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Ciclo XXXI

When the patient does not speak the doctor's language: an analysis of interactions in healthcare with occasional vs. experienced cultural mediators

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To my precious, autistic and very intelligent daughter, Alice Elena Holliday;
To Roberta Marchiori, without whom I would not be here;
To the memory of Gianfranco Cecchin;
To Giuliana Diani, extremely professional Professor, who let me go when time had come;
To Professor Lorenzo Fasolo, the most cultured and sensitive person I have had the privilege to know, who generously taught me a lot;
To my extremely generous ex-husband, Galen Lee Holliday; and, finally,
To my eternal platonic love Juan Riveros Toledo.

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INTRODUCTION

0.1Objectives of this work

The aim of this work is to analyze how people communicate within the medical setting when the patient who needs to receive assistance does not speak the doctor's language and needs someone providing linguistic help in order to communicate with the medical staff. The study focuses on those cases where such 'interpreting service' is not provided by a qualified interpreter, but either by a cultural mediator, employed and trained by the healthcare institution, or by an ad hoc interpreter, usually a bilingual relative or friend of the patient, not necessarily trained to interpret. The main objective of this work is to analize features of interaction involving doctors and patients, supported by either cultural mediators or ad hoc interpreters. The data come from a single collection of encounters recorded in healthcare services in two areas in North Italy: these encounters are all maternity check ups with patients from West African countries like Ghana and Nigeria. They are thus highly comparable. Since it is not easy to collect data with ad hoc interpreting (in that, unlike those with intercultural mediation, these encounters are not pre-planned), the data collection is limited to a very small set of 3 interactions (approximately 40' recording each). While such small set does not allow for any generalization of my results, it suggests differences worth exploring.

0.2Communication in medical care

Medical communication has been the object of scientific inquiry for a while. In particular, studies of doctor-patient interaction have focused on the structure of communicative patterns, the accomplishment of doctor-patient relationships and the specialized dynamics through which conversation develops during the medical encounter, with the hope of providing guidelines to healthcare personnel to improve their services (Heritage and Maynard 2006a; 2006b;

Drew and Heritage (1992). Such work highlights that the medical establishment is an apparatus of the social system, which takes care of those individuals who are sick and has the task of helping them recover in order to go back to their normal life. This apparatus clearly orients talk occurrences within the system. Heritage and Maynard's (2006a) approach to context, however, is, in their words, 'bottom up', in that it focuses on the way conversational choices shape the context of communication. This approach accounts for a peculiarity of conversation analysis, the approach I will be using in my work, which investigates the social and cultural context which is 'made relevant', that is called for or considered important in the hic et nunc of the interaction. Heritage and Maynard's (2006a) work focuses on monolingual data, but it highlights the development of a sociological perspective on the doctor-patient relationship from an interactional point of view, that can be usefully taken into account when looking at other types of data.

0.3 The chapters

My thesis is divided in 5 main chapters, including this introduction. A brief overview of each chapter is provided in what follows.

0.3.1Dialogue interpreting

In the first chapter I analyze the definition of dialogue interpreting, which includes different types of communicative activities and interpreting providers with varying expertise, thus representing a debatable concept. Further I introduce some basic concepts which describe what happens during a tryadic exchange among patient, interpreter and doctor, that is to say the main dynamics of these types of conversation. The discussion will make reference to the work of Mason (1999), who provides a framework possibly explaining how cultural mediation and ad hoc interpreting may be considered as two typologies of dialogue interpreting, and the scientific relevance they may have for communication in a plurilingual world. Another crucial reference is to Wadensjö's (1998) work on interpreting as a form of interaction. In Wadensjö's theory, communicative coordination among the participants is mainly achieved

through interpreting and is in fact an important part of interpreting. Wadensjö sees the interpreter as a coordinator of what is being said, and considers the activities of translating and coordinating as intertwined and both fundamental for the construction of the interaction. In the second part of the chapter I analyze how contextual assumptions and different types of inferences (Mason 1999) affect talk, and the fundamental role they play in shaping communication. The chapter then focuses on the concepts of role and position related to the interpreter, as well as on how participant's positioning shifts throughout the interaction.

0.3.2Ad hoc interpreting

In this second chapter I explain the notion of ad hoc interpreting within medical care more in depth. I introduce a distinction between two types of ad hoc interpreters, who are members of the staff (hired by the healthcare service as doctors, nurses, or cleaners, see Pöchhacker and Kadric 1999), and those who are friends or relatives of the patient. I focus on the different identities of the ad hoc interpreter. Unfortunately, the literature on ad hoc interpreting in the medical field is not abundant and studies often lack a precise description of the interpreting personnel observed, which makes it difficult both to understand which studies do in fact refer to ad hoc interpreters and the origins and the development of this interpreting practice, particularly with reference to how such ad hoc service sometimes becomes permanent. While the data focus on a specific type of ad hoc interpreter in maternity settings (the patient's husband, normally the father of the baby), the second chapter takes a wider perspective on different types of ad hoc interpreting, including that performed by children. A lengthy section of the chapter is dedicated to ad hoc interpreting performed by children, which has raised ample debate in the literature. Even though 'child brokering', as it is usually referred to, does not appear in my data, its frequency and importance at a global level had to be at least mentioned in order to make differences clear when adults are involved as brokers. The chapter also discusses the peculiarities of female patients being accompanied by their husbands to the medical encounter with their pros and

cons. I then discuss the problem of whether it should be a patient's decision to involve an ad hoc interpreter, a cultural mediator or a professional interpreter. Another important section of the chapter is the one where I discuss the differences between professional interpreting and ad hoc interpreting and the dilemma about which type of interpretation should be chosen, a choice that also depends on the type of circumstances and on contextual variables. I then introduce the concept of 'cultural safety', namely the fact that patients should always feel culturally safe, and the concepts of cultural context and cultural background. Finally I discuss ad hoc interpreting in European healthcare institutions and in Italy, and I conclude the chapter with the ongoing global debate about ad hoc interpreting: positive perceptions, negative perceptions, mixed perceptions and the ethical question on whether ad hoc interpreters should be paid or not.

0.3.3Conversation Analysis (CA)

In the third chapter I introduce the methodology that I have chosen to analyze the data in chapter 4: Conversation Analysis (CA). The chapter is based on the discusssion of a single handbook that I chose as particularly suitable to guide me through the CA approach, that by Hutchby and Wooffitt, second edition (2008). The authors illustrate the origins of the method and how it was effectively applied in contexts where institutional interactions take place. Even though analyses of institutional talk are considered to begin with the publication of Drew and Heritage volume, *Talk at Work* in 1992, Hutchby and Wooffitt (2008) explain that previous work by Sacks was inherently institutional and aimed to providing suggestions to improve communication in a psychiatric center. Basic concepts such as the definition of a conversational turn and principles of turn construction are summarized and clarified. Principles of sequence construction are then explained by clarifying the meaning of adjacency pairs, preference, the collaborative structure of turn-taking, and the main indicators of such structure: gaps, overlaps, feedback channel and other pseudo-verbal characteristics.

0.3.4Data Analysis

The data are part of a collection known as AIM (Analysis of Interaction and Mediation), a corpus of interactions gathered in the last 15 years thanks to the work of researchers belonging to a national research network coordinated by the University of Modena and Reggio Emlia and including nine more universities in Italy. The data were recorded before my PhD started so I was not involved in the data collection, which made it hard to reconstruct contextual information about the patients and their husbands, while information on the healthcare service was accessible. The data consists in three interactions where the patient's bilingual husband translates for his wife and the three interactions where the interpreter is an experienced cultural mediator hired by the healthcare service. The choice to compare the ad hoc interactions with those involving a cultural mediator playing the role of the interpreter has two main objectives: to highlight certain specific features of ad hoc interpreting and to understand whether there are differences betweeen the two types of interpreted interaction. Even though the data is scant, it covers most of the phenomena I found in the over 100 hours of the English/Italian subset of the AIM data collectiion. The analysis develops around three main topics. The first is the interview phase, normally covering the first part of the medical encounter and focusing on the patient's symptoms, which I analyze using two excerpts. The second is the provision of reassurance to the patients, which is a rather common feature in maternity check-ups and gave me material to compare interpreting by an ad hoc interpreter and by a cultural mediator. The third is the role emotions play during the encounter. Emotions (and the interactional management thereof) are looked at in a particular situation, that is, before discussing solutions to problems which have arisen in the interaction, such as, for instance, being overweight.

0.4 Summing up

The analysis thus provides insights into two types of dialogue interpreting which have raised interest (and debate) in the literature, i.e. cultural mediation and ad hoc interpreting. What they have in common is that neither of them

normally includes a professional interpreter, or at least this is not a requirement for interpreting to be carried out. Still, these forms of interpreting are widely practiced, particularly in the healthcare field, where the delicacy of the emotional situation and the need for the patient to ‘trust’ the medical provider have often been considered as ‘separate’ achievements, in some way not included in the interpreter’s professionalism. The necessity to better understand what actually occurs when a. cultural mediators, b. interpreting husbands are involved, makes analyses of the data worthwhile.

1.0 DIALOGUE INTERPRETING

In the following sections I will provide a definition of 'dialogue interpreting', explore its structure, introduce the participants in it and attempt to explain its main discourse features and interactive dynamics.

1.1 Definition

The definition of dialogue interpreting is a controversial one, in that dialogue interpreting may include a variety of activities. The difficulty in finding a suitable definition of dialogue interpreting in this study arises from the fact that some of the mediated interactions that will be analyzed in the following chapters represent borderline events, which not all definitions may actually accommodate. My study is based on an analysis of authentic interactions, where interpreting is provided by bilinguals with a variety of skills and experience, and my aim is to look at the practices that are involved in this type of talk. I thus need a definition where 'talk' is the main focus, independently of the roles or abilities of the interpreter. Two seminal studies in which dialogue interpreting is looked at as a type of interaction are those by Ian Mason (1999) and Cecilia Wadensjö, (1998). Both see dialogue interpreting as a form of communication including one bilingual interlocutor translating talk from and into the languages spoken by the other two. Dialogue interpreting is thus an umbrella term including:

> what is variously referred to in English as Community, Public Service, Liaison, Ad Hoc or Bilateral Interpreting – the defining characteristic being interpreter-mediated communication in spontaneous face-to-face interaction. (Mason 1999: 147)

In her work Wadensjö (1998) similarly provides a characterization of the type of talk she is dealing with by including labels which are traditionally used to refer to the profession: community or liaison interpreting.

> Interpreting carried out in face-to face encounters between officials and laypeople, meeting for a particular purpose at a public institution is (in English speaking countries) often termed community interpreting […]. Sometimes liaison interpreting is used as a synonymous term […]. (Wadensjö 1998: 49)

Most commonly, dialogue interpreting is also a form of institutional interaction in that, as mentioned in Wadensjö's description above, one of the participants is often the provider of some service, while the other is a service-seeker or a 'client' of the institution. From this perspective, Mason and Wadensjö's definitions seem to suggest that dialogue interpreting can also be considered as a form of asymmetric talk between professionals and laypeople. A point raised by Gavioli (2009), namely the fact that all participants in face-to-face interaction actively contribute to its shaping, is also particularly significant. As a matter of fact the interaction can be seen as a communicative system, which is constructed and shaped by the verbal collaboration of the speakers. This sheds light on the real structure of the interaction, where two speakers (in so-called dyadic interaction) and three speakers (in a so-called triadic interaction) can be viewed as functions belonging to a communicative system, namely the interaction. In fact, an action carried out by one of the speakers inevitably triggers another participant's reaction and their co-ordinated mutual interactional efforts structure and shape the system they belong to, as clearly demonstrated by Baraldi and Gavioli (2012).

In a study of interpreted medical encounters in UK primary care Greenhalgh et al. (2006) note that the interpreter, whose presence turns the meeting into a triadic interaction, changes the dynamics of the communication process. This can create technical and operational challenges, including trust issues, time pressures, a mismatch of agendas, differences in expectations and power imbalances all of which can promote strategic action (i.e. speech that seeks consciously or unconsciously to manipulate an outcome) rather than communicative action (i.e. sincere efforts to achieve understanding, and reach

consensus) by all parties. However, these problems seem not to arise when the interpreter is a family member, as she/he is more trusted by the patient. Therefore, being able to understand how communication is structured and how the different interactional elements function and relate to each other is essential in order to understand how the conversational system works, and hopefully find new and improved solutions for providing an ever more efficient interpreting service.

1.1.1 Wadensjö's approach: the interpreter as talk coordinator

According to Wadensjö (1998), an interpreter-mediated encounter can be considered and explored as any other form of social interaction, where the interlocutors collaborate in the creation and structuring of communication. The interpreter definitely plays a fundamental role in shaping the conversation, and in Wadensjö's perspective s/he has not just the role of a translator, but also that of a coordinator of the talk. (Wadensjö 1998) In this respect, Wadensjö considers 'interpreting' as the combination of two different but intersecting intersecting activities: translating and coordinating:

> Regarding 'interpreter-mediated interaction' as a social phenomenon and the basic unit of investigation I must see 'interpreting' as consisting of both aspects. In theory, translating and mediating may be distinguishable activities, but in practice they are intimately intertwined. (Wadensjö 1998: 7)

These very different, and yet intertwined activities (translating and mediating) inevitably affect interpretation and mediation as well. The actions of translating and coordinating the communicative process are inevitably present during an interpreting service. The constant oscillation betweeen the two actions stems

from the implicit requirement to adapt to the communication needs of a given moment during the meeting: in order to accomplish the circumstantial communicative goal, the interpreter will have to occasionally give priority to the mediating process, and sometimes to the action of accurately and precisely translating what is being said. When interpreters find themselves in the situation of having to mediate between the other two parties, they are clearly giving priority to the interactional goal of the communicative situation, the linguistic choices adapt to such communicative goals. Wadensjö also introduces a distinction betweeen two types of interpreter orientation, only one of which has communication as its main goal. In their choices, interpreters may orient to 'the text' or to 'the interaction'. The text is for instance the text of an utterance independently on its context, the interaction is what embeds the utterance and gives it sense:

> 'Interpreter utterances' are provided in order to bridge a linguistic gap (between two languages in use) and a social gap (between two or more language users). In transcribed discourse it is possible to trace indications of 'interpreter utterances' being designed to match both these tasks. Occasionally the one demands more efforts than the other. One dimension of classification would therefore be whether utterances show evidence of the translating aspect or the coordinating aspect being foregrounded; whether interpreters are text orientated or interactionally orientated. (Wadensjö 1998: 109)

Therefore, throughout the development of the interaction, interpreters can either be, and often are at the same time, text oriented (which means that they favor communication by carefully rendering what is being said in the other language), and/or they can coordinate talk and can thus be interactionally oriented, which means that, during the translation process, not only do they consider the linguistic aspects, but also the social ones, which are represented by the participants' need to communicate with each other. This,

however, might lead to problems in defining and managing the role of the interpreter.

1.1.2 Interpreter’s role and expectations

Hsieh (2005) investigated the conflicts which exist for interpreters in managing their role, highlighting the importance of a non-neutral performance by interpreters in order to ‘resolve conflicts in their role performances and others’ role expectation’. In fact, communication success depends and relies on the interdependence of all the actors involved: patient, provider and interpreter, who are part of a specific communicative context (social settings and institution policies). Hsieh distinguishes between two main problems, i.e. sense of conflict and the source of conflict. As for sense of conflict the starting point is the long-standing question of neutrality and invisibility of the interpreter. A classic conduit performance is sometimes impossible, according to the evolution of the conversation and this generates the sense of conflict. The sources of conflicts are, in Hsieh’s view, much more complex. She notes four of them. Firstly, one needs to consider the ‘others’ communicative practices’, that is, the possible variations in the classical conduit pattern in which every utterance is directed to the other participants and relayed by the interpreter. When this changes (i. e., the doctor talks to another provider in front of the patient, or the patient is unwilling to disclose his/her problem), a conduit performance seems to be insufficient. Secondly, changes in participant dynamics, which may require the interpreter to adopt a different role such as when the doctor talks to a nurse regarding other issues, or the primary participants decide to talk and exclude the interpreter because there exists a degree of understanding between them. In the first case an intervention by an interpreter is necessary, while in the latter case, the interpreter is able to adopt an “invisible” role to solve the issue. Thirdly, there exist institutional constraints, such as filling in questionnaires, writing instructions, time management and conflict (for example, the doctor wants to leave while the patient wants to stay). They depend on the institutional culture and the

interpreter may be forced to abandon neutrality in such circumstances. Lastly, expectations can also prove to be a source of conflict. As the interpreter acts in a conduit role, they often make judgements on how to relay, or even elaborate on clinical information they are required to translate.

Hsieh (2005) also provided possible resolution strategies for certain issues, namely: (i) creating boundaries so that the interpreter's role changes according to the situation for example alter their behavior so that they behave differently inside and outside the medical examination context; (ii) (re)defining relationships and identities so that the other speakers are aware of when their role changes. Normally, it will be necessary for the interpreter to mark this change clearly; (iii) the use of manipulating communicative strategies such as hedging by introducing sentences with a preface ("the doctor thinks that it might be…), or by using other linguistic strategies such as by choosing a less negative word to lower its power.

Another study carried out by Hsieh et al. (2015) considered the role of expectations in interpreted medical encounters in which attention was drawn to the special concern for the providers' expectations which will differ depending upon their speciality: oncology, obstetrics etc.. Firstly, they influence the process of interpreting, and thus represent a preliminary condition for the development of the performance. Secondly, expectations are (to a certain extent) justified, since they are normally related to the activity of a single specialty, nursing for example, which requires an important care and emotional dimension, which should be transmitted by the interpreter (the so-called «Patients Ally» dimension). The authors recognize three factors that motivate providers to utilize a wide variety of interpreters according to their needs: (i) time pressure / lack of availability, especially in emergency conditions often lead providers to choose untrained interpreters. (ii) special requirements according to the specific specialty (a family physician, for example, may have a long-term relationship with both patient and interpreter); (iii) 'the conduit role' in which the interpreter is often seen as just a vehicle, a machine, through

which words pass and are conveyed. This element in particular is still decisive in shaping the providers' expectations, seeing the interpreter just as a 'speaking dictionary', as if translation could be performed by substituting specific terminology.

In yet a further article on conflict management in medically interpreted conversations, Hsieh et al. (2010) focused on the issue of trust. The study deals with the four dimensions of trust which exist between the provider and interpreter, and how trust relates to quality and equality requirements. Firstly, there is the issue of interpreter's competence, and the extent to which they can deliver difficult medical diagnoses and words with precision and accuracy during interpretations. The breakdown in trust occurs because the patients cannot evaluate the interpreters' performance due to their own lack of linguistic skills. Secondly, as a team, providers and interpreters should share the same goals. If they do not then the trust which exists between them can be compromised. This may also be magnified by an interpreter inserting their opinions and making active judgements during interpretations. Thirdly, there is the issue of professional boundaries betweeen interpreter and practitioner, which can be ill-defined and therefore quite weak. The lower status accorded to interpreters by doctors can add to this problem. Moreover, the institutional context can confuse the providers and interpreters' relationship as it has the potential to further reduce the clarity of the bounderies. Fourthly, team work is very important in providing efficient and appropriate care. If the patterns of collaboration are not in good order then trust will be undermined.

1.2 The social structure of the institutionalized interaction

In this section the structure of interaction, the way it is constructed and its close bond with interpreting will be discussed, in order to provide an explanation of how interactions among the three parties work, how they develop, and their relevance in different types of contexts.

1.2.1 Interpreting as Interaction

Wadensjö's *Intepreting as Interaction* (1998) was the first study which aimed at analyzing the role and actions of the interpreter during the interaction with the other participants in the conversation. By observing real conversations which involved the interpreter and those who needed the interpreter's assistance, be they institutional providers or seekers, Wadensjö (1998) was able to carry out both a sociological and a linguistic study, which highlighted the actions performed by each speaker during the conversation and how their joint communicative efforts contributed to the social construction of the interaction. Wadensjö (1998) underlines that the interaction is not the product of the actions of one person in particular, no matter how much one speaker actually intervenes during the conversations. On the contrary, all speakers actively contribute to the structuring process of the interaction, even though the ways they essentially influence the conversation may be very different depending on the circumstance they are experiencing, on the environment and on each speaker's individual context or personal cultural background. In this respect, it is significant that, in order to study the actions of interpreters during a mediated interaction, the author actually considers all parties involved in the conversation. As a matter of fact the author specifies that her work deals with what happens among all speakers and not only with the interpreter's performance. Therefore, in order to understand the social nature of institutionalized forms of talk in which an interpreter is present, it is essential to observe how all participants behave, and to analyze everything that is said, and not just the interpreter's behavior and utterances as a monologic position would do. According to Wadensjö (1998), a monologic position would consider the process of oral translation as the mere transmission of a piece of information from one person to another, both in the role of interpreter and speaker.

Wadensjö (1998), on the contrary, draws heavily on Mikhail Bakhtin who stated that the messages conveyed during an interaction are, at least partially,

socially co-constructed by the people involved. In other words, it is a model which considers language as dialogic. Thus, while the monologic view of language automatically implies a linear structure of language use, the dialogic view assumes a sort of circularity in the structuring of social discourse, which inevitably involves all the speakers as active parties of the interactional system. This happens because what is uttered, for example, by speaker B inescapably shows B's understanding of speaker A's contribution, and speaker A's contribution affects speaker B's following response.

1.2.2 'Talk as text' and 'talk as activity' and the interactional view of the interpreter-mediated face-to-face encounter

Wadensjö (1998) makes a fundamental distinction between what she calls talk as text and talk as interaction, to identify two different and yet complementary ways of considering the interpreter-mediated face-to-face encounter. Therefore, while the talk as text view focuses on the 'texts' of the single utterances as separate units, according to the talk as activity perspective, utterances are analyzed as participants' contributions forming co-costructed actions. In the latter perspective, meanings are constantly negotiated and re-established by the participants to a conversation (Wadensjö 1998). In order to exemplify the difference between the two standpoints, the author presents a sequence extracted from an interaction that took place in a Swedish courtroom. The speakers are a judge, an interpreter and a suspect who can only speak Russian. Wadensjö points out that, before the reported sequence, the judge had asked the suspect if she/he confessed to the theft, which, as highlighted by the author is a routine question during Swedish courtroom procedures. At the beginning of a trial, the prosecutor reads the accusations and the judge asks the suspect to voice her/his innocence. The suspect should then plead guilty or declare her/his innocence. In Swedish the question is usually worded by asking the suspect if he/she confesses to the crime, and the suspect is supposed to simply answer affirmatively or negatively. However, in

the particular case described and analyzed by Wadensjö, the suspect answered the judge's question by providing a long elucidation of the facts, which the author interpreted, because the suspect had not understood that the judge only wanted him/her to simply reply with a 'yes' or 'no'. The sequence presented by the author starts with the judge's turn. The judge rephrases the question, hoping to end the conversation by asking the suspect: 'So you don't confess to the theft.' (Wadensjö 1998: 23). The interpreter translates the judge's turn as following: 'That is you don't confess to the theft' (Wadensjö 1998: 3), at which point the suspect answers 'yes' and the interpreter translates it 'no' into Swedish. Wadensjö observes that, according to the talk as text view, the interpreter's rendition 'no' of the suspect's utterance 'yes' would be classified as a mistake. Nevertheless, by comparing this sequence with what was uttered before it took place, the author states that the interpreter's rendition is an attempt to compensate what would otherwise have been impossible to translate, because there is no equivalence between Swedish and Russian. Consequently, the interpreter's utterance is not a textual rendition of the suspect's 'yes':

> With the interactionistic approach, on the other hand, I would look for other types of explanations. I would not invoke at all any general rules of equivalence, but try to take the perspectives of those acting, to understand what the judge, the suspect and the interpreter were trying to do in relation to each other in the situation at hand. (Wadensjö 1998: 23-24)

Conversation is the basic tool individuals have to shape the interaction, which is also the starting point for the construction of their human relationships. Cecchin and Apolloni (2003) underline that, in social situations, all human beings willingly or unwillingly organize themselves by talking to each other, because conversation automatically generates interactive rules:

> Esseri umani in relazione non possono non generare qualcosa. Gli uomini, lo vogliano o no, mentre parlano si

organizzano, perché la conversazione genera regole interattive. (Cecchin and Apolloni 2003: 76).

Communication is therefore accomplished through the interaction structuring process, which is based on conversation, and interaction is the basis for the construction of relationships.

Communicative issues in human interactions mirror the dichotomy between the structure of language and the structure of reality. The way language is structured makes it difficult for human beings to use it in order to describe reality, and yet it is one of the basic tools individuals are forced to use if they want to communicate with each other. Selvini Palazzoli et al. (1971) state that the difficulties they first encountered in their practice with schizophrenic patients was largely dependent upon the influence the configuration of language had on their work and, they highlight that this happened because while the structure of reality is "living and circular", the structure of language is linear, since language dictates a linear ordering of data in discursive sequence and so then we decide and enforce acceptance of the idea that the universe is organized on a linear basis. Furthermore, since language demands subject and predicate, actor and acted upon, in many different combinations and permutations, we conclude that this is the structure of the world. However, we soon learn that we cannot find such a concretely defined order except by imposing it, and we thereafter operate by setting a limit in the middle of a continuous variation. (Selvini Palazzoli et al. 1971: 32)

Since language is essential to communicate, but its linear structure does not allow individuals to fully represent reality (which has a circular and systemic structure), it is legitimate to argue that language can often be perceived by speakers as an obstacle, rather than as a useful instrument for the accurate delivery of a message, and human beings regularly have to try and adapt it in order to represent reality as they perceive it. During an interpreter-mediated face-to-face encounter, the task of 'shaping' language in

such a way that it can represent reality as faithfully as possible is all the more difficult, because the contextual situation of the interpreter-mediated interaction is usually more complex than a conversation among participants who speak the same language. And yet, in order to achieve the communicative goal, namely the conveyance of messages, interpreters are forced to alternately use two different languages in the most accurate way possible. When participants in a conversation do not speak the same language, the presence of an interpreter or cultural mediator during the encounter adds a certain complexity to the situation, mainly because of the language barrier. In order to overcome the problem of adapting the structure of language to a description of reality, the authors of the above-mentioned work underline the need to combine the analogical approach, i.e. a descriptive and linear language, with the digital one, in other words, a series of dichotomizations, such as subject-object, before-after, etc.

When participants in a conversation speak different languages, and the presence of an interpreter or cultural mediator is necessary during the encounter, they have an additional and overriding problem of incorporating analogical and digital approaches while communicating and thus constructing the interaction, compared to a conversation where participants speak the same language: to accurately communicate what they want to say with the aid of an interpreter. Inasmuch as the structure of reality is circular, the interaction between the parties constitutes a circular system which is not static, but dynamic and constantly changing, as it spontaneously mirrors the structure of reality.

