Co-constructing Dyadic Sequences in Healthcare Interpreting: a multimodal account

Sergio Pasquandrea
Università per Stranieri di Perugia, Italy

ABSTRACT
This study focuses on interpreting in healthcare settings, taking into account a corpus of medical encounters involving Italian doctors, Chinese patients and an Italian interpreter. In the data, the interpreter and the patients often interact dyadically in Chinese, thus excluding the doctors from active participation. The aim of the study is to investigate the way dyadic sequences are co-constructed by the interactants, in their both verbal and non-verbal dimension. The analysis concentrates on the final stage of the sequences, i.e. the translation from Chinese to Italian, in order to show that closing the dyadic sequence and initiating the translation is the result of a complex negotiation, involving all the participants who use several semiotic resources to perform their communicative actions. The methodology is based on conversation analysis, but also draws on research on multimodal communication.

KEYWORDS: conversation analysis, dyadic sequences, healthcare interpreting, multimodality.

Introduction

In the last two decades, a great number of studies have analyzed interpreting from an interactionist and dialogue-based perspective (see Knapp-Potthoff and Knapp 1987; Carr et al. 1997; Wadensjö 1998; Metzger 1999; Bolden 2000; Davidson 2000; Roy 2000; Mason 2001; Davidson 2002; Angelelli 2004a, 2004b; Baraldi and Gavioli 2007; Pöchhacker and Shlesinger 2007a; Gavioli 2009). They have demonstrated that interpreters can play a variety of roles and fulfil a wide range of activities, such as coordinating the interaction, negotiating meaning, co-constructing participation, contextualizing utterances, mitigating *face-threatening acts*, repairing miscommunication, sharing responsibilities for the management of the communicative process, modulating affectivity, or dealing with cultural differences, among others. Nowadays, it is a well-established notion that the role of the interpreter cannot be reduced to that of a *translating machine* or a *neutral third part*. Interpreter-mediated encounters, instead, must be regarded as discursive events, influenced by a complex array of social, cultural and interactional factors, in which interpreters are *ratified participants* (Goffman 1981) in the ongoing interaction.

The great majority of these contributions, though, have devoted attention only to the verbal side of the mediated encounters. Little effort has been made to shed light on the role of multimodal factors, such as gaze, gesture, posture, proxemics, or object manipulation. After the pioneering studies by Lang (1978), few other works on multimodality in interpreters' discourse can be listed: among them, Apfelbaum (1998) on the rhythmic synchronization of interpreter-mediated interaction on the basis of interpreter's projection of next turns; Metzger (1999) and Roy (2000) on sign language interpreting; Wadensjö (2001) on interpreters' proxemics during joint narratives in psychotherapeutic sessions; Mason (2009) on the influence of gaze and pitch intonation in the interactional negotiation of interpreters' multiple identities; Ticca (2010) on the influence of non-verbal signals on the behaviour of ad-hoc interpreters; and Pasquandrea (2011) on the multimodal co-construction of turn-taking in

interpreter-mediated medical encounters.

Such sparseness contrasts with the solid body of research on multimodality in social interaction, firmly established in the last thirty years by several authors (see Kendon 1967; Goodwin 1980, 1981; Schegloff 1984; Heath 1986; Schegloff 1998; Goodwin 2000; Scollon and Scollon 2003; Kendon 2004; Norris 2004; Schegloff 2005; Mondada and Markaki 2006), whose studies have demonstrated that non-verbal features are part of an integrated and consistent system of semiotic resources, constituting the basis for human face-to-face communication.

On the contrary, mediated interaction is a very interesting locus to study the role of multimodal resources in face-to-face interaction, in that it is a multiparty interaction involving a complex participation format, with different roles/responsibilities from each participant. In addition, it takes place in a multilingual environment with at least three participants having asymmetrical access to each other's language. In particular, mediated *healthcare* interaction implies that the doctor is engaged in a great amount of multitasking, performing many actions at the same time, even more than what is usual in ordinary doctor-patient interaction.

This contribution builds on the above mentioned studies in the field of interpreting studies, on the one hand, and on multimodal interaction, on the other, in order to try and integrate the analysis of both verbal and non-verbal features in the analysis of interpreter-mediated interaction. In particular, it focuses on one specific action performed during the medical consultations, i.e. giving or requesting translation after sequences of dyadic interaction between the interpreter and the patient.

By *dyadic*, I mean any sequence in which, *by initiative of the interpreter*, the conversation abandons the *triadic* pattern (where interpreters regularly and methodically translate each of the doctor's and patient's turns immediately after they have been uttered), and establishes a communicative axis centred on the patient and the interpreter with the exclusion of the doctor. Such a definition includes what Wadensjö calls interpreters'' *expanded renditions* ("[the] one[s] that include[s] more explicitly expressed information than the preceding 'original' utterance") and *non-renditions* ("an interpreter's initiative or response which does not correspond (as translation) to a prior 'original' utterance") (1998:107-108; original format), as well as any other sequence in which the interpreter does not simply and merely translate the doctor's words. Examples are the sequences in which the interpreter autonomously gives or asks for information, answers the patient's questions and requests, does small talk, or provides instructions and advice about bureaucratic procedures.

Dyadic sequences have already been studied before (see, among others, Wadensjö 1998; Davidson 2002; Amato and Gavioli 2007; Valero Garcés 2007; Ticca 2010). None of the previous studies, though, has analysed the role played by multimodal factors in shaping the participation structures negotiated during the interaction, except for Ticca 2010, which, however, only examines patients' behaviour. In contrast, this contribution, , focuses on doctors' communicative strategies, claiming that, through the use of multimodal semiotic resources, they are able to retain a certain degree of control over the ongoing interaction, even when it takes place in Chinese, a language of which Italian doctors are very unlikely to have command. The final phase of the dyadic sequence, i.e. the translation, will be taken into account in order to look at how doctors manage the closure of the sequence; whether and, if yes, how they are able to monitor the ongoing interaction and recognize the ending of the dyadic sequence; who initiates the translation; what communicative resources are mobilized by the interactants; and

what the outcomes for the organization of interpreter-mediated interaction are. The analysis will show that multimodality is frequently employed to manage potentially troublesome situations, e.g. involvement in several simultaneous actions, transitions between different phases of the visit, or misalignments with the other participants in the interaction.

Data

The data used for this study are taken form a corpus of 16 medical consultations, involving Italian physicians and foreign patients, collected in a primary care centre in Forlì, Italy, between 2006 and 2007.[1] The general aim of the research was to gather naturally occurring data of interpreter-mediated doctor-patient interaction, in order to allow for the observation of the actual communicative dynamics taking place during such encounters. Data were video-recorded, so as to preserve the discursive event in its entirety, including multimodal elements, such as gaze, gestures, body positioning of the interactants, spatial arrangement of the environments.

