Functions and dialogic forms of mediation in healthcare systems

Claudio Baraldi
(University of Modena and Reggio Emilia, Italy)

claudio.baraldi@unimore.it

This presentation is about mediated interactions in healthcare settings, that is interaction between speakers of different languages talking to each other with the help of a third party,

who is considered a mediator in some cultural traditions (e.g. Italy) and a community interpreter in many others (e.g. Sweden, USA).

In line with the Italian tradition, I will refer to this third party as “mediator”, rather than as “interpreter”.
Mediation services in healthcare provide help in those communications where speakers do not share the same language and culture and where, normally, healthcare providers are local and patients are migrants or from ethnic minorities.

The mediators I will look at in this presentation, provide help using interpreting (or translation) as a means to achieve triadic communication in bilingual settings.

Mediation services in healthcare systems can be analysed from two different perspectives:

1. Organisation (decision-making)
2. Practice (mediated interactions)
In this presentation I will focus on practice and my objective is to clarify the methodological and theoretical assumptions which lie behind research in the practice of mediation.

In theoretical terms, the practice of mediation is observed here as interaction.

Mediation is visible in interactions in that:

1. It is visible in participants’ actions (turn-taking) and in the alternation of participants’ actions (turn-taking).

2. The sequence of actions (turns) indicates the achievement of mediation.
Mediators are active participants in the interaction: they interpret and coordinate their interlocutors’ actions.

Mediators’ actions are necessarily intertwined with those of their interlocutors (alternation of turn-taking).

Neither mediators nor their interlocutors can control the consequences of their actions, which are produced in the interaction.

**General questions**

1. What are the general features of mediation as interaction?
2. In which conditions and with which range of variability does mediation operates?

The following suggestions are based on the results of a long-term research in the healthcare services of Reggio Emilia and Modena (Emilia-Romagna, Italy).

My presentation concerns:

1. The specific function of interpreting (translating) in mediation (language facilitation or LF)

2. The function of mediation in the healthcare system

3. The function of mediation for the achievement of intercultural communication
More specifically, I analyse the different ways in which:

1. LF is accomplished

2. The accomplishment of LF enhances forms of mediation

3. These forms of mediation lead to forms of patient-provider communication

4. The forms of mediation shape provider-patient communication as “intercultural”.

Accomplishment of linguistic facilitation (LF)
A preliminary problem in the interaction between providers and migrant patients is the actual possibility of achieving understanding under conditions where a language is not (or is not sufficiently) shared between the participants.

Mediation is the means allowing the participants to communicate with each other, in triadic (provider-mediator-patient) interactions.

LF is therefore the basic function of mediation.

LF includes different ways of reacting to interlocutors’ “translatable” turns (turns that can be translated), thus creating different opportunities for interlocutors’ active participation in the interaction.

In this way, LF should facilitate communication between the parties by assuring common understanding and by promoting interlocutors’ active participation through the coordination of their actions.
Therefore, LF:

1. Assures mutual understanding

2. Facilitates direct communication between the parties

The very activity of interpreting (translating) is an activity of mediating.

LF is the result of the coordination of the mediator’s and the other participants’ (provider and patient) actions.

The interplay among these three participants’ actions allows for the construction of mediated interaction.
LF can include the following actions:

1. “After-turn” translations, after a provider or patient turn

2. Suspensions of translation in dyadic sequences of talk with the provider or the patient

3. “After-sequence” translations, reporting to the other interlocutor what was said during dyadic sequences

4. Participation in negotiation of direct communication between provider and patient

After-turn translations

Immediate turn translation allows the second participant to reply immediately after first turn completion.

This is what it is generally expected from interpreting.

Immediate translation keeps the participants in contact. It seems functional to transmission of information.
However, immediate translation seems to be functional to transmit simple information.

It does not help if more complex problems of understanding or participation arise in communication. In these cases, translation may need to be suspended in order to solve communicative problems which are often prior to the actual provision of translation.

Suspensions of translation and dyadic sequences include:

1. Questions to patients
2. Requests for clarifications to patients or providers
3. Minimal responses (to providers or patients):
   - Continuers ("mhm")
   - Acknowledgement tokens ("okay")
   - Echoes of words or short sentences
4. Instructions/recommendations for patients
5. Direct answers to patients or providers
Suspensions of translation favour dyadic sequences. This can create problems because one participant is excluded from communication, for a period of time.

This creates the necessity of after-sequence translations, which cannot have the same form of immediate after-turn translations, as mediators need to summarise the content of a sequence.

After-sequence translations have two functions:

(1) summarising
developing
glossing
making explicit
the “gist” of an earlier turn

(2) projecting a direction for subsequent turns by inviting responses
After-sequence translations are important because they re-connect the participants’ actions after dyadic sequences, through the mediator’s coordination.