1.2.3 Coordination of the participants' moves and negotiation of meanings in the construction of the interaction

The construction and structuring process of an interpreter-mediated face-to-face interaction is the result of a joint negotiation of meanings and messages

through a collaboration of all the participants in the communicative event, including the interpreter. By applying Goffman’s participation framework approach, Wadensjö (1998) analyses how the speakers coordinate their actions and therefore negotiate meanings during the interaction. In Wadensjö’s view, the interaction is at least partly characterized by what she calls an ‘interpreter-mediated interaction order’ (Wadensjö 1998: 152). This order underlines the joint participation of all the speakers in the construction of the interaction and the interpreter’s fundamental role as a rightful participant:

> In a conversation involving three or more persons, sense is arguably made also on the basis of the participation framework, continuously negotiated in and by talk, in other words, on the basis of how interlocutors position themselves in relation to each other. (Wadensjö 1998: 153)

To conclude, the interaction is constructed through the constant verbal negotiation among the participants, including the interpreter. The way in which the participants position themselves in the interaction, the importance of inferences and their power relations will be closely analysed in the next sections.

1.3 How contextual assumptions affect communication during an interpreter-mediated face-to-face interaction

In this part of my work I will discuss the speakers’ inferences, their importance in the conversation and the fundamental role played by context in the construction and shaping of an interpreted interaction.

1.3.1 Mason’s discourse approach

Wadensjö (1998) analyzed specific sequences in an interaction and showed how communication is the result of a continuous negotiation of communicative actions between the speakers. Mason (2005) adopted Wadensjö’s dialogic approach, but his investigation focuses on the fundamental role played by

context during the interaction, as well as the interpreter's central role in shaping and constructing the different phases of negotiation, in relation to the embedding context of interaction. Mason (2005) analysed selected sequences from different interpreter-mediated face-to-face encounters using the framework of discourse analysis and demonstrated that not only do the actions performed by an interpreter during a face-to-face interaction clearly display his/her occupational responsibility, but also provide meaning to the other speakers' utterances, since all speakers throughout the interaction constantly negotiate their assumptions about what the other speakers have said. Moreover, these assumptions actively contribute to the renewal and shaping of the conversational context. However, despite the presence of a stable 'speech-exchange system' through the interpreter's translational service, Mason's data show that the participants' 'mutual accessibility' to each other's assumptions only rarely occurs, as deviating contexts might arise during the conversation. Therefore Mason considers context to be a flexible and mutable system, which is constantly re-created and re-constructed through participants' assumptions of their co-participants' utterances (Mason 2005: 360).

Mason (2005) shows that considering the interpreter's actions during the conversation as being exclusively aimed at a proper transmission of the linguistic meaning of utterances is only a partial view of the tasks the interpreter performs and of the role she/he plays in the interaction. In fact, in order to have a more complete overview of the interpreter's role throughout the interaction, and how the joint communicative effort of all speakers contributes in shaping context, it is necessary not only to focus on the linguistic meaning which needs to be conveyed, but also on how the different utterances are conceptually linked to one another and how the linguistic meaning is perceived by the different participants in the conversation, and thus defines the context.

In his discussion of interlocutors' assumptions, Mason (2005) makes reference to Sperber's and Wilson's principle of relevance by whhereby an assumption is relevant in a context if and only if it has some contextual effect in that context,

where ‘contextual effect’ is to be understood as some improvement to the hearer’s representation of the world. According to Mason, since the content of an utterance does not change the contextual outcome, i.e. the inferences made by the speakers up to that moment, the utterance appears to be ‘underspecific’ (Mason 2005: 362), namely completely irrelevant to the understanding of the message the speaker wanted to originally convey. Mason (2005) also points out that the way in which we receive the messages conveyed by other speakers is strongly influenced by our own perceptions and goals. Therefore, we might perceive as important something that was considered a secondary issue by the participant we are talking with. Conversely, an utterance, which is considered to be particularly relevant by the speaker who voiced it, might seem to be irrelevant by the other participants in the conversation.

1.3.2 Allowable, contextually plausible and actual inferences

Mason (2005) highlights three different types of inferences that can be made during an interaction: allowable inferences, contextually plausible inferences and actual inferences. Allowable inferences are made according to the principle of relevance in such a way that it seems as if the context is not defined. Contextually plausible inferences also depend on the principle of relevance, but they appear to be ‘matched against co-text and context in such a way that only likely interpretations are retained.’ (Mason 2005: 363) Actual inferences are the ones made by the speakers and they are closely related to what Mason (2005) calls ‘perlocutionary purpose of the text’. i.e. the text’s main objective according to what we expect from the text. These inferences are more subtle and vague, since they depend on the speaker’s mood at that precise moment. Therefore, as highlighted in the previous section, different receivers of the message will react in different ways. In order to conduct a proper analysis of the data, Mason (2005) suggests not only that a record of received meanings is kept, but also that it is considered in relation to the linguistic, cultural and

interactional context, as well as the constantly varying perlocutionary purpose of the speakers.

1.3.3 The creation of context and the pre-existing context

A crucial aspect of Mason's research is represented by the role context plays in the development of the interaction, by its definition within the interactional framework and by the way inferences work within the interactional process. Mason (2005) underlines the fact that being able to guess the speakers' emotional status, intentions and thoughts at the moment the conversation takes place is a very difficult task, as previously observed by Conversation Analysis (CA) scholars (bibliographical references). As a matter of fact, when a conversation is under scrutiny, an analysis, it cannot provide any information about the interactional context, which it is usually left to the analyst to speculate upon. CA scholars propose two ways of solving the problem. One possible solution is to observe how the participants react to what is uttered by the other person. In this way, the data are not the result of the analyst's personal view, but evident in the sequences of utterances which construct the interaction. By quoting Cicourel, Mason (2005) puts forward a second solution, i.e. the addition of ethnographic data to the analysis of the conversational turns. This last solution provides an alternative context to the already existing one (the local context), from which the definitions of a narrow and of a broad context stem:

> He shows how, in judging the significance of local moves within a conversation that takes place in a medical setting, material facts about the participants are of central relevance. The fact that the setting is a teaching hospital, that one of the participants is a trainee and that he had recently attended a lecture on septicemia, for example, constitute information that is necessary for an understanding of particular utterances. In this way, Cicourel distinguishes between a "narrow" and a "broad" context, both of which are vital to an understanding of interaction. (Mason 2005: 364)

At this point the author points out that the concept of 'narrow' and 'local' context vs. the idea of a 'broad' context can be considered for an analysis of interpreter-mediated face-to-face encounters. Mason (2005) highlights the fact that the interpreter's utterances represents a very particular type of reaction, because in a three-party interaction, the interpreter alternately plays the role of the answerer, and of a communicator who is well aware of the recipient of the message. Consequently, while dyadic interactions which are usually analyzed according to the CA methodology present extemporaneous conversations where the speakers react to what is uttered by producing a direct answer, in a triadic interaction the interpreter, who is one of the participants in the conversation, also provides an instant answer to what has been said by one of the speakers, but the interpreter's utterance is actually an account of what has been previously uttered by one of the speakers:

> Interpreter performance can therefore provide valuable evidence of take-up, of the sense they make of others' talk and how they respond to it. […] The dialogue interpreter faces both ways: as a responder to what has been said and as a receiver-oriented producer. The receiver orientation (cf. Sperber and Wilson's definition of context, cited above) is thus tempered by a producer-oriented behaviour of representing (a version of) what has been said. (Mason 2005: 364-365)

Since the interpreter is indeed one of the speakers and actively contributes to the construction of the interaction, he/she certainly has to surmise the meaning of what has been uttered before translating it, while simultaneously having to deal with his/her own perceptions and viewpoints. Therefore, the interpreter's actions undoubtedly do accord to the principle of relevance, but, at the same time, they need to be evaluated without forgetting the relevant impact the interpreter's personal objectives, feelings etc. have on the development of the interaction (Mason 2005). Furthermore, what Mason calls

‘underdeterminacy’, i.e. the quality of underlying, real meaningfulness which characterizes the uttered turns, contributes to the illocutionary unpredictability of the process used to transfer the message. Therefore, the context within which the interaction takes place plays a fundamental role not only in creating a framework for the interaction itself, but also for the development of the different meanings of what is uttered by the speakers.

1.3.4 Inferences and topic shift roles in the construction of the interaction

Mason’s study (2005) suggests that the inferences made by the interpreter during the interaction may result in an explicit output, which inevitably has an impact on the development of the interaction. The interpreter might even completely change the nucleus of conversation (Mason 2005).

Another key aspect which depends on the speakers’ assumptions and which clearly contributes to the structuring process of the interaction is what Mason calls ‘topicalization’ (Mason 2005), i.e. a considerable topic-shift during a conversation. A simple move made by the interpreter triggers a series of consequences, which significantly affects the interaction. The interpreter’s action defines the path the development of the interaction will take and, at the same time, the context within the interaction is an entity which is constantly negotiated among the participants. According to the author even though shifts and re-topicalizations may occur during a interpreter-mediated conversation, the reciprocal availability of the inferences made by al the speakers during an interaction does not appear to prevent the speakers from knowing each other's real communicative intentions.

Despite the lack of reciprocal approachability of contextual inferences, Mason (2005) points out that the interaction keeps developing anyway and, thanks to the institutional scenery, it safeguards the fulfillment of the institutional requirements. Therefore, it can be concluded that, even though

each speaker can potentially access the other speakers' inferences about what has been said, they surely influence the speaker's reaction and therefore her/his linguistic choices once he has to produce his/her turn, in many of the examples chosen by the author this approachability does not appear, and this lack of reciprocal approachability of contextual inferences does not prevent the interactional system from reaching the original institutional objectives:

> Mutual accessibility of contextual assumptions does not seem to be preserved by many of these moves yet the 'speech exchange system' (Schegloff, 1999) of dialogue interpreting proceeds undisturbed and this, together with the institutional setting, ensures that institutional goals are served. (Mason 2005: 371)

Therefore, the interaction develops in spite of the lack of reachability of one of the speaker's inferences by the other speaker involved in the conversation. And because the interaction is part of the institutional context, the institutional goal will be preserved anyway.

1.4 Interpreters in the dialogue: role, positioning and footing

In the following paragraphs I will discuss the relevance of role, positioning and footing in the interaction and the basic differences that characterize them.

1.4.1 Dialogue interpreting: role or position?

One aspect on which Mason's research focuses is the difference between the notion of role and the notion of position within the dialogue interpreting domain (Mason 2009). By adopting an interactional and a descriptive approach, Mason suggests that, within the dialogue interpreting sphere, the concept of role differs considerably from the concept of position. In fact, the author claims that while the concept of role is static and immutable, position represents a changeable, flexible concept, as the position of a participant within an interaction is constantly altered by the process of joint negotiation among the speakers. Therefore, Mason's study is a listing description of the

different unconscious methods the participants employ throughout the interaction in order to position themselves and the other speakers, and how they are influenced by the positions of the other participants. Mason analyzes the interactions he presents in his study by focusing on the actions of all the participants and by observing how the moves made by one participant influence the other participants' moves and, conversely, how these affect the moves of one particular speaker. The author's priority is not to judge the interpreter's service and the actions of the other participants from a professional point of view, but to understand the effect that each participant's moves have on the whole interaction and on its development. By referring to Wadensjö's work, Mason (2009) explains that while the notion of 'role' presupposes a pre-determined function of the speaker, which is established before the interaction takes place, the 'position' of the speaker within the interaction constantly changes according to the participants' reciprocal moves:

> In this respect, a useful distinction is made by Wadensjö (1998), following Goffman, between "activity role" and "participation status" or "footing". Whereas an activity role involves mostly pre-determined stances deemed to be appropriate for fulfilling a particular socio-professional task, the "footing" adopted by participants is of a temporary and evolving nature. Loosely defined by Goffman (1981: 128) as "the alignment we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance", footing is perceptible through the frequent shifts enacted by participants, often within a single utterance. These shifts may be from one addressee or a group of addressees to another, say, or they may have to do with the ownership or non-ownership of the meaning one seeks to express. (Mason 2009: 53)

Therefore, the choice of whether or not to align with what is being said by a participant in the conversation and the subsequent response of the other participants to this alignment, determine the speaker's position within the interaction, and this position is always calculated. (Mason 2009)

The author then introduces the concepts of intended meaning and hearable meaning, i.e. the message a speaker really wants to convey, and the

way in which a speaker's message is perceived by the hearer, a perception that largely depends on the hearer's attitude towards what is said by her/his interlocutor and by her/his response to it. The author highlights the complexity of this situation in this exchange during an interpreter-mediated face-to-face encounter: if it is very likely that the other person's message in a dyadic interaction will be misinterpreted, misconceptions will be all the more frequent when a conversation takes place among three people. Moreover, Mason quotes a study, which describes the Canadian Convention Refugee Hearing in detail, highlighting the fact that the asylum seeker is supposed to '"Construct a Productive Other"' (Mason 2009: 55). In other words, the asylum seeker is not expected to project him/herself, but it is required of him/her to be able to create and structure a suitable kind of '"Convention Refugee"' (Mason, 2009: 55).
Mason points out that in interpreter-mediated face-to-face interactions it is virtually impossible for the interpreter to orally translate everything uttered by the other speakers, because conversational dynamics prevent the interpreter from acquiring a completely objective point of view while translating what is being said. Therefore, expecting the interpreter to have a completely neutral view of the situation and to interpret the other participants' turns faithfully and correctly mirrors an unrealistic, utopian perspective on interpreting. Mason's study focuses on the analysis of interpreted-mediated interactions in order to observe how the participants position themselves and how their position is simultaneously influenced by the others' positions. The author identified the following conversational position-influencing strategies: '[…] orientation to others, attempts to control responses, contextualization cues, markers of in-group solidarity, gaze and discoursal choices' (Mason, 2009: 56), which will be briefly discussed in the following sections. It is these position-influencing strategies which can lead to problems in a interpreted-mediated interaction. Haralambous et. al (2018) considered the experience of immigrant patients, interpreters and doctors operating in the field of dementia. They found that there existed different perceptions between interpreters and clinicians as to the

the role of the interpreter and they were not resolved led to a lack of trust, an increase in tensions and inefficiency.

1.4.2 Positioning shifts through orientation to others

One of the ways in which the interpreter is able to position him/herself during the interaction, and thus position the other participants as well is through what Mason calls 'orientation to others' (Mason 2009), namely the way in which the interpreter decides to render the other speakers' utterances. Mason highlights the fact that the interpreter is often expected, especially in American courtrooms, to act as if he/she was not an active participant in the conversation, and as if he/she had no personality, nor a point of view. Basically the interpreter is considered to be simply a conveyor of messages, and therefore a powerless figure. Mason quotes Berk-Seligson (1990), who noted that, as stated above, this static view of the interpreter's performance is particularly widespread in American courtrooms. The author then provides a sequence extracted from a conversation between an attorney, a witness and their interpreter during the hearing for the O.J. Simpson murder case, in order to show that, by translating the turns literally and mechanically as the interpreter is expected to do, it is clear that s/he is not considered as a legitimate participant in the interaction that is taking place. In this respect, the passage offered by Mason is particularly significant: the sequence begins with the attorney who asks what the name of the airline is, and the interpreter translates the question faithfully. The witness answers by saying that it is 'TACA', thus clearly making a mistake, since the real name of the airline is TACK. However, in the following turn, the interpreter translates accurately what previously uttered by the witness by saying 'It's TACA'. (Mason 2009: 57) At this point the attorney asks the witness if she can repeat it and spell it, and the witness directly answers the attorney's questions by saying 'TACA' again. The interpreter decides to intervene by translating into Spanish the second question asked by the attorney, therefore asking the witness to spell the name

of the airline. This time the witness spells the name 'TACK' correctly, and the interpreter repeats the correct spelling of the word. The whole sequence clearly shows that the interpreter is regarded and acts as an exact translating machine:

> Let us note, in passing, that in behaving as required, the interpreter also positions herself as belonging to a "community of practice" (Wenger 1998) – the court of law – whose practices she has internalized and constantly reproduces. In such circumstances, the interpreter's own actions and those of other participants position her as a "non-person". At the same time, of course, this position positions other participants as being responsible for their own utterances. Thus, positioning can be both reflexive (i.e. positioning oneself) and interactive (as when one positions another participant by one's own moves; see Davies and Harré 48)

In the example provided by Mason, the position the interpreter assumes within the interaction through the precise and literal translation of the other speakers' utterances, simultaneously affects the other participants' positions as well. Thus positioning is both reflexive and interactive, in that it determines the position of the person who performs the communicative actions in a certain way and, at the same time, it establishes the position of the other two parties in the conversation, who, compared to the interpreter can be communicatively freer, with a certain degree of power. However, the more or less powerful position of the interlocutors depends on the interpreter's moves. (Mason 2009)

Mason (2009) suggests that several studies have already highlighted the possible marginalization of one of the speakers, but the question that spontaneously surfaces is, can other speakers outweigh the interpreter's control by changing their footing and become the primary interlocutors in the interaction? Mason states that this dramatic interactional alteration is possible, providing that the speakers who defy the interpreter's power are acknowledged as having sufficient prestige to do so. Since the phenomenon happens

frequently in face-to-face interpreter-mediated encounters, Mason concludes that, among the different communities of practice, it is actually possible to consider the existence of an interpreter community:

> The absence anywhere in the literature of any converse examples of the power-less participant (immigrant, patient, etc.) successfully intervening in this way points conclusively to an unstated assumption about positions across a range of genres within interpreter-mediated exchanges. The interpreter has power to sustain or interrupt the normal turn-taking sequence. This power may, occasionally, be challenged – but only if the challenger is recognized as having the status and authority to do so. Otherwise, the third party is effectively (if temporarily) excluded and positioned as bystander. The regularity of this behaviour points to an interpreter community of practice, overlapping with the other communities of practice, of which they become part by their professional activity. (Mason 2009: 61)

1.4.3 Alteration of the footing through responses control

A variation of the speakers' positions throughout the development of an interaction with three participants can also be obtained by seeking to control the given responses. Mason (2009) quotes an example in which the interpreter alters the immigration officer's question. In the sequence, an immigrant is being interviewed to clarify the circumstances which prompted him to request asylum. The immigration officer asks whether there were dead people or anything else. The interpreter translates the turn by asking: 'People were killed in the course of the incident or?' The author highlights the fact that in this sequence the interpreter modifies the question asked by the immigration officer by making it more allusive. Mason (2009) notes that in an interaction with three speakers, one of the participants can position him/herself, as well as the other participants, by trying to control the other interlocutors' responses:

> From the point of view adopted in this paper, the relevant point is that participants in three-way exchanges (police officers, attorneys – and also interpreters) may from time to time seek to control the replies of their interlocutors by asking preferred-response questions. In doing so, they position themselves as making a prior assumption about the truth of some state of affairs and position their interlocutor as likely to agree with their assumption. The interlocutor can, of course, refuse to accept this positioning by denying the assumption. However, such dispreferred responses require more elaboration, rendering acquiescence with the offered position more likely […]. (Mason 2009: 62)

The acceptance of the position offered is evident in another sequence (Mason 2009) where the interpreter appears to be friendly to the immigrant at first, by encouraging the immigrant to provide a suitable reply to the immigration officer's question by saying: 'Did you look for work? You looked for work and there wasn't any?' (Mason 2009: 62), whereas the immigration officer's original question was: 'Did you look round for a job in Poland?' (Mason 2009: 62) However, after the immigrant's affirmative answer, the interpreter says: 'Yes, he was looking for work but there was no work.' (Mason 2009: 62), thus showing that she shares the immigration officer's communicative objectives and a certain willingness to follow a particular tendency in order to reach the institutional objectives, rather than wanting to genuinely help the Polish immigrant. The author concludes that while role is a fixed concept, useful to identify the contextually relevant speakers of an interaction, the participants' positioning during the development of the interaction is not only jointly constructed by all the speakers, but may also vary considerably and can consequently modify the speakers' alignment.

1.4.4 Positioning shifts through contextualization cues

Contextualization cues can produce positioning shifts. Mason (2009) quotes Gumperz (1982: 131) to explain that contextualization cues are a group of linguistic elements, which indicate the way in which speakers express their intentions and how the speakers' messages are perceived by the hearers. Contextualization cues incorporate code-switching, changes in style, prosodic elements, lexical and syntactical features and the employment, or avoidance, of standard structures all of which have an implicit meaning and thus have to be inferred from the particular context in which they occur.

Consequently, it is necessary to deduce them by considering the context in which they appear. Usually they are produced through a change in the linguistic conduct, and this is why they often cause misinterpretations especially when the interaction is characterized by considerable cultural differences.

Contextualization cues play an important role in the interactional exchange. Nevertheless, it is difficult for interpreters to render contextualization cues, because they are very personal and depend entirely upon the speaker's individual perceptions and points of view (Mason, 2009). The author quotes Wadensjö's work (Wadensjö 1998) who, referring to Goffman, explains the difference between the concept of 'displaying' and the concept of 'replaying': when the interpreter 'displays' what has previously been uttered, he/she does not render the prosodic features, connoted words and colloquial expressions of the other speaker's turn, thus signaling a certain distance. On the other hand, the concept of 'replaying' refers to the interpreter's identification with the speaker whose turn he/she has to translate: the interpreter position him/herself as the main speaker and translates faithfully what has been uttered. However the action of 'replaying' what has been said could create problems, as the interpreter's effort might be perceived as impolite towards the speaker who originally uttered the turn, since contextualization cues appear to be a particularly personal communicational tool.

1.4.5 In-group solidarity and communicative balance

In-group solidarity is another aspect that can affect communication in an interpreter-mediated face-to-face encounter. Mason points out that those utterances which express 'power, deference, solidarity, distance' (Mason 2009: 66) can be either highlighted or refined, and subsequently be used or disregarded. During the conversation, the detectable significance of the uttered messages is built on their use; for instance when the interpreter and one of the speakers share a common cultural background they usually refer to each other using common courtesy expressions. Nevertheless, the research conducted by Berg-Seligson shows that using or not using these expressions modifies the reaction provoked by the utterances. Furthermore, the use of colloquial expressions by the interpreter indicates a reduction of the hypothetical space between speakers (which the other interlocutor might not have wanted) and reinforce the power position in circumstances where there is a power imbalance.

A study by Bot (2005) examining the use of direct speech and reported speech by interpreters found many do not repeat what was said, but instead use reported speech, the consequences of which not only confirmed the interpreter's role as an intermediary and indicated the person who was talking, but was an important tool in organizing turn-taking. Moreover, Bot concluded that the use of reported speech, or the alternation between direct and indirect speech, did not have an alienating or distancing effect on either the patient or the medical practioner, nor did it lead to any confusion in what was being said.

1.5 The importance of non verbal communication: gestures and gaze in the negotiation process

Paralinguistic features play a fundamental role in the construction of the interaction, in that they contribute both to structuring the development of participation and to the joint negotiation of the turns (Mason 2009). Lang (1978) analyzed the gaze, posture and gesture of speakers in Papua New Guinea's courtrooms and realized that these paralinguistic characteristics can determine the inclusion or the exclusion of participants from a conversation. For instance, if an interpreter voluntarily avoids gaze during a conversation she/he probably wants to communicate her/his exclusion from what is being said at that precise moment, thus transforming a three-party interaction in a two-party communicative exchange. Conversely, the other speakers may treat each other as reciprocal interlocutors by not gazing at the interpreter during the conversation, thus positioning her/him not as a real participant in the interaction, but as a listener who must simply give voice to the other participants' utterances. In the relatively scarce dataset used by the author, it is possible to recognize certain patterns which suggest that the direction of gaze directly affects the inclusion or exclusion of a participant from the interaction in a three party, interpreter mediated face-to face encounter. The author points out that, for instance, sometimes the immigration officer might gaze exclusively at the interpreter while asking routine questions or registering the immigrant's personal data, and the interpreter may gaze back at the immigration officer. The reciprocal actions of the immigration officer and the interpreter obviously leave out the person who does not speak the language which they are using to communicate with each other. Nevertheless, as noted by Mason (2009), this interactional scheme is not very frequent in this kind of interview. The immigration officer usually gazes only at the interviewee when he/she interviews him/her, while the interpreter alternately looks at the immigration officer and at the immigrant during the translating process, depending on who is speaking at that moment. In order to be able to direct his/her gaze towards both interlocutors, the interpreter obviously has to constantly turn his/her head, and this movement sends an important message, namely that the interpreter wants to be included in the interaction as a rightful participant. The Polish immigrant sits at the opposite side of the table from the

immigration officer. Interestingly, in two of the interactions analyzed by the author, both interviewees, a man and a woman, usually look at the interviewer if he/she is speaking to them, but not if it is their turn to speak. When the interviewees have to answer the questions, they gaze at the interpreter. Therefore, the interviewees position the interpreter as their real addressee. Mason (2009) explains that there are different motives behind this action: one of them might be the interviewees' belief that they are able to convey messages only if they speak their language, and the same could be said of the immigration officer who directs his gaze only at the interpreter while asking personal information to the interviewees. However, as stated above, the result of these actions is that the interviewees have no chance to really present themselves to the immigration officer. In fact, by not looking directly at him/her, the immigrants position themselves as left-out participants, thus positioning both the immigration officer and the interpreter as the main interactional figures.

A study by Vranjes et. al (2019) used a sophisticated eye tracking device to monitor the interplay of gazes and head nods between patient, medical practioner and interpreter, which made it possible for utterances and eye movement to be accurately synchronized, thereby enabling a detailed anaysis to be undertaken. They concluded that although nods and gazes were used by both practioners and interpreters to affiliate with the patient, they were used by them in different ways. The interpreter's nods tended to be in response to the patiuent's gaze, and functioned as an invitation to the patient to concur. Moreover, a mutual gaze with the patient tended "to intensify the interpreter's listener responses and her display of affiliation" (Vranjes et al. 2019). Head nods by the practioner are target-specific, and are actively used to promote their affiliation with the patient. In both cases the affiliative responses of the interpreter and practioner were linked to their social position and to the interactional goals of the encounter.

Gesturing is also an important means of conveying information during the communicative process. Gerwing and Li (2019) found that when an interpreter translated the patient's uttererance without incorpoarting bodily gesture, the accuracy of the meaning of the translated speech was compromised. However, if they included the gesture the meaning remained more faithful to the original meaning. They therefore called for further training to be given in this area so that interpreters will include gesturing in their translation.