For the purpose of this study, six visits have been taken into account on the basis of their uniformity with regard to the number of participants, their roles and native languages. In particular, three are obstetrical/gynaecological visits, involving three different Italian doctors, three Chinese patients and one Italian interpreter (in one of the visits, two children are also present); and three are paediatric visits, involving one Italian doctor, one Italian nurse, one Italian interpreter (the same as in the obstetrical visits), three Chinese parents (two mothers, one father) and four Chinese children ranging from one month to eight years old. The patients speak Mandarin Chinese[2] and have little or no command of Italian; none of the doctors has any understanding of Chinese. The interpreter is an Italian woman of about 30 years, who works regularly in the primary care centre; she holds a university degree in Chinese and has good fluency, but no specific training in healthcare interpreting or intercultural mediation.[3]

The six visits last a total of one hour 46 minutes; five of them last approximately 20 minutes, while the other one lasts six minutes. They were recorded using two stand video cameras, one pointing at the doctor, who sits behind the desk, and the other one at the patient and the interpreter, who usually sit one besides the other, on the other side of the desk. The researcher was not in the room during the visits.

In the six visits examined, 37 dyadic sequences have been found,[4] that last from a few seconds, to several minutes.

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1 The corpus consists of ca. six hours of video-recorded interaction. The participants are four different Italian doctors, two Italian nurses, three interpreters (one Italian, one Moroccan and one Chinese) and 35 patients of different ethnicities, nationalities and native languages (Chinese, East European, Middle Eastern, North-African, African, Romani). Data were collected by Dr Piera Margutti, within a research project on interpreting in healthcare settings, funded by the Università per Stranieri di Perugia and directed by Professor Anna Ciliberti. They were translated from Chinese to Italian by a native speaker of Mandarin Chinese, who also assisted the author, who has a basic command of the Chinese language, during the transcription process.

2 Some of the patients are not native speakers of Mandarin Chinese: however, they always use Mandarin while speaking with the interpreter, switching to their own dialects only during brief interactions with their children.

3 In the Italian healthcare system, the tasks of interpreters often tend to overlap with that of intercultural mediators. This contrasts with the practice in the English-speaking countries, where the two functions tend to be clearly defined and separated. See footnote 15 for further discussion on this issue.

4 I did not count as dyadic sequences those taking place before and after the actual beginning of the visits (e.g. when the interpreter welcomes or greets the patients), or those in which the interpreter expands her turn just in order to ask for clarification, solve misunderstandings, or collect information strictly necessary to provide the translation or fulfil the task assigned by the doctor.

Methodology

The methodology is based on Conversation Analysis (henceforth: CA), an approach to communication first developed by Harvey Sacks and Emanuel Schegloff in the early Seventies (Sacks et al. 1978; Atkinson and Heritage 1984; Sacks 1992; Schegloff 2007), which provides an articulated system of tools for the analysis of human social behaviour.

CA's field of study is spontaneous conversation, also called *talk-in-interaction* (Sacks et al. 1978; Schegloff 2007), i.e. face-to-face communication, taking place in real-life settings. It is studied through natural data, without any use of laboratory simulation. CA's primary concern is the study of the formal patterns which guide the organization of talk-in-interaction, i.e. the procedures that allow interactants to co-construct orderly sequences of talk. The basic unity of analysis is the *turn (at talk)*, which can be defined as any stretch of talk produced by any single speaker.[5] Interactants are able to detect the points where another speaker's turn is potentially complete and it is possible for them to take the floor (*transition relevance points*, henceforth TRPs), thus accomplishing a smooth and precisely timed alternation of turns.[6]

A key concept in CA's methodology is *sequentiality*, i.e. the assumption that each turn is interpreted as the direct consequence of the preceding one(s), and, at the same time, as a conditional constraint to the following one(s); therefore, interactants constantly monitor the development of conversation, in order to respond consequentially to the previous speaker's moves, and to check whether their own contributions are being correctly interpreted. The analysis tries to account for the way they cooperatively organize their communicative moves on the spot. It always starts from the observation of interactants' actual behaviour and follows the unfolding, step-by-step development of the conversation, aiming to reconstruct the participants' own emic orientation, through a fine-grained investigation of their communicative actions. CA assumes that any feature of speech, even apparently irrelevant ones (pauses, overlaps, fillers, in-breaths, repetitions), may be crucial in the co-construction of the ongoing interaction, and needs to be analyzed and motivated.[7]

Finally, it is important to emphasize that, in CA, conversation is regarded primarily as a means employed by humans to build social interactions:

> CA is only marginally interested in language as such; its actual object of study is the *interactional organization of social activities*. […] Words used in talk are not studied as semantic units, but as products or objects which are designed and used in terms of the activities being negotiated in the talk (Hutchby and Wooffitt 1998:14; italics in the original).

This study also builds on research on multimodal interaction, i.e. on the role of non-verbal semiotic resources (gaze, gesture, body orientation, object manipulation, spatial arrangement, etc.) in the organization of face-to-face interaction. The importance of multimodality in coordinating the interaction has been demonstrated both in ordinary conversation (Kendon 1967; Goodwin 1980; Norris 2004; Mondada 2009a, 2009b; Rossano et al. 2009) and in institutional discourse (Heath 1986; Psathas 1990; Robinson 1998; Ruusuvuori 2001; Bolden

5 In fact, turn boundaries are often subject to contextual negotiation (for a more detailed discussion, see Schegloff 2007:3-7).

6 The system by which speakers synchronize and coordinate their turns has been one of the first fields of inquiry for CA scholars, e.g. in the groundbreaking studies by Sacks et al. (1978).

7 For further reference on CA, its methodology and historical development, see Hutchby and Wooffitt (1988); Drew and Heritage (1992); Lerner (2004); ten Have (2007).

2003; Lerner 2003; Modaff 2003; Mondada 2006, 2007). Interpreter-mediated interaction, involving three or more participants interacting in different languages, with complex participation frameworks, is likely to enhance the importance of multimodal resources, as the analysis will show.

Doctors' participation in dyadic sequences

In this section, a single dyadic sequence will be taken into account, in order to show how the participation of the interactants in the ongoing interaction can be analyzed solely in its verbal dimension. The excerpt showed in Example 1 is the beginning of a dyadic interaction. In the first lines, the patient, a Chinese woman who came for a routine visit during pregnancy, is answering to a series of the doctor's questions concerning her dietary habits.

Example 1

01	PAT:	***yībān dōushí chī mǐfàn***
		I usually eat rice.
02	INT:	*m::h. (.) no lei <u>ma</u>ngia::, (.) mattina::: mezzogiorno e sera:,*
		mh... no she eats... at morning... lunchtime and evening...
03	DOC:	*non ha* [*proble:mi=*
		she doesn't have any problem.
04	INT:	[*e:::h man*[*gia*::
		ehr... she eats...
05	DOC:	[=*perfetto*.
		perfect.
06	INT:	*insomma::, un'alimentazione normale,*
		well... a normal diet.
07	DOC:	*certo. (.) e:: riesce a bere <u>ta:</u>nto <u>ve</u>ro.*
		sure. and... she manages to drink a lot, doesn't she?
08	INT:	***shuǐ ne (.)***
		what about water?
09		***yītiān néng hē duōshao***
		how much do you drink each day?
10		(0.5)
11	PAT:	***shuǐ (.) shuǐ*** [***yītiān,***
		water... water each day...
12	DOC:	[*((to INT)) °(io) invece ho perso::,°*
		I have lost, instead...
13	PAT:	***hēde bù duō(h::)***
		I don't drink much... *((giggles))*
14	INT:	***o: nàge yīnggāi duō hē yìdiǎn ne***
		oh, well, you must drink a bit more.
15	PAT:	=°°***duō hē yìdiǎn o***°°
		drink a bit more?
16	INT:	**duì**
		yes.

