m:h ]
912  MEDf   in the morning?
913  PATf   *in the morning *sometimes I take tea (.) or pap
     gynf   *typing---------*
914  PATf   *in the morning
     gynf   *m.c.
915         *(0.7) *
     gynf   *typing*
916  MEDf   mh
917  PATf   because in the afternoon *time I* take let me see
     gynf                          *typing*
918  PAT    *s o m e* more ( ? ? )
     gynf   *typing *
919         *(0.4) *
     gynf   *typing*
920  MEDf   m:h
921  PATf   *so:
     gynf   *typing-->
922  MEDf   in the* morning (.) tea *with what ?
     gynf      -->*                *m.c.
```

A real dyadic sequence then begins in line 922, when the mediator asks a question to elicit more details from the patient about what she eats during the day. From this point, the clinician's engagement in EMR work results in an expanded mediator–patient dyad.

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Extract 1 (part 2) [GYNf = gynaecologist; MEDf = mediator; PATf = patient]

```
922  MEDf   in the* morning (.) tea *with what ?
     gynf      -->*                 *m.c.
923  PATf   *tea (.) or pap (0.3)*
     gynf   *typing--------------*
924         (0.3)
925  PATf   o[r (the)] bread
926  MEDf    [ o r ? ]
927  MEDf   a pap custard?
928         (0.5)
929  PATf   *yes
     gynf   *typing-->
930  MEDf   mh
931  PATf   or our Nigerian (.) pap*
     gynf                       -->*
932         (1.4)
933  MEDf   eh?
934         (0.6)
935  MEDf   which?
936         (0.8)
937  MEDf   which *Nigerian pap?
     gynf         *m.c.
938  PATf   (our) *akamu  *(and) carton milk
     gynf         *m.c.   *pen noise
939         (0.6)
940  MEDf   a:h
941         (0.3)
942  PATf   m:[h
943  MEDf     [mh
944         (0.5)
945  PATf   (not) the white
946         (1.1)
947  MEDf   okay
948  GYNf   che cosa ha detto?
            what did she say?
```

Extract 1 part 2 shows the interactional achievement of the expanded mediator–patient dyad. At line 922, the mediator expands her rendition with “in the morning (.) tea with what?”, thereby pursuing further details from the patient while the clinician remains focused on electronic documentation, as indicated by ongoing typing and a mouse click. Typing continues throughout the patient’s response in line 923 and again between lines 929 and 931, while the mediator keeps the elicitation going, providing continuation feedback to the patient’s answers (line 930). Several noticeable gaps (932, 934, 936) follow, after which it is the mediator who again takes the floor (lines 935 and 937) to seek clarification about the type of food mentioned by the patient, and thus continuing an expanded dyadic sequence with the patient down to line 947. During this extended dyadic exchange, the mediator does not render the talk into Italian, possibly because the clinician is still audibly engaged with the EMR work.

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Instead, the mediator continues eliciting information directly from the patient, delaying her rendition until the clinician explicitly requests it at line 948 ("*che cosa ha detto? / what did she say?*").

This extract shows how periods of EMR activity can result in an expanded mediator–patient dyad, in which the consultation progresses through the mediator's elicitation of additional details while the clinician remains occupied with documentation. The interpreter–patient dyad functions as a holding space that allows the consultation to progress in the absence of direct clinician involvement. The mediator sustains the question–answer sequence with the patient, thereby ensuring that relevant information is produced while the clinician is simultaneously engaged in documentation tasks. The clinician re-enters the interaction, interrupting her typing, and with an explicit request for translation, thus ending the mediator–patient dyad and resuming the collection of the information provided by the patient (line 948).

From an interactional perspective, these two parts of the extract show complementary dynamics. In Part 1, the mediator–patient exchange begins and the clinician takes advantage of it to initiate typing (line 913), thus exploiting the dyadic talk as a space for documentation. In Part 2, by contrast, the dyad is expanded precisely because the clinician remains absorbed in EMR activities: the mediator compensates for the clinician's temporary unavailability by expanding her interaction with the patient through a request for information (line 922) and further requests for clarification (lines 927 and 937). In both cases, the consultation progresses through the mediator–patient exchange, which functions as a holding space until the clinician re-joins the triad.