Therefore, given the frequency of dyadic sequences, the ways in which after-sequence translations are achieved are very important in defining the quality of LF.

Participation in negotiation of direct communication

1. Providers’ attempts to speak and display understanding of the patient’s language.

2. Patients’ opportunities to speak and display understanding of the native language
Participation in negotiation of direct communication

3. Mediators’ encouragement and help to speak the interlocutor’s language and promotion of direct contact

or

mediators’ claims of interpreting and competition in speaking with the patient

Mediation can take different forms, depending on the way in which LF is accomplished:

1. LF can promote separation between the parties, impeding communication and enhancing forms of excluding mediation
2. LF can promote construction and assessment of We-Identities, and thus ethnocentric mediation
3. LF can promote construction of new narratives in the interaction, favouring dialogic mediation.
Separation and excluding mediation

Mediators become the privileged interlocutors, through:

1. Autonomous questions, direct answers, instructions, recommendations in separate dyadic sequences, which exclude one party.

2. Competitive translations, where instead of supporting interlocutors’ efforts to speak each other language and achieve direct communication, the mediator insists in exercising her interpreting role.

Construction/assessment of We-Identities and ethnocentric mediation

1. Mediator’s autonomous initiatives promote shared expectations with one of the parties e.g. sharing same cultural identity with the patient ("we belong to the same culture") or sharing a similar professional ethos with the provider ("we are doing the same job").

2. Mediators defend the shared identity constructed with patients in the interaction with providers, or they reinforce the shared professional ethos constructed with providers in the interaction with patients.
Dialogic mediation

LF can promote patients’ and providers’ personal expressions, and mutual adaptation of these expressions.

It can open spaces for increasing providers’ and patients’ opportunities of active participation.

In this way, LF can promote the construction of new narratives in the interaction.

Construction of new narratives.

Narratives are condensations of information in stories (Baker 2006), which are constructed in communication.

In particular, dialogic mediation can promote the telling of new narratives of coordination and mutual sensitivity.
Promoting new narratives means:

Creating the conditions for the growth and stabilization of new and alternative stories of participants’ “positive”, “sensitive” and “mutual” positioning

Through:

1. Initiatives that expand providers’ questions, explanations and information, in a way that favours patients’ understanding and active participation.
2. Initiatives that support and confirm direct communication between the parties, which allows their co-production of stories.

3. Initiatives that connect dyadic sequences and after-sequence translations, through:

(a) Provision of minimal responses to allow participants’ expressions (showing sensitivity in dyadic interaction)

(b) Stimulation of participants’ expressions by asking for more, encouraging to go on, providing feedback

(c) Re-construction of the first party’s narrative with the second party, through after-sequence translations.
Forms of mediation and actions of LF

Many actions of LF can be included in all forms of mediation:

- Expansions in dyadic sequences
- After-sequence translations
- Mediators’ actions during negotiations of direct communication between patient and provider

These actions can characterize excluding, ethnocentric and dialogic forms of mediation.

What seems important here is the way in which LF is included in complex sequences of talk.

The way in which LF is achieved by the mediator clearly influences the organisation of these sequences.

Mediation takes a form through the effects of mediators’ actions on other participants’ opportunity to act and express their own perspectives.
Facilitation of patient-provider communication (function in the healthcare system)

Patient-provider communication is based on structures of the encapsulating healthcare system.

These structures are:

1. The basic guiding distinction between illness and health
2. The roles of providers and patients
3. The expectations of medical authority and patients’ adaptation
In particular, the debate concerning patient-provider communication highlights two approaches concerning the roles and expectations of patients and providers.

**Doctor-centred**

*Vs.*

**Patient-centred**

**Doctor-centred communication**
Patients are expected to adapt to the “voice of medicine” (Mishler 1984), i.e. that they accept doctor’s authority. Hierarchical relationships based on difference in competence.

**Patient-centred communication**
Patients are expected to be competent interlocutors and doctors are expected to display sensitivity and encourage patients’ active participation, i.e. expression of needs, worries and concerns (e.g. Kaba & Sooriakumaran 2007, Mead & Bower 2000, Zandbelt et al. 2005).
Mediation can promote or impede:

1. Medical authority
2. Patients’ voice

The promotion or impediment of providers’ authority and patients’ active participation depends on the form of mediation.

**Dialogic mediation:**

1. Encourages patients’ active participation and expression of needs and emotions, confirming patients as competent participants

2. Supports doctors’ actions, confirming their authority, supporting their diagnoses or their competence in their interaction with patients.

Dialogic mediation can support patient-centred communication (Baraldi & Gavioli 2007, 2010), while supporting providers’ medical authority

1. Provider’s responsibility in promoting patient’s active participation
2. Dynamics of patients’ expanded narratives and return to “doctorable” issues
3. Optimization of visits, though mitigated with problem attentiveness and sensitivity for the patients’ needs and worries.