Non-verbal emotional responses are an important part of the communication process; the meaning of an utterance shorn of its emotional context can lead to a completely different interpretation of the primary speaker's meaning. This is particularly so in communication is between two people from very different cultural backgrounds, in which emotions are likely to be expressed in different ways, and thus become a likely cause of misunderstandings. However, the problem is far more nuanced than this; there are three people in the conversation, all of whom will be emotionally involved, albeit to different degrees, and this clearly requires that the emotions are managed if the interaction is to successfully achieve its goals in an efficient way. Hsieh and Nicodemus's study (2015) into the area of emotion management in interpreter-mediated medical encounters provides a review of the complexities of the topic, through an examination of:

(a) the interpreter's management and performance of others' emotions. In order to face this case, it is possible to distinguish several strategies: (i) embedding emotional and affective content, which can guarantee a smooth conversation due to the minimization of the interpreter's visibility; (ii) the use of the first person, which can lead to a certain confusion because emotions can be seen as the interpreter's instead of the patient's; (iii) re-enactment of others' emotion, which can be risky especially when the interpreter is the "actor" of negative feelings (Hsieh and Nicodemus 2005: 1476). In general, one has to keep in mind that cultural differences in emotion display can be

very subtle according to different cultures. In addition, and consequently, also non-verbal display may entail different meanings in different cultures.

(b) Empathy as emotion work in healthcare interpreting.

Even though neutrality is normally seen as a fundamental feature of interpreting, in healthcare interpreting it is necessary to build rapport and give emotional support in order to satisfy the needs of both providers and patients. Thus, the role of empathy acquires great importance.

(c) Emotion contagion and vicarious trauma in healthcare interpreting. Talking in first person, a strategy often used by healthcare interpreters, can lead to vicarious trauma, for example, because they were once refugees themselves or already subjected to various forms of oppression. Their review concluded that, in order to guarantee quality and equality of their service, interpreters should "evaluate and prioritize the various clinical, interpersonal, and therapeutic objectives as they consider the best practice in managing their own and other speakers' emotions," (Hsieh and Nicodemus 2015) and proposed a normative model to guide future research and practices of interpreters' emotion management in cross-cultural care.

Yet, a study by Theys et.al (2019) which sought to identify the ways in which physicians, patients and interpreters express emotions, react to emotional expressions and/or coordinate the emotional interaction in interpreter-mediated consultations, concluded that although physicians, patients and interpreters operate together in co-constructing emotional communication, and that a decrease in emotional communication might compromise the patient's quality of care, there is still a lack of scientific evidence on the subject, and that successful emotional communication is dependent upon the successful interaction of the participants.

1.6 Interpreter's actions and power imbalances

1.6.1 Interpreting and power

A social and cultural discrepancy between the primary interlocutors who speak two different languages, but nevertheless need to communicate with each other, is a phenomenon that occurs regularly in most institutions, in different social and cultural contexts and in countries worldwide. Because of the reciprocal lack of knowledge of the other person's native language, the speakers involved in the conversation necessarily need the linguistic aid of an interpreter. As Wadensjö (1998) pinpointed on several occasions, Mason and Ren (2012) underline the traditional view of the interpreter as having a role that is linear and almost 'passive' and directly implies a passive position, her/his indistinctness, impartiality and a certain nonalignment. This approach was considered as the mainstream one for several years.

The idea of considering the interpreter's performance as a perfect and almost automatic translational mechanism is very far from reality and the concrete interpreting experience. (Mason and Ren 2012) The authors state that, although the interpreter cannot and does not act as an impartial, detached and neutral speaker during face-to-face interaction, he/she nevertheless retains and exerts a specific type of power throughout the interaction and, thanks to his/her linguistic knowledge is able to prevent any usurpation of his/her particular kind of authority. However, the kind of power the interpreter demonstrates to possess during the interaction is not the institutional power, associated with different types of bodies, associations and social groups. Drawing considerably on Foucault's vision of power, Mason and Ren (2012) remark that the system of relationships within which power operates by creating a certain kind of continuous pressure, is active in every social reality: 'The network of relations of which Foucault speaks operates at all levels and in all social groups and is in a state of constant tension." (Mason and Ren 2012: 237) Therefore, continue the authors, when observing and analyzing face-to-face interpreter-mediated interactions, it is particularly relevant to distinguish between two kinds of power: institutional power, which, as stated earlier, refers to the power possessed by institutions and certain types of establishments, and interactional power, which belongs to interpreters

and which they employ during different phases of the interaction, as part of the coordination process highlighted by Wadensjö (1998), as underlined in the previous paragraphs. The interpreter utilizes different communicative tools to exert his/her interactional power, but they all depend on the linguistic skills and knowledge in both languages used during the conversation, which the other two speakers lack. In fact, it is through verbal and non-verbal expressions, lexical choice and intonation that the interpreter is able to coordinate the encounter, which will partly determine the aftermath of the conversation.

1.6.2 The exertion of institutional power in the interaction's construction process

Mason and Ren (2012) suggest that, regardless of the institutional setting, during an interpreter-mediated face-to-face interaction, interpreters possess and can exert very little institutional influence. This interactional aspect is evident in very different situations, and, by quoting two examples of interpreter-mediated interactions during two famous court hearings, Mason and Ren (2012) show that the power relationships and balance are previously structured by the institution itself. The authors then underline how the interpreter's lack of institutional power is particularly manifest in courts, even though interpreters appear not to be able to gain and apply institutional power during other types of encounters:

> For example, when interviewed, Angelelli's (2004a) healthcare interpreters appear to be keenly aware of power differentials and of the inescapable institutional constraints on their behavior. The effects of institutional power on the interpreter's practice are real but may just be somewhat less conspicuously manifested than in Examples 1 and 2 above […]. (Mason and Ren 2012: 241)

Moreover, the fact that interpreters do possess and employ interactional power during the conversation structuring process does not necessarily mean that, by doing so, they compensate for their lack of institutional power in specific situations. In fact, the two aspects are present and affect the interaction during all its phases, and in different ways:

> It is not therefore being argued here that interactional power replaces institutional power in certain social settings: both dynamics work together at all times and may offer opportunities for change or challenge, as Inghilleri (2003: 262) suggests.' (Mason 2012 and Ren: 241)

1.6.3 How interpreters apply interactional power during an interpreter-mediated face-to-face encounter

As stated in the previous sections, according to Mason and Ren's view interpreters lack any substantial institutional power during the vast majority of interpreter-mediated face-to-face encounters, but nevertheless possess and exert interactional power, thanks to their linguistic knowledge, which the other speakers do not have, or have previously only partially acquired. Referring to Wenger's outlook on power (date), Mason and Ren (2012) highlight two notions, which seem to be inevitably connected with the concept of power: the notion of 'community' and the notion of 'identity'. As individuals, being at the same time part of different communities, we construct our identity by continuously taking into account the features and values of the different communities we belong to, in order to understand whether or not they do reflect our personality, and through the constant social exchanges that inevitably occur within the communities (Mason and Ren 2012). Therefore, if the existence of a community depends strictly on the human beings that are part of it, at the same time individuals constantly construct and re-construct their identity through social negotiation with the rest of the community. According to Mason and Ren (2012), this distribution of power is particularly useful in explaining the interactional power interpreters exert during face-to-

face interactions for the institutions in which they work. The authors identify three ways in which the interpreter can employ interactional power throughout the conversation with the other two speakers: the interpreter can assume the role of co-interlocutor, of an empowerment actor or he/she can choose a non-neutral position (2012: 232).

The decision to adopt the role of co-interlocutor happens regularly: Mason and Ren (2012) point out that, even though interpreters are supposed to faithfully translate every single utterance produced by the other participants in the conversation, and although they are usually requested to act quite mechanically during a face-to-face encounter by the rules established by various bodies, several studies, such as the one conducted by Davidson (2000), which focuses on the role of the interpreter as 'gatekeeper' of the interaction, have demonstrated that interpreters do take part in the conversation and actively contribute to the construction of the interaction:

> For instance, interpreters may voluntarily introduce themselves, propose a meeting format, explain cultural differences, answer a question, make a suggestion, or conduct small talk with one or both parties. As gatekeepers, they may sometimes even withhold certain information that they deem inappropriate (vulgar remarks, cultural taboos, etc.) or irrelevant, even if they are trained not to do so. (Mason and Ren 2012: 242-243)

A further example of the interpreter unintentionally withholding valuable information is outlined by Penn and Watermeyer (2012). In their intercultural health care study in South Africa, the authors drew attention to the existence of verbal asides between participants in interpreter-mediated consultation, noting that they were often construed as hindering the interpreting process and thus not interpreted. Often these asides, dependent upon the context, are 'small talk' used to provide a comfortable environment, in order to align the interpreter and the patient or to offer guidance, but from which important

pertinent topics may arise, offering critical diagnostic and therapeutic information, information which is valuable but remains untranslated.

Another way interpreters apply interactional power is by acting as an empowerment personality. When interpreters feel the need to aid one of the parties involved in the interaction, because they perceive him/her as being in an interactionally unfavorable position, they may choose to perform certain verbal and/or non-verbal actions, which can actively help the 'weakest' participant. Mason and Ren (2012) state that, hypothetically, in a dyadic interaction both participants are equal, and their positions are balanced. However, in practice, the speaker who represents a certain authority or body and retains a particular type of information is actually institutionally in a prevailing position in relation to the other speakers. The participant who finds him/herself in a more advantageous position from an institutional point of view, could decide to actively benefit from it, thus creating a considerable interactional unbalance (Mason and Ren, 2012). The authors also argue that, in these situations, the involvement of an interpreter, apart from transforming the interactional structure from a dyadic into a triadic one, also contributes to modifying the way the power aspect has characterized the interaction up to that moment:

> Because of their unique access to the resources of the two languages and cultures at work and depending on processes of identification and negotiation, interpreters are capable of empowering or assisting comparatively weaker parties to exercise their responsibility to make decisions for themselves. (Mason and Ren2012: 243)

Therefore, being an empowerment figure, as the interpreter is in the above mentioned situations, actually means being able to help the weakest participant to consider the power he/she possesses and to help him/her exert it during the conversation and the development of the interaction. (Mason and Ren 2012) The interpreter is able to do this by using different communicative

tools. He/she, for instance, might prompt a speaker's reaction to a never-ending utterance produced by the other speaker, who represents the institutional body during the conversation. The interpreter can also urge a patient to ask for more information about his/her disease from a doctor who is being too quiet, or he/she might produce an utterance to interrupt too long a monologue, in order to give the weakest party a chance to reply and even defend him/herself. According to Mason and Ren (2012) the relevant aspect of these situations is the fact that the interpreter is able to perform a certain action thus exerting his/her interactional power, because he/she is able to identify with the weaker participant and his/her communicative necessities.

The further way in which interpreters apply interactional power during the development of an interaction in face-to-face encounter is by actively refusing to adopt a neutral position during the conversation. As underlined by Wadensjö (1998) and by Mason and Ren (2012) and as often highlighted in the previous paragraphs, apart from the exceptional rules established by CHIA (2002), interpreters are always required to adopt a detached attitude during any type of interview, by displaying an impartial and neutral disposition and by translating every single word uttered by the participants in the conversation. Even if a request for help is directly made to the interpreter during the interaction, the interpreter is expected not to satisfy it. Interpreters who do not follow these strict rules are often judged as bad and unprofessional individuals who are not willing, nor able to respect the guidelines of the institutions for which they work. Nevertheless, the authors point out that, the codes of conduct established by the different bodies around the world do not seem to mirror what actually happens during real interpreter mediated face-to face encounters. As a matter of fact, during actual practice, interpreters are never completely neutral, not only because of the contextual situation in which they find themselves, together with the other speakers, but also because of both their personal views and social and cultural backgrounds, which might influence the development and outcome of the interaction:

> Interpreters mediate between two cultures, but this does not mean that they are placed at the very center of the two cultures. Their own cultural identity and affiliation to communities of practice may affect their understanding and interpretation of the situation and may influence their decision making. This kind of understanding, interpretation, and decision making is not totally devoid of subjective judgment, attitude, and personal feelings. (Mason and Ren 2012: 244)

It is therefore practically impossible for interpreters to be completely neutral while mediating in a face-to-face encounter. Mason and Ren (2012) state that it is possible to observe the way interpreters exercise interactional power through the analysis of their positioning and of the direction of their gaze. The interpreter's positioning depends on his/her willingness to agree or refuse to assume a certain position proposed by one of the other speakers or, more rarely, by both of them. This can be achieved, for instance, by adding a question, which, although coherent with the topic and the communicative context of the conversation, may be an initiative taken by the interpreter. According to Mason and Ren (2012), the interpreter's actions are at times characterized by his or her empowerment, the one-word question asked by the interpreter had the power not only to re-position herself as an interpreter, who is also an active member of the institution they work for, but also to modify the contextual situation by prompting the foreigner's admission of having previously lied. Even though this extremely influential interactional power can at times not be favorable for the interpreter, it nevertheless represents a potent communicative tool, which the interpreter can use throughout the conversation. If the role as co-interlocutor, and the aspects of empowerment and non-neutrality are the instruments the interpreter can use to determine his or her position, or to re-position him/herself during the conversation, the interpreter's gaze can considerably affect the interaction. Mason and Ren (2012) highlight that the interpreter's action of listening while simultaneously grimacing at the person who is speaking will usually prompt the speaker to ask the interpreter to repeat what had been said, in order to obtain an explanation.

However, when the interpreter looks away from the speaker, while sulking at the same time, his/her behavior is normally perceived as a way to negatively connote what is being said, and to detach him/herself from the interaction. Mason and Ren (2012) remark that these attitudes can be adopted by the interpreter both consciously and unconsciously, but they nevertheless have a considerable impact on the interaction. At the same time, the interpreter can display a totally different type of behavior as well: he/she can also decide to participate actively in the interaction and take a clear stance by looking intensely at the speakers and by employing gestures as well, in order to support what is being uttered by the speaker he/she is translating for:

> This stance is a clear example of what Wadensjö (1998:247) calls "relaying by replaying" rather than "relaying by displaying". In this sense, displaying would involve minimizing expressiveness and thus dissociating the interpreter's self from the testimony being translated whereas replaying, as in this case, involves an attempt to re-present in translation all the expressiveness of the previous speaker. Such a stance is a clear attempt at empowerment of the institutionally weaker party in the exchange. Taken together, these two cases of gaze and gesture provide a clear illustration of the interpreter's scope for departing from strict neutrality, for exercising interactional power, and for alignment within and between communities of practice. (Mason and Ren 2012: 248)

Mason and Ren (2012) conclude that the roles played by the interpreter during different phases of the interaction, which are clearly evident in the excerpts of real conversations provided by the authors, can regularly be observed in interpreter-mediated face-to-face interactions. The authors also highlight that the different attitudes assumed by the interpreter during the interaction have been analyzed by different experts, thus confirming that the notions of the interpreter as co-interlocutor namely, empowerment, non-neutrality, positioning and direction of gaze, even though called in different ways,

constantly evolves together with the construction and re-construction of the interaction, modifying the contextual situation as well.

1.6.4 Conclusion

What can be observed in so many of these exchanges is the way in which power is negotiated between participants, including the interpreter. Institutionally, participants start, are nonetheless distinguishing features of the interpreter's behavior throughout the process of the construction of the conversation. The primary finding of Mason and Ren's research is the fact that it proves that power is exercised during the interaction, because it has been negotiated among the speakers. Moreover, the negotiation process is not a definite one, from very different positions; but the inherent inequalities between different positions are, without doubt, subject to a constant process of re-contextualization. (Mason and Ren 2012: 249)

2 AD HOC INTERPRETING

2.1 Ad hoc interpreting: an introduction

As will probably be clear from chapter 1, dialogue interpreting, including dialogue interpreting in healthcare, has become an important and recognized field of research. In medical interpreting in particular, a massive necessity of providing interpreting services quickly has had the consequence that 'interpreters', that is, the bilingual participants providing translation in the conversation, are not necessarily professionals and have a number of different profiles and types of experience.

Indeed, a considerable amount of interpreting in healthcare is provided by participants whose role is just occasionally that of a translator, which is why they are called ad hoc interpreters. They can be considered to belong to two main categories: a. bilingual personnel of the hospital, like doctors, nurses or other assistants, or b. accompanying friends or relatives of the patients.

While the ad hoc interpreting system is rather spread all over the world, the attention it has received has not been extensive. Some notable exceptions are provided by work in German healthcare institutions by Meyer (2002; 2007) and by Bührig and Meyer (2004) and by C. Baraldi (2016) and Gheorghiu (2012), the latter, however, not in medical contexts. Despite the worthiness of such research, as those pioneering studies showed, analyses devoted specifically to ad hoc interpreting in a medical context have been scarce: Ryan et al. (2019) and R. Tuube and B. Ekanjume-Ilongo (2018) stand out as two welcome although unusual recent examples of the interest that is starting to be shown in this area.

2.2 The context

At the close of the twentieth century and at the beginning of the twenty-first century, because of the high number of immigrants moving to different countries across the world, different types of bodies in several countries have had to face a new reality, forcing themselves to re-organize their services to

accommodate the needs of the new incoming residents, in hospitals, courts, schools and other public institutions. This situation has dramatically changed the society in a variety of ways, and several institutions have had to adapt accordingly. Since healthcare satisfies fundamental human needs (and rights), healthcare institutions have had not only to keep providing their services in suitable quantity, but also to ensure access to anyone in need.

Alongside cultural mediators and professional interpreters, another form of interpreting service has thus started to develop in hospitals and health care institutions, called ad hoc interpreting. This form of oral translation presents certain unique features, which differ considerably from those pertaining to other forms of interpretation.

2.2.1 The main features of ad hoc interpreting

One of the most evident and immediately recognizable features of ad hoc interpreting is that, contrary to other forms of interpretation, it is not a proper 'service' and indeed cannot be planned or scheduled by medical providers. Consequently, ad hoc interpreters usually know the persons they accompany well and are prepared to deal with their needs or requests, which they often know in depth. They do not (normally) have received interpreting training. This is probably the reason why this form of interpreting is often regarded as 'spontaneous' (Meyer 2007). In brief, ad hoc interpreting can be defined as a form of dialogue interpreting , occurring in community services, where a bilingual individual translates betweeen interlocutors who do not speak the same language. Ad hoc interpreters are not expected to be trained interpreters and even though they may have some experience, they have rarely received any formal training.

2.2.2 Who is the ad hoc interpreter?

Ad hoc interpreters are individuals who perform the role of an interpreter without having received any formal training. They can be divided into two sub-categories which will be analyzed later in this work: bilingual or multilingual

medical staff, who are asked to translate for those colleagues and patients in need to communicate with each other, and the patient's bilingual or multilingual family members or friends, who play the role of interpreters for those dear to them.

Their service is often improvised, due to the fact that they are usually called to translate when no other professional is available (as often happens when bilingual or multilingual personnel are asked to interpret), or, in the medical field, when a member of the hospital's health care staff member realizes that the person who is accompanying the patient for their medical consultation is competent enough in the languages involved to translate what is being said.

2.2.3 Ad hoc interpreting and professionalism

Part of the problem concerning the professionalism of the person who plays the role of the interpreter is actually caused by the presence of participants who can be classified into two categories: those who are paid for a job in the healthcare system (e.g. nurses, doctors or other types of carers or assistants) and those who simply accompany the foreign patient. Those who simply accompany the patient cannot be expected to be professional. Also doctors and nurses who participate in the encounter are professionals. This adds to the problem of professionalism. Paradoxically, the ad hoc interpreter is the only non-professional person accomplishing a professional task in the interaction. Professionalism is not a matter of being paid or not paid and I am not suggesting here that there is a particular difference in the provision of the interpreting service between the two categories, but the fact that the existence of other professionals who play this role may have created the confusion surrounding the concept of 'non-professionals'. In this work I will analyze data which involve a doctor, a patient and a cultural mediator or a family member as ad hoc interpreter.

2.3 Family and friends as ad hoc interpreters

2.3.1 Ad hoc interpreters as cultural brokers

A study by Ho (2008) underlines that family members acting as ad hoc interpreters can effectively play the role of cultural brokers, thus actively supporting the patient during the medical visit and enabling the doctor and the patient to communicate efficiently with each other. The study conducted by Ho on the engagement of ad hoc interpreters in U.S. institutions reinforces the view according to which ad hoc interpreting performed by a family member may in fact represent a suitable form of interpretation in certain circumstances, and also hints at the fact that the intimate relationship between the patient and his/her family represents a fundamental aspect of the patient's personality and identity and therefore can ease the process of making an important decision regarding their health.

Krystallidou (2017), who studied interpreting during end-of-life care, although not contradicting the findings of Ho, emphasizes that family members are not necessarily appropriate in all situations. Her study found that family members acting as interpreters compromise patient autonomy and hinder patient preferences from being realized, and therefore calls for the use of professional interpreters in such situations.

Watermeyer (2020) found that the quality and type of interpreters varies considerably depending upon the context: ranging from professionally trained interpreters to ad hoc interpreters with varying degrees of training including those without any training at all. Her study concluded that a "one size fits all" approach is not suitable to all situations, and that interpreters should be used to meet the needs of the moment, whether it is to facilitate trust and flexibility or accuracy and to what extent asides, and gestures are translated. Moreover, she points out that interpreters, whether professional or ad hoc, even in cases in which they have received no training, are part of a team and that greater consideration should be given to their role as a coordinators as this promotes

trust and flexibility on all sides, and lies at the heart of a successful interpreting interaction.

To conclude, the studies mentioned above indicate not only that different types of interpreters may be available in different situations, but also that, depending on the situation, one form of interpretation (including ad hoc interpreting) might actually be more appropriate than another, according to the contextual variables of the moment.

2.3.2 Female patients and the accompanying family member

Ticca and Traverso's study (2015) highlighted two fundamental aspects about the expression of physical perceptions by foreign patients, during medical consultations, when accompanied by a family member playing the role of an interpreter. The first aspect is the difficulties encountered by female patients in expressing the way they feel, and the symptoms which characterize their discomfort, where the description of the patient's malaise constitutes a basis for diagnoses or for more complex actions. The other aspect concerns the tension which characterizes the interaction when it becomes necessary to communicate the patient's perceptions to the doctors during the discussion about patient's symptoms or during the patient's examination. The analysis conducted by the authors showed that, on the one hand, the ad hoc interpreter's knowledge prior to the medical consultation plays a more relevant role during the important moments of the medical encounter. In fact the ad hoc interpreters will often reply to the doctor's question, without translating the question to the patient. Even though this conversational format of the interaction temporarily excludes the patient from the verbal exchange, it is, nevertheless accepted by all the participants (which does not necessarily mean that it is fair). On the other hand, each speaker showed an understanding of the importance of having direct access to the information about pain and the way the patient feels. The analysis also showed that the patient's intimate feelings are displayed by the patient herself as a relevant aspect of her

personal sphere. In this case, intimacy is constructed by the patient, who reconfigures the participatory framework by bodily excluding her husband, namely the ad hoc interpreter, when she starts explaining her gynecological problems. Intimacy can be constructed by using verbal and paraverbal resources. For instance, at a certain point during the analyzed interaction, the doctor resorted to certain paraverbal resources such as prosody, intensity and timbre, while performing a critical maneuver on the patient's body. Paraverbal resources were used not only to simplify the current operations by, for instance, reassuring and encouraging, but also as a method to reorganize the participatory framework in order to select the recipient of the utterance. In the two corpuses analysed by the authors, the fact that the interpreters are also family members played an important role for the development of the medical encounter: a certain tension characterized the moment in which the reciprocal and shared knowledge in the dyadic interaction between interpreter and patient are questioned by the exchanges.

2.3.3 Ad hoc interpreting performed by children

A large number of family members performing the role of ad hoc interpreters during medical encounters are children. My data do not involve children as ad hoc interpreters, so many of the issues raised about child brokering and interpreting does not actually apply to the cases I will analize in chapter 4. Ad hoc interpreting by children is however an increasingly studied practice and a particularly delicate one. So here I will summarize the main points of the debate concerning child brokering because some are probably to be considered with some attention even in ad hoc interpreting occurring via adult family members.

The reasons behind the choice of having a child interpret for a family member are numerous and varied: she/he might be the only person available in an emergency situation, or, by going to school on a regular basis in the host country, she/he might have developed certain fundamental linguistic skills which the parents have not had the chance to acquire, either because they

spend most of their time in the house, or with other immigrants from their home country, or who do not have to speak the language of the host country at work. Valdés, Chávez and Angelelli (2003), whose study focuses on children of Latino immigrants acting as interpreters in the United States, state that it has always been typical for Latino immigrants to move to the United States without knowing English very well, and thus decide to live close to other Latino families and groups, thereby remaining partially isolated from the rest of the society. The authors state that being part of a Latino community inevitably offers certain advantages to the Latino immigrants, such as support in facing the difficulties of everyday life in a foreign country. However, being able to get a driver's license and buy a car, renting an apartment, organizing school for their children or applying for a social security number are activities that become particularly hard to carry out in a foreign country when one decides to live within an immigrant community with a common language. Therefore, although the immigrant may feel protected and supported by his/her sense of belonging to a community, at the same time this also entails some inevitable disadvantages, such as the lack of English language proficiency, which ultimately affect the role children play in their families. The second generation is, more often than not, bilingual, as the children of Latino immigrants must attend schools in which English is the spoken language. This is how, at a certain point, they may be asked by their parents to interpret for them in different situations, often within a bureaucratic context (Santiago 1999). Valdés, Chávez and Angelelli (2003) state that, Latino families often rely on family members, who emigrated before them to the United States, in order to deal with the outer world and information in English. However, it often happens that they ultimately count on their children for linguistic help, even though they have not yet acquired all the linguistic skills in English. Nevertheless, the family trusts them to carry out translating tasks, including harder ones: 'Young interpreters, then, are members of immigrant families whose parents, aunts, uncles, and siblings call on them to broker the world that surrounds them.' (Valdés, Chávez and Angelelli 2003: 63) The authors explain that while carrying out their research, they expected the general

perception of children acting as interpreters for their parents and/or other family members to be a positive one, especially considering the high frequency of the services provided. Nonetheless, they soon discovered that non-qualified young interpreters were not just considered to be failing in providing useful assistance, but were generally perceived in a very negative way, even though their presence within the different institutions did, in fact, have a considerable impact on the communicative processes with foreign patients. Interestingly, the authors found that the overall skepticism about ad hoc interpreting performed by children was essentially closely linked to the administration's specific regulations, which established the fundamental characteristics interpreters must possess in order to provide the appropriate type of aid to the person in need:

> We soon discovered, however, that inquiries about young interpreters were frequently met with some hostility and suspicion. Public service workers, for the most part, denied ever having seen young interpreters at work. Some, however, reported having had to repair particularly bad and inaccurate interpretations offered by young children for their parents. A few individuals, among them trained community interpreters working in medical settings, described the use of youngsters as family interpreters as a particularly cruel form of child abuse. We determined that the distrust that we encountered was due primarily to existing requirements governing access by all citizens to public services. […] As a result of such regulations, immigrant monolingual Spanish speaking adults in all public service settings are, in theory, to be helped by bilingual employees. […] Not surprisingly, personnel in these offices questioned about the use of child interpreters in those settings – even at times when no bilingual employees were present – strongly denied the need for any such services except in the case of very rare languages. (Valdés, Chávez and Angelelli 2003: 64-65)

Therefore, the issue of the negative perception or denial of youngsters interpreting for their relatives depends largely on the fact that, according to different laws, they are not supposed to be providing that type of linguistic

assistance. Strangely enough, the interviews conducted by the authors on children and teenagers performing the role of interpreters for their parents suggest that many of them are quite happy to help their relatives when they are in need, feel more self-confident by providing interpreting services, and at the same time are able to judge their performances impartially.