More broadly, the clinician's engagement with the computer re-orients the interaction into two parallel dyads, clinician–computer and mediator–patient. The computer thus becomes an additional participant in the encounter, treated by the interlocutors as temporarily displacing the clinician's attention. The mediator's role extends beyond translation: by sustaining the patient's talk during the clinician's engagement in typing, she effectively guarantees the continuity of the institutional project (the elicitation of a dietary history) while accommodating the dual demands of communication and digital documentation. A summary of what the patient said to the mediator (data not shown) re-engages the clinician in the triad and contributes to the fulfilment of the digital task.

In Extract 2, an interactional space for a mediator–patient dyad is once again generated while the clinician engages in typing.

The sequence begins with the clinician offering advice in Italian on dietary adjustments (lines 241–246), culminating in the specific recommendation to eliminate fizzy drinks ("*lei dovrebbe togliere le bevande gassate / she should give up fizzy drinks*" line 246). The mediator provides continuation feedback at line 244 (followed by further advice from the clinician) and again at line 247. After a 0.7 second gap, the mediator produces a confirmation token ("*mh*"), and in line 249 begins rendering the clinician's advice into English for the patient (lines 249–253).

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Extract 2 [OBSf = obstetrician; MEDf = mediator; PATf = patient]

```
241 OBSf   ci sono alcune cose che si possono fare per vedere se
           there are some things that can be done so as to see if
242        (.) migliora
            it/she ((can)) improve
243        (0.3)
244 MEDf   e:h
245        (0.4)
246 OBSf   lei dovrebbe togliere le bevande gassate
             should  give  up  fizzy  drinks
247 MEDf   si:
           yes
248        (0.7)
249 MEDf   mhm (.) *there are some things (.) that you*
    obsf           *typing----------------------------*
250        have to do
251        (0.2)
252 PATf   °okay°
253 MEDf   and to see whe*ther (.) you feel better
    obsf                 *m.c.
254 PATf   °okay°
255        (0.6)
256 MEDf   anything (.) containing (.) gas (0.4)
257        *you don't you don't* you are not supposed to take
    obsf   *typing-------------*
258        them
259        (0.9)
260 PATf   °okay°
261        (0.2)
262 MEDf   e:h (0.6) water (0.7) that contains *gas
    obsf                                      *m.c.
263 PATf   e:h water that contains *[gas]
264 MEDf                           [e:h] *all these coca
    obsf                          *m.c.  *m.c.
265 MEDf   cola all *these
    obsf            *m.c.
266        (0.6)
267 MEDf   all these
268        (0.9)
269 PATf   [°okay°]
270 MEDf   [ that ] *contain gas
    obsf            *typing-->
271        (0.4)
272 PATf   [[°okay°]
273 MEDf   [[ e : h] you don't drink them*
    obsf                              -->*
```

Similarly to what occurs in Extract 1 part 1, as soon as the mediator renders, keyboard typing starts. The clinician thus apparently remains engaged in EMR-related work, thereby leaving space for a mediator–patient dyadic sequence to

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develop until the end of the extract (line 273). Even in this case, the shift from triadic to dyadic talk is not done without hesitation, but once the clinician starts typing and stops giving verbal feedback, the mediator engages in expanding the clinician's initial prompt (question or advice) by interacting with the patient. This sequence shows that while the clinician is engaged in EMR-related work, the mediator can use the dyadic space with the patient to produce more detailed expanded renditions that clarify or elaborate on the meaning of the clinician's original utterances.

Extracts 1 and 2 illustrate a recurrent practice in the corpus. The clinicians initiate topics/sequences and then rely on the mediator–patient dyad to sustain the consultation while they are engaged in computer-based documentation. During this phase, the mediator and patient form a temporary interactional unit that enables the history-taking to progress without interruption. The mediator ensures that the interactional project continues despite the clinician's partial withdrawal. The patient, in turn, orients to the mediator as the most available conversational partner, negotiating clarifications directly with the mediator while the clinician is typing.

4.2. Patients taking the initiative during clinicians' EMR work

Extracts 3 and 4 show that patients themselves sometimes take the initiative to ask questions or make comments while clinicians are occupied with the EMR. Rather than waiting passively, then, patients too may "have their space" with the mediator to ask for advice or elaborate on their symptoms while the clinician is typing. In these moments, patients typically orient to the mediator as their most available interlocutor, turning the interaction into a dyadic exchange that unfolds independently of the clinician's immediate participation. These initiatives underline that patients are not passive participants waiting for the clinician's availability. Instead, they display interactional agency by mobilising the mediator as a conversational partner, thereby contributing to the co-construction of the medical encounter. Extract 3 provides the first example of a patient taking the initiative to raise a new topic while the clinician is engaged in EMR work.