Mediation may affect

1. Providers’ responsibility in promoting patients’ participation
2. Patients’ expansions and return to doctorable issues
3. Optimization of the visit, mitigated by attentiveness and sensitivity for patients and the ways in which they are achieved in the interaction
Dialogic mediation:

1. Contributes to expand patients’ expression of concern and to get back to doctorable issues (e.g. through autonomous questions).

2. Promotes the doctor’s responsibility and care of the patient’s perspective (e.g. through after-sequence translations), negotiating what is “translatable” for the patient (e.g. through minimal responses).

3. Collaborates in optimising the visit, in a patient-centred perspective.

Excluding and ethnocentric forms of mediation:

1. Reduce doctors’ sensitivity for patients, treating them as inactive, incompetent or unreliable recipients, or producing ethnocentric statements.

2. Reduce doctors’ authority competing with them for the “ownership” of communication with patients and thus excluding them from competently communicate with patients.
Dialogic mediation is coordination-centred communication, which enhances cooperation between providers and mediators and patient-centred communication.

Excluding and ethnocentric forms of mediation are mediator-centred form of communication, which reduce cooperation with providers and impede patient-centred communication.
Some studies have looked at intercultural communication as management of differences between pre-established cultures (e.g. Hofstede 1980; Guirdham 2005; Ting-Toomey 1999).

Other studies argue for a communication-based approach, that is cultures are not predefined packages and their relevance is constructed in communication (e.g. Baraldi 2006; Carbaugh 2005; Gumperz & Cook-Gumperz 2009; Vershueren 2008).

In this second perspective, intercultural communication is seen as a type of communication in which cultural diversity is observed and treated as a meaningful phenomenon

“Intercultural” communication originates from narratives of “cultures” and “cultural differences”.
In mediated interactions, the achievement of intercultural communication and narratives of cultural differences depend on the ways in which providers’ and patients’ actions are coordinated, rather than on the “cultures” that participants bring with them in communication.

**Excluding mediation**: creates separation and disintegration, through mediators’ initiatives, such as lack of translation and substitution of cultural identities.

**Ethnocentric mediation**: creates hierarchies in provider-patient communication, which can facilitate assessment of participants’ We-identities and promotion of “over-adaption” of migrant patients’ actions.
Assessment of We-Identities:

1. Mediators’ initiatives create shared expectations and identities with one party

2. Mediators’ translations project confirmations and enforcements of these expectations and identities in the interaction with the other party

3. Shared expectations and identities with one party are confirmed and enforced in the interaction with the other party

Dialogic mediation expands expectations of personal expression, therefore it may favour cross-cultural adaptation of patients’ and providers’ actions.

However, dialogic mediation does not necessarily display “cultural” positions.

The opportunities offered to patients, in particular of expressing new narratives, enhance their “personal” rather than “cultural” perspectives.
Therefore, mediation can be dialogic without bringing cultural differences to the fore. It can promote patients’ active participation without acknowledging and promoting “cultural differences”.

Is mediation “intercultural”? Although mediation is generally defined as “intercultural”, the main function of dialogic mediation is not to promote cultural narratives.

The only clear and unambiguous construction of cultural narratives is negative and is associated with ethnocentric mediation.

Therefore, “intercultural” mediation is an ambiguous definition for mediation. It focuses on “cultural” narratives, while the main feature of mediation seems to be the form of communication.
Conclusions

The three functions concerning mediation

1. Language facilitation

2. Facilitation of patient-provider communication,

3. (problematic) facilitation of intercultural communication

are clearly intertwined.
However, their distinction is useful because it allows for an analysis of distinguished components in mediation.

The reconnection of these components shows the interplay among them and thus an observatory of its complexity.

This analysis highlights the importance of ways of achieving language facilitation and forms of mediation in order to understand patient-provider mediated communication.

Research on mediation can provide transcripts of mediated interactions, to stimulate reflection and discussion on the practice of mediation.

The actual process of mediation (in the interaction) is made available in terms that are accessible to providers and mediators.

Through awareness-raising exercises, based on transcripts, providers and mediators can be facilitated in their own understanding of the interactional resources that either allow or impede effective mediation.
Research on mediation as interaction:

1. Can allow providers to see mediation as a practical accomplishment.
2. Can offer providers and mediators resources for “doing” and monitoring mediation.
3. Can offer providers and mediators the opportunity to understand treatment of migrant people as a result of their joint construction in the interaction
4. Can allow providers and mediators to reframe the interaction, in order to obtain more effective results.

Therefore, research on mediation as interaction can be an effective instrument to promote positive change in healthcare systems.