EDITORIAL

by Daniela Zorzi*

Conversational studies on doctor-patient interaction have a long tradition on an international level: a well documented review (Heritage e Maynard, 2006) that has presented in detail different perspectives and researchers, has evidenced that these studies, starting from the 70s have increasingly moved the emphasis from the communicative behavior of the doctor (particularly, they emphasized how the doctor's dominance in the management of the interaction can prevent the patient's supply of relevant information for the diagnosis and therapy) to the shared work of doctor and patient together, who try to build a mutually comprehensible discourse, which can also be acceptable on both the level of the information and the relationship.

The aim of these researches, which apply the tools of Conversation Analysis of institutional interaction (Heritage e Clayman, 2010) is two-fold. On one hand, it is observed that certain courses of discursive actions are influenced by the institutional character of the encounter, characterized by the following elements: participants have a shared objective, coherent with the social nature of the institution (*goal-orientation*); specific constraints operate on what the participants treat as an adequate contribution to the ongoing discourse (*particular constraints*); the interaction is associated to certain aspects of reasoning , inferences and implications which allow certain interpretations instead of others, ordinarily held in the everyday conversation (*inferential frameworks*) (Drew e Heritage, 1992, p. 22). On the other hand, it is observed that discursive forms not only determine what is said next, but also affect the behavior or the attitude of interlocutors, with effects on the diagnostic and therapeutic domain, which is the ultimate aim of the doctor/Health operators –patients encounters. For instance, an open question such as "What can I do for you

* Daniela Zorzi is Full professor in Teaching of Modern Languages at the Advanced School in Modern Languages of Interpreters and Translators at the University of Bologna; zorzi@sslmit.unibo.it

today?" leads to an answer four times longer than responses to closed questions such as "Sore throat and runny nose for two days, huh?" : this practice not only leaves space to obtain more, potentially useful information for the patient's diagnosis and therapy, but influences positively the patient who appreciates the possibility to tell by enough detail and time his problem (Heritage e Robinson, 2006). Another example, in the Italian context, is relative to lexical choices: the doctor talks about 'bacteria' with a migrant patient calling them "small animals"; the patient reacts with a harsh attitude: "he talks to me as someone who cannot understand at all"; the simplification made by the doctor (who ascribes his interlocutor an inadequate cultural and linguistic competence) opens up a conflict that has to be repaired, in order for the encounter to be positively closed (Orletti 2000, p. 114).

The access to health services by migrant patients has introduced in the doctor-patient interaction new relevant factors: among many, the supposed scarce competence of the Italian language, the different forms of addressing the health operators, the presence , not always explicit, of cultural assumptions, with the consequent risk of cultural misunderstandings or emotive resistances of various nature. Courses of actions which make these variables emerge are presented in the papers by Orletti, Fatigante e Pasquandrea in this volume.

In order to reduce these distances and facilitating the relationship between the migrant patient and the institution, health systems have introduced linguistic and cultural brokers: professionals with various degree of competence and specialized training: they range from the dialogic interpreter trained in academic courses, to the *ad hoc* interpreter (a friend or a relative of the patient with a sufficient competence in the Italian language), to the cultural mediator, often a member of the migrant community, with training of various nature (and not always present).

Their presence has obviously transformed the interaction: it is no more a dialogue between two persons, but, rather, between three, who concurrently work at solving the patient's problem. Studies on doctor-patient interaction, mediated by or at the presence of a mediator, although relatively recent in the Italian framework , have already described, by means of the detailed analysis of video-recorded and transcribed interactions, various courses of action (Gavioli, 2009), particularly highlighting – in this first stage the forms in which the mediator addresses both the doctor and the patient. Overall, the mediator speaks both as a ratified participant, i.e. having the same rights of primary participants (the doctor and the patient), producing a great variety of discursive moves: s/he poses questions, introduce topics,

offer evaluations and suggestions, reproach and comforts, tell and inform), and as translator of what other participants tell. Even in that case her/his behavior varies: s/he can act – rarely – as *conduit*, meant in the restrictive terms of someone who translate everything that is said, literally without adding, cutting or modifying anything; or, s/he can act as *clarifier*, modifying the original discourse, so that s/he can clarify contents, actions and expectations not always shared, in order to ensure mutual understanding between parties; or else, s/he can act as c*ultural broker*, proffering information that are culturally appropriate in order to overcome cultural differences which may lead to misunderstandings. For 'cultural difference' we mean –in this context – the set of beliefs, values and assumptions which determine the forms of interaction and the meaning of discursive actions. Finally, s/he can cat as *advocate*: often talking on behalf of the patient and negotiating directly with the health operators the therapeutic bureaucratic and needs of the patient. S/he cares not only of the quality of the communication, but also of the quality of the system overall.