While the gynaecologist is typing the information previously received (i.e. for how long the patient has been suffering from itchy skin; lines 75–6), the patient raises a new topic in English, asking whether she should use natural oil for her stomach and breast (lines 77–82). This initiative occurs while the clinician is clearly engaged in EMR-related activities (lines 74, 79, 80–1, 83), and murmuring to herself, as indicated by the softer delivery of "allora / so" (line 75), and by the paused articulation of some of the syllables in the sentence "tre (.) o (.) qua(.)ttro / three (.) or (.) fo(.)ur" (line 75). The patient thus orients to the mediator as her most available conversational party, addressing her questions about creams and oils directly to her.

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Extract 3 (part 1) [GYNf = gynaecologist; MEDf = mediator]

```
74          *(1.8)
     gynf   *typing-->
75   GYNf   °allora° (.) tre (.)
              so        three
76          [o (.) qua(.)ttro (.) settimane]
            or       four          weeks
77   PATf   [of  course  I should u:se natu]ral* olio?
     gynf                                   -->*
78          (0.8)
79   PATf   for the stomach (.) I should *stop using:* my cream
     gynf                               *typing-----*
80          *(0.4)
     gynf   *typing-->
81   PATf   I should* use natural
     gynf        -->*
82          *olio [for the] stomach and for the breast?*
83   MEDf         [ m  h  ]
     gynf   *typing-------------------------------------*
84          (0.5)
85   MEDf   *hm
     gynf   *typing-->
86   PATf   uh I* don't know
     gynf    -->*
87          (0.6)
88   MEDf   [[m h   m h]
89   PATf   [[*no (   )]
     gynf     *typing-->
90          (1.6)* + (1.0) + *(1.0)* + (0.4) + *(4.4)*  + (0.4)
     gynf     -->*          *typing*          *typing*
91   MEDf   *what cream?* depends on what cream *you use
     gynf   *typing-----*                       *typing-->
92   PATf   e:h I use (.) mh Skin Success
93          (0.4)
94   MEDf   m:h
95   PATf   e:h
96   MEDf   what you know exactly what* it contains?
     gynf                           -->*
97          (0.3)
98   PATf   m:h
99          (1.1)
100  PATf   I don't know
101         (0.4)
102  PATf   *but its other name i:s (.) Fade Milk*
     gynf   *typing------------------------------*
103         (1.6)
104  MEDf   m:h
105         (0.3)
106  PATf   mh
107         (0.8) + *(0.9)--------* + (0.9)
     gynf           *m.c. + typing*
108  MEDf   no if it doesn't *contain mercury is* i:s okay
     gynf                    *typing------------*
109         (0.4)
110  MEDf   *look at it if it contains mercury (.) don't use it
     gynf   *typing-->
111  PATf   okay
112         (1.9)* + (0.7)
     gynf     -->*
```

The mediator responds minimally at first (lines 83 and 85), producing continuers (*"mh"*), which display attention but do not yet directly address the patient's concern. While the clinician can still be heard typing (lines 85–6), the patient produces a claim of lack of knowledge (*"I don't know"*, line 86), which indirectly strengthens the relevance of her request for a missing piece of information. In response to this, the mediator does not render and instead steps in more actively (line 91) by asking a follow-up question (*"what cream?"*), immediately followed by a statement *("depends on what cream you use"*) which both explicates the rationale behind the question and indirectly shows the mediator's competence regarding the topic at hand. The patient's initiative thus recruits the mediator into a dyadic sequence that unfolds in parallel with the clinician's typing activity.

As the patient specifies the product she uses (*"Skin Success"*, line 92), the mediator pursues more details about its composition (line 96). The patient produces a feedback token (line 98), then, after a relatively long gap (line 99), she first claims her lack of knowledge (line 100) and then provides an additional piece of information (line 102) as a candidate answer to the mediator's question. During this sequence, the clinician can often be heard typing (lines 91–96 and 102). Although the patient cannot provide the requested information, the mediator still provides a relevant piece of information ("if it doesn't contain mercury is okay" line 108), followed by an explicit medical recommendation ("look at it if it contains mercury don't use it", line 110).