The dyadic sequence which starts in lines 8-16 is one of the longest found in the corpus,[8] lasting continuously for almost four minutes, during which the doctor seems to make no attempt to intervene and elicit a translation.

The *e* [and] in line 7 is noteworthy. Heritage and Sorjonen (1994) have demonstrated that, in medical encounters, *and-prefaced* questions usually perform two tasks: linking a question-answer sequence to a wider sequence, constituting a coherent activity; and characterizing the question as *unproblematic* and *routine*. Both features are consistent with what happens in Example 1. As to the first task, the turn in line 7 is indeed part of a larger activity, i.e. a series of questions constituting an inquiry about the patient's diet. As to the second task, the routinary character of the question in line 7 is supported by the analysis of the previous turns. The translation of the patient's answer in line 2 is introduced by a *no*: as several studies have shown (Licari and Stame 1988, Stame 1994, Margutti 2007:35), in Italian a turn-initial *no* often does not work as a negation, but rather as a pragmatic marker, expressing minimization. This is exactly the case in this turn, where the patient's eating is characterized as *ordinary* and *non-problematic*. This interpretation is confirmed by the interpreter, who defines the patient's eating as normal (line 6), and by the doctor, who provides two positive assessments (line 3 and line 5) and an agreement token (*certo* [sure], line 7). Thus, the *and-prefaced* question in line 7 is a further confirmation of the *routine* character of the ongoing activity.

During the dyadic interaction, both features of the doctor's question are subverted. First of all, the dyadic interaction interrupts the activity of inquiring, which will not be resumed. Secondly, the interpreter reformulates the doctor's turn as a straightforward question, implicitly loading it with a more problematic orientation (lines 8-9), i.e. categorizing the patient's behaviour as potentially troublesome. The following turns by the patient clearly show that she has understood this orientation: the hesitation in line 11 and the giggle in line 13 can be interpreted as a display of embarrassment (see Haakana 2001, about the use of laughter as a means for acknowledging and remedying delicate activities in doctor-patient interaction).

Moreover, in line 15, the interpreter censors the patient's answer and gives her advice about food, i.e. performs actions which should be a prerogative of the doctor alone, and which fall outside of her professional boundaries. In the subsequent conversation (not transcribed here), too, the interpreter keeps on talking about medical subjects and giving advice to the patient in a competent and professional fashion.

Meanwhile, the doctor shows no intention to interrupt the ongoing interaction in order to retrieve her role; instead, she works with the computer, looking at the screen or at some papers on the table. Apparently, the doctor authorizes the long dyadic interaction, without trying to interfere. This kind of interactional dynamics are consistently observable in many dyadic sequences found in the corpus.

In the next sections, the doctors' behaviour will be observed, in order to try and see whether this impression of non-participation is confirmed by the analysis of the finest details of the interaction.

8 Only the beginning of this sequence is represented here; another excerpt of the same encounter is discussed below, in Example 3.

Data analysis: initiating translation

In this section, the different ways in which translation is initiated will be analyzed. The retrieving of the information after a dyadic sequence can follow two basic modalities. The translation may be spontaneously provided by the interpreter, or may be elicited by the doctor through an explicit verbal request.[9]

An example of spontaneously initiated translation can be observed in Example 2. In lines 4-5, a brief dyadic sequence takes place, in which the interpreter asks the patient for details not explicitly required by the doctor. In line 8, after the end of the sequence, the interpreter produces an acknowledgement token ("hm"), and then translates immediately, without any need for the doctor to make a request.

Example 2

1	DOC:	*com'è andato il parto?*
		how was the childbirth?
2	INT:	***shēng háizi de shíhou dōu méiyǒu wèntí ma***
		when you gave birth to the baby, was it all right?
3	PAT:	***dōu méiyǒu wèntí hmh***
		all right. *((giggles))*
4	INT:	***hm. (.) h:: shì shùnchǎn (.)***
		hm. ehr... was it a spontaneous birth...
5		***hm:: nàge (.) shì zìránchǎn háishi °pōufùchǎn °***
		hm... I mean... was it a natural birth or a cesarean birth?
6	PAT:	***zhège zìrán shēngchǎn***
		it was a natural birth.
7	DOC:	[( )
8	INT:	[*hm. (.) è:: hm stato un parto naturale è andato tutto bene*
		hm. it... hm was a natural birth, everything went well.

This seems the default modality for providing translation, since 13 out of 18 dyadic sequences which receive translation are translated spontaneously by the interpreter without a verbal request by the doctor.

The second modality, which constitutes the main focus of this paper, concerns the sequences where the translation does not take place spontaneously, but must be explicitly elicited by the doctors. An instance is shown in Example 3, taken from the end of a very long dyadic sequence, the opening of which has been analyzed in Example 1. In the first lines, the conversation between the interpreter and the patient has been already going on for about three minutes and a half, while the doctor was engaged in other activities. In particular, in line 1 the doctor has just hung up the receiver after having answered a brief telephone call (see the Appendix for multimodal annotations).

9 Actually, about half of the dyadic sequences (19 out of 37 found in the 6 visits) receive no translation at all. They are usually sequences containing small talk about mundane topics, or explanations of bureaucratic procedures which are not deemed relevant for the doctor to know, or expanded renditions of doctor's turns (e.g. explanations, clarifications, repetitions, etc.). There is a certain number of sequences in which some important piece of information is not translated (*zero renditions*, as Wadensjo 1998:108 calls them). Although such instances could be very interesting, their analysis would go beyond the scope of this contribution.

Example 3

*INT>PAT; PAT>INT
1 INT: ***hm::, tsk >**zěnme shuō nàge< tāipán yìdiănr wàng ***xià (.)**
hm, how can I say, well, (if) the placenta is a bit low-lying,
*DOC...>INT **DOC.....>***desk

2 ***nà jiū gěi nǐ zuò pōfùchān ne (.)**
then they'll make you do a cesarean birth.
*DOC moves gaze on the desk

3 ***kěshì rúguǒ (.) méiyǒu shénme zhè- [¶zhèyīlèi yuányīn***
but if... there is not a reason like this...
¶DOC opens the address book

4 PAT: **[tèshū: (.) hm::,**
a peculiar...,

5 ***tèshū qìngkuàng**
a peculiar case,
*DOC>PAT

¶INT nods and shakes her head
6 ***¶nà yībān dōu yào shùnchăn***
then they usually have a spontaneous birth.
*DOC>address book
¶DOC turns pages of the address book

*PAT>DOC; INT...>middle-distance towards desk
¶PAT smiles and nods
7 *¶(1.5)
*DOC>PAT
¶DOC closes and moves the address book

**INT...>DOC
8 DOC: ¶**aveva* ***qualcosa da chiedermi?**
did she have something to ask me?
*DOC>address book **DOC...>INT
¶DOC opens address book

¶INT smiles
9 INT : *no m'ha *¶chiesto::: h:: n- se: prima che scada il ¶¶termine, (.)*
well she asked me... h... n- if... before the term (of the pregnancy) comes,
*DOC>address book
¶DOC smiles and takes some sheets from within the address book
¶¶DOC nods slightly

10 *se prima del termine, (.) *¶.hh eh insomma- (0.6)*
if before the term... ah well...
*DOC...>INT
¶DOC puts the sheets on the desk

11 *>ho mal- dolori così cosa devo fare<*
I feel ache... pain or so what should I do?