All translating or non translating actions, can alternate within the same meeting and the choice is influenced by the discursive context: in order to be active and properly placed in the discursive sequence, one needs specific knowledge and competences – which would need to be target of dedicated training. A review of the training curricula for interpreters in the Italian context (Zorzi, 2009) has revealed relevant differences between the curricula proposed by local institutions, mostly addressed to representatives of local migrant communities and those offered by universities, mostly addressed to Italian students. In the first case there has been a preference toward knowledge and competences related to the migrant phenomenon in the economic and political sense, to the institutional mechanisms. to relational dynamics in a psychosocial perspective, (only in very rare cases there is a focus on the medical context), ignoring the linguistic dimension: for instance, there is no project that offers advanced courses of Italian language, or curses on specialized registers (e.g., juridical, educational etc etc.) References to the interpretive techniques are extremely vague and they do not reflect the complexity of recent findings in *interpreting studies*.

On the contrary, the academic courses on language dedicate inadequate attention on the social aspects of the migration, ignoring the social and institutional expertise that are the primary object – if not the only one – of the meetings that need the presence of a cultural/linguistic mediator. Both students who train in hospital wards and the health personnel legitimately complain about this lack of training. The teaching of Italian and foreign

languages is, instead, well documented. The techniques of interpreting are present, included either in foreign language courses or *ad hoc* courses.

In both contexts there is an almost total lack of reflexive activities, which focus on the discursive interaction in its integrity, observing in detail how the success (or insuccess) of a session depend on the coordinated actions of *all* participants and they are not solely managed by the mediator. The awareness of the complexity and relevance of the interactional processes and their management , which may bring to the joint construction of knowledge and relationships, are not yet the target of a specific education. The linguistic and social competences, both constituting the mediator's specific work, are viewed as if they were mutually independent: one is conceived as merely a psycho-cognitive competence, the other as a broad set of information on culture and society. A serious discussion on how linguistic and social competences merge in the interaction, for example, as regards the opportunities of participation offered to the interlocutors or, the relevance of what is said or translated in certain parts of the interaction, seems completely absent. Furthermore, there is no discussion on how, by means of the interaction, participants are categorized and how, by means of these categorizations, social relationships are built and determined. The education of mediators, in the health (and not only) domain, should rely not so much on a priori or ideological prescriptions but, rather, on the analysis of what effectively happen in the interactions. This aspect is clearly stated in the introduction to the volume, collecting the works of the 2007 international conference, *Scienze sociali, e salute nel XXI secolo: nuove tendenze e vecchi dilemmi* (*tr. Social Sciences and Health in XXI century: new tendencies and old dilemmas*, in the section on *Immigrazione, Mediazione culturale e Salute* (*tr. Migration, Cultural Mediation and Health*) (Baraldi *et al* 2008, p.12): «After having passed the stage in which we asked ourselves "who the mediator is" and "what is the mediator's role", a stage which helped to define mediation services, what is relevant now is the answer to the question "what the mediators actually do"».

Researches on mediated interactions developed until now contribute to clarify (as exemplified by Baraldi and Gavioli, this volume) and lay down the basis for an educational training which, starting from the reflection and awareness on what really happens in an interpreter- mediated interaction, and from the professional experience accumulated, allows the mediators to strengthen their interactional competences by identifying both the discursive strategies that bring success (in mutual comprehension) and the interactional weaknesses, that is, actions which can inhibit the interaction.