However, such recommendation is noticeably delayed. After the patient's answer (line 102), which is completely overlapped by typing, a long 1.6 second gap occurs (line 103), followed by a mediator's feedback token (line 104), a patient's feedback token (line 106), and then a further long gap of 2.6 seconds, partly overlapped by the clinician's typing (line 108). Only after this long gap does the mediator display her medical knowledge and provide her piece of advice, which is acknowledged by the patient with an "okay" (line 111). In doing so, the mediator orients to the fact that the clinician is still engaged in her EMR activities, which once more creates space for the continuation of the dyadic exchange with the patient, while postponing rendering. The guidance, provided by the mediator and delivered during the clinician's typing episode, addresses the patient's immediate concern and contributes to her sense of being heard. Extract 3 part 1 illustrates how patients may orient to the clinicians' temporary engagement in parallel activities like filling digital forms as "a temporary absence": they are not passive during typing episodes, but display agency by introducing new topics and seeking advice. Their initiatives temporarily reconfigure the participation framework: the mediator becomes a pivotal primary interlocutor, providing information as required by the patient, and later relaying the exchange to the clinician. Moreover, the extract also shows that while keeping the patient engaged and attending to their overtly manifested immediate needs, mediators monitor the clinician's engagement in EMR activities before providing medical information and/or advice.

Extract 3 part 2 shows the continuation of the same interaction, starting from the moment in which the mediator shifts from speaking English with the patient to starting her rendition into Italian.

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Extract 3 (part 2) [GYNf = gynaecologist; MEDf = mediator]

```
113  MEDf    mh
114          (0.7)
115  MEDf    mh (.)  no *la< la* crema che *sta usando
                     no  the the  cream that she is using
     gynf              *typing*          *typing-->
116  GYNf    mh mh?*
                 -->*
117  MEDf    se: *infatti* non voleva: usare *più: la crema sulla*
             if indeed she wanted to no longer use the cream on her
     gynf        *typing *                  *typing-------------*
118          pan:cia
             belly
119          (0.3)
120  MEDf    sì (.) la la la crema che u:sa di solito
             yes   the the the cream that she usually uses
121  GYNf    che cosa [usi] di solito?
             what do you usually use?
122  MEDf             [sì]
                       yes
123          (0.6)
124  MEDf    [[e:h ho chie]sto (.) [uhn] uhm si chiama Skin Success
              eh I've asked        uhn uhm it's called Skin Succes
125  GYNf    [[che crema]          [mh ]
              which cream
126  MEDf    però non sa che cosa: contiene
             but she doesn't know what it contains
127          (0.5)
128  MEDf    mh (.) così le ho detto se m:h
             mh     so  I've asked if m:h
129          (0.3)
130  MEDf    se: le:gge
             if she reads
131          (0.3)
132  MEDf    se va a leggere a guardare se contiene il mercurio (.)
             if she goes and reads and looks if it contains mercury
133          allora: deve smettere di usare se contiene mercurio
             then she must stop using it if it contains mercury
134  GYNf    [[ sì ]
               yes
135  MEDf    [[#e:#]
               and
136          (0.4)
137  GYNf    possiamo suggerirti un: una crema un olio anche un:
             we can recommend a a cream an oil also an
138          olio di ma:ndorle che è quello che .hh (.) insomma ha
             almond oil which is the one which         I mean has
139          [un costo] un pochino più: (.) ehm (.) contenu:to e
             a cost ((which)) is slightly more  ehm  reasonable and
140          può andare be:ne
             it can work well ((for you))
```

It is interesting to notice that it is the mediator who finds a way to have the clinician re-join the conversation. Following the patient's final acknowledgment (line 111), which is uttered while the clinician is typing, there is a 2.6 second gap, which is partly overlapped by the clinician's typing (line 112). This long gap is followed by a mediator feedback token "mh" (line 113), reiterated in line 115 after a 0.7 second gap (line 114), both produced in the absence of any typing. Only after her second feedback token does the mediator start to render the information gathered during the preceding dyadic exchange with the patient by saying "no la< la crema che sta usando / no the< the cream that she is using" (line 115). In doing so, the mediator seems to orient to the suspension of the EMR activities before trying to recruit the clinician back into the interaction. However, the clinician's typing activities are resumed soon after the beginning of the mediator's rendition (line 115) and, although the clinician produces a feedback token with rising intonation ("*mh mh?*" line 116), seemingly displaying her willingness to listen to the mediator, the mediator's following explanation (line 117) is still overlapped by typing sounds, which show that the clinician is only partly devoting her attention to the mediator's words. The mediator nevertheless succeeds shortly thereafter in gaining the clinician's full attention (lines 120–1), and in relaying both the patient's information (lines 124 and 126) and the medical recommendation given (lines 128–133), which the clinician confirms as correct (line 134) before providing an alternative recommendation of her own (lines 137–140). Extract 3 part 2 therefore shows that the mediator's monitoring of the clinician's EMR activities is not only instrumental in choosing whether to add further details for the patient (like in the first part of Extract 3), but also in determining whether transition to rendering is feasible and apposite.