In line 1, immediately after the end of the phone call, the doctor briefly glances at the interpreter (Figure 1), then looks back at something on the table (Figure 2).

Figure 1: Doctor looking at the interpreter

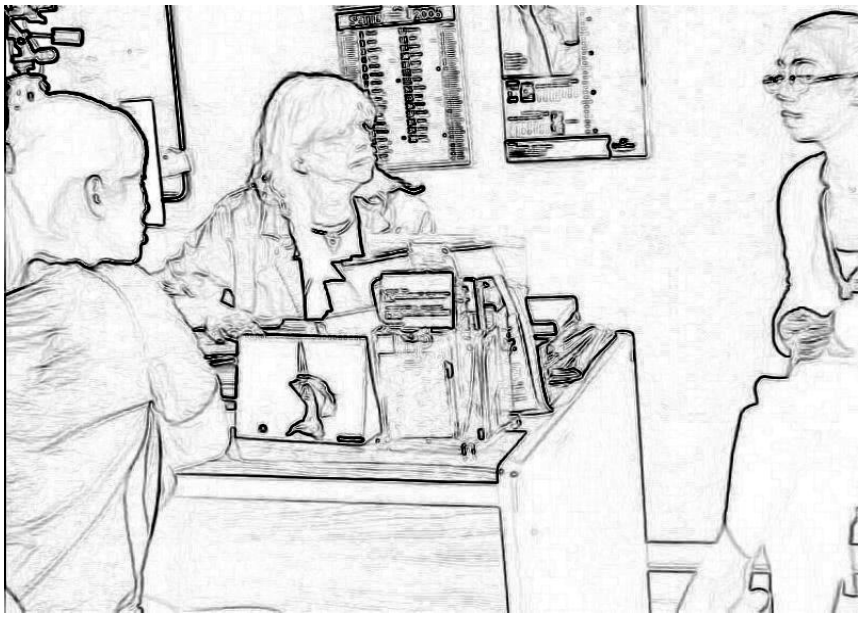
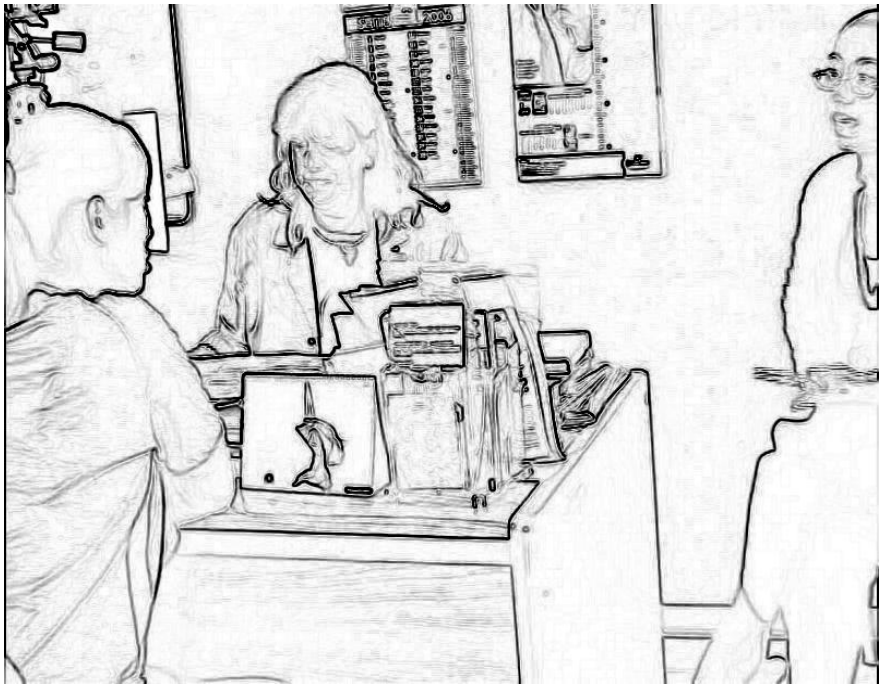


Figure 2: Doctor withdrawing gaze from the interpreter



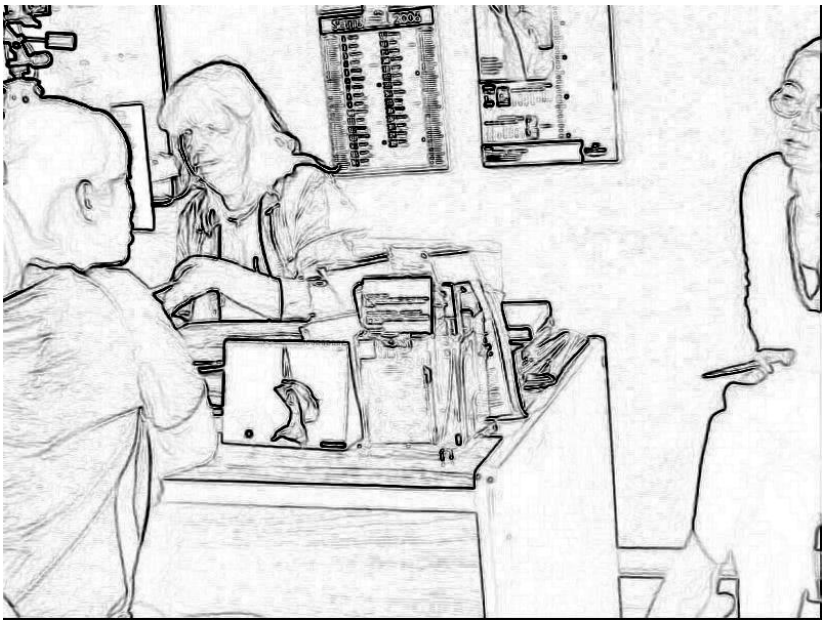
The start of the gaze movement towards the interpreter coincides with the interpreter uttering a filler ("hm") which signals hesitation, whereas the doctor's gaze returns to the table as soon as the interpreter restarts her turn.

It is important to emphasize that, since the doctor has no understanding of the Chinese language, her gazing at the interpreter or at the patient cannot be directly related with an active participation in the conversation. Instead, the timing of the two movements suggests

that they may be interpreted as an attempt to detect a TRP, i.e. a potential completion of a turn or sequence, and to seek for a gaze contact with the interpreter in order to obtain translation. This practice can be regularly observed in the corpus: as shown in Pasquandrea (2011), doctors seldom interrupt the dyadic sequences (in the 6 visits, only 3 instances of interruption can be observed), preferring instead to monitor the ongoing interaction, waiting to acknowledge a TRP.