Employing children as ad hoc interpreters obviously also automatically poses certain questions regarding the appropriateness of the role for such young individuals, and inevitably raises certain social and ethical issues relating to the protection of the psychological balance and general wellbeing of the child used as an ad hoc interpreter. Ho (2008) points out that in certain cultures, families are organized according to precise structures, each member having a specific role, and life events are planned accordingly. When a family member starts having health problems, which require urgent medical assistance, the relative who finds him/herself in the situation of having to interpret to allow communication to take place between patient and doctor may not be performing a role which corresponds to the one he/she is used to playing within the family structure, which might cause an unpleasant and destabilizing situation for everyone involved, particularly in the case of children. The situation where a child has to interpret for a parent might make the parent feel particularly stressed or uncomfortable, because he/she is supposed to be the person who assists the child in cases of need, and not the other way around. This view is partially supported by Cirillo (2017), whose study conducted on teenagers attending high school in a city in Northern Italy showed that some of them were not always happy to find themselves in the interpreter’s role, nor did they feel comfortable translating orally for their parents or family members, and preferred not to be asked for help in such situations. The author points out that the way a child or young teenager feels, when asked to interpret, depends on a number of different factors, which include their cultural background, the family structure and the environment surrounding the child or young adult:

> Clearly, children are not always happy to serve as interpreters and translators for their parents, as is evident from the findings of Section 3. Brokers' feelings are in fact many and varied in both the family and school contexts, ranging from pride and enjoyment to a sense of obligation and dislike. Mixed feelings were also noted in previous and concurrent data collections [...]. (Cirillo, 2017: 310)

In order to better define the different psychological, social, cultural and ethical implications of employing a child as an ad hoc interpreter in different institutional settings, further research is needed, which should also take into account the geographical context.

2.3.4 The basic role of the patient in the decision-making process about the interpreting service

According to Ho (2008), the decision of whether to use a professional interpreter or a family member to interpret during the medical encounter should nevertheless always be left to the patient. The study by Ho (2008), while suggesting that more practical research should be carried out in order to explore the way ad hoc interpreters acquire their knowledge and interpreting abilities, as well as to how patients feel about having a relative interpret for them, also highlights the fact that family members acting as ad hoc interpreters might possess certain skills that counterbalance the fact that they have not received formal training.

2.4 Professional interpreting vs ad hoc interpreting

2.4.1 Different kinds of interpreting service

In this section I will discuss some views on professional interpreting, ad hoc interpreting performed by bilingual family members, and ad hoc interpreting performed by bilingual volunteers. There are obvious differences in the type of service these three categories can provide, and in my discussion below I will

try to make clear whether there are some services which could be more appropriate in certain situations compared to others. A particularly interesting aspect raised in the study by Hadziabdic and Hjelm (2013) is that ad hoc interpreting can be broken down into two sub-categories: the first, is representation by bilingual family members, and the second is representation by bilingual medical staff. The authors note that, even though the two clearly share certain aspects, they are also characterized by very different features, which will require further research.

2.4.2 The relativity of circumstances

Ho's (2008) work raises a particularly interesting topic which characterizes the debate on professional interpreting vis-a-vis ad hoc interpreting, namely that few studies on ad hoc interpreting actually differentiate ad hoc interpreting performed by the patient's relatives and ad hoc interpreting performed by bilingual volunteers, hospital staff or other people who are not emotionally related to the patient. This point is particularly relevant, because family members who translate for the people they care for perform certain actions on a daily basis, which are closely linked to the patient's health condition and which, therefore, inevitably affect the interaction between doctor, patient and ad hoc interpreter when they talk with each other:

> Family members who are familiar with a patient's medical, personal, and care history often have a larger medicalized vocabulary than clinicians realize, since many family members may have accompanied the patient to medical appointments, discussed with healthcare professionals regarding their loved one's conditions, searched for information from other sources, and/or cared for the patient at home and in the hospital. Even in cases when a family interpreter may lack extensive knowledge in medical terminology, she or he may still be able to explain complex issues to the patient in meaningful terms without using medical jargon. For example, in explaining the natural cause of advanced leukemia to a patient, a family member may make reference to the patient's prior experience, or the

> situations of other relatives or acquaintances who had similar conditions to convey the message. (Ho 2008: 226)

The author concludes by stating that both professional interpreting and ad hoc interpreting can be equally useful, with each type of interpreting assistance offering specific advantages. Whether professional interpreting is more appropriate than ad hoc interpreting or vice- versa depends on a number of factors which have to be carefully evaluated each time, and which must also take into account the type of medical encounter, the urgency of the situation, the context of the clinical and familial situation of the patient, as well as the patient's personal desires and feelings about the choice of interpreter, as they might prefer linguistic help from a person who they know will take care of them at home.

Similarly, a recent study by Theys et al. (2020) shows that the creation of an emotional bond between doctor, patient and interpreter is a very delicate co-constructed process, which involves several dynamics. This seems to confirm Ho's statement that the choice of the type of interpreter is a particularly important one, which can have serious repercussions on the outcome of the medical consultation. This seems to be confirmed by a new study by Roberts and Sarangi (2020) according to whom, when a patient's companion is present during the medical consultation, either to simply accompany the patient, or to act as an interpreter if needed, the encounter seems to have little in common with an actual interpreting service where two languages are involved, and appears to be very similar to a monolingual triadic encounter.

For what concerns interpreting services provided by bilingual volunteers, an article by Pöchhacker and Kadric (1999) highlighted how a Serbian hospital cleaner, who was asked to interpret for a foreign family during a medical consultation, not only was not able to keep focused on the task she was carrying out, but did not interpret some turns correctly either. The negative perceptions about ad hoc interpreting will be discussed later in this chapter,

but it is important to underline that this form of interpreting is probably the one with most negative consequences.

2.4.3 Conclusion

The above mentioned studies suggest that the choice of which type of interpreter to use depends on many different factors which, at times, are impossible to foreseee (see Pöchhacker and Kadric (1999)). However, each kind of interpreting service might be useful in certain circumstances.

2.5 Ad hoc interpreting and cultural safety

Ho (2008) introduces a significant concept, later highlighted by Leanza (2012) which refers both to the issue of patient-centeredness and to the debate on the advantages of ad hoc interpreting, namely the fact that patients should, at all times, feel culturally safe:

> Cultural safety is not just about individual interactions – it is about the environment or the overall framework in which patients receive care. A culturally safe environment is one that facilitates and engages in respectful practices, as well as delivers safe services, as defined by those who receive the care. It acknowledges and respects that patients come from diverse backgrounds with varying needs and cultural references. Patients in a culturally safe environment feel empowered to voice their concerns without having to worry that their concerns or experience will be marginalized or dismissed as irrelevant, strange or backward. (Ho, 2008: 228)

Ho's (2008) article, which deals specifically with the form of ad hoc interpreting where a relative of the patient plays the role of the interpreter during the medical encounter, underlines that family members acting as ad hoc interpreters could also play the role of cultural brokers, thus actively supporting the patient during the medical visit and enabling the doctor and the patient to communicate effectively with each other. The study conducted by Ho

on the employment of ad hoc interpreters in U.S. institutions reinforces the view according to which ad hoc interpreting performed by a family member may in fact represent a suitable form of interpretation in certain circumstances (such as, for instance, when an intimate issue has to be discussed), and also hints at the fact that the intimate relationship between the patient and his/her family represents a fundamental aspect of the patient's personality and identity and therefore can ease the process of making important decisions regarding their health. However, according to the author, the decision of whether to use a professional interpreter or a family member to interpret during the medical encounter should always be left to the patient, thus underlining the importance of a patient-centered approach when it comes to choosing the most appropriate type of interpreting assistance in a given context, which was also suggested by Meyer (2007). One possible solution suggested by the author automatically implies that the ability of family members to perform the role of interpreters cannot by determined in emergency situations by the medical staff or when the clinical conditions of the patient require the doctors to make an immediate important decision. However, the study by Ho (2008), while suggesting that more practical research should be carried out in order to explore the way ad hoc interpreters acquire their knowledge and interpreting abilities, as well as to how patients feel about having a relative or a member of staff interpret for them, also highlights the fact that family members acting as ad hoc interpreters might possess certain skills that counterbalance the fact that they have not received formal training. In this respect, the author raises a particularly interesting argument which characterizes the debate on professional interpreting vis-a-vis ad hoc interpreting, namely the fact that few studies on ad hoc interpreting actually differentiate ad hoc interpreting performed by the patient's relatives and ad hoc interpreting performed by bilingual volunteers, hospital staff or other people who are not emotionally related to the patient. This point is particularly relevant, because family members who translate for the people they care for, perform certain actions on a daily bases, which are closely linked to the patient's health condition and which, therefore, inevitably affect the

interaction between doctor, patient and ad hoc interpreter when they are in discussion with each other:

> Family members who are familiar with a patient's medical, personal, and care history often have a larger medicalized vocabulary than clinicians realize, since many family members may have accompanied the patient to medical appointments, discussed with healthcare professionals regarding their loved one's conditions, searched for information from other sources, and/or cared for the patient at home and in the hospital. Even in cases when a family interpreter may lack extensive knowledge in medical terminology, she or he may still be able to explain complex issues to the patient in meaningful terms without using medical jargon. For example, in explaining the natural cause of advanced leukemia to a patient, a family member may make reference to the patient's prior experience, or the situations of other relatives or acquaintances who had similar conditions to convey the message. (Ho 2008: 226) I

Hence it could also be assumed that these relatives who accompany a family member to the doctor on a regular basis in order to interpret for them gradually become acquainted with some of the basic terminology and with the medical context and may therefore be able to help the patient more than another interpreting figure.

2.5.1 The influence of the (cultural) context

In the introduction to *Rethinking Context*, Duranti and Goodwin (1992) state that providing a definitive and proper definition of 'context' could be misleading and is virtually impossible, not only because the term has been researched from many different perspectives throughout the years (if not centuries), but also because of its inner complexity, which is determined more by the role context plays in a given situation and by its practicality, than by an abstract definition of the concept itself: 'At the moment the term means quite different things within alternative research paradigms, and indeed even within particular traditions seems to be defined more by situated practice, by use of

the concept to work with particular analytic problems, than by formal definition.' (Duranti & Goodwin 1992: 2) Therefore, context finds its most appropriate definition in situations in which it contributes to its shaping and defining and, at the same time, the way different situations intermingle, generate and construct the context they are embedded in. Linguistically speaking, context and talk are reciprocally constructive, in that it is through talk that human beings shape reality and, consequently, the context in which they live, as well as the underlying context actively contributing to the production and formation of talk:

> Recent work in a number of different fields has called into question the adequacy of earlier definitions of context in favor of a more dynamic view of the relationship between linguistic and non-linguistic dimensions of communicative events. Instead of viewing context as a set of variables that statically surround strips of talk, context and talk are now argued to stand in a mutually reflexive relationship to each other, with talk, and the interpretive work it generates, shaping context as much as context shapes talk. (Duranti & Goodwin 1992: 31)

A recent study by Ticca (2017) demonstrates the importance that the contextual situation acquires in shaping the different identities the ad hoc interpreter develops during a medical encounter with a physician and a foreign patient. The author's research findings suggest not only that the ad hoc interpreter (which she calls a 'lay interpreter') cultivates and inhabits different identities throughout the medical visit, but that these identities are shaped both through the construction of the interaction, and by the social and medical context that is also certainly shaped by the interaction, while at the same time serving as its backdrop. The data analyzed by Ticca (2017) show that, depending on the different moments and phases of the interaction, the ad hoc interpreter can alternately act as a 'translator', as an 'expert', and as a 'social peer' (Ticca 2017), and these different roles which the ad hoc interpreter acquires while providing interpreting assistance appear to depend on a number

of different factors, which are all linked with the interaction, the interactional goals, and the context within which the interaction takes place and which, at the same time, is shaped by the interaction:

> One of the main results concerns the complex interpretive work carried out by lay interpreters, who rely both on the understanding of the interactional activities and on their cultural knowledge. Although difficulties in understanding arise during talk, it is also evident that their emergence depends in part on the background of the ongoing interaction. On the whole, these studies reveal *interpreting* to be a multidimensional phenomenon (i.e. multimodal - verbal and non-verbal -, interactional, cultural, social) implying the accomplishment of social actions that respond to specific interactional and social goals, and emerging constraints and troubles, whose intricacy is still in need to be studied. (Ticca 2017: 111)

Felberg and Skaaden (2012) however reject the idea of differences in cultural context as an explanation for interpreting difficulties, rather they see the explanation itself as a source of confusion, one which threatens the finding of a meaningful solution. They argue that the problems associated with interpreting difficulties lie at the human level, citing concentration and language proficiency as examples, as more important than cultural context.

> We argue that the use of the concept of culture may lead to 'othering' of minority patients, may conceal rather than reveal communication problems, and may confuse the intersection between interpreters' and medical professionals' areas of expertise. Ultimately, not only minority patients' health but also medical personnel's professional integrity may be threatened. (Felberg and Skaaden 2012: 1)

2.5.2 The influence of the (cultural) background

All of the actions previously mentioned and described by Ho (2008) are

obviously performed by the patient's relatives and would not be carried out by an ad hoc interpreter who does not belong to the patient's family circle. Therefore, the author indirectly underlines the relevance of the contextual situation for both the ad hoc interpreter and the patient, when analyzing the advantages and disadvantages of ad hoc interpreting within the medical field performed by family members. In fact, the author continues, the idea according to which a worried, upset and/or even desperate relative, who is feeling that way because of the patient's condition, and who finds him or herself in the situation of having to interpret for the patient, might not necessarily hinder the patient's independence, as certain authorities have argued in taking a position against ad hoc interpreting, because the actual ability of the patient to maintain his/her autonomy depends on a number of circumstantial variables which include, among others, the way the physician decides to communicate certain types of information to the patient. Another concern identified by a number of studies concerning the use of family members as ad hoc interpreters deals with the protection of the patient's private data and confidentiality. However, Ho (2008) states that a patient who has a strong relationship with his/her family, might actually feel certain details of his/her private life to be more protected if the person who interprets for him/her is a relative. Moreover, when the patient is a member of a relatively small group of immigrants who has come from the same country and has had to integrate into the new one, he/she might feel as if the private information regarding his/her health is better preserved if the linguistic assistance during medical encounters is provided by a family member who shared the same experiences and knows not only the patient's personal life, but also about his/her medical history. Ho (2008) suggests that, in order to respect the patient's position on this matter, it would be advisable to inform the patient of their rights as they relate to privacy and confidentiality by providing them with the necessary paperwork in their own language, before the medical encounter takes place. This also would give physicians the chance to understand the patient's own views on the matter, while providing the patient with a chance to make a decision on whether to ask a relative or a professional interpreter to

perform the interpreting service. This point proves to be of the upmost importance because it highlights a feature which characterizes interpreting services in general and ad hoc interpreting in particular, namely the central role played by the patient in the decision-making process, which relates to the type of interpreter which should be employed. Therefore, Ho (2008) supports Meyer's stance on the importance played by the patient's position on this delicate issue: 'If doctors are in doubt, they should ask the patient' (Meyer 2007:11). Finally, the author discusses another key point which is of concern to detractors of ad hoc interpreting, that is, the repercussions that the ad hoc interpreting service performed by a relative of the patient can have on the family structure and its balance. According to the author, this situation can be relatively easily dealt with by taking into account and respecting the patient and his/her family members' wishes, the context they live in and how the patient's conditions affect both his/her family and their surrounding environment. In order to achieve these multiple goals, a meeting with the family and patient before the actual medical encounter could clarify the options available and offer the patient the chance to choose to be linguistically aided by a relative, such as in cases where relatives take care of each other when in need, and which may not only be expected, but may also define the individual's sense of belonging to the group. (Ho 2008: 228) The author concludes by stating that both professional interpreting and ad hoc interpreting can be equally useful, with each type of interpreting assistance offering specific advantages. Whether professional interpreting is more appropriate than ad hoc interpreting or vice- versa depends on a number of factors which have to be carefully evaluated each time, and which must also take into account the type of medical encounter, the urgency of the situation, the context of the clinical and familial situation of the patient, as well as the patient's personal desires and feelings about the choice of interpreter, as they might prefer linguistic help from a person who they know will take care of them at home. In this respect, Ho (2008) introduces a significant concept, which I have already previously quoted, and which refers both to the patient-centeredness issue and to the debate on ad hoc interpreting, namely the fact that patients should, at all

times, feel culturally safe:

> Cultural safety is not just about individual interactions – it is about the environment or the overall framework in which patients receive care. A culturally safe environment is one that facilitates and engages in respectful practices, as well as delivers safe services, as defined by those who receive the care33. It acknowledges and respects that patients come from diverse backgrounds with varying needs and cultural references. Patients in a culturally safe environment feel empowered to voice their concerns without having to worry that their concerns or experience will be marginalized or dismissed as irrelevant, strange or backward. (Ho, 2008: 228)

To conclude, on the basis of the analyzed literature, in order to create and provide better and appropriate communicative services for foreign patients in need within the different health care systems throughout the world, it is necessary and desirable not only to focus on the interpreter's identity, but also on the concept of 'patient's centeredness' and on the fundamental role played by the social and cultural context where the service is provided, as well as by the social and cultural background of the patient who, after all, if not the only protagonist of the interaction between doctor, patient and interpreter, is, in fact, the real protagonist of the medical visit.

2.6 Ad hoc interpreting in European healthcare institutions

Ad hoc interpreting in the European medical field is characterized by specific features, which differentiate it from ad hoc interpreting in the American medical field, while maintaining certain aspects in common. One of the characteristics ad hoc interpreting in European and American health care institutions have in common is its definition. For instance, the following mentioned definition provided by CHIA on the basis of the NCIHC is very similar to the one provided by Meyer (2007), which constitutes the basis for the framing of ad hoc interpreting in Europe:

> An untrained person who is called upon to interpret, such as a family member interpreting for her parents, a bilingual staff member pulled away from other duties to interpret, or a self declared bilingual in a hospital waiting-room who volunteers to interpret. Also called a *chance interpreter* or *lay interpreter* (NCIHC). (CHIA 2002: 64).

> […] ad hoc interpreting is typically the spontaneous, relatively unprepared engagement of people with language skills in communication with non-native patients, be they employees with a migrant background, tourists or business travellers from abroad. (Meyer 2007:10)

Both definitions clearly label ad hoc interpreters in the medical field as those individuals who, without having previously received any type of formal or informal training, are requested to orally translate what is being said between the medical staff and the patient. They can be relatives or friends of the patient, as well as acquaintances or multilingual personnel, as long as they seem to know the language of the patient (without any type of assessment of language competence) during the medical encounter. The fundamental difference between ad hoc interpreting in American and European healthcare institutions does not lie in the identification of who ad hoc interpreters are, but in the way their interpreting assistance is perceived.

2.6.1 Ad hoc interpreting in Italy

Because of the considerable migration flows to Italy, over the past two decades, Italian healthcare institutions have occasionally found themselves in the overwhelming situation described by Ozolins (2002), and have thus been forced to use ad hoc interpreters, and not just cultural mediators or

professional interpreters, in order to communicate with foreign patients. Amato and Garwood (2011) explain that the phenomenon of immigration started to be considered problematic in the 1980's and Italy signed its first immigration law in 1986, which was followed by the Martelli law in 1990. Thanks to these laws, Italy has started to welcome immigrants who wanted to move to the country. However, the authors highlight, these laws did not mention the need for translation and interpreting services for the newcomers. It has taken a while before cultural mediators started to be trained (Amato and Garwood 2011) This situation might have encouraged ad hoc interpreting performed by friends and family members. Meyer's findings fully and clearly confirm that ad hoc interpreting performed by family members is indeed gradually becoming an increasingly widespread practice in European hospitals, mainly due to financial considerations, and presents very specific features, such as intimacy and confidentiality, which can be particularly useful in certain delicate situations, as they can encourage the patient to be more trusting of the situation and of the doctors who will have to take care of him/her. From this perspective, ad hoc interpreting could represent an essential communicative tool in specific medical contexts, namely gynecological consultations and prenatal check-ups, as is the case for the data I have analyzed for this study. Nonetheless, other studies which focus on the ad hoc interpreting situation in Italy, such as that undertaken by Rudvin (2006), highlight a problematic situation, which needs to be taken care of as soon as possible. In her work, Rudvin argues that ad hoc interpreters are often employed carelessly by Italian healthcare institutions which tend to overlook the fundamental needs and rights of migrant patients, who must be taken care of in the best possible way. The author underlines the fact that ad hoc interpreting in Italy is a very widespread practice and, because there are no precise and definite policies which regulate the employment of interpreters, Italian healthcare institutions need to establish certain rules for the provision of specific professional service as soon as possible:

> Language services for migrants in Italy today leave much to be desired. The use of unqualified interpreters is the rule rather than the exception; poor recognition of the profession and need for quality training and accreditation lead to the rampant use of ad-hoc solutions and there is a practically non-existent awareness of the numerous professional and cross-cultural issues involved in public service interpreting. The situation cries out for the implementation of interpreter-training programmes and for awareness-raising courses for service providers. (Rudvin 2006: 57)

Rudvin (2006) continues her reasoning by pinpointing that immigration in Italy has been constantly increasing over the last few years and is still increasing at the moment. One of the reasons why Italy is such a desirable destination is because of its geographical position: not only is it almost at the border of Eastern European countries, but it is also very close to Africa. Italy is also relatively easy to reach by different transport means, but in spite of these significant factors, which make it the destination for many migrants, its services are inefficient. The author identifies ad hoc interpreting as being the main form of interpreting assistance in Italy and, although she recognizes its fundamental importance and effectiveness for the structuring of basic communication, even in emergency situations, at the same time she highlights the major limitations that it is subjected to, thus complicating a situation that is already hard and which does not guarantee language rights at all:

> Solutions to the problem of communication have generally been proposed and provided very much on an ad-hoc basis, that is – for each individual situation/problem a solution is sought on the spur of the moment, not planned and provided for ahead of time. Often, family members and friends will be used in hospital or social service settings, and unqualified bilinguals as police and court interpreters. The implications for ethical issues such as impartiality, bonding, confidentiality, and trust in the interpreter as a professional are naturally jeopardized when unqualified interpreters are employed. (Rudvin 2006: 60)

On the basis of the available literature, it could then be concluded that ad hoc interpreting still represents the first and most widespread form of interpreting service provided to migrants in Italy and, though particularly useful and even essential in a variety of situations, it probably needs to be regulated more precisely in order to take full advantage of this service.

2.7 Positive and negative perceptions of ad hoc interpreting

In the paragraphs below, negative, positive and mixed perceptions about ad hoc interpreting will be discussed. Despite their slightly different stances on ad hoc interpreting which are closely linked to the geographical, social and cultural context of the countries where this type of service is present, in every country mentioned in the present study the debate on the advantages and disadvantages of employing different types of ad hoc interpreters (family members, friends, acquaintances, bilingual or multilingual personnel and bilingual or multilingual children) is still open and represents an important, ongoing contemporary social issue. One of the aspects that make the debate on ad hoc interpreting possible is the recognition of its value and its contribution to the institutions which decide to rely on their help in communicating with foreigners who cannot speak the language of the host country.

Although, as has already been mentioned, the literature on the topic is relatively limited, the presence of ad hoc interpreters in healthcare contexts has been observed (Wulf and Schmiedebach, 2010; Rosenberg, Leanza and Seller, 2007). This happens not only because one of the solutions adopted by foreign patients to get access to healthcare is that of asking bilingual friends or a relative to accompany them, but also because of the practical institutional needs, often determined by urgent situations, as highlighted by Ozolins (2002):

> […]now have at least an ad hoc approach to interpreting. Attempts are usually made by individual institutions or services, - a social security office perhaps, or individual hospitals or police stations – to find go-betweens to fulfill an interpreter or mediator role. There is usually no concept of training, little thought of accreditation or registration, but response to an immediate need is given by using available bilinguals. As a general rule, those countries of most recent immigration and most recent awareness of their cultural diversity would figure here. (2002: 23)

2.7.1 Ad hoc interpreting: positive perceptions

As suggested by the literature analyzed in the following paragraphs, in certain situations ad hoc interpreting has proved to be a fundamental translational instrument to allow communication between foreign patients and medical personnel. There are different contexts within which ad hoc interpreters have played an important role in the construction of the interaction, as for instance shown by Meyer (2007) and by Rosenberg, Leanza and Seller (2007)

2.7.2 Ad hoc interpreting within the medical field: an underestimated resource

As noted by Meyer (2007), ad hoc interpreting within the health care system will continue to be used as a fundamental communicative tool. Because the vast majority of foreign patients who request medical help from public medical clinics are migrants without the possibility of employing a professional translational service, they are usually accompanied to medical visits by a relative or friend who has lived in the foreign country long enough to acquire at least the basic linguistic skills which are necessary to communicate with the doctors and the medical personnel, or by their children who go to school and have learnt how to speak the language of the host country and can therefore

translate what is being said during the interaction (Antonini, Cirillo, Rossato & Torresi 2017). On the other hand, hospitals and public medical institutions, which provide the highest number of medical services to patients in need, often lack the necessary funds to either pay professional interpreters for their linguistic assistance, or to train their internal staff, so that they can be in a position to translate for foreign patients when the circumstance occurs (Meyer 2007). Consequently, even though ad hoc interpreting has been and continues to be criticized by the literature on the topic, it is undoubtedly true that it will continue to play an extremely important role in enabling communication within healthcare institutions between individuals who do not speak the same language. Moreover, among the different basic services people need when moving to a different country, medical care probably represents the most basic form of primary care. Therefore, as ad hoc interpreters are employed in different situations, during the daily life and routine of a migrant, it is all the more likely that their help will keep being requested in the future. As demonstrated by the careful review of the literature by Karliner, Jacobs, Chen and Mutha (2007), even though most research proves to favor professional interpreting within a medical context, at the same time the results regarding the use of ad hoc interpreters are not always precise according to a meta analysis:

> We examined the studies in three different groups, those that compared the effect of professional and ad hoc interpreters, those that only examined the effect of professional interpreters (compared with either a non-interpreted LEP group, another type of professional interpreter, or most commonly, a language concordant group), and those that did not separate out the effect of professional and ad hoc interpreters. We found that professional interpreters improve clinical care more than ad hoc interpreters do, and that they can raise the quality of clinical care for LEP patients to match or approach that for patients without a language barrier. Even when the effect of professional interpreters is not separated out from that of ad hoc interpreters, there is evidence for a benefit. However, the results in this group of studies are not as

strong or consistent. (Karliner, Jacobs, Chen & Mutha 2007: 749)

Moreover, a study by Albl-Mikasa (2019) investigating the institutional context of interpreting in the medical field concluded that doctors and practitioners should be provided with a knowledge base of the functions and role of the interpreter in order for them to better perform their task, so that the medical institutions can make maximum use of their resource. Although she does not draw a distinction between ad hoc and professional interpreters, specific knowledge of the role of the ad hoc interpreter is implicit in his argument, and will further legitimize the role of the ad-hoc interpreter.