Similarly to what occurs in Extract 3, in Extract 4 the clinician announces that the patient's scan will include an evaluation of the stage of pregnancy ("facciamo la datazione / let's calculate the ((due)) date", line 290), after which she starts the activity while simultaneously reading aloud the information she is entering into the form. Following a 2.2 second silence in line 295, the patient takes the initiative and orients to the mediator as the most immediately available interlocutor.

While the clinician shows engagement in EMR activities (by getting silent and starting typing; lines 290–294), the patient self-selects and asks a question in English about hospitalisation options after delivery (lines 296–297). This is a clear example of a patient taking the initiative to ask a question of particular relevance to her, while the clinician is clearly not available, and orienting to the mediator as the most accessible participant in the interaction.

Unlike in Extract 3, the mediator here does not provide an answer, but waits until the clinician is available, thus orienting to the relevance of the clinician's temporary engagement. At line 303 the clinician stops typing and seemingly acknowledges both the patient's utterance and the following silence ("che c'è Mary / what's the matter Mary?"), since neither a rendition has been received, nor talk has continued in English. Only after the clinician's solicitation does the mediator render the patient's concern (lines 305–314) and reassures the patient by clarifying that she will receive accurate information in due time (lines 325–326).

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Extract 4 [OBSf = obstetrician; MEDf = mediator; PATf = patient]

```
290   OBSf   faccia*mo la datazione
             let's calculate the ((due)) date
                   *m.c.
291          (1.0)
292   OBSf   Amira (0.3) A::(.)bami (0.2) Moghai
293          *(7.8)
      obsf   *m.c.
294   OBSf   quand'è nata il tredici lu*glio (1.6) ottantuno*
             when was she born on the thirteenth July    eighty-one
                                        *typing--------------*
295          (2.2)
296   PATf   erm I mean it's too early but I also would like to
297          know the hospitalization options after delivery
298          (0.4)
299   obsf   m.c.
300          (0.2)
301   obsf   typing
302          (0.5)
303   OBSf   che *c'è Mary ?
             what's the matter Mary?
                 *moves mouse
304          (0.5)
305   MEDf   °vu*ole  sapere cosa farà°
              she wants to know what she's going to do
      obsf      *m.c.
306          (0.6)
307   PATf   *°mh°=
      obsf   *m.c.
308   MEDf   =e- e- lo sa che è pre- è presto
              e- e- she knows that's ear- it's early
309          (.)
310   PATf   he[h : : : ]
311   MEDf     [è presto]
               it's early
312   OBSf   shìh:
             yhehs:
313   MEDf   *ma vuol sapere cosa< co-* come funziona qua qua-
             but she wants to know what< ho- how it works here whe-
      obsf   *typing------------------*
314   MEDf   quando è ora di (.) par*torire ((chuckles softly))
             when it's time to   deliver the baby
      obsf                          *typing-->
315          (0.9)
316   OBSf   è un po'* prestino
             it is kinda early
                  -->*
317          (0.7)
318   MEDf   £I said that [ it'  too  early£] ((chuckling))
319   OBSf                [intanto cerchiam-]
                          meanwhile we'll try<
320   OBSf   credevo che tu mi (.) p- perché credevo che
             I thought that you    b- because I thought that
321          tu [ mi  chiedess-  ]
             you would ask me<
322   PATf      [£I said it's too] early£
323          ((both MEDf and PATf chuckle softly))
324   DOCf   comunque non ti preoccupare [quando se- ]
             anyway do not worry          when you'r-
325   MEDf                               [don't worry] (.) when we
326          are going on=
327   OBSf   =quando sei alla fine della gravidanza
             =when you're at the end of the pregnancy
```

Although with a different sequential dynamic, this extract shows that clinician's engagement in EMR activities can create space for patients' initiatives to shift the visit to topics that are not yet on the clinician's agenda. The patient, in this case, asks about hospitalisation while the clinician is engaged in a parallel activity. Although the mediator does not answer the patient's question, she treats the clinician's engagement in typing as a parallel activity and waits for the clinician to get re-engaged. The patient's concern therefore remains in the mediator–patient space until the clinician asks what the patient has said. Only then does the mediator provide the rendering. This is a clear delayed relaying**:** the timing of the translation is shaped by EMR use, and the mediator withholds the turn rather than speaking into the clinician's divided attention. It can be noted that the silence of the patient and of the mediator is addressed by the clinician as significant ("*che c'è Mary? / what's the matter Mary?*"), and the re-engagement practice used by the clinician in this case is similar to what was seen in Extract 1, where after the mediator's "okay" the clinician asked a question prompting the mediator's rendition of the patient's words. The rendition, normally a summarised one, re-establishes the triadic form of talk.