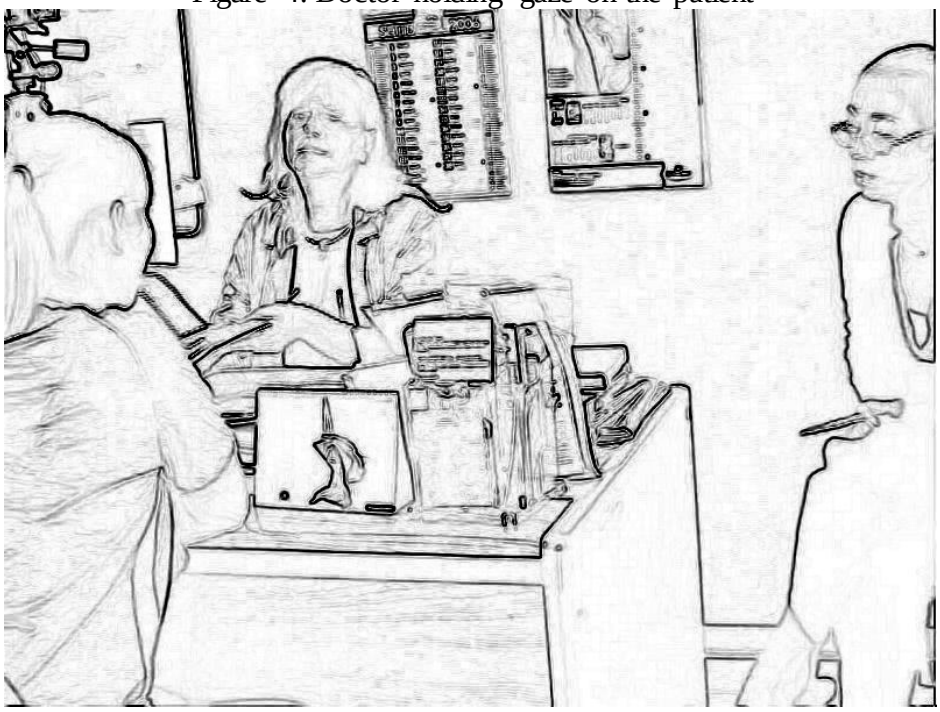
In lines 2-3, the doctor moves her gaze back and forth on the desk and then takes an address book, thus initiating a new action, which requires a certain deal of attention and engagement. In line 5, the doctor glances at the patient (Figure 3), who is currently speaking.

Figure 3: Doctor looking at the patient



This gaze can be interpreted as a new attempt to detect a TRP. Then, at the end of the patient's turn (line 6), the doctor looks briefly at the address book, seeking for something inside it; and finally, during the 1.5 seconds pause in line 7, looks back at the patient, holding her gaze upon her for more than a second (Figure 4). The patient returns the doctor's gaze, smiling.

Figure 4: Doctor holding gaze on the patient



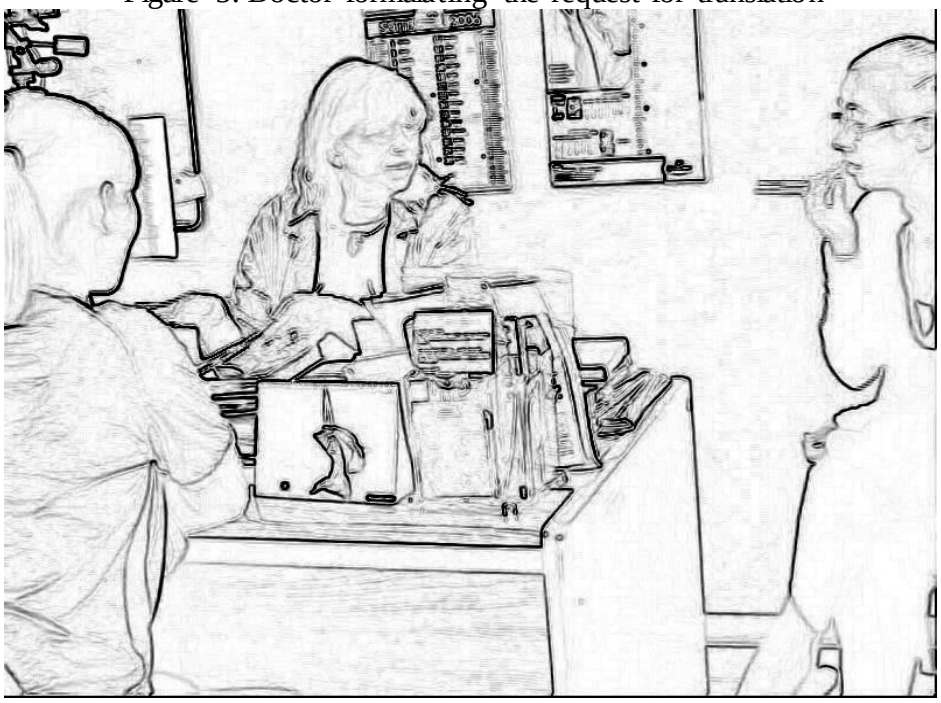
The reciprocal gaze between the doctor and the patient, during the long pause[10] in line 7, can be interpreted as an acknowledgement that the dyadic sequence has come to an end. The interpreter, too, displays disengagement from the previous conversation by moving her gaze from the patient to the desk to a *middle-distance* position.[11]

In line 8, after another brief glance to the address book (while opening it), the doctor looks at the interpreter (Figure 5) and formulates the request for translation.

10 In CA, it is commonly assumed that a pause lasting for more than one second is "long" (Jefferson 1989), and therefore relevant for the managing of the interaction (it may reveal some kind of interactional problem or signal the end of a turn, or sequence of turns).

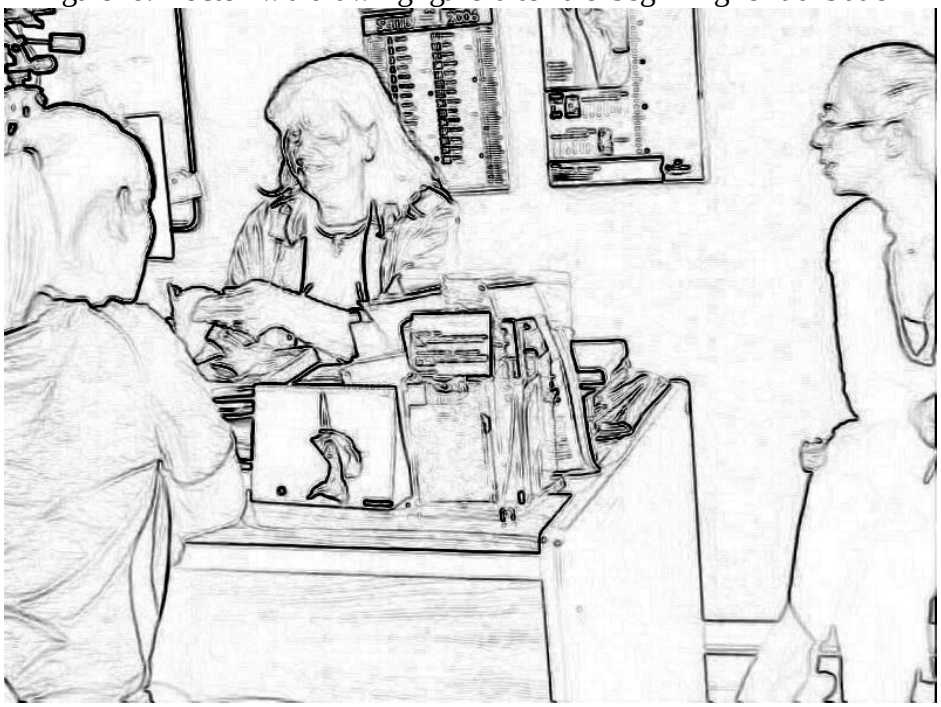
11 Heath describes the *middle-distance* position as one where "the patient is looking into the middle distance, away from the other, yet at no particular object in the local environment" (1986:108). Robinson and Stivers (2001) note that this position is often adopted during transitions between different activities.