To conclude, some studies conducted on ad hoc interpreting seem to confirm that this form of interpreting proves to be particularly useful in certain situations, to the point that it can be considered as a legitimate form of translational service.

2.7.3 Ad hoc interpreting and the willingness to facilitate communication

Another positive perspective on ad hoc interpreting, is presented by Meyer (2007). By providing a description of a situation which could easily occur, on a daily basis, in a German hospital, he firstly underlines a fundamental feature which characterizes ad hoc interpreting, i.e. the fact that the process of starting to provide interpreting assistance is, more often than not, a gradual one, even though, as previously stated, the decision to ask them to orally translate is usually quite sudden. In fact, the author explains, if a Turkish patient of a German hospital cannot speak German fluently, thus making it difficult for the doctors and the hospital's personnel to provide and ask for information, his bilingual visiting son can suddenly, and yet slowly in terms of the acquisition of his new interpreting role, become a significant figure in allowing the medical staff and the patient to communicate with each other. Meyer's view of ad hoc interpreting highlights the fact it could be a

useful practice in certain contexts, although certainly not in emergency ones. His definition of ad hoc interpreting within the healthcare system, given above, underlines its improvised and natural features: 'Therefore, ad hoc interpreting is typically the spontaneous, relatively unprepared engagement of people with language skills in communication with non-native patients, be they employees with a migrant background, tourists, or business travelers from abroad.' (Meyer 2007: 10)

According to Meyer, the fact that a person simply speaks the patient's and doctor's languages within the medical environment is the only necessary requirement to become an ad hoc interpreter, in fact he states that: "Everybody who is present or within reach and speaks the language of the patient and the physician" (Meyer 2007: 10) can fall under the definition of ad hoc interpreter. Moreover, he adds, linguistically untrained personnel can actually learn a lot about oral translation through this practice, which can ultimately be extremely good for those patients who need linguistic assistance in order to able to speak with the doctor. Therefore, he continues, ad hoc interpreting should not be judged necessarily as a negative interpreting practice, and one should never forget that the general knowledge of the ad hoc interpreter depends largely on three aspects:

1) their cultural background;

2) whether they are native speakers of both languages used during the interaction, or if they learnt the second language later in life;

3) their personal willingness to help the doctor and patient communicate with each other.

Meyer concludes by reflecting upon the choice of employing an ad hoc interpreter, who is also a relative or close friend of the patient, to provide linguistic assistance. He states that the topic of the medical consultation is a key element, because in certain circumstances it might be best not to involve the family in the situation, thus relying on a cultural mediator or professional interpreter for linguistic assistance. However, on other occasions, it might

actually be better to have an ad hoc interpreter available, because he/she might be able to provide essential information for the arrangement of proper care. Clearly, the central role played by the patient should never be forgotten: if the medical staff find it hard to decide what type of interpreting service would be best in the given situation, they should always ask the patient what he/she would prefer, as by having an interpreter the patient feels to be the best person to play that role in that specific circumstance, might help in the construction of an interaction which will allow the doctors to find a solution to the medical problem as quickly as possible.

Despite the numerous problems presented by ad hoc interpreting in hospitals (such as the general lack of organization of linguistic support, the fact that ad hoc interpreters tend to ignore subtle, but yet fundamental, linguistic expressions while translating), Meyer stresses the importance of the role played by ad hoc interpreters in the medical field for the transmission of important medical knowledge between migrant patients and doctors, and advises that, for these reasons, ad hoc interpreting should not be removed; on the contrary it should be continued, but certain crucial guidelines should be followed, which would include proper training and remuneration for the bilingual medical staff who are available to interpret during medical encounters, the provision of adequate interpreting service for those hospitals which must take care of a high number of immigrants, accurate training for doctors on how they should deal with interpreters, and the signalling of important language barriers which prevent communication as a general rule for the medical staff.

Another perception of ad hoc interpreting strictly performed by family members and professional interpreting is offered by a peculiar study conducted in Montreal (Canada) by Rosenberg, Leanza and Seller (2007). In their work, the authors analyze the debate on the use ad hoc interpreting performed by the patient’s relatives vs. professional interpreters by presenting the doctors’ views on the matter. The study describes the doctors’ different perspectives on

the employment of professional interpreters and ad hoc interpreters during the medical visit. This qualitative research was conducted by videotaping the medical encounters where patient, physician and interpreter were present, thus also providing important information about the extralinguistic behavior of the participants, and then interviewing the doctor who was one of the participants during the interaction while showing him/her the recorded video of the medical visit where he/she was present. The outcomes of the research lead to the belief that all the doctors interviewed had precise expectations of both professional interpreters and family members playing the role of the interpreter: while both categories were expected to perform the interpreting role in the same way, professional interpreters where occasionally expected to act also as cultural mediators, whereas ad hoc interpreters were also supposed to perform the role of carer. A significant point raised by this research is represented by the notion of 'control': because the family member acting as an interpreter during the medical visit usually knows both the patient and his/her medical history in depth, when compared to a professional interpreter, the doctors felt they could not 'control' the medical encounter in the manner they wanted when an ad hoc interpreter was translating because they tend to have their own agenda:

> Most physicians found working with professionals less difficult than with family interpreters, because the former were perceived to rarely have their own agenda. As the professional interpreter was almost exclusively transmitting information, the physician was able to maintain more control over the encounter process. Some family interpreters also performed caregiver functions. It was in their role as caregivers that they brought their own agendas to the encounter. The competition between the agendas of the family interpreter, the physician and the patient rendered the communication task more complex. (Rosenberg, Leanza & Seller 2007: 288)

Therefore, while the study conducted by Traverso (2002) highlighted the

risk of excluding the patient from the interaction, due to the fact that the ad hoc interpreter, knowing many details of the patient's clinical history, tends to ignore the translational process, and communicate directly with the doctor, Rosenberg, Leanza and Seller (2007) stress the power of the ad hoc interpreter during the interaction, given by the ad hoc interpreter's knowledge of the patient's medical history, noting that, on the other hand, it could cause physicians to feel that they are losing control of the situation. The authors conclude that, although ad hoc interpreting performed by family members is perceived by physicians as being less precise for the purpose of obtaining important medical information, the relatives themselves could, at the same time, be an important source of general information about the patient, which is nevertheless equally and particularly useful for the diagnosis. Moreover, the family members who acted as ad hoc interpreters and whose performances were analyzed in my work, actually did fulfill the role of carers, which the doctors indirectly expected them to do. According to the authors, in this respect, the problematic aspect is to be found in the doctors' attitude, who often do not voice their requests, thus not making it possible for ad hoc interpreters to clearly understand how they can meet the physician's requirements. Interestingly, the existing relationship between the family member acting as ad hoc interpreter and the patient is considered to be, by the physicians interviewed, both an indispensable source of information (in that it could allow them to fully understand the patient's history, and therefore help them solve the problems) and a potential threat, in that it could prevent the doctor from developing an independent relationship with the patient, which constitutes the basis for the development of mutual trust between doctor and patient, a fundamental requirement for the success of medical treatment. However, as stated by the authors, the most relevant aspect which emerged from this research is the fact that the collaboration between physicians and family members acting as interpreters during the medical visit presented different aspects compared to the work carried out by physicians with professional interpreters in the same circumstances. Even though the close bond which ad hoc interpreters maintain with the patient could effectively

hinder the development of a meaningful connection between doctor and patient during the medical encounter, at the same time it can occasionally facilitate communication, in that the doctor will start to be perceived as a 'collaborator' by the family. Conversely, when the patient appeared to maintain a central and independent role during the medical check-up, doctors preferred a professional interpreter to be present, because he/she would allow the patient's autonomous contributions to be appropriately expressed. This led authors to conclude that, despite the difficulties presented by ad hoc interpreting, the physicians interviewed proved to have used the communication rules they had been trained to apply only when professional interpreters were used, and this affected the development of the interaction in a negative way, as it caused it to be particularly artificial with the result that the development of the relationship between doctor, patient and interpreter lacked spontaneity, thus making it more complicated to find a solution to the patient's problems. On the other hand, thanks to the more relaxed atmosphere created by the presence of a relative performing the roles of interpreter and of caregiver simultaneously, doctors did not follow the communication rules they had previously acquired and that they employed when the professional interpreter was present during the interaction. Instead, they were actively able to work with ad hoc interpreters as members of the same team, and this resulted in a more relaxed and ultimately more effective and productive medical encounter.

A relatively recent study by Larrison, Velez-Ortiz, Hernandez, Piedra and Goldberg (2010), which focused on the satisfaction of patients and staff with the ad hoc interpreting service offered at a U.S. federally qualified community health clinic (CHC), and significantly entitled *Brokering Language and Culture: Can Ad Hoc Interpreters Fill the Language Service Gap at Community Health Centers?*, confirmed the general positive perception, of both patients and health center staff, of ad hoc interpreting assistance. The research findings described in this study suggest a possible path for ad hoc interpreters, which Meyer (2007) also drew attention to in the above mentioned work, namely the chance to receive proper training, thereby professionalizing their services and

thus providing proper interpreting assistance to those patients in need. Although the study focuses mainly on ad hoc interpreting performed by bilingual individuals (staff members or volunteers), and differentiates it from ad hoc interpreting performed by relatives or acquaintances of the patient, it nevertheless sheds and extremely positive light on the oral translation performed by ad hoc interpreters, by highlighting the fact that their skills should actually be implemented, instead of discouraging them from undertaking the role in favor of professional interpreters, even though the general perception still seems to favor professional interpreting more than ad hoc interpreting:

> Ad hoc interpreters may offer and opportunity to create an agency-level approach to addressing the workforce gap in professional medical interpreters. Despite research that has consistently reported ad hoc interpreters create lower levels of satisfaction and higher levels of communication errors than professional interpreters, they have the most important prerequisites to becoming professional medical interpreters: bilingual fluency and a desire to interpret. Several factors such as interpreter training, medical staff training to work with interpreters and style of interpretation have been shown to influence the effectiveness of the interpretation services, thereby clarifying best practices for professional medical interpreters (Hatton & Webb, 1993; Karliner et al., 2004; Flores, 2005). (Larrison et al. 2010)

2.8 Ad hoc interpreting: negative perceptions

The vast majority of literature on ad hoc interpreting presents negative perceptions and perplexities about ad hoc interpreters and the service they provide to foreign patients and doctors. The main concern presented by the literature is the physician’s opinion about his/her inability to properly communicate with the patient via the ad hoc interpreter.

This was confirmed in a study carried out in Holland, by Zenedel et al. (2018) in which both patients and GPs exhibited a lack of trust, control and satisfaction in ad hoc interpreters, noting that they failed to translate more than half of their utterances. However, Zenedel et al., in a slightly earlier study in 2016 study, drew attention to the fact that ad hoc interpreters carry out many other tasks, such as advocates and care-givers and were trusted by the patients more so than professional interpreters.

As stated above, Baraldi's (2016) study on ad hoc interpreting in an educational setting further emphasizes the imprecise translation of ad hoc interpreters, who may have other goals, in this case achieving pre-assigned educational tasks. Catalina Iliescu Gheorghiu (2012) found the same pattern emerging in medical encounters in Spain, in which she found that ad hoc interpreters, although enabling the interaction, were not sufficiently trained to provide accurate translations, and exposed the need for more professional interpreters as well as training for all parties to accommodate the presence of an interpreter. Yet another study of medical encounters using ad hoc interpreters, this time from Lesotho by Thuube and Ekamjune-Ilongo (2018), found a similar pattern with the interpreters making numerous errors and omissions, distortions and editorial decisions.

However, there are wider concerns, which are pertinent to all interpreters and not just ad hoc interpreters. Haralambous (2018) concluded that each party in a triadic consultation will have different perceptions of their roles which can lead to tension and inefficiency. This study is supported by T.Greenhalg's earlier study (2006), which concludes that triadic consultations generate a lack of trust, increase time pressures, create a mismatch of agendas and expectations, as well as power imbalances for all parties. Interestingly, she also notes that in cases where family members act as ad hoc interpreters some of the problems can be mitigated.

2.8.1 Ad hoc interpreting and the doctor's difficulty to communicate with the patient via untrained medical staff

Unlike the area of research being discussed in this paper, the vast majority of studies conducted on ad hoc interpreting in the medical field have so far only focused on the interpreting services provided by bilingual medical staff, and most of them have uncovered negative consequences in using this type of interpreting assistance. In fact, research on ad hoc interpreting usually confirms what is generally considered to be an inaccurate, and therefore problematic, form of oral translation.

This negative consideration is clearly displayed in Franz Pöchhacker and Mira Kadric's work (1999). The two authors underline the degree to which ad hoc interpreting within the medical field was in widespread use at that point in time. They highlighted the fact that, although different kinds of interpreting training programs have been offered, not only in English-spekaing countries, but also in a number of other countries, interpreting services are still often performed by non-professional interpreters, usually by the patient's relatives or the clinic's personnel. The case study presented by the authors concerns a Serbian hospital cleaner playing the role of the interpreter during a speech therapy session. The patient is a ten-year-old Bosnian child accompanied by his parents. The results of the research highlight the ad hoc interpreter's inability to properly render the translational turns, both in terms of form and content. As a consequence, the specialists, who did not realize what was happening, were not able to properly communicate with the patient and this eventually resulted in a poor quality of the medical encounter. Interestingly, in order to refer to the ad hoc interpreter, the authors talk about an 'untrained' and 'natural' interpreter and mention Harris and Sherwood's (1978) definition of 'natural translation' to refer to the interpreting assistance provided by the hospital cleaner: "natural translation", i.e. "[t]he translating done in everyday circumstances by people who have had no special training for it" (1978:162) The adjectives 'natural' and 'untrained' are clearly used by the authors to refer to the ad hoc interpreter; in fact, in the conclusion they state that: 'Though unprecedented within its geographic and institutional context, the study

corroborates many of the concerns voiced in the literature about the *ad hoc* use of bilingual staff for the function of interpreting' (Pöchhacker & Kradic 1999: 177). Hence, ad hoc interpreting is viewed as a 'natural' and 'spontaneous' form of interpretation, which, however, gives rise to concerns about the ultimate effectiveness of the transmission of information and, in an apparent paradox, about the natural flow of communication during the interaction. Interestingly, the authors do not consider the ad hoc interpreter as the person responsible for the failure to achieve the communicative goal during the medical visit, instead they put the blame on the institution for not having been able to "appreciate the complexities of mediated communication across cultures." (Pöchhacker & Kadric 1999: 177) Therefore, the authors concluded that further investigation on the topic should be carried out, in order to help healthcare professionals understand the limits of the types of assistance which they provide to patients, and thereby are indirectly criticising the employment of non professional bilingual helpers for communication purposes, during medical check-ups.

2.8.2 When ad hoc interpreters are psychiatric patients

An original study, which shares this dubious outlook on the efficiency and the usefulness of ad hoc interpreters, was conducted on what was probably one of the first documented cases of ad hoc interpreting. Wulf and Schmiedebach (2010) discuss a particular case of ad hoc interpreting, in which the patients of a psychiatric clinic performed the role of interpreters so that doctors and other inmates could communicate with one another. The research was conducted using a number of medical records collected by the authors, pertaining to the years 1900 to 1903, which described the type of service and documented its outcome. The patients were guests of a psychiatric hospital in Hamburg and all came from Eastern European countries. They had all previously tried to emigrate to the United States, but, upon their arrival, they were diagnosed as being mentally ill and were subsequently sent back to Europe. Because they could barely speak German when they arrived in Hamburg, bilingual patients

who could speak German and the language of the patient, were used as interpreters. The consequences of this action produced negative results: not only were the features of the interpreting assistance directly linked to the unstable mental condition of the patients, and to the ad hoc interpreters, who were themselves inmates of the institution, but the ad hoc interpreters also ended up identifying themselves with the doctor's role, thus providing their own diagnoses and medical advice. Even though the study in question presents an unusual case, it does shed light on one of the main risks of ad hoc interpreting, which may occur when the responsibility for oral translation is assigned to bilingual individuals based solely on the fact that they can speak both languages of the other speakers involved in the conversation. Véronique Traverso (2002), whose study focused on the interaction between doctor, patient and ad hoc interpreter (who, specifically, is either a relative or close friend of the patient, and not a staff member), highlights a significant point: the characteristics of general linguistic uncertainty, disorganization and the lack of professional training, which are typical of ad hoc interpreting, can occasionally become a considerable hindrance to the communication process between doctor and patient, who tend to "disappear" behind the ad hoc interpreter, with the probable subsequent loss of important medical information. The author points out that in this triadic interaction between doctor, patient and 'linguistic intermediary' or *intermédiaire linguistique* (Traverso 2002: 81), as she calls the 'interpreters' in her data, it is the doctor and the patient who clearly define the context of the medical visit. She subsequently presents a list of factors that come into play in this type of interaction:

Relatif à l'interprète

- degree of competence for the two languages involved

- affinity to the two respective cultures

- affinity to the primary interlocutors

- knowledge of the subject discussed
- experience with mediator-situations

Relatif à la situation

- formality and interactional goals
- number of parties involved

Relatif aux autres partenaires

- degrees of competence in the other language (Traverso 2002: 92)

The author states that some of these factors proved to be especially significant in the data she analyzed. The interpreter's knowledge of French is certainly one of them, because when it is not high standard, a particular effort on the part of both the interpreter and the doctor is necessary to communicate and, in this situation, the patient tends to be left out by the other participants who are busy trying to understand each other. Another key feature, which emerged during the author's analysis of the data, is the relationship between the interpreter and the patient, which will be discussed in the following paragraph.

2.8.3 The patient's exclusion

Traverso (2002) points out an important aspect which, to the best of my knowledge, has not been mentioned in the literature on ad hoc interpreting, namely the fact that the interaction develops in different ways, depending on whether the ad hoc interpreter is the patient's husband, the patient's daughter or a woman close to the patient. It is the ad hoc interpreter's identity and gender, and the way they affect the interaction, which is of the utmost importance because it highlights the role identity plays in the joint construction of the interaction, and provides a platform for further research. The final point in the above mentioned list of factors which the author considers to be

relevant is the patient's proficiency in French: since the translation process of the questions posed by the doctor is neither standardized nor methodical, a poor knowledge of the language spoken by the doctor could considerably marginalize the patient from the interaction. Another interesting point raised by Traverso's analysis concerns the relative's knowledge of the patient's condition prior to the visit, which plays a major role at certain specific and relevant moments of the medical encounter: in fact, it happens rather frequently that the ad hoc interpreter answers the doctor's questions directly thus skipping the translation process. Interestingly, Traverso states that, even though this interactional dynamic entails the temporary exclusion of the patient from the interview, it is nevertheless fully accepted by each of the protagonists in the interaction. On the other hand, each participant also shows an understanding of the importance of obtaining information about physical pain and/or emotional discomfort directly from the patient. Therefore, all participants agree that they need the active participation of the patient (obviously through the provision of the translation of what is being said, since he/she does not speak the doctor's language) when information about his/her physical pain or his/her psychological status is needed. Traverso concludes that intimacy is co-constructed by the protagonists of the interaction, and that the fact that the patient's relative plays not only the role of interpreter, but also the role of interlocutor, can cause a certain amount of friction between the ad hoc interpreter and the patient, which seems to confirm the results which have emerged from other studies conducted on ad hoc interpreting.

2.8.4 Ad hoc interpreting in emergency rooms

A recent piece of research by Wang (2016) offers a particularly negative view on ad hoc interpreting: the study, based solely on part of the literature produced on ad hoc interpreting, analyzes the situation in emergency departments in United States hospitals. The author does not distinguish between ad hoc interpreting performed by family members and ad hoc interpreting performed by bilingual hospital staff, volunteers or other

physicians: the negative impact of ad hoc interpreting on patient care highlighted by the study is true for all classifications of ad hoc interpreters. Wang (2016) highlights the economic advantage, for the institutions, of using ad hoc interpreters to facilitate communication between doctor and patient, not only because by choosing an ad hoc interpreter the hospital does not have to worry about remuneration, but also because this way the institution does not have the economic responsibility of training medical interpreters. The outcomes of the research described in the literature on the topic analyzed by Wang prove that foreign patients that need to be treated in the emergency rooms of U.S. hospitals are more satisfied when a professional interpreter is used rather than an ad hoc interpreter. Moreover, the mistakes made by ad hoc interpreters while providing linguistic assistance had a more serious impact than those made by professional interpreters. While admitting to the partial impediments in the way the study was conducted (such as the fact that it is based on a limited set of data), Wang concludes that U.S. hospitals should only consider the use of professional interpreters for emergency situations, thus presenting quite a dramatic and alarming picture of the limitations of ad hoc interpreting within medical contexts characterized by urgency:

> It is realistic for hospitals to take direct costs into account and relieve financial burdens by heavily relying on ad hoc interpreters instead of training professional interpreters and implementing professional interpreter service. Nonetheless, professional interpreters contribute to patients' shortened length of hospital stays, reduced medical errors and better resource utilization (fewer repeated diagnostic testing of patients, etc.), which are beneficial for cutting long-term hospital costs. Apart from reducing hospital costs, the implementation of professional interpreters will cut down patients' waiting times and help limited-English-proficient patients gain clearer explanations from providers in an emergency department setting, which will invariably lead to positive health outcomes and improved satisfaction rates. (Wang 2016: 255)

Ho (2008) interestingly identifies four reasons why ad hoc interpreting performed by family members is often generally perceived as a counterproductive practice and a form of oral translation which could entail considerable problems. The author states that the first reason why the interpreting performance of a patient's relative is sometimes not trusted lies in the ad hoc interpreter's probable lack of general medical knowledge and specific medical terms. Ho states that this aspect usually discourages medical staff from asking a family member (but also other bilingual, untrained people) to interpret, as they fear that the risk of making mistakes could potentially be dangerous for the patient and ultimately for them as well, since they have the responsibility of finding a solution to the patient's problems as quickly as possible. Moreover, in certain dramatic circumstances, family members could find themselves emotionally under a considerable amount of stress, which could lead to a poor quality translation, thus creating an additional problem both for the medical staff and for the patient who needs to be treated. A significant feature which characterizes the situation just described is represented by both the potential practical urgency of the circumstance and also by its ethical implications: if a patient cannot effectively communicate with the physician who has to treat him/her due to the lack of appropriate interpreting assistance provided by a nervous relative, he/she is in fact not being granted the same type of care that other individuals would receive on a regular basis in the same circumstance. The second reason identified by Ho deals with the issue of patient's autonomy:

> Respect for patients' autonomy is generally considered the capstone value in Western bioethics, and the main justification for requiring clinicians to obtain informed consent for treatments. When family members are unable and/or unwilling to correctly interpret relevant information, patients' understanding of their situations, and thus their ability to deliberate according to their priorities or provide informed consent, may be compromised. (Ho 2008: 224)

Unfortunately, as noted by the author, clinical situations in which communication problems become a stumbling block for family members who interpret for the patient are usually the critical situations in which the life of the patient is at stake. Owing to the fact that certain cultures consider discussing some diseases or medical conditions to be unacceptable, being aware of the potential communicative difficulties that these circumstances can represent is particularly important. This second reason is directly linked with the third: ad hoc interpreting is usually seen as a threat to the patient's privacy. Ho (2008) underlines that, in the U.S., the training of professional interpreters includes a significant consideration of the ethical issues, which are likely to be directly encountered in their profession, and future interpreters learn the specific ethical rules they must respect when carrying out their job. Because family members who perform the role of interpreters during the medical encounter are substantially untrained oral translators, they are also most likely to be unaware of the ethical implications of their role and therefore might lack a fundamental ability to deal with certain problems according to the established or specific moral and ethical values. Furthermore, the patients might not feel at ease having a close relative receiving key information about their medical condition before they do, and the information in question could potentially create discomfort and uneasiness in the patient. Therefore, in this case ethical issues may arise not only because ad hoc interpreters had not been trained, but also because of the patient's rightful unwillingness to disclose a certain type of information in front of his/her family. The inability of family members performing the role of ad hoc interpreters to fulfill the basic ethical requirements imposed by the circumstances could lead to relevant problems involving the general health of the patients as well. The embarrassment perceived by the patient while dealing with certain topics concerning her/his medical condition when one of her/his relatives interprets during the medical visit leads to another reason for the widespread perception of ad hoc interpreting performed by the patient's relatives as being particularly negative. Moreover, if the patient has to be treated for a particularly serious and debilitating condition, it might be particularly complicated for relatives to

interpret, as they already have to deal with a huge amount of stress, which derives for the patient’s severe circumstances. Ho (2008) states that, in these cases, professional interpreters should be hired not only to alleviate family members from the additional task of translating but also because, by doing so, they offer them a practical chance to resume their legitimate role within their familial structure, which is important for the balance of all the family members, especially in a stressful medical situation:

> This is especially concerning in cases when the diagnoses are unexpected and/or grim, since it may be difficult for some family members to hear and translate about a loved one’s critical illness and prognosis, and then assume their usual role within the family. Given that many family interpreters are also caregivers, who may have additional familial and professional responsibilities, imposition of such emotionally exhausting tasks can further compromise their well-being. Professional interpreters, who are usually impartial strangers to the family and the patient, can relieve all parties of such additional stress and may thus be a better resource for interpreting medical information. (Ho 2008: 225)

In spite of the perplexities surrounding the use of family members as interpreters during medical encounters and, especially during medical consultations about serious health issues and/or emergency situations, the author also underlines the potential effectiveness of ad hoc interpreting performed by relatives of the patient in certain given situations, as well as the fact that, under specific circumstances, it might actually be advisable to employ a family member as an ad hoc interpreter, instead of a professional one. By quoting a study which compared mistakes made by ad hoc interpreters during oral translation with those committed by professional interpreters (which concludes that, not only is there usually no difference between the two categories in terms of the numbers of mistakes made, but also that ad hoc interpreters tend to make fewer mistakes than professional interpreters in terms of fluency) (Flores et al. 2003), and another study which suggests that

there is a discrepancy between the doctor and the patient’s perception of ad hoc interpreters, in which the former tends not to trust the patient’s relative in the role of interpreter, while the latter seems to feel more comfortable by having a family member translating what is being said (Kuo and Fagan 1999), Ho (2008) suggests that the decision about whether a relative of the patient is the right person to interpret during a medical visit should be made by considering each individual carefully, as family members might possess very different communicative skills and their knowledge of the foreign language might vary considerably. The author, therefore, suggests that the decision of asking a family member to play the role of interpreter in order to help doctor and patient communicate with each other should be made on the basis of an interview with the physician and the relative of the patient who is supposed to act as interpreter, before the actual medical visit takes place. During this brief meeting, the doctor would be able to gain important information about the patient’s relative, mostly concerning his/her linguistic skills, his/her knowledge of the patient’s condition and medical terms, as well as his/her willingness to play the role of the interpreter.

