Functions and dialogic forms of mediation in healthcare systems

Claudio Baraldi
Università degli Studi di Modena e Reggio Emilia

Linguistic and cultural mediation services are those in charge of providing 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. On these occasions, help is provided by a third party, a “mediator” in some countries’ tradition or a “community interpreter” in others’. This third party provides help using interpreting as a means of achieving triadic communication in bilingual settings. In line with the Italian tradition, I call this third party as “mediator”, rather than “interpreter”.

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 then the means allowing the participants to communicate with each other, in triadic (provider-mediator-patient) interactions; mediators are active participants in these interactions and mediation can be seen as an interactional communication system. Language facilitation (LF) is therefore the basic function of mediation. LF includes different ways of reacting to interlocutors’ “translatable” turns, thus projecting different opportunities for interlocutors’ active participation in the interaction. LF should facilitate communication between the parties by assuring common understanding and by promoting interlocutors’ active participation through the coordination of their actions.

This presentation shows that: (1) as mediation is achieved through LF, it is important to analyse the different ways in which LF is accomplished; (2) the ways of accomplishing LF can enhance different forms of mediation; (3) different forms of mediation lead to different forms of provider-patient communication; (4) mediation can shape provider-patient communication as "intercultural", in different forms.

There are different ways in which mediators react to the turns that could be translated: (a) after-turn rendition, or rendition provided after completion of a doctor/patient turn; (b) suspension of rendition and construction of dyadic
sequences, e.g. when the mediator engages in talk with the doctor or the patient to clarify worries, therapies or advice; (c) after-sequence rendition, when mediators report to the other interlocutor what was said during sequences following action type (b) above; (d) participation in negotiation of direct communication, e.g. through code-switching or display of understanding of the interlocutor’s language. Each of these types of action can assure some kind of coordination in the interaction, mediating between the parties.

Mediation can take different forms, depending on the way LF is accomplished: (a) LF can promote separation between the parties, de facto impeding communication and promoting forms of excluding mediation; (b) LF can promote construction and assessment of We-Identities, promoting ethnocentric mediation; (c) LF can promote co-construction of new narratives in the interaction, promoting dialogic mediation.

LF allows mediation of provider-patient communication. LF can either promote both medical authority and migrant patients’ voice, or impede both of them. The promotion or impediment of doctors’ authority and patients’ active participation depends on the form of mediation. Dialogic mediation leads to a form of patient-centred communication encouraging patients’ active participation and expression of needs and emotions, confirming them as competent participants. It also upgrades doctors’ actions, confirming their authority, supporting their diagnosis or their competence in their interaction with patients. Excluding and ethnocentric forms of mediation reduce both patient-centred communication and doctors’ authority. They reduce doctors’ sensitivity for patients, treating them as inactive, incompetent or unreliable recipients or showing ethnocentric attitudes. They reduce doctors’ authority competing with them for the “ownership” of communication with patients and thus excluding them from competently communicate with patients. Excluding and ethnocentric forms of mediation correspond to mediator-centred communication, which is based on the upgrading of mediators’ authority. Dialogic mediation corresponds to a coordination-centred form of communication, which enhances cooperation between providers and mediators and patient-centred communication.

This leads us to re-think the idea of “intercultural” communication in a different light. Many studies have looked at intercultural communication as management of differences between pre-established cultures. Other studies, instead, argue for an interaction-based approach, that is cultures are not predefined packages and their relevance is constructed in communication. In mediated interactions, the achievement of intercultural communication depends on the ways in which providers’ and patients’ actions are coordinated, rather than on the features that participants bring with them in communication. Mediation can thus be seen as a contribution to coordinating the parties’ actions in communication, in a way that allows for the different perspectives of the participants to be expressed and dealt with. Excluding and ethnocentric forms of mediation can create, respectively, disintegration and hierarchy in provider-patient communication. Dialogic mediation does not necessarily display “cultural” positions. The opportunities offered to patients through dialogic mediation, 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 diverse patients’ active participation without acknowledging and promoting “cultural differences”.

This approach provides an empirically grounded research methodology that can allow managers and practitioners to see mediation as a practical accomplishment, without renouncing to observe its social and cultural presuppositions. This kind of research can offer managers, providers and mediators resources for “doing” and monitoring mediation. It offers to both healthcare providers and mediators the opportunity to understand treatment of migrant people as a result of their own efforts in communication: they can see mediation as joint construction in the interaction and attempt to reframe the interaction, in order to obtain more effective results. Furthermore, this research can provide transcripts of mediated interactions, which can be used as a form of training to stimulate reflection and discussion on what is going on in mediation and on how it is achieved: the actual process of mediation is made available in terms that are accessible to managers, providers and mediators. Through awareness-raising exercises, based on these transcripts, managers, providers and mediators can be facilitated in their own understanding of the interactional resources that either allow or impede the achievement of effective mediation. In this way, research on mediated interactions can become an effective instrument of positive change in healthcare services.