Figure 5: Doctor formulating the request for translation



In line 9, after the interpreter has started to translate, the doctor does not look at her anymore, but moves back her gaze on the address book, and takes some sheets of paper (Figure 6); nonetheless, the doctor displays her participation in the interpreter's turn, by returning the interpreter's smile and by nodding while she speaks.

Figure 6: Doctor withdrawing gaze after the beginning of translation



In other words, line 7 marks a transition between two sequences, each characterized by a distinct constellation of the participants. In lines 1-6, the interpreter and the patient are the main participants, and gaze at each other, while the doctor is excluded from this communicative axis. In line 7, the disengagement of the interpreter, the reciprocal gaze

between the doctor and the patient, and then the doctor gazing at the interpreter, allow the doctor to negotiate both a new participation framework, where the main axis runs between the doctor and the interpreter, and a change of the language used in the interaction, with a code-switching from Chinese to Italian. In lines 8-9, the new framework is already established, and the doctor does not need to keep her gaze on the interpreter anymore. The doctor brings her gaze back to the interpreter only in line 10, when the interpreter utters a series of verbal and non-verbal fillers (*.hh eh insomma*) signalling hesitation, and thus potentially requiring a repairing intervention by the doctor.

Moreover, the necessity of performing another action (taking sheets of paper from the address book) creates some disruptions in the gaze movements, e.g. in lines 6-7, where gazing at the patient is slightly delayed, or in line 8, when the gaze towards the interpreter is deferred. In both cases, the delay is due to the need of temporarily bringing back the attention to the address book.

The analysis shows that the lack of translation at the end of the dyadic sequence (line 7) is due to the lack of mutual gaze and, by consequence, the lack of mutual alignment between the doctor and the interpreter, caused by the engagement of the doctor in a concurrent action.

The observation of the doctor's gaze movements also reveals that she constantly monitors the ongoing interaction, seeks for gaze contact in TRPs, and is able to establish co-presence and negotiate a new participation framework multimodally. In other words, the strategic use of multimodal features (gaze, head turns, object manipulation) allows to regain control of the interaction after a prolonged rupture. It is also noteworthy that performing more than one action simultaneously (e.g. monitoring the conversation/searching in the address book; displaying engagement/working with the computer, etc.) requires a subtle and complex timing, in order to obtain coordination and mutual alignment between the interactants.

The analysis of Example 3 has demonstrated the role of gaze in establishing the roles of the interactants in the ongoing interaction. The next example shows how another semiotic resource, namely body orientation, can contribute to the negotiation of participation. Example 4 involves another case of doctor-initiated translation. In line 1, the interpreter is giving advice about the use of the contraceptive pill, repeating and expanding on what the doctor has previously said.

Example 4

		*INT>PAT / PAT>INT
1	INT:	***chī wán le yīge hézi (.) nà jiù mǎshàng zài chī ne (.)***
		after you've finished one box, you immediatly take it again,
		*DOC>computer
2		***zài kāishǐ chī xīnde hézi***
		you start taking a new box.
3	PAT:	***hm hm*** *((nods))*
4	INT:	***hǎo ma***
		okay?
		*INT>middle-distance
5		*(2.0)

6 DOC: >°*che diceva?*°*<
what did she say?
*DOC...>INT

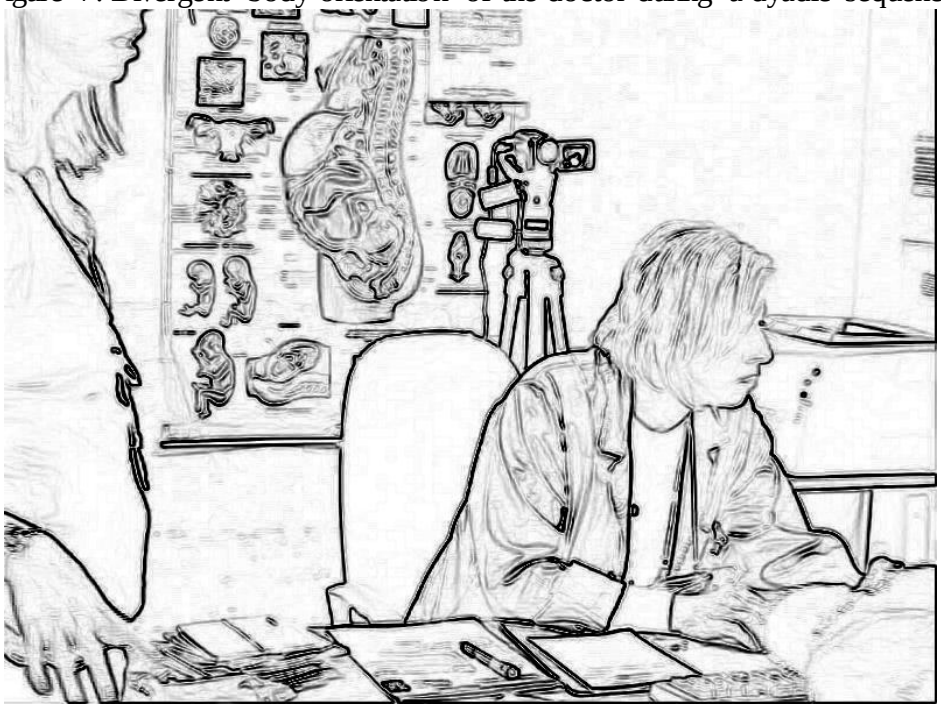
*INT>PAT
7 INT: ***ránhòu,***
then...
*DOC>computer

*INT>DOC
8 **ah- no-* (.)
oh, well...

9 *le ho chiesto::: se: >aveva qualche domanda ha detto< no::*
I have asked her... if... she had some question, she said no...