5. Conclusion

The analysis of the extracts reveals that the use of electronic medical records does not interrupt or weaken clinician–mediator-patient communication but can be actively coordinated within the triadic encounter.

Since the clinicians' engagement in typing is treated as a parallel activity making the clinician temporarily unavailable, it creates a space for possible alternative activities. In some cases, these are initiated by the clinicians themselves, who begin the history-taking and then allow the mediator to expand on the information elicited. By exploiting the translation sequence as a space for documentation, clinicians reduce the extent to which typing interferes with the progression of the consultation. In this sense, the mediator–patient dyad becomes a resource that enables clinicians to reconcile the competing demands of digital record-keeping and empathic communication.

At the same time, patients display interactional agency during clinicians' typing. When the clinician starts typing, patients seize the opportunity to raise new concerns, ask questions, or seek advice from the mediator, who remains accessible or alternatively puts the reply/ies on hold and waits for the clinician's restored availability. This demonstrates that patients are not passive recipients of information but active participants who use the availability of the mediator to ensure their concerns are voiced and addressed; in these cases, it is the patient who initiates a dyadic sequence and recruits the mediator into it. However, these initiatives also create the need for subsequent integration, as the mediator must later relay the patient's questions or statements to the clinician, ensuring that no clinically relevant information is lost. Moreover, both patients and mediators orient to EMR activities as sequentially relevant in the turn-taking system. In particular, mediators are shown to withhold their renditions until EMR activities

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are seemingly finished, or to monitor EMR activities so as to find a suitable space for the clinician to re-join the triadic exchange.

Mediators can also make strategic use of typing episodes, either by addressing the patient directly or by soliciting more information in expanded dyadic sequences. These findings suggest that typing episodes should not be viewed as mere moments in which the interaction is suspended, but as interactional opportunities that different participants can use in complementary ways. Whereas previous research on clinician–patient consultations without interpreters has shown that talk often remains suspended for up to 5–10 seconds while clinicians attend to documentation (e.g., Greatbatch *et al.* 1993; Heath and Luff 2000), the sample of data we analysed here (typing episodes extracted from 311 encounters) suggest that in interpreter-mediated encounters the mediator–patient dyad fills these potential gaps, reducing silences to a minimum and facilitating the flow of interaction during the visit. Clinicians manage institutional tasks without halting history-taking, mediators exploit pauses to strengthen relational and communicative continuity, and patients contribute by bringing in their own concerns.

In conclusion, this study contributes to research on interpreter-mediated medical encounters by showing how technological mediation intersects with linguistic and cultural mediation in shaping the organisation of talk. It highlights the need to train clinicians to remain sensitive to the interactional consequences of computer use and to equip mediators with strategies for managing patient initiatives during typing episodes. Future research could extend this analysis to video-recorded data, to capture the multimodal resources (gaze, gesture, body positioning) that further structure these triadic dynamics, and to other digital contexts such as telemedicine, where the role of mediators may evolve in different ways.

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APPENDIX: Transcription conventions

Transcription of vocal conduct follows the Jeffersonian conventions used for Conversation Analysis (Jefferson 2004; Hepburn & Bolden 2017). The symbols used for the data in this paper appear below:

[	Onset of overlapping talk.
]	End of overlapping talk.
[[	Beginning of a new turn overlapping the beginning of another speaker's new turn
=	Latching between turns-at-talk both by the same speaker or between the turns of different speakers
(0.5)	Duration of a silence in seconds

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(.)	Minimal silence, usually < 0.2 seconds
wo(.)rd	Minimal silence within a word
wo:rd	The sound followed by a colon is stretched
wor-	Word cut-off
word<	Word is sharply interrupted
°word°	Softer delivery
#word#	Creaky delivery
£word£	Smiley voice
( )	Inaudible or indecipherable speech
(word)	Transcriber's best guess at uncertain speech
word/ward	Possible alternatives
* *	Onset and end of EMR actions
*-->	The action described continues across subsequent lines
-->*	until the same symbol is reached
m.c.	Mouse click

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