2.9 Ad hoc interpreting: mixed perceptions

The literature on ad hoc interpreting often highlights certain features which have been seen as problematic. One of the main problems of ad hoc interpreting seems to lie in the ad hoc interpreter’s lack of subject knowledge and linguistic skills. Starting from the assumption that the quality of the interpreter’s service depends purely on his/her knowledge of the foreign language, Hadziabdic and Hjelm (2013) state that the studies conducted on relatives playing the role of the interpreter during medical visits have produced different results: some patients seemed to be more comfortable and at ease in having a family member interpret for them, but relatives may feel flustered when having to deal with certain types of information, thus leaving parts of the conversation untranslated. Moreover, patients might worry about the potential mistakes their relative could make while translating, and it could be easier for

the relatives to make important decisions about the patient’s health, when necessary, if they do not have to translate as well. Therefore, the authors recommend that the option of having a family member translate for the patient should be carefully evaluated on a case by case basis, as the decision may have either positive or negative consequences, depending upon the specific circumstance of their relationship. In fact, Kaczmarek (2016) referring to all interpreters in general points out that conceptions of the role of the interpreter are not static and absolute, but relate to the differing viewpoints of the parties involved, thereby reinforcing this approach. However, continuing to use bilingual healthcare staff as interpreters may be an appropriate choice, in that the medical knowledge and the necessary communicative linguistic skills are mastered by one person, and there is no risk of key information being lost. On the other hand, the authors highlight the fact that in this situation it could be difficult to carry out both roles simultaneously and provide a competent service as a healthcare provider and as an interpreter. They then underline that the focus should always remain on the communicative goals represented by interpretation and state that even though there are undoubtedly several financial and practical advantages in having a healthcare staff member performing the role of interpreter, bilingualism does not necessarily mean that a person is also able to translate orally. Moreover, bilingual medical staff might not have the sufficient linguistic training to engage in oral translation during a medical encounter, and consequently might not be able to fulfill their professional goals accordingly. It is also necessary to consider the fact that their code of ethics will differ from the one that must be followed by interpreters. The authors therefore conclude that bilingual family members and bilingual medical staff should definitely not be excluded from the role of interpreter during medical consultations, but that the choice of relying on their assistance should be made together with the patient and his/her family.

2.10 Should ad hoc interpreters be paid?

Because of the fact that, as underlined in the previous paragraphs, ad

hoc interpreters who are neither the patient's relatives nor the patient's acquaintances, but volunteers are usually employed in emergency situations, or when no other type of translational service is available, it is almost taken for granted by both the institutions and by the patients that they will not receive a proper remuneration for their interpreting assistance. Moreover, since ad hoc interpreters are either relatives and/or friends and acquaintances of the patient, or bilingual or multilingual medical employees who already receive a regular salary for other types of services they provide to the clinic where they work, it is largely felt that ad hoc interpreters who are not family members or friends, should not be paid when orally translating for a patient in need. The literature which has discussed this point is very limited and has mostly dealt with the potential costs of professionalizing and qualifying ad hoc interpreters. In their study conducted in the United States, Larrison et al. (2010) highlight that, in spite of the fact that many studies have identified numerous disadvantages in ad hoc interpreting, there is, in fact, a huge potential in using ad hoc interpreters, because of their multilingualism and high level of motivation, and they should therefore be trained by the CHC (Community Health Clinic) with the intention that they become professional interpreters:

> Although the incorporation of ad hoc interpreters at the studied CHC encountered a number of challenges, attention to their unique work situation mitigated high turnover, low levels of commitment to clients, and a decline in overall satisfaction with services by LEP clients. In particular, the CHC's organizational climate, with higher than usual levels of support and innovation, coupled with the interpreters' commitment to the Latino community played a substantial role in helping the ad hoc interpreters develop and evolve over the years toward becoming professional medical interpreters. The case study indicates that this process could have been strengthened by the availability of funding that made full-time medical interpreting a viable healthcare profession and formalized training that provided a pathway to professional status. (Larrison et al. 2010: 404)

The one author who strongly believes that, despite the fact that a clinic's multilingual medical staff are already paid a salary for other professional tasks, they should nevertheless receive extra remuneration when performing the role of an ad hoc interpreter, is Meyer (2007). The author points out that ad hoc interpreting should not disappear, because, as later also stated by Larrison et al. (2010), it will always provide a useful communicative resource for foreign patients who need to communicate with a hospital's or a clinic's medical personnel. However, the author does conclude that more precise regulations to protect patients are needed, while the issue concerning a potential salary for ad hoc interpreters should also be addressed. Meyer (2007) underlines the fact that ad hoc interpreters do not receive a salary for their interpreting assistance, because it is seen as a sort of mandatory task they have to perform, due to the circumstances: "Ad hoc interpreters don't get paid for their services. The service is usually perceived as a kind of social or moral duty – by themselves and those around them." (Meyer 2007: 10) Therefore, the work of the ad hoc interpreter could often be taken as a given, both by those who decide to ask for their help and by the ad hoc interpreters themselves who, being aware of the fact that they can speak the languages used during the interaction, often feel as if it is their responsibility to facilitate communication. As a possible solution, the author proposes not only that healthcare institutions should invest in a program to train ad hoc interpreters, but also that they should be proportionally remunerated for their useful interpreting assistance.

3 CONVERSATION ANALYSIS

3.0 Introduction

The focus of this thesis was introduced in the previous chapters, where I discussed both the concepts which inform the analysis of mediated talk as a form of interaction and the debate which accompanies research on 'ad hoc' interpreting – my main objective here. The present chapter deals with the description of a theoretical-methodological approach, Conversation Analysis (CA from now on), which lies at the basis of Wadensjö's work and is often referred to in the literature on interpreter-mediated interaction (e.g. Amato 2012; Gavioli 2009; 2012; 2016). This approach was developed in the late 1960s in the U.S.A thanks to work in sociology by Harvey Sacks and his colleagues, Emmanuel Schegloff and Gail Jefferson. Their first joint paper, published in 1974 in a journal on language and linguistics, highlighted that far form being a chaotic and unregulated phenomenon, conversation is based on a series of rules, which allow the participants to take turns and "negotiate" their rights to talk in communication. CA has subsequently become one of the major instruments for the inquiry of social interaction in a multiplicity of settings.

The settings that are of interest for my work here are the medical setting and the more recent field of interpreter-mediated interaction, in medical settings in particular. Here I intend to concentrate on the latter work. However, in order to foreground my discussion, it is probably worthwhile to have a general overview of CA fundamentals. To do this, I have relied on one of the many handbooks on CA that are nowadays available, namely, Hutchby and Wooffitt's, second edition (2008).

While such a choice may be debatable, it is especially relevant to my work for a number of reasons. First, CA has been around for a while and it has developed in a number of subfields. Mapping the field of CA is thus nowadays a huge work, well beyond the goals of this thesis and probably much beyond the work of any thesis. Second, while possibly a debatable point *in se*, Hutchby and Wooffitt's handbook (1st edition) was written and published in 1998 when

the authors were young postdocs. This makes it particularly suitable for a doctoral thesis whose aim is not to discuss the basics of the methodology, but to apply it to a specific and rather unexplored field, that of ad hoc interpreting. Finally, I used the 2008 revised edition, which has been enriched and made clearer, following ten years of feedback and updates to include new knowledge in the discipline (Hutchby and Wooffitt 1998: viii).

One of the problems in this choice is clearly that the points I am dealing with are not systematically attributed to the researchers who actually explored them. There is a lot of work in first generation (Harvey Sacks, Emmanuel Schegloff, Gail Jefferson, Anita Pomerantz) and second generation (John Heritage, Paul Drew) CA studies which is discussed by Hutchby and Wooffitt (2008) and reformulated in terms of analytic tools for those who want to use them. In summarizing these tools, I cannot but refer to my main source, the handbook I have chosen.

Thus following Hutchby and Wooffitt's (2008) handbook, this chapter is organized as follows. In the first part I will provide a definition of what CA is and describe its development. In the second part, I will focus on some of CA 's practical applications. In the third part, I will explain the main tools CA uses in approaching the study of conversation dynamics.

3.1 CA birth and definition

CA's main objective is to study the different ways in which people use language in real situations. As mentioned in 3.0, the CA founder is considered to be Harvey Sacks, a sociologist at the University of Los Angeles and Irvine. Sacks started to study the way conversation is organized while working on a suicide helpline in Los Angeles. He was subsequently able to obtain recorded copies of the conversations. By recording and transcribing the interactions, he had the chance to both listen to them multiple times and to read them on paper, so that they could be analyzed systematically. He noted that there were

recurrent patterns in the structure of conversation and listed them. This generated the basic analytic method, which is still used today.

Roughly speaking then, CA is the study of talk and of the talk dynamics participants adopt to communicate with each other in everyday situations. In the words of Hutchby and Wooffitt:

> At the most basic level, conversation analysis is the study of talk. To put it in slightly more complex terms, it is the systematic analysis of the talk produced in everyday situations of human interaction: talk-in-interaction. (Hutchby and Wooffitt 2008: 11)

Therefore, CA studies the way in which speakers interact and how they use the spoken language to achieve their communicative goals. CA is not a "linguistic" approach in a traditional sense because it does not investigate the microstructure of language in terms of language components like morphemes or syntactic chains. It is however a micro-analytic approach investigating the effect that each conversational turn has on the following one(s), thus actively constructing the verbal interaction on the basis of systematic dynamics. CA looks at the microstructure of language focusing on the function of single, sometimes apparently meaningless, items (e.g the feedback channel), the structure of turns (e.g. questions) as well as the relation of each conversational turn with the previous and the following one(s) (where a key role is played by responses).

In studies of language, CA offers two main novelties: the first is the focus on recurrent verbal structures of interaction (e.g. questioning-answering, inviting-accepting/declining, etc.); the second is a method which looks at communication from the perspective of the interlocutors. In this respect, meaning is not simply achieved as a projection of one speaker, but also through the response of the interlocutor(s) and their interpretation (or uptake) of previous utterances:

> […] CA is a radical departure from other forms of linguistically oriented analysis in that the production of utterances, and more particularly the sense they obtain, is seen not in terms of the structure of language, but first and foremost as a practical social accomplishment. […] CA seeks to uncover the organization of talk not from any extraneous viewpoint, but from the perspective of how the participants display for one another their understanding of 'what is going on'. (Hutchby & Wooffitt 2008: 12-13)

In conclusion, CA is not an analytical method applied to explore conversational dynamics from an external point of view, because it actually focuses on the internal communicative mechanisms activated by the speakers, and on the reactions each speaker produces to what has been uttered by the other speaker/s. In other words, CA aims to uncovering the relational value of the utterances which constitute the very essence of a conversation between two speakers or among more speakers.

3.1.1 Turn organization and conversation construction

Hutchby and Wooffitt (2008) explain how conversation is naturally structured and organized. The authors clarify that the sequential organization of conversation strictly depends on how, within their turn, speakers react to what was previously uttered. The turn uttered by the participants in response to other participants' previous turns expresses the interlocutor's understanding of what comes first. Speakers' understanding may align or misalign with their interlocutors' previous projections and we can normally observe misalignment when some form of repair is enacted as a response to 'second turns'. This process is called *next proof procedure*, namely the fact that, in order to study how meaning is constructed through utterances, it is necessary to carefully observe speakers' 'uptakes', i.e. what happens in 'subsequent' turns following a particular initiation. The so-called next proof procedure is the fundamental instrument of CA as it ensures that conversation is analyzed by observing what

actually happens as a mutual construction of the participants, rather than the analyst's interpretation. The reported on by the authors is extracted from a conversation between a mother and her son, before the Parent-Teachers' Association meeting takes place. The mother asks: 'Do you know who is going to that meeting?' (Hutchby and Wooffitt 2008: 13) The authors note that the mother's utterance can be interpreted in two different ways: the mother could either be curious about who is going to the meeting, or she might want to tell her son who is going, because she already had that type of information. The first interpretation would require a direct answer, but the second would require another question, as a response: 'No, who?' (Hutchby and Wooffitt 2008: 14) Therefore, if the mother's question is decontextualized, it could seem to be equivocal. Nevertheless, '[…] for CA, the issue is how the participants make sense of any given utterance.' (Hutchby and Wooffitt 2008: 14) Consequently, the analyst's task is to observe how the interlocutors interpret each other, through their own responses, and therefore make their interpretation known. 'Who?' demonstrates that he attributes to what his mother previously said the sense of starting new information giving. Nevertheless, in the following turn, the mother says: 'I don't know!' (Hutchby and Wooffitt 2008: 14), which proves that her son's previous assumption did not reflect the meaning of her utterance. After this turn, the son re-interprets what was said by his mother and provides her with the small amount of information he possesses: 'Ouh:: prob'ly: Mr Murphy an' Dad said prob'ly Mrs Timpte en some a' the teachers.' (Hutchby and Wooffitt 2008: 14) According to the authors, this short exchange shows that:

1) The way interlocutors comprehend and interpret the other interlocutors' utterances develops in the same way sequences of talk do, and that is why it is possible to analyze different types of conversations, which are co-constructed by all participants, by applying the next turn proof procedure;
2) Participants' contributions to conversation are subject to negotiation among the interlocutors; this means that some actions (like giving or getting information, as in the example

above) may need to be pursued during a conversation and are normally achieved in sequences of actions rather than single participants' actions.

In other words, the son's answer: 'Who?' does not mean that he actually did not know, but that he was approaching the conversation ('orienting', as stated by the authors) by assuming erroneously that his mother actually wanted to announce who would be going to the meeting. However, the development of the sequential structure of the conversation shows the son that he interpreted his mother's communicative intentions wrongly. As a result, at the end of the sequence the son re-orients himself towards what his mother actually meant. The son's communicative actions, then, clearly prove that a careful observation of each turn and how turns are intrinsically connected to one another supports the analysis. (Hutchby and Wooffitt 2008: 15) Consequently, the next turn proof procedure is a key concept for CA.

3.2 Foundation of Conversation Analysis: the contribution of Harvey Sacks

In the first section of this chapter, the great contribution of Harvey Sacks to the creation and the development of CA was mentioned, as he is considered the founder of the CA approach. Even though Sacks was the one who pioneered research in conversation, following his example a certain number of scholars started exploring human conversation and interaction as well. Among these, there were Sacks' main teammates: Emanuel Schegloff and Gail Jefferson. (Hutchby and Wooffitt 2008) Sack's research was revolutionary in that it aimed at analyzing the social structure underlying everyday conversation. His theory was that at the basis of regular conversation there is a precise and structured order and, in order to investigate this order, it is necessary to observe the different features of recorded interactions, in that they can be listened to, transcribed and consulted multiple times by the analysts. Therefore, Sacks started to analyze any type of conversation that he

could find, in order to identify particular features and repetitive patterns. The first interactions he analyzed were recorded conversations between an operator of the suicide helpline where Sacks worked and the person who called the service with the hope of receiving help. CA as a discipline was initiated through these close observations of the recorded interactions. Sacks noted that most phone calls started with the operator providing his/her name, and the caller answering by providing his/her name as well. However, Sacks observed that one particular conversation slightly differed from this pattern; the caller found it difficult to understand the operator's name and gave an answer that was new in that context:

(2) [Sacks, 1992(1): 3]
A: This is Mr Smith, may I help you
B: I can't hear you.
A: This is Mr Smith
B: Smith
(Hutchby and Wooffitt 2008: 16)

Sacks noticed that until the end of the conversation the operator had a hard time to obtain the caller's name. The callers reticence in providing their names was a relevant problem for the Suicide Prevention Center. Nevertheless, Sacks considered the issue from an entirely different perspective. The sociologist was more preoccupied with the point in the conversation at which it was possible to recognize the caller's reticence in providing his/her name. This point of view constituted Sacks's radically new methodology for analyzing conversation. As a matter of fact, Sacks was interested in understanding whether the caller's statement about not being able to hear the operator was actually a communicative strategy to avoid providing his/her name after having heard the operator's name. (Hutchby and Wooffitt 2008)

3.2.1 Consequences of Sack's observations

Three main ideas were generated by Sack's observations. The first one has to do with the fact that, during an interaction, what is said is actually employed by the speakers as a tool to reach specific communicative goals. This means that a simple utterance such as the one which appears in Sack's example: 'I can't hear you', might in reality express the speaker's unwillingness to provide his/her name, rather then communicating that the speaker really cannot hear what the operator has said. As demonstrated by Sack's following investigations, the declaration of not being able to hear the operator's previous utterance establishes an orderly communicative sequence of talk during which the operator gradually loses the chance to find out what the caller's name is, unless he asks the caller directly to provide it again. In this way, the caller can start communicating with the agent without necessarily having to give his/her name and without openly rejecting the agent's request. (Hutchby and Wooffitt 2008) The second point is that conversation can actually be considered as a structured system, with its own communicative rules and patterns. Sacks actually suggests that what is uttered by a speaker constitutes a communicative action which is contextualized in a specific situation. Consequently, the structural and orderly feature of talk is strictly connected to the characteristics of the conversational context it belongs to:

(2) [Sacks, 1992(1): 3]
A: This is Mr. Smith, may I help you?
B: I can't hear you
A: This is Mr. <u>Smith</u>
B: Smith
(Hutchby and Wooffitt 2008:16)

> In this particular instance, the respective activities being engaged in by the caller and the agent are, broadly speaking, those of seeking help about a feeling of suicidalness and of finding a way of providing that help. As Sacks remarks elsewhere, the agent has good organizational reasons for seeking the caller's name since the Suicide Prevention Center tries to keep records of all its contacts. But the caller may equally have good social reasons for wanting to avoid giving a name, since by that act, she becomes organizationally categorized as a 'potential suicide'. It is in this interactional context that the

> conversational move of doing 'not hearing', in the sequential context following the agent's announcement of his name, becomes analysable as a method for avoiding giving one's name (Hutchby and Wooffitt 2008: 18)

Hutchby and Wooffitt (2008) highlight that Sack's theory differs considerably from speech act theory, another linguistic approach to conversation and its social employment. In the 1960s, J.L. Austin proposed the so-called speech act theory, according to which every single utterance produced an action, instead of merely picturing reality in terms of what was true or false, as many philosophers of language (such as the logical positivists of the Vienna School) had hypothesized up to that moment. (Hutchby and Wooffitt 2008) While Sacks was working on his data, another linguist, John Searle, used the speech act theory to demonstrate the existence of specific patterns and structures that could make it possible to consider an utterance as a promise, in a paper entitled: 'What is a speech act?' (1965) However, the authors observe, Searle's investigation did not take into account the contextual situation in which the utterance was produced. Moreover, he used an intuitive approach, instead of an empirical one, to analyze his data. (Hutchby and Wooffitt 2008) On the contrary, Sacks carefully observed the data he had available, which were recorded and transcribed everyday conversations, which occurred in the real world. The third idea includes both the focus of CA and a sociological methodology and expresses the concept that talk-in-interaction can be fully analyzed, instead of simply representing a tool through which it is possible to observe social occurrences:

> This represents a challenge to conventional sociological thinking which sees talk as essentially trivial, except in so far as it is a tool for finding out about larger-scale social phenomena such as class, gender or deviancy, through responses to interview questions, for example. It also challenges the standard perspective in sociolinguistics, which attempts to show a casual relationship in the ways in which linguistic variables are themselves affected by sociological variables (Labov, 1972). (Hutchby and Wooffitt 2008: 19)

The authors underline that in the 1960s while Sacks, by observing human social interactions, noticed that they are orderly and organized systems. The linguist Noam Chomsky claimed that everyday conversations cannot be properly linguistically analyzed, as they do not follow a precise scheme and are not structured. Chomsky's perspective considerably influenced the following studies on structural linguistics and proposed a view according to which human beings are able to verbally communicate with one another because of a 'tacit knowledge of linguistic structures' (Hutchby and Wooffitt 2008: 20) Conversely, for CA the premise of the presence of order in every single turn of a sequence of talk entails a careful analysis of every single detail of an utterance, before labeling it as unimportant. (Hutchby and Wooffitt) Therefore, the authors identify four basic points which constitute the key methodological notions of CA and explain the fundamental difference between discourse analysis and CA:

> - Talk-in-interaction is systematically organized and deeply ordered
> - The production of talk-in- interaction is methodic.
> - The analysis of talk-in-interaction should be based on naturally occurring data.
> - Analysis should not initially be constrained by prior theoretical assumptions. […] Distinguishing between discourse analysis in linguistics (Brown and Yule, 1983) and conversation analysis, Montgomery (1986: 51) remarks that the former approach tends to be concerned with 'verbal interaction as a manifestation of the linguistic order', whereas 'conversation analysis is more concerned with verbal interaction as instances of the situated social order'. (Hutchby and Wooffitt 2008: 21)

According to the authors, the great conceptual difference between discourse analysis and CA is paramount in order to understand how to properly analyze the available data. They highlight the fact that CA stems more from a sociological approach than a linguistic one, thus considerably differing from discourse analysis. Therefore, while CA considers talk as a specimen of the

contextualized social structure, the approach of discourse analysis considers talk as the expression of the linguistic system. The basic difference between the two approaches has to be taken into account by the analyst while exploring everyday talk, in that they represent two completely different ways of considering not only language in general, but also social interaction and verbal instances in particular. (Hutchby and Wooffitt 2008)

3.3 Ethnomethodology and Conversation Analysis

Conversation Analysis is often confused with another approach called 'Ethnomethodology'. In their book *The Handbook of Conversation Analysis*, Sidnell and Stivers (2014) explore the close link between CA and Ethnomethodology. The authors explain that in the introduction to the first volume of one of his studies, Sacks' collaborator, Schegloff, presents Harold Garfinkel and ethnomethodology after having listed some salient details about Sack's instruction. Schegloff's objective was to highlight the influence that ethnomethodology had on Sacks' studies, after the sociologist had the chance to meet Harold Garfinkel in person. While talking about Garfinkel's work on ethnomethodology with other people, Sacks introduced his own personal point of view. At the same time, at the beginning of the 1960s, Sacks was also attending Garfinkel's lectures which he was giving together with Edward Rose. Once at UCLA, while working as a lecturer, Sacks had the chance to work with Garfinkel and at the Center for the Scientific Study of Suicide. It is difficult to determine how Garfinkel's studies and stance influenced Sacks's development of CA, but it is certain that, to a certain degree, ethnomethodology played a crucial role in the creation of CA. (Sidnell and Stivers 2014) The authors state that in one of his papers, *On Sociological Description* (OSD), Sacks declared that Garfinkel's work and their meetings provided him with the necessary inspiration to develop his theories. OSD and ethnomethodology had some elements in common: 1) criticism towards Sociology for frequently referring to language, which should be explored as an autonomous field of research; 2) the imperative to analyze 'conventional wisdom' as an individual's starting point

for the employment of language, instead of trying to explain, negatively connoting the individual's natural use of language with the individual's other occupations; 3) the recognition of the importance of fragmented accounts, instead of considering them as uninteresting from a sociological point of view, and as an issue that needs to have a solution. (Sidnell and Stivers 2014) The influence of ethnomethodology on CA can easily be observed in one of Schegloff's early papers: Schegloff's discussion about a 'distribution rule' (Sidnell and Stivers 2014) during a phone call and his statement about the answerer speaking first denotes that Schegloff starts his exploration of conversation observing what could actually be responsible for its infraction, and this aspect highlights the impact of Garfinkel's work on Schgloff's analysis. Sacks also draws heavily on ethnomethodology. Nevertheless, the authors note, it is not possible to state that Sack's work is based solely on ethnomethodology. For instance, Sacks' OSD paper discusses whether or not Sociology can be considered a science, and this is a focal point of CA's methodological issue:

> That is, attention to practical reasoning and the methods of commonsense analysis for Sacks would eventually mean a subtle but radical analytical shift from direct examination of a given utterance in talk to the interpretation that a recipient makes of that utterance. (Sidnell and Stivers 2014: 15)

The authors provide an example: during a lecture in 1966, Sacks notes that when the therapist, whose name is Dan, introduces the other participants to the interaction by saying: 'Jim, this is Al, Ken and Roger', it assumes that the people named will have certain reactions, in order to understand what they will have to utter next. Ken, Roger and Al are introduced by 'this is', instead of being, for instance, collected. Therefore, as proved by the content of their subsequent utterances, they do not need to answer Dan, as they would have otherwise done if Dan had summoned them. This sequence exemplifies a fundamental principle for conversation analysts, namely the fact that in order

to explain an utterance as a social activity, it is of the upmost importance to observe how recipients react to it:

> In the consideration of conversational turns of talk, here – in the handling of what happens next – is a tool for examining "members' methods" that is both influenced by and a contribution to methodological enquiry. This reciprocal relation between ethnomethodology and Conversation Analysis is manifest in many ways, another example being the joint concern with the ordinary, the mundane, the everyday social world (Schegloff, 1992b: xxiii), which in Sacks' (1984b) work receives exquisite articulation in a lecture that has been published under the title, "On Doing Being Ordinary." It suggests how the ordinariness of the world is an achievement of members' concerted practices rather than a feature that is inherent to social life. (Sidnell and Stivers 2014: 15)

Therefore it can be concluded that, although the actual differences between Conversation Analysis and Ethnomethodology are still unclear, the two disciplines do have certain aspects in common, such as the focus on everyday social life. It can thus be extremely easy to confuse one with the other.

3.4 The structure of conversation

In the previous sections it was often underlined that conversation possesses its own structure and is orderly organized. The structure of conversation includes sequences of talk, which are made by turns, which contain the speakers' utterances. Each element, which contributes to the construction of conversation, will be explored in the following sections.

3.4.1 Conversational turns

Conversational turns represent the basic unit of conversation, and a series of turns constitutes a sequence of talk. It is undoubtedly true that some social objects are constructed out of conversation, such as laws, regulations and

ideologies etc., whereas some actions, such as asking, warning and recommending etc. are performed throughout talk. As mentioned above in the previous paragraphs, the primary goal of CA is to undertake a practical analysis of everyday talk, thus demonstrating that anything we say and do is controllable, neatly ordered and interesting for our interlocutor(s). Therefore the advantages of employing CA as an analytical methodology lies in the fact that it focuses on observable patterns of conduct. The main objectives of CA, can thus be summarized as follows:

1- Analyzing how the speakers design their turns;
2- Analyzing what the turn projects as (a) possible next turn(s);
3- Analyzing the response(s) to that turn and the action that is constructed.

The natural pauses of a speaker can be within the turns or between turns and displaying a list acquires the meaning of 'not being done yet' in a speaker's turn, and the way a turn is designed makes a certain kind of response more 'expectable'. A fundamental principle of the process of turn design is the fact that what is uttered by a speaker strictly depends on the other speaker's previous utterance. (Sidnell and Stivers 2014) This aspect highlights the notion of cohesion, which characterizes human talk, i.e. the speakers' habit to construct their turns on the basis of the content of previous turns. (Sidnell and Stivers 2014) The pace of the turn could certainly vary and the various turns can be characterized by occasional elongations and overlaps and by the choice of words. The design of turns, is thus characterized by the following aspects:

- Choice of words
- Intonation
- Speed of talk
- Overlap with the other speaker
- Repairs
- Inbreath and outbreath
- Pauses within turns

- Pauses between turns
- Stress and emphasis
- Grammatical construction

When analyzing a conversation, it is thus of utmost importance to carefully observe not only what the speakers utter, but also their silences and other extralinguistic aspects which contribute to the construction of the interaction.

3.4.2 Turn construction basis

One of the specific goals of conversation is to explore and explain the sequential order of talk, in that the turns of talk do not just appear as numerable entities of the conversation, but they are actually governed by a logic order which is possible to analyze and properly define. Hutchby and Wooffitt (2008) underline three aspects that arise from the turn-taking structure of conversation and according to the turn exploration of CA. The first one has to deal with the turn, which is uttered as a response to a previous one. The so-called 'next turn' contains the speaker's *expression* of his/her understanding of what has previously been uttered by the other speaker. This is the reason why the already mentioned 'next-turn proof procedure' is a reliable analytical strategy in order to understand not only how the turns are related, but also the significance of the turn which was uttered before the one we start our analysis from. Basically, it is by observing *the end* that it is possible to understand *the beginning*. What is more, the link between the various turns shows how the participants to the conversation carefully analyze what has been uttered up to that moment in order to shape their turns and to negotiate their positions. (Hutchby and Wooffitt 2008) The second aspect, which emerges from the turn-taking structure of talk and CA's analysis of turn-taking, is the inferential action performed by the 'next speaker', namely how the 'next speaker' interprets and understands the previous speaker's turn. The authors point out that this aspect is closely linked to ethnomethodology, but CA slightly differs from the ethnomethodological perspective, in that it

considers the sequential order and the inferential order of talk as equally relevant, which practically means that the participants to a conversation can employ the sequential position of a turn, i.e. where it is placed within a sequence, in order to form their understanding of the other speaker's action. (Hutchby and Wooffitt 2008) The third aspect has to do with the temporal dimension of talk. The sequential, inferential and temporal aspects of talk constitute the basis for the creation of turns and, consequently, sequences of talk:

> A third crucial dimension that emerges from CA's emphasis on turn-taking is that talk-in-interaction has a *temporal* order. That is, talk is produced in time, in a series of 'turn constructional units' out of which turns themselves are constructed. Meanwhile turns at talk act as the vehicles for actions – complaints, requests, offers, warnings, and so on. Conversational structures – the patterns and sequences that conversation analysts have revealed to be at work in the unfolding accomplishment and mutual recognition of actions in interaction – are the crux of this interplay between sequential, inferential and temporal orders in talk. (Hutchby and Wooffitt 2008: 42)

It is therefore clear that, in spite of having many aspects in common, ethnomethodology and CA are, at the same time, very different. For CA the interchange of sequential, inferential and temporal concepts plays a fundamental role in the construction of sequences of talk through turn construction units.

3.4.3 Sequence construction procedure

3.4.3.1 Adjacency pairs and preference

Hutchby and Wooffitt (2008) underline that one of the most evident features of conversation is that some utterances are organized in pairs. The

pairing of turns includes questions and answers, greetings and the relative responses and invitations, which can be accepted or not. The authors highlight that the analysis of conversational pairs represented one of the main interests of Sacks, who, in 1972, classified what he named 'adjacency pairs', because the utterances which constitute the two parts of the pair are supposed to appear in conversation one right after the other. An adjacency pair is a micro-sequence of talk, which is made up of two easily identifiable and ordered turns: the first one constitutes the first part of the adjacent pair and requires a specific kind of response, which constitutes the second part of the pair. (Hutchby and Wooffitt 2008) The authors provide the example of an invitation: the turn where the speaker invites the other speaker is the first part of the invitation-adjacency pair, which specifically requires either the other speaker's acceptance or refusal. On the other hand, the second speaker's response constitutes the second part of the adjacency pair. Hutchby and Wooffitt (2008) underline the significance of the name of these 'paired' utterances: they are called 'adjacency pairs' because, in theory, the two statements belonging to two different speakers, are supposed to be uttered one next to the other, even though, occasionally, this is not the case, as it can be observed in the following example quoted by the authors:

(1) [Levinson, 1983: 304]
1 A: Can I have a bottle of Mich? **Q1**
2 B: Are you over twenty-one? **Ins1**
3 A: No. **Ins2**
4 B: No. **A1**
(Hutchby and Wooffitt 2008: 43)

The question uttered by participant A is clearly the first fragment of an adjacency pair. However, in the following turn, participant B does not complete the adjacency pair, in that his/her utterance represents another first part of a new adjacency pair (Ins1 = insertion 1). At this point, speaker A completes the second adjacency pair by answering speaker B's question uttered in the immediately preceding turn, by saying 'no', which prompts speaker B to complete the first adjacency pair by answering 'no', thus giving speaker A no

permission to obtain the requested drink. The authors highlight that this example shows another relevant feature which characterizes adjacency pairs, namely the fact that paired utterances also suggest the orientation of the speakers towards adjacency pairs and insertion utterances. Orientation is the ability possessed by the speakers to reciprocally show one another that they have comprehended what each utterance aims at communicating. (Hutchby and Wooffitt 2008: 44) Therefore, the authors state, adjacency pairs do not only represent the combination of two particular utterances such as invitation and acceptance/declination or request and acceptance/refusal. Adjacency pairs also offer the chance to observe how participants to the conversation mutually understand and interpret what is uttered during the development of the interaction, which is a basic notion of CA. Consequently speakers can use the adjacency pair logic to show one another their comprehension and personal interpretation of their reciprocal utterances. This leads to the discussion of a concept called *conditional relevance*: provided that the first segment of an adjacency pair is being produced, the second one is therefore important, thus if the second segment is not uttered, the participant who uttered the first segment might deduce that there must be a reason for such a relevant absence, as shown in the following example quoted by the authors:

(2)[TW:M:38]
1 Child: Have to cut the:se Mummy.
2 (1.3)
3 Child: Won't we Mummy.
4 (1.5)
5➔ Child: Won't we.
6 Mother: Yes.
(Hutchby and Wooffitt 2008: 45)

In this example, the child asks a question. Since the mother does not respond, the child keeps repeating the question twice after two pauses (line 2 and 4). After the second repetition, the mother finally answers, showing the relevance of giving the requested answer and the constraint posed by the child's question. The authors point out that adjacency pairs represent an important conversational structure, which can provide relevant information regarding the

speakers' intentions and subsequent actions throughout the development of talk by utterers of first segments. This demonstrates how talk-in-interaction is not limited to turn-taking, as it actually performs actions through the turn-taking procedure. Therefore, the absence of a turn where it should be can easily be understood as the non-accomplishment of an action.

3.4.3.2 'Preference'

Adjacency pairs present a peculiar inferential feature, which has to do with the fact that some first pair segments render the alternative actions significant in second place. (Hutchby and Wooffitt 2008: 46) The research conducted on these type of adjacency pairs suggests that the substitutions have no counterpart, which means that they are created in different ways compared to their corresponding negative option. These differences are represented according to the concept of 'preference', and the authors state that the structure for agreements is called the 'preferred action turn shape', whereas the disagreement structure is called the 'dispreferred action turn shape'. (Hutchby and Wooffitt 2008) It is of the utmost importance to underline that, within the CA framework, the notion of preference is not used in order to investigate the psychological motives of the individuals involved in the conversation construction process. According to the CA principles, the idea of preference is used in order to recognize and understand the characteristics of the configuration of turns related to certain undertakings, which the speakers utilize to make assumptions about the actions expressed by the turn. (Hutchby and Wooffitt 2008)Quoting Sacks, Hutchby and Wooffitt (2008) remark that the first parts of adjacency pairs can be formulated in order to encourage a certain type of answer, and a good example of this is one of the speaker's addition: 'isn't it?' at the end of the utterance, which prompts the other speaker to respond affirmatively:

(4) [JS:II:28]
1 Jo: T's- it's a beautiful day out, isn't it?

2➔ Lee: Yeh it's just gorgeous.

(5) [VIYMC:1:2]
1 Pat: It's a really clear lake isn't it?
2➔ Les: It's wonderful.
(Hutchby and Wooffitt 2008: 47)

On the other hand those turns, which somehow do not reflect what is expected in the first part of the adjacency pair, are characterized by so-called 'dispreference markers'. These markers include expressions such as 'Well' and 'Um' at the beginning of the utterance:

(6) [Sacks, 1987: 58]
1 A: Yuh comin down early?
2➔ B: Well, I got a lot of things to do before getting
3 cleared up tomorrow. I don't know. I w- probably
4 won't be too early.
(Hutchby and Wooffitt 2008: 47)

Speaker A seems to expect an affirmative answer from speaker B. As a matter of fact, speaker A does not choose to formulate the question in a way that would encourage a negative answer, as in the following case: 'You are not coming down early, are you?'. (Hutchby and Wooffitt 2008: 47). Nevertheless, speaker B does not want to respond affirmatively, and therefore formulates his/her answer in such a way that it clearly expresses two important characteristics of dispreferred turns: by displaying a certain hesitation he structures the turn in such a way that his/her disagreement is barely perceivable and the disagreement appears only at the end of the utterance and in an uncertain way. Consequently it can be concluded that preferred actions are displayed directly and clearly, whereas dispreferred actions are accompanied by markers which express hesitation and appear at the end of an utterance. The authors point out that the examples provided underline the extremely relevant role played by participants' inferences for CA, as well as the fact that they deal with the ways in which participants' inferences have an ethical or judgemental facet:

> These points bring out again the centrality, for CA, of the inferential properties associated with speakers' moves in interaction sequences. They also address the ways that those inferences have a distinctly moral, or evaluative, dimension. Speakers can be seen not only to be establishing and maintaining mutual understanding of one another's actions in sequences of talk, but also to be holding each other accountable for those actions. In this sense the adjacency pair framework, and the preference organization that operates for some types of adjacency pair, constitute an important site in which to observe the relationships between patterns of language use and structures of social action. (Hutchby and Wooffitt 2008: 49)

It can then be concluded that adjacency pairs in general, and their aspect of preference in particular, are extremely relevant for a proper and as exact as possible analysis not only of the turn-taking organization, but also of the interaction as jointly constructed by all the participants. In the next section, other relevant aspects of talk will be described.

3.5 The structure of turn-taking

Transcribing data is an essential aspect of the systematic study of talk in order to conduct proper research on conversation. Transcribing has three main goals: representing talk as an activity, revealing crucial details of participants' conduct and showing the aspects of position and composition. Therefore, the action of transcribing can be considered as an analytical practice for the exploration of talk. Conversation should be transcribed verbatim, i.e. word for word, reporting pauses (also called 'intra-turn silences' or 'gaps' when the speaker interrupts him/herself and starts talking again after a while), and precise timing, because every single detail might be particularly relevant in the interaction construction process. If the transcribing phase is carried out correctly, it faithfully represents with written language what is uttered during an interaction by its participants, including the temporal and sequential relationships of the utterances. Hutchby and Wooffitt (2008) explain how CA sees language as a system, and specifically as a 'speech language system',

with a sequential and technical structure. This structure is first described in a seminal article by Sacks, Schegloff and Jefferson first published in 1974 and then reprinted and highly cited, which gave birth to what we now consider CA methodology. In what follows, I will describe the main features of turn-taking as illustrated in Hutchby and Wooffitt (2008). First, turns are methodically allocated to the speakers. This is done on the basis of three rules: a) turn-taking is present in every conversation; b) speakers are inclined to talk one at the time; c) turns are taken with the shortest possible gap or overlap between them (Hutchby and Wooffitt 2008). Moreover, the turn-taking scheme is characterized by two phases: the 'turn construction' phase and the 'turn distribution' phase.

Conversational turns are made up of so-called TCUs, namely turn-construction units, which roughly (but definitely not always) match linguistic classifications such as sentences, clauses, exclamations and phrases. The authors state that it is always very important to emphasize that that the conversation analyst is not supposed to analyze each utterance from a linguistic point of view, i.e. trying to explain what a sentence or phrase is. In fact, within the CA framework, what matters is the whole construction of a turn, and not one of its minor units. This characteristic of CA brings about two main features of turn-construction units. The first one is that they are characterized by a certain 'projectability', which means that during a turn-construction unit, the participants can project the type of construction unit and when it will probably end. The second feature is that turn-construction units inevitably lead to 'transition-relevance places', which are the points where the turn-construction unit ends, thus giving the other participant the chance to construct his/her turn. (Hutchby and Wooffitt 2008: 50) Example 8, quoted by the authors, highlights these two basic features:

(8) [SBL: 1:1:10:15]

1 Rose: Why don't you come and see me some[times
2 Bea: [I would
3 like to
4 Rose: I would like you to

(Hutchby and Wooffitt 2008: 50)

The first speaker in the first turn is clearly formulating an invitation, and the second speaker is able to acknowledge this. The fact that the second speaker considers the first speaker's utterance as an invitation is shown in the second turn, when the speaker accepts the invitation before the first speaker has completed her turn. Therefore, by overlapping with the first speaker's utterance, Bea demonstrates not only to predict one of Rose's turn-construction units, but also that she understands the meaning of the type of invitation expressed by that unit. This is the reason why the next turn proof procedure is particularly useful in order to understand and analyze the speakers' reciprocal comprehension of each other's utterances. However, if Rose had added another turn-construction unit to her turn, such as the temporal expression: 'this week', things would have been different. (Hutchby and Wooffitt 2008) This brings about a certain number of rules:

> At the initial transition-relevance place of a turn:
> *Rule 1* (a) If the current speaker had identified, or selected, a particular next speaker, then that speaker should take a turn at that place.
> (b) If no such a selection has been made, then any next speaker may (but need not) self-select at that point. If self-selection occurs, then first speaker has the right to the turn.
> (c) If no next speaker has been selected, then alternatively the current speaker may, but need not, continue talking with another turn-constructional unit, unless another speaker has self-selected, in which case that speaker gains the right to the turn.
> *Rule 2* Whichever option has operated, then rules 1(a)-(c) come into play again for the next transition-relevance place.
> (Hutchby and Wooffitt 2008: 51)

If these rules are applied to the case described above, namely if Rose had added the expression 'this week' at the end of her turn, thus prolonging it and

no longer being almost at the end of the utterance, then Bea's projection of Rose's turn before its completion would not have represented a violation of these rules.

In reality, Bea conformed to rule 1(b), and in case her projection had revealed to be inaccurate, it would not have been relevant according to the CA framework, because as the authors state, speakers orient to probable transition-relevance places, and not to real ones. (Hutchby and Wooffitt 2008) There is a logic behind this: if the speakers waited for a speaker to finish talking before starting their turns, there would be the possibility either for the speaker to continue talking, or for another speaker to start a new turn. Consequently, speakers orientate according to the expected end of the utterance, instead of the real end of the turn, as proved by empirical data. This leads to the central notion of the temporal development of talk-in-interaction. By looking carefully at the conversation between Rose and Bea, it is possible to observe that temporal, sequential and inferential orders are closely linked together. 'Inferential order' indicates that conversational turns are a verbal mean to perform social actions. (Hutchby and Wooffitt 2008) Subsequently these actions are to be evaluated by the receiver of the message throughout the development of the interaction. In the abovementioned example, Bea expresses a sort of verdict about the kind of action performed by Rose through her turn, at the moment when she decides to start her own turn. According to the transition-relevance place, the point in the conversation at which Bea starts talking is the reasonable moment within the turn-taking system when she actually can do so. However, according to the temporal development of the turn, there is no silence between Rose's and Bea's turns, which means that the social action performed by Rose through her request to go and see her sometimes has been accomplished before the end of her turn. As a matter of fact, through the unfolding of time, an additional social action could have been performed by Rose, by specifying, for instance, to go and see her sometimes during that week, or during that month. Such an addition would have had other consequences for the sequence of talk. There is a relevant aspect which

emerges at this point of the reasoning, namely the fact that all the above signifies that the issue of whether Bea's turn would have been seen as disruptive of the turn-taking structure is upon the speakers to decide. Basically, it would have been Rose's task (as she was the speaker to produce the following utterance) to suggest that Bea's turn was interrupting her previous turn. It can therefore be concluded that the problem about the way rules are applied and work throughout the development of conversation is dealt with by the participants. This demonstrates that turn-taking rules are empirically employed by the participants of the conversation, who may also orient to apparent disruptions of these rules. (Hutchby and Wooffitt 2008)

3.5.1 Overlaps

What immediately meets the eye, when looking at an overlap, is the fact that it seems to be the expression of a speaker's inability to understand that the other speaker's previous turn has not been completed yet. Nevertheless, Hutchby and Wooffitt (2008) state that research has proved that overlaps frequently happen when transition-relevant places may appear. Even though overlaps may look somewhat disorganized, the authors underline that Jefferson's research above all indicates that overlapping talk actually does follow a precise order and is particularly organized. When an overlap occurs it is indeed possible to notice the speakers' orientation towards the already mentioned turn-taking rules. In order to explain this, the authors quote and analyze the following sequence of talk:

(10) [NB:II:2:1-2]
1 N: Hello:,
2 E: .hh HI::.
3 (.)
4 N: Oh hi:::='Ow are you Edna,
5 E: FI:NE yer LINE'S BEEN BUSY.
6 N: Yeah (.) my u-fuhh! h- .hhhh my fa:ther's wife
7 ca:lled me,h .hhh So when she calls me::, h I
8 always talk for a lo:ng ti:me cuz she can afford it
9 an' I ca:n't.hhh[hhhhh[huh]
10 E: [↑OH::[:::]: my [go:sh=Ahéth]aght=

11 N: [↑AOO::::hh!]((falsetto))
12 E: =my phone was outta order:
13 (0.2)
14 N: n[:No::?
15 E: [I called my sister an' I get this busy en then I'd
16 hang up en I'd lift it up again it'd be: busy.
17 (0.9)
18 E: .hh How you doin'.
19 N. .t hhh Pretty good I gutta rai:se.h .hh[hh
20 E: [Goo:[ud.
21 N: [Yeh
22 two dollars a week.h
23 (.)
24 E: Oh wo:w
(Hutchby and Wooffitt 2008: 55)

In this sequence there are numerous overlaps and the left-hand square bracket is used to highlight their onset. (Hutchby and Wooffitt 2008) The authors say that it is possible to define each of them as following a certain order and as showing the speakers' orientation towards likely transition-relevance places as the moments where they have the chance to begin a turn. In order to prove the point, they consider part of the sequence as an example: in turn 9, what Edna's protracted exclamation 'OH:::::' overlaps with Nancy's discreet laugh which is produced at the end of her turn: 'So when she calls me::, h I always talk for a lo:ng ti:me cuz she can afford it an' I ca:n't'. Therefore, the exclamation 'OH' begins at a transition-relevance place, although the beginning overlaps with Nancy's almost soundless laugh. There is another good example in line 11. Nancy's 'AOO::::hh! ((falsetto))' is a loud laugh which appears to overlap with the not yet completed previous utterance, where Edna points out that she believed her phone was out of order. Nevertheless, through a careful observation of the entire sequence, it is possible to find out that Nancy's laugh starts at a probable transition-relevance place. As a matter of fact, in the previous turn Nancy said something amusing about spending a long time speaking over the phone when his father's wife calls, since her father's wife has plenty of time to talk on the phone, whereas Nancy does not. At this point Nancy starts to laugh almost noiselessly, which is transcribed with multiple 'hs'. Edna answers with a penetrating 'OH::::: my

go:sh' and Nancy responds with an equally piercing 'AOO::::hh!' Most likely Nancy is assuming that Edna is reacting to her tale and therefore begins to laugh because she considers Edna's OH::::: my go:sh' to be an answer to her story. Edna does not interrupt her turn, but keeps talking: 'OH::::: my go:sh=Ah thaght my phone was outta order'. However, the overlap produced by Nancy can be considered as the result of her orientation to the first chance available for the completion of the turn. This is how it is possible to consider something, which is only apparently untidy, as the outcome of the speakers' orientation to the turn-taking rules. (Hutchby and Wooffitt 2008) The authors point out how the quantity and frequency of overlaps work exactly in the aforementioned way: signaling the result of the participants' orientation to the turn-taking guidelines. Hutchby and Wooffitt underline that Jefferson (1984) recognizes three main classifications of overlaps onset. The first one is called 'Transitional onset' and refers to the moment when a next speaker takes the turn at a likely transition-relevance place. The second classification is called 'Recognitional onset' and indicates when the next speaker is convinced to have understood what the other speaker uttered and is able to project the end of the turn, even though this might happen before the turn is completed. The third classification is called 'Progressional onset' and refers to a speaker's idea about the completion of a turn, after a moment during which the conversation does not flow, because there is not enough expressiveness inside a turn. The authors provide another example to explain the three classifications, even though it has to be taken into account that talking on the phone is quite different from talking face-to-face. In the sequence, the two participants are talking over the phone, one of them is a host, and the other one the caller. They discuss about dogs, the possibility of training them, and the dog owner's responsibility to make sure that their pets do not disturb other people or create any sort of damage:

(9) [H:2.2.89:4:1-2]
1 Host: Well did you- did you then explain that, you
2 understood that, you know dogs have the call of
3 nature just as er as people do, and they don't
4 have the same kind of control and so

5 the[refore, s- so
6 Caller: [No, but dogs can be tr[ained
7 Host: [I haven't finished,
8 so therefore the owner… being there has the
9 responsibility…
(Hutchby and Wooffitt 2008: 56)

Hutchby and Wooffitt (2008) highlight the fact that the overlap in turn 6 can be considered as an example of the first classification, namely the transitional onset, because as they had already pointed out before in the other sequences, even though the host considers the overlap to be an interruption, it might be that the caller has considered that moment in the conversation as a conclusion moment, namely as a transition-relevance place, and has consequently oriented to it. The authors define the transition overlap onset as being the moment when the next speaker is actually doing what he/she is supposed to be doing, according to both his/her entitlements and responsibilities. As a matter of fact he/she does not do what would be usually defined as an interruption or discourtesy, without giving the other speaker the chance to complete his/her turn. Conversely, the other participant is also doing something completely rightful and correct by uttering a single turn, which is made up by several constituents. (Hutchby and Wooffitt 2008) The authors claim that their extract adds an important aspect to Jefferson's comment on the transition overlap onset, i.e. the fact that the transitional onset is simultaneously the perfect well-ordered moment for the production of an overlap, while being considered an interruption place by the participant who is still speaking. It can therefore be concluded that overlaps and a seemingly disruptive behavior, do not signal the participants' willingness to ignore the rules of turn-taking; quite on the contrary, they are proof of the fact that speakers actually do orient and respect the rules, and they can even be considered as the practical verbal result of this orientation of the speakers. (Hutchby and Wooffitt 2008)

3.5.2 Repair

As previously mentioned repair (Schegloff, Jefferson, Sacks 1977) is one of the main aspects, which characterize conversation and includes several different actions performed by the speakers while communicating with each other. Hutchby and Wooffitt (2008) point out that a repair could be, for instance, the correction of a mistake made inside a turn, for example those occurring because of several overlaps, and any other kind of rectification that is made throughout the development of a conversation. The term 'repair' has to be understood in two ways: the first one certainly refers to the mistakes occurred during conversation, which need correction, whereas the second one indicates the interruption of a turn or sequence, in order to take care of a problem which emerged during the construction of talk. The CA literature on repair is extensive, and one of the main goals of the research on repair is to prove that it is actually another expression of the speakers' orientation to the turn-taking rules. (Hutchby and Wooffitt 2008) There are two ways to express the speakers' orientation. The authors underline the fact that the turn-taking organization already includes some strategies in order to correct mistakes. This means that the guideline which suggests that speakers should talk 'one at a time' is not respected in case of an overlap. However, this situation is automatically repaired, in that one of the main features of the turn-taking system is transformed, i.e. one participant is inclined to stop talking before the end of a turn. In order to explain this point, the authors report three sequences as examples:

(11) [SBL:2:2:3:38]

1	Zoe:	an' he sorta scares me
2	Amy:	Have you seen 'im?
3	Zoe:	.hhh We:ll I(m) I've met 'im
4➔	Amy:	.hhhhh Well uh actually: [when she's-
5➔	Zoe:	[An' the way the:y
6		pla:y. Oh:-
7		(.)
8	Amy:	Serious huh?
9	Zoe:	.h Yah,

(Hutchby and Wooffitt 2008: 58)

(12) [TRIO:2:III:1]

1 Marjorie: We:ll? She doesn't kno:w. .uhhh:
2 huhh [huh-huhh-huh-huh-heh-heh]
3 Loretta: [O h h m h y G h o : d,]
4➔ Marjorie: hhhhh Well it [was an-
5➔ Loretta: [Are you watching Daktari:?
6 (0.2)
7 Marjorie: nNo:,
8 (.)
9 Loretta: Oh my go:sh Officer Henry is (.) ul-locked in
10 the ca:ge wi- (0.3) with a lion.