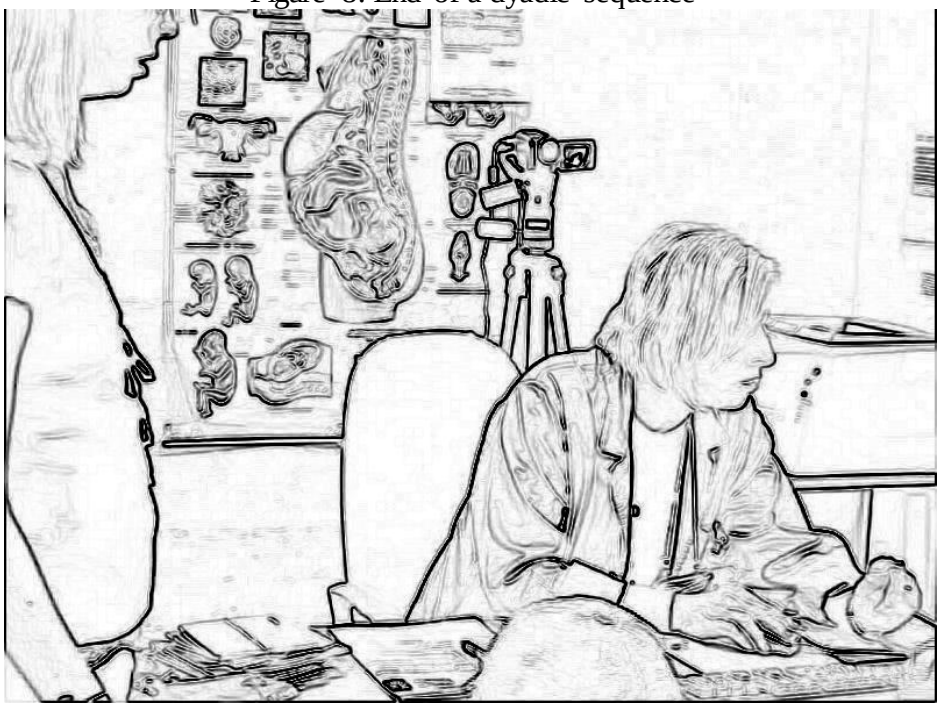
In lines 1-5, the doctor is engaged in working with the computer (Figure 7). Her whole body is oriented towards the computer and strongly diverges from the interpreter and the patient, thus embodying her prevailing engagement towards this activity.

Figure 7: Divergent body orientation of the doctor during a dyadic sequence



After the end of the dyadic sequence (line 4), a long pause follows (line 5), in which the interpreter disengages herself from the conversation with the patient, but does not start translating (Figure 8).

Figure 8: End of a dyadic sequence



The doctor cannot see the interpreter's gaze and body orientation, but can obviously perceive a significant interruption in the ongoing interaction, which she exploits for requesting the translation (line 6). The doctor starts her turn in line 6 while still gazing at the computer and turns her head towards the interpreter only at the end of the same line (Figure 9).

Figure 9: Doctor initiating the request for translation

At this point, her posture clearly shows a *body torque* (Schegloff 1998)[12]: her torso and her arms are oriented towards the computer, with the right hand still holding the mouse, whereas her head and her gaze are oriented towards the interpreter. Such a position signals a double engagement: one action (working with the computer) is temporarily suspended, while the other (achieving gaze contact with the interpreter) is performed. The first one still remains dominant, since, as Schegloff (ibid.) has demonstrated, the lower parts of the body tend to remain stable and to display the main orientation, whereas the upper parts tend to embody temporary or less stable actions.

In line 7, the interpreter starts talking to the patient in Chinese again, gazing at her, then realizes what the doctor has said, and remediates it by looking at the doctor and answering to the request in Italian (line 8). As soon as the interpreter starts speaking Italian and a mutual gaze is established (line 9), the doctor moves her gaze back to the computer, releases the body torque, and returns to her main action (Figure 10).

Figure 10: Doctor withdrawing gaze from the interpreter

Through gaze and body posture, the doctor is able to display her engagement in two actions at the same time, and to modulate her involvement in each action, suspending the activity with the computer and then reprising it as soon as the gaze contact with the interpreter has been established. The interpreter responds to the shift in the doctor's posture and gaze, since she does not start translating until gaze contact has been established. Moreover, she seems to treat the doctor's return to the computer-oriented position (line 8) as a signal of low engagement in the current conversation, because, as example 4b shows, after a brief and summarized translation (lines 8-10), she returns to the previous conversation with the patient (lines 11-13).

12 Schegloff describes *body torque* as a position in which the speaker shows "divergent orientations of the body sectors," arguing that it often signals "engagement with multiple courses of action and interactional involvements, and differential ranking of those courses of action and involvements" (1998:536).

Example 4b

8	INT:	*ah- no-* (.)
		oh, well...
9		*le ho chiesto:::, se:, >aveva qualche domanda ha detto< no::*
		I have asked her... if... she had some question, she said no...
10		*la pillola hai capito ha detto che ha capito, (.) .hh*
		the pill, have you understood, she said she's understood...
11		***rúguǒ nǐ mǎshàng jiù juédìng ne (.)***
		if you decide right now,
12		***háishi jiùshì nǐ chī nàge bìyùnyào bù fāngbiàn ne***
		otherwise, well, you don't find it suitable to take the pill
13		***yāo fánghuán huòshi***
		and want the IUD instead [...]

Coordinating doctors' and interpreter's action during dyadic sequences

The analysis has shown that doctors actually delegate a great deal of their communicative tasks to the interpreter, who, during dyadic interactions with the patients, performs several communicative actions, such as inquiring for details (Example 2, lines 4-5), providing answers to patients' doubts and concerns (Example 3, lines 1-3), or even giving explanations and advice about medical problems (Example 1, line 14; Example 4, lines 1-3).

The wide space of manoeuvring granted to the interpreter is confirmed by the analysis of the interactional dynamics during the dyadic sequences. As an example, doctors usually do not interrupt the dyadic interactions,[13] preferring instead to wait for them to come to a spontaneous end. This is even more significant, since the doctors, who do not have any command of the Chinese language, have no way to check whether the interaction between the interpreter and the patient is following the correct course; they can only rely on the interpreter's account to be informed of the content of the dyadic interaction. Therefore, it could be expected that the doctors solicit the translation and even interrupt the dyadic sequence, which, however, seldom happens. By not interfering with the conversation between the interpreter and the patient, the doctors seems to take it for granted that the activity is following a non-problematic route, where their intervention is not required.

This behaviour may be explained by the good relationship between the doctors and this particular interpreter,[14] who works in the primary care centre on a regular basis and therefore is supposed to have gained a good understanding of the practical problems of healthcare. The interpreter often aligns herself as institutional agent, e.g. using the first-person plural pronoun to refer to herself and the doctors together, as in example 5, line 7.

13 Interruptions of the dyadic sequences by the doctors are very rare in the corpus: some such cases are analyzed in Pasquandrea (2011:470-475).

14 A good relationship between the doctor and the interpreter is not at all obvious, as many studies on *ad hoc* interpreters show (see, among many others, Meyer 2001; Traverso 2003; Valdés 2003; Ticca 2010).