Findings from this first season of studies indicate several aspects of interest. Among others:

- turn-taking dynamics by the mediator and the other participants. For instance, the systematic tendency of the mediator to self-select as the doctor's primary interlocutor, by responding to the questions addressed by the doctor to the patient, or producing backchannels in order to display that he has understood or inviting the doctor to continue, brings to an increasing marginalization of the patient, with a consequential loss of information;
- the translating strategies used by the mediator. For instance, to choose not to translate the doctor's displays of assessment or acknowledgment of the patient's state, because they treated as communicatively irrelevant, obtains to enhance the distance between the doctor and the patient, contributing to the patient's dissatisfaction;
- forms of negotiation of cultural meanings and social competences by means of which the participants build their mutual understanding. For instance, the provision of explanations about cultural habits facts could lead the doctor to modify a treatment or, suggest behaviors that are more culturally appropriate as compared to the original, standard proposal;
- discursive forms of negotiation of agreement and mitigation strategies, such as paraphrases, reformulation and local choices of language and register, which prevent and help to solve conflict between interlocutors. For instance, a reproach by the doctor can be mitigated or reframed as an advice or, it can be supported by an account and explanation. These courses of action, which are not always translated, can nonetheless bring more likely to the patient's acceptance of the doctor's point of view or, can even bring the doctor to understand the patients' point of view.

These are only few examples: the analyses have also evidenced other aspects such as the management of affect and emotions, codeswitching, ways in which the patient's state or behavior is assessed and how these assessments are responded to by the participants. And the research is still ongoing.

These are certainly useful information for mediators and for those who are involved in the mediators' training, although they should not be interpreted as fixed instructions on what one should do or not do. As we were saying, these are actions that owe their success or not because they appear at a certain point in the sequence of turns and their interpretation

depends on the sequential placement, and the subsequent reactions by the interlocutors: as an instance of this, the cultural information can sometimes account for a certain behavior, sometimes can enhance the disagreement or initiate an instructional sequence, thus deepening the asymmetry between the doctor and the patient. The core aspect is, then, help the mediators to develop, by means of the analysis of naturally occurring interactions, the awareness that every action brings to certain consequences which not only have effects on the comprehension but, most of all, it has effects on the patient's behavior.

As already said, most researches on mediated interaction in the Italian context have, until now, examined the mediator's conduct only. Although they take into account both the patient's and the doctor's contributions to the talk. Since the analytic perspective we assume considers the doctor-patient interaction as a co-construction of meanings and relationships, aimed at providing a solution to the patient, the mediator's actions influence those of all other participants. At present few studies started to examine the doctor's behavior too: particularly, focusing on instances in which the doctor addresses the mediator as the only legitimate addressee, despite the patient is present. and their ways of interaction: this research domain has been solicited by mediators themselves, who posited how they experience trouble in understanding and agreeing with the health operators; health operators as well can profit from these researches, in that they are still not fully used and prepared to interact with the patients by means of a third person.

A final consideration regards the following. Scientific studies that, from a linguistic perspective, deal with interactions in the healthcare setting scan be distinguished in three types, depending on the kind of relationship that the health institutions establish with the researchers. First of all, there are studies that focus *on* the communicative, both oral and written, modalities, engaged by health operators and/or on the modalities between health operators and patients: in these cases the interest relies upon the researcher and it is primarily a research interest, which only indirectly may produce applications. The line of research on mediated encounters fall within this category. The theoretical model chosen, Conversation Analysis of Institutional interaction, based on the (video)-recordings of natural encounters, implies a close collaboration between health institutions and researchers , particularly for what regards the authorization to observe and document private events: in order to record and publicly display the collected data the health institution and its Ethical Committee need authorize the enterprise and they are, then, all involved.

In the future, we hope that health institutions themselves will see the study of interaction as beneficial to the proper accomplishment of their institutional and organization activities: in this case, there would be a primary interest in an "applied" research, in which the institutions would call and ascribe the researchers the task to find solutions to their own problems, which they have themselves identified. Or, we hope it can be the case for researches done *together with* the professional members of the healthcare institutions: in these cases, the initiative can start from both interlocutors (researchers and staff) who work together in a relationship of reciprocity: research and intervention proceed together. In this direction the Roundtable reported in this Special Issue is a good example of how professionals who face the challenge of multiculturalism in their practice offer their collaboration to cope with them.

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