(13) [SBL:2:2:3:42-3]

1 Amy: So: uh::::: she said [don't worry about i:t=
2 Zoe: [Mm hm.
3 Amy: =an:d an' I jus' thought .hh the nex' ti::me
4➔ uh that [I have-
5➔ Zoe: [No:w uh see Pat anno:ys my Frank. hh
6 (0.3)
7 Amy: Ye:ah.
8 (0.2)
9 Zoe: Uh he:'s told me that.
(Hutchby and Wooffitt 2008: 58)

In every quoted sequence, immediately after the beginning of an overlap, the participant who still had to complete the utterance interrupted her turn, as it can be seen in the fourth line of each conversation. The first two sequences present a number of features which belong to the organization of the turn-taking process, and which the speakers orient to when they withdraw from the conversation. Hutchby and Wooffitt (2008) explain that in the first sequence Zoe and Amy are commenting on the antagonistic behavior of a couple they know, with whom they play bridge. The utterance in line 5 appears to be a protraction of the third line, namely Zoe's previous turn, as Zoe starts the turn by uttering: 'An'' (and). Between turn 3 and turn 5 Amy takes the initiative to begin a turn, which she interrupts after two overlapping words in turn 5, without completing it. The following example (sequence 12) is extracted from a telephone conversation. The caller, Marjorie, is returning a call in order to recount a conversation she's just had with a friend. Loretta seems to be watching 'Daktari', a well-known show from the 1960's, when she answers the phone. At this point two things happen at the same time: Marjorie considers Loretta's exclamation: 'Ohh my Gho:d' as an answer to her previous statement

about a person who 'doesn't know' and keeps talking, taking that answer as a starting point. As a matter of fact, Loretta's exclamation: 'Ohh my Gho:d' actually refers to an incident which occurred during the TV show she is watching ('Officer Henry is (.) ul-locked in the ca:ge wi- (0.3) with a lion'). Even though the conversation between the two women is clearly interrupted, Marjorie repairs the interruption by leaving her utterance unfinished, thus letting Loretta start another turn. Nevertheless, the last sequence appears to be even more disjointed. It is extracted from a later moment during the same call between the two friends Amy and Zoe. They are talking about the two friends they play bridge with. (Hutchby and Wooffitt 2008: 59) Zoe produces an overlap by uttering: 'Pat anno:ys my Frank' (line 5): however, the meaning of Amy's previous turn is not discernable: 'the nex' ti::me uh that I have…'. Therefore, this overlap cannot be recognized, not even as a transitional one, nor has there been an interruption as in the obvious case in sequence 12 or a prolongation of a previous turn as in sequence 11. What Zoe's interrupting utterance is actually expressing is Zoe's empathy towards Amy's criticisms of their friend Pat who, as Zoe states, irritates her husband, Frank, as well. (Hutchby and Wooffitt 2008) Consequently, it can be relatively easy to infer that, in aiming to solve the turn-taking issues, speakers orient themselves towards several aspects of their developing conversation.

3.5.3 The progressive structure of repair

The research on repair has focused primarily on the type of repair, which, as the above mentioned examples show, entails the temporary interruption of an utterance or sequence of talk in order to take care of an evolving conversational issue. (Hutchby and Wooffitt 2008: 59) The kinds of issue that could arise during a conversation are not restricted to a small group; quite the contrary, there exists a wide range of conversational problems, which the participants take care of, or attempt to, through repair. The authors point out that the relevant difference between the beginning of a repair, and the repair itself. There is also a remarkable difference between a repair started by the

speaker who caused the communicative problem, and a repair started by another speaker. Therefore, there exist four fundamental kinds of repair:

- Self-initiated self-repair: Repair is both initiated and carried out by the speaker of the trouble source.
- Other-initiated self-repair: Repair is carried out by speaker of the trouble source but initiated by the recipient.
- Self-initiated other-repair: The speaker of a trouble source may try and get the recipient to repair the trouble – for instance if a name is proving troublesome to remember.
- Other-initiated other-repair: The recipient of a trouble-source turn both initiates and carries out the repair. This is closest to what is conventionally understood as 'correction'.
(Hutchby and Wooffitt 2008: 60)

The data observed by researchers studying repair is useful in explaining how the different types of repair work within a conversational sequence:

(14) [Heritage I:II:1]
1 I: Is it flu: you've got?
2➔ N: No I don't think- I refuse to have all the:se things
(Hutchby and Wooffitt 2008: 60)

In this short dialogue, the second speaker (N) begins to answer the first speaker's (I) question: 'No I don't think-', but then interrupts the utterance to say something different, specifically that he/she rejects the idea of having the flu. The following example, on the other end, shows a case of other-initiated self-repair:

(16) [GTS:5:3]
1 Ken: Is Al here today?
2 Dan: Yeah.
3 (2.0)
4➔ Roger: he is? hh eh heh
5 Dan: Well he was.
(Hutchby and Wooffitt 2008: 60-61)

The authors explain how Roger's turn in line 4 'he is? hh eh heh' is an instance of the so-called Next Turn Repair Initiator (NTRI) Other examples of NTRIs are questions such as 'what?', 'huh?' and also non-verbal expressions, for instance a perplexed face expression. NTRIs play several roles within the conversation,

as shown by the following sequence, where the speaker identified with the letter A makes a repair by partially repeating the previous turn uttered by speaker K, thus reprocessing the communicative issue:

(18) [GTS:II:2:54]
1 K: 'E likes that waider over there,
2➔ A: Wait-er?
3 K: Waitress, sorry,
4 A: 'Ats bedder,
(Hutchby and Wooffitt 2008: 61)

The following extract shows instead a self-initiated other-repair. In this sequence, the first speaker (B) has a hard time recalling a person's name, and this problem prompts the second speaker's (A) repair:

(19) [BC:Green:88]
1➔ B: He had dis uh Mistuh W-m whatever k- I can't
2➔ think of his first name, Watts on, the one that
3 wrote [that piece
4 A: [Dan Watts.
(Hutchby and Wooffitt 2008: 61)

The last type of repair is the other-initiated other-repair, which accomplishes three things: it allocates the cause of the communicative issue in the previous utterance, it identifies the cause of the issue and it solves the issue in one turn. This type of repair is the one which most evidently highlights the participant's 'mistake'.

3.5.4 The positioning of repair

Repair depends on the chronological structure of talk-in interaction. (Hutchby and Wooffitt 2008) This means that, within the development process of an utterance thanks to its turn-construction units, there are certain places where a repair might start due to the appearance of a communicative problem. Obviously, the first position where a repair can be produced is within or right after the turn construction unit in which the problem appears, as illustrated by the following example:

(22) [T1:SA:F:F]
1➔ A: .h>Well<>yu've< actually wro(t)-
2 rung the wrong number
(Hutchby and Wooffitt 2008: 62)

In this sequence the problem is an incorrect word which is left unfinished and then substituted with the right one ('rung' instead of 'wrot(t)). It is thus evident that self-repair begins before the completion of the utterance's first construction unit. The second position where repair can appear is at the following transition relevance place after the problem has occurred. This type of repair can also take place in the turn following the turn which includes the issue, i.e. 'in a next speaker's subsequent turn' (Hutchby and Wooffitt 2008: 63):

(24) [Heritage:II:I:call 3:1]
1 S: Mister Samson's house? c'n [I help you?]
2 I: [H e l l o:]
3 I: Mister Samson?
4➔ S: It's not M'st Samson it's his assist'n can I help you
(Hutchby and Wooffitt 2008: 63)

The communicative problem in this conversation is I's conviction in wanting to talk to 'Mister Samson', when he/she is actually speaking with his assistant, as S clarifies at the beginning of the following turn, thus making a repair. Hutchby and Wooffitt (2008) note that Schegloff (1992c) stated that most of the issues that arise during conversation can be relatively easily solved through a structural process: throughout the TCU (turn construction unit) which presents the issue, the subsequent TCU and the following turn. What is more, these repairs can be started by the speaking participant, or another participant. However, in the first case, the 'other' speaker who initiates the repair might be considered responsible for the interruption of the speaking participant's turn. There exist, though, other situations where there are issues which can be solved only after the following turn. (Hutchby and Wooffitt 2008) This happens when one of the participants has not comprehended the content of the other

speaker's utterance, but the miscomprehension is not instantly evident, as proved by the following extract:

(25) [From Schegloff, 1992c: 1321]
1 M: Loes, do you have a calendar,
2 L: Yeah ((reaches for her desk calendar))
3 M: Do you have one that hangs on the wall?
4➔ L: Oh you want one.
5 M: Yeah
(Hutchby and Wooffitt 2008. 64)

The question: 'Loes, do you have a calendar' is not clear because it can be interpreted in two ways: either M is asking L for a calendar because he/she needs one, or he/she wants to check something on L's calendar. The latter option is how L interprets M's question. However, by asking: 'Do you have one that hangs on the wall?' M makes it clear that he/she actually would like to receive a calendar from L. This means that the original issues, i.e. L's misinterpretation of M's question, is recognized and solved in the fourth turn. (Hutchby and Wooffitt 2008) The authors conclude that the quoted examples prove the fact that repair plays a central role in conversation, not because the action of correcting what is wrong is important, but to ensure mutual understanding of what is being said, in order to avoid further misunderstandings and possible arguments. (Hutchby and Wooffitt 2008)

Conclusion: In this chapter I tried to illustrate some of the main principles of Conversation Analysis, because it is the method I will use in the following chapter to analyze my data. I will recognize the CA features described above in the interactions above where the interpreting service is provided by a cultural mediator and in those interactions where an ad hoc interpreter is present. By observing them and how the participants interact, I will draw my conclusions.

4. DATA ANALYSIS

4.0 A short premise on my data collection

The data that will be analyzed in this chapter belong to a data collection known as AIM. AIM means Analysis of Interaction and Mediation and is the name of a research network developed around work from the University of Modena and Reggio Emilia[1] through contacts with other research centers in Italy and abroad. In particular the AIM database has been collected starting from the early 2000s thanks to agreements between the University of Modena and Reggio Emilia and the local healthcare bodies, in Modena and Reggio Emilia.

The data for my thesis were collected randomly in the course of a research project dealing with comparison between interpreted and non-interpreted interaction[2]. During the data collection, some encounters happened to be recorded where interpreting was provided by some patients' relatives, normally their husbands. Of a total of 11 recordings, 4 were in English-Italian, of which one was inaudible. This gave me three encounters altogether. For a year, I have tried to increase the collection by contacting institutions in both the South East Venetian area where I live and the Modena/Reggio Emilia services. However, due to the impossibility of planning encounters where the patients are accompanied by 'their own interpreters', no new conversations could be collected during my PHD research program.

Since the collection occurred by chance and I was not directly involved in the project (which was concluded before my PhD started), contextual details like the patient's precise age and provenance were not available, nor was it any longer possible to have access to the patients' records. In order to highlight chracteristics which might be peculiar of the ad-hoc interpreted data, my

[1] http://www.aim.unimore.it/site/home.html

[2] It was a project founded by the University of Modena and Reggio Emilia, 2014-16 (FAR funding program 2014)

analysis includes 3 more encounters where the interpreter is an experienced professional hired by the healthcare service. These three encounters too were selected from the data assembled within the research project mentioned above. Selection was such as to guarantee maximum comparability with the ad hoc interpreted data.

In what follows I briefly describe the data set analyzed in this thesis.

4.0.1INTERACTIONS WITH AN AD HOC INTERPRETER

CSFS3: The participants in this interaction are a gynaechologist, a patient at the end of her pregnancy and her husband who plays the role of ad hoc interpreter. The conversation lasts about forty minutes, not only because the interaction between doctor and the husband/interpreter does not flow because of the latter's weak knowledge of the Italian language, but also because the doctor tends to provide lengthy explanations and the atmosphere is relaxed, so the participants often laugh together, making it diffficult for a non professional interpreter to coordinate talk and intervene with translating contributions. The husband directly talks to the doctor, leaving his wife out of the conversation most of the time, even though the wife demonstrates to understand some things that are being said and she shows this by laughing at one of the doctor's remarks at the beginning of the interaction. At a certain point the doctor performs an ultrasound scan test and calls the midwife in to make sure that all the parameters for a woman at the end of her pregnancy (34 weeeks) are fine. They check the parameters and reassure the patient that everything seems to be okay.

A0030830:

The participants in the conversation are a doctor, a patient and an ad hoc interpreter, who is again the husband of the patient. The exchange lasts thirty minutes. The patient is in the mid to late stages of pregnancy and is undergoing different types of tests. The conversation shifts between English and Italian. The doctor can speak basic English, although she is not fluent. The conversation is easy-going but focused. The husband is party to the wife's medical history and her current situation. When the doctor speaks English the patient usually replies in English. However, sometimes the husband replies on

behalf of his wife, without actually involving her before replying. When the doctor speaks Italian the husband occasionally translates for his wife, but more often answers for her without translating, thereby excluding her from the conversation. This is the case during the ultrasound examination, and when arranging a further appointment: the wife's contribution is restricted to an occasional 'OK'. Towards the end of the conversation, the patient talks directly to the doctor in English about pain she was experiencing and about her diet. The husband occasionally intervenes to translate, and often takes the opportunity to continue the conversation in Italian. Throughout the conversation the husband is dominating his wife's responses, either by answering for her, making approving noises, taking decisions for her, involving himself in the conversation even when it is English, or by forming a direct relationship with the doctor while sidelining his wife. It was, however, not a fractious relationship but one in which all parties appeared happy with the pattern of the conversation and their respective roles.

A0020830

The parties to the conversation are a midwife, who can speak some English, a patient and an ad hoc interpreter who can understand Italian, but does not speak it very well. The patient understands some basic Italian. The conversation lasts almost forty minutes. The patient is able to respond to some of the midwife's simple comments when she speaks Italian. The interpreter knows the patient's medical conditions and situation and so responds directly to the midwife without translating for the patient. The midwife often switches into English to ensure the patient has understood, possibly because the interpreter is failing to relate what is said to the patient. Even when the patient is responding directly to the midwife the ad hoc interpreter intervenes. During tests, e.g. when the patient's weight is being taken, the conversation is largely in Italian and the ad hoc interpreter does not provide a translation. Likewise, when being asked important questions the interpreter rarely translates but answers for the patient. The patient only reiterates what has been said by the 'interpreter'. Clearly the midwife tries to communicate directly with the patient to circumvent the interpreter answering for the patient, but even then the husband still intervenes. On other occasions when the patient has difficulty

understanding the midwife, the interpreter does not translate. All administration issues are in Italian and take place between the midwife and the patient's husband. The patient is sidelined for most of the conversation, which is dominated by the ad hoc interpreter (her husband) and on occasions the patient seems unable to communicate what she apparently wishes (see Amato and Garwood 2011)

4.0.2INTERACTIONS WITH A CULTURAL MEDIATOR

VOCE 32 The conversation takes place between a doctor, a patient and a cultural mediator. The conversation lasts approximately twenty minutes. The cultural mediator takes a direct role in directing the conversation, asking for additional information that has not been asked for by the doctor, for example whether the patient has high blood pressure. The mediator does not translate exactly what the doctor says, for example 'congenital deformations' is translated as 'any sicknesses.' Likewise she will not translate exactly what is said by the patient, for example when the patient answers ninety-six or ninety seven referring to the year in which she had her operation the mediator simply says ninety-seven. The mediator also mistranslates utterances. The patient is going to have an ultrasound check as the liquid content in her womb has reduced. The doctor discusses certain details about the patient with the mediator, and the patient says very little, appearing sidelined in many parts of the interaction. Unfortunately her utterances are not audible in many cases, so it is not possible to understand large portions of the conversation when discussing arrangements for ultrasound and induced labour. The mediator explains to the patient the benefits of induced labour, assuages her fears, and helps to convince her to go along with induction. There is a minimal contribution from the patient, but she appears to be aware of what is being suggested and happy with the mediator's help.

Osp4_010105

The conversation takes place between a midwife, a patient and a cultural mediator. An intern is also present. The conversation is erratic in parts in that the understanding between the parties is not clear. The opening exchange in which the midwife tries to ascertain personal details is difficult and poorly

focused, and she struggles to find basic information. The patient has a problem with her pregnancy. The obstetrician explains the situation which the mediator translates for the patient. The translation is not a literal one, and it is unclear as to how much the patient understands, as she only responds with sounds, not words. It maybe necessary to perform an ultrasound test, which the mediator again explains to the patient. The conversation finishes with dietary advice. The patient is passive throughout and rarely uses words to communicate. The mediator therefore dominates the conversation, and the midwife is totally dependent on the mediator in communicating with the patient. The mediator reinforces her own position by forging a relationship with the midwife independent of the patient, sometimes laughing and joking with the midwife, while excluding the patient, who, on the other end, decides not to interrupt.

Osp2_010105

The conversation takes place in a medical setting between a doctor, a patient and a cultural mediator, and lasts approximately twenty-five minutes. Two nurses and an intern are also present. The doctor speaks Italian, the patient speaks English. The cultural mediator translates. At the beginning the doctor asks questions about the medical history of the patient. The mediator translates each doctor’s turn; although not always a literal translation the meaning is retained. If the patient manifests uncertainty about the question, the mediator follows up with explanations and/or rephrases the question, at times using examples. When the mediator knows the information the doctor requires from the patient, she ignores the patient and answers directly, then relates what has been said to the patient, even though sometimes omitting details of some relevance. Understanding between the mediator and the patient is not always good and confusion often arises, for example when asked about previous pregnancies, and about the patient’s weight and height. The patient is ignorant about some of these facts, but also does not appear to understand what is being asked, although she does not ask for clarification. This encourages the doctor to try and find information in other ways, for example by asking for her file and by making educated assumptions. At one point the interns also intervene in the conversation in an attempt to find out

the information required. When discussing the arrangements for inducing the birth on the following day it is the mediator who prepares her for the experience and explains in detail what the patient must bring and what will happen. This goes far beyond the doctor's explanation.

4.1 My data analysis

The aim of this chapter is to analyze the communicative differences between medical encounters with a foreign patient mediated by an ad hoc interpreter and medical encounters with a foreign patient mediated by a cultural mediator. As mentioned above, in the data analyzed, both cultural mediators and ad hoc interpreters are of the same provenance as the patients. This aspect is of the utmost importance from a communicative point of view, because both the cultural mediators and the ad hoc interpreters are familiar with certain cultural, social and personal assumptions, which characterize the patient's background and which enable the mediator or the ad hoc interpreter to easily grasp the significance of the patient's utterances and silences, or even to give voice to the patient's impressions, which they show to have access to. The analysis is organized as follows: each section focuses on either a relevant phase or a relevant achievement in the encounters, with examples from ad hoc interpreting and comparable examples with cultural mediators being analyzed. A comparison is carried out as a conclusion of each section.

4.1.1 Opening the medical encounter: greetings and 'what's the matter'

A routine way to start medical encounters is with the doctor asking the patients what brought them to the visit. It is thus normally the doctor who asks a question like 'what's the problem?'. In interpreted interaction, this is not always the case, as the interpreter may ask this question first to involve the patient immediately and then render the patient's answer. In this section I analyze four extracts, two with an ad hoc interpreter, two with a cultural mediator. In all the cases examined here it is the doctor who speaks first.

Let us look at Extract 1 below. It is interesting to observe that the patient's husband interpreting ad hoc throughout the encounter does not intervene at the beginning and lets his wife and the doctor get in contact. The doctor asks in Italian how the patient is doing. Although the patient's knowledge of the Italian language is scarce, she nevertheless provides her answer in Italian rather than English. Therefore, even though the interviewed patient just knows a few words in Italian, she actively chooses to answer in the doctor's native language, rather than choosing the one she is more familiar with, thus displaying that she has actually understood the doctor's question and has some access to the Italian language:

Extract 1 (AD HOC INTERPRETER)

1DOCf: allora? come stai?
(so? how are you?)
2PATf: b[ene]
3DOCf: [how] are you [((laughter))]
4PATf [I'm fine]
5DOCf: .h (??) [(??)]
6PATf: [(??) ye]s

There is an interesting code-switching aspect in this extract, which matches the adjacency pair detectable in turns 1 and 2: the doctor and the patient try to understand each other using the linguistic resources they have available to themselves. In Extract 1, the doctor makes an effort to repeat her initial question in English, thus displaying her knowledge of this language, even though the patient has previously already answered her question in Italian. At this point the patient answers the doctor's question in English, by translating her previous answer. Although the following turns are partially unclear, most likely the doctor poses another question in English to the patient, which is promptly answered by the patient in English. It is interesting to note that, in the quoted exchange, not only do the turns reflect the complete communicative absence of the ad hoc interpreter in the translating process, but they also display a considerable amount of overlap, which possibly shows a

sort of interactional complicity between the doctor and the patient. At the same time, it might be observed that this complicity is obtained through a linguistic alignment of the patient: in other words, if the doctor speaks first, the patient follows her/his linguistic code in order to co-construct complicity through the interaction. Such a complicity is achieved even because the ad hoc interpreter does not actively interrupt the doctor and patient's exchange of turns, thus using the next-turn proof procedure to monitor the conversation. Something quite similar happens in Extract 2, which is taken from another ad hoc interaction:

Extract 2 (AD HOC INTERPRETER)

1OBSf: come stai?
(how are you?)
2PATf: °thanks° (1) oh: [oh]
3OBSf: [((laughter))] brava ((laughter)) [((laughter))]
([((laughter))] bravo ((laughter)) [((laughter))])
4ADHm: [s]ì adesso[:]
([ye]s now:)

As can be observed, in this excerpt the patient does not answer the midwife's question in Italian, which was posed in this language. However, she does show that she has understood the physician's question, by answering 'thanks' in English. Interestingly, at this point in the conversation, the midwife pays a compliment to the patient: 'brava (bravo)', thus expressing her approval of the patient's understanding of her previous turn uttered in Italian. Consequently, the communicative action performed by the obstetrician suggests the obstetrician's trust in the patient's linguistic skills in the foreign language (Italian). In fact, the absence of the linguistic alignment detected in extract 1 does not prevent the creation of complicity between doctor and patient. However, this co-construction seems to have different features as compared to the previous case. If, in extract 1, the patient aligns to the doctor's linguistic code, thus generating a language switch, in extract 2 the doctor's role seems to be more decisive. She guides the complicity by laughing and maintaining the Italian language. The next-turn proof procedure is then broken by the

intervention of the ad hoc interpreter that, however, until that moment has not participated in the turn exchange and does not align with the doctor's remark. He limits himself to utter 'sì adesso: (yes now:)', which suggests the ad hoc interpreter's willingness to provide further information on that particular topic. The ad hoc interpreter is answering the doctor's question in the patient's place. This is a recurring pattern with untrained ad hoc interpreters and untrained cultural mediators (Amato and Garwood 2011). This is precisely why it could be dangerous. They take conversational space away from the patient, with the best of intentions, but the result is a disempowerment of the patient.

In those interactions where a cultural mediator is present in order to play the role of interpreter, the physician's request for the patient's private information which includes personal data such as the patient's address, how many years she has been living in Italy, her medical history etc., is either provided directly by the mediator or is asked by the physician in such a way which displays that she had not registered it the first time, or is asked by the physician using the third person to talk about the patient. Therefore, even if the data is insufficient to draw definite conclusions, in those interactions mediated by a cultural mediator it may be inferred that, at the beginning of the interaction, the physician does not ask how the patient is, and momentarily shows no interest in the patient's perception of her condition. This is supported by Extract 3 and Extract 4:

Extract 3 (CULTURAL MEDIATOR)

1OBSf: (dove hai detto dove vivi?)
(where did you say you live?)
2MEDf: (dove dicevi) [(??)]
(where did you say [(??)])
3OBSf: [non a Mo]dena?
([not in Mo]dena?)
4PATf: no
5OBSf: Savignano?
6MEDf: uhm uhm

Extract 4

1DOCf: non so se le spieghi il discorso sulla privacy?

(I don’t know whether you will explain the privacy policy?)
2MEDf: sì
(yes)
3DOCf: possiamo parlare (poi semmai) con la famiglia e col marito che [così]
(we can talk –if anything- with the family and with the husband so that)
4MEDf: [sì]
5DOCf: le chiedo anche la firma [grazie]
(I also request her signature [please])
6MEDf: [okay]
7MEDf: now what is the problem. the doctor says that
8MEDf: she will let you sign for
9MEDf: for privacy
10MEDf: that is in case of any problem they can talk with your husband (.) and maybe if your friends or your family (.) come here to look for you they will tell them that th- (.) you have said that.

In fact, the presence of the cultural mediator changes the next-turn proof procedure. Even though the doctor speaks first, there is no direct answer by the patient, who is replaced by the mediator. It might be concluded that, according to the data analyzed, the presence of the ad hoc interpreter or the cultural mediator affects some aspects of the conversation: how it is co-constructed by means of the next-turn proof procedure, the elements of design – such as overlaps – and also the presence of a different type of complicity. In extracts 1 and 2 this is directly created by the doctor and the patient. Actually, the ad hoc interpreter does not intervene, and this absence helps the co-construction of complicity. On the other hand, the complicity between the doctor and the cultural mediator seems to be more related to a sort of institutional goal, that is, giving information useful for the success of the conversation.

4.1.2 The history-taking interview and the development of the participants’ relationship through the interaction

Another interesting aspect which characterizes the interactions with an ad hoc interpreter is the interview phase during the medical encounter, when

the physician asks the patient how she is currently feeling and whether she has experienced any symptoms. This part of the medical encounter is a particularly delicate one, in that the patient has to provide private information, which could turn out to be embarrassing. Interestingly, as Extract 5 shows, in one of the ad hoc interactions, even though (or perhaps because) the patient's husband is present as an interpreting provider, the doctor decides to ask the questions in English, thus addressing the patient directly:

Extract 5
1OBSf: so
2OBSf: do you feel pain? (.) stomach pain?
3PATf: ye:s: more pain
ye:s: more pain
4OBSf: eh (.) everyday? o:r? only sometimes
5PATf: sometime
6OBS: sometimes
7OBS: today for example?
do you feel [pain?]
8PATf: [yeah]
9OBSf: yes

Even in this case, the co-construction of the conversation occurs in absence of the person who translates, similarly to the two cases analyzed in section 4.1.1. In turns 6 and 9 the midwife repeats the patient's utterances to confirm understanding and acceptance of her answers and make sure that she has properly understood what the patient wants to communicate. It is interesting to note that the midwife decides to start using English after the patient's husband asks her a question in Italian, which follows a long communicative exchange in English and, partially, in Italian, which positioned the patient as the participant with the right and competence to participate in the conversation. The same happens in another interaction where an ad hoc interpreter (the patient's husband) is present, as shown in Extract 6. It is clear that the midwife uses the little English she masters in order to avoid talking with the husband about the patient, and to communicate directly with the patient. This is a very interesting feature in the data I worked on: whenever

their knowledge of English allowed them to do so, the doctor(s) and midwife/ves tried to get directly in contact with the patient:

Extract 6

1OBSf: okay
2OBSf: non hai ancora cominciato a sentire muovere?
don't you: feel your baby move?
3PATf: uhm uhm uhm
4OBSf: okay it's possible because it's (.) early
5ADHm: so:
6OBSf: early [yes]
7ADHm: [uhm] I agree [ah:]
8OBSf: [yes] [[°yes yes°]]
9PATf: [[yeah]] (okay)
10OBSf: .h
11ADHm: io ho già de[tto a le:i]
12OBSf: [(it was sta]rt four time)
13OBSf: (which month?)
14PATf: (°come here°)
15OBSf: at