Example 5

1	PAT:	***nà rúguǒ yúchǎnqī dào de shíhòu***
		but if, when the term of the pregnancy comes,
2		***wǒ dùzi hài méi tòng nà::***
		I don't feel bellyache, then...
3	INT:	***nà rúguǒ yúchǎnqī* (.)**
		well, if the pregnancy term...
4		***dào le nǐ dùzi hài méi yǒu tòng ne***
		has come and you still don't feel bellyache
5		***nà jiùshi yúchǎnqī nà yītiān ne***
		then, the last day, that day...
6		***fǎnzhèng jiùshi nǐ zuìhòu yīcì dào zhèlǐ lái jiǎnchá de shíhòu ne* (.)**
		anyway, well, when you come here for the last control,
7		***h::m (.) wǒmen (.) wǒmen jiùshi huídá yīqiè gēn nǐ shuō le***
		hm... we... we will give you all the explanations.

Besides, many of the activities the interpreter performs during the dyadic interactions in our data, such as discussing the treatment prescription, giving information about the Italian medical system, and coping with cultural differences, also relate to the double nature of the interpreter's work: translator and, at the same time, intercultural mediator.[15] In other words, another reason why an interpreter is granted such ample freedom of movement in managing the interaction with the patient is that she is not perceived as a mere translator, but also, and sometimes chiefly, as a bridge between doctors and patients.

Not interrupting a dyadic interaction, though, does not imply giving up completely the control over the ongoing interaction. Data analysis shows that, even when engaged in another activity, and apparently uninterested in the parallel conversation between the interpreter and the patient, the doctors nonetheless employ several strategies in order to try and monitor the interaction. Such strategies include the use of multimodal semiotic resources, which prove particularly useful in the instances where, due to the lack of their linguistic limitations, doctors are not able to follow the ongoing conversation.

In Examples 3 and 4, several instances are analyzed, in which the doctor exploits the dyadic sequence to initiate other concurrent activities, such as working with the computer, writing, reading reports, etc. In such cases, the timing of the different actions performed, and their embodiment through gaze and body orientation, allow the doctors to modulate their engagement in each action. An action can be relegated to the background, and then foregrounded again, or can be suspended or delayed, according to the contingencies which condition the unfolding of the interaction. Much of the communicative alignment between the doctor, the patient and the interpreter is achieved multimodally.[16]

15 As already explained in footnote 3, in the Italian system interpreters are often required to fulfil the tasks of intercultural mediators, too. It must be added that such researchers as Wadensjö (1998) Angelelli (2004a), Pöchhacker and Shlesinger (2007b), Baraldi and Gavioli (2009) hold the view that dialogue interpreting inevitably leads to a direct involvement of the interpreter in the discursive event taking place, including its cultural and social presuppositions; therefore, interpreters are necessarily faced with the need of managing intercultural, as well as strictly linguistic issues.

16 Pasquandrea (2011) also shows how a request for translation can be achieved multimodally, without any need for a verbal request. Thus, many apparently *spontaneous* translations should be actually counted as *(multimodally) elicited* by the doctor.

Finally, the analysis has shown that the request for translation at the end of the sequence is interactively negotiated, and occurs as the result of constant monitoring, which allows the doctor to detect relevant TRPs. In contrast, the lack of translation in TRPs, as in Example 3, line 7, or in Example 4, line 4, can be explained by the lack of mutual alignment in gaze and body orientation: the different lines of action performed by the participants do not find a connection, and the translation is not initiated. In such situations, it is the doctor who must elicit the translation through a verbal request.

Conclusions

In this contribution, some dyadic sequences have been analyzed, with the purpose to see what interactional dynamics take place in such interactions; how the closure of the sequences is negotiated and the translation is initiated by the interpreter; and what role multimodal factors (namely, gaze and body positioning) play in the process.

The analysis has demonstrated that multimodal semiotic resources play a crucial role in the development of the interaction. In particular, multimodality seems to perform three main functions: monitoring the ongoing interaction, displaying engagement in the activities performed, and reorienting the participants' constellation. The doctors often gaze at the current speaker, in order to monitor the ongoing interaction, to look for the completion of the sequences, to seek gaze contact or to use multimodal clues (gestures, facial expressions) in order to try and follow the conversation. Such behaviour shows that the doctors, although seldom intervening directly in the conversation, often do not completely yield control over the interaction, even if it takes place in a completely unknown language.

The analysis has also shown that, during dyadic sequences, the doctors are able to manage a great amount of multitasking, performing many actions at the same time, by using multimodal resources such as gaze, posture or body movements, to coordinate the ongoing interaction and keep control of it. These resources are used alone, or in combination with each other and with verbal language, according to the actions performed and to the communicative aims of the participants.

Finally, the translation at the end of a dyadic sequence often appears to be interactionally achieved. Providing or not providing translation is the product of a complex interplay among the communicative actions performed by the participants and the interactional context in which they take place, which includes both verbal and non-verbal factors. The mutual engagement between the doctor and the interpreter is not to be taken for granted: in many cases, it has to be locally established and negotiated, using both speech (e.g. verbal requests) and embodied practices such as gaze and posture. By strategically employing all of these semiotic resources, doctors are able to retain control of a complex interactional space, e.g. reorienting the participation framework after a dyadic sequence.

The current findings enhance our understanding of the role played by multimodality in human social behaviour, in general, and in interpreter-mediated interaction, in particular. Verbal and non-verbal semiotic resources constitute an integrated system, which needs to be analyzed as a whole, in order to gain a thorough understanding of the communicative dynamics of interpreter-mediated interaction.

In addition, this contribution adds to a growing body of discourse-based works in interpreting studies, which tends to regard interpreters as active participants in a communicative event, whose actual dynamics need to be carefully examined.

Author's Email Address:
sergio.pasquandrea(a)yahoo.it

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Appendix: transcription conventions

Lines in Chinese are in italics/bold, lines in Italian are in italics. English translation is under each line. Chinese is transcribed in Latin characters, according to the conventions of the Pinyin system. Participants are identified as follows: DOC (doctor); PAT (patient); INT (interpreter).

Data are transcribed according to the conventions commonly used in Conversation Analysis:

(1.5)	pause (in seconds and tenths of seconds)
(.)	micro-pause (shorter than 0.2 seconds)
↑	sudden rise in pitch
↓	sudden drop in pitch
.	descending intonation
?	ascending intonation (not necessarily interrogative)
,	suspended intonation
-	abrupt interruption of talk
=	latching with previous utterance
TEXT	loud volume
°text°	quiet volume
°°text°°	very quiet volume
<u>text</u>	Emphasis
>text<	faster pace of speech
<text>	slower pace of speech
[	start of overlapping talk
((text))	description of non-verbal activity
(text)	unclear or dubious words
( )	Unintelligible
(2-3 syll)	unintelligible (with approximate number of syllables pronounced)
:::	elongation of a sound
h	out-breath
.h	in-breath
hmh	Laughter
tsk	tongue click

Multimodal elements are transcribed according to the following conventions:

Doc>Int	participant gazing / being gazed at (e.g. Doc gazes at Int).
Doc.....>Int	gaze movement (e.g.: Doc moves gaze towards Int).
¶	description of body movement, posture, gesture, facial expression.
* / ¶	synchronization of the multimodal annotations with the corresponding stretch of talk.

Gaze/movements by doctors are below the line, interpreter's and patient's ones are above the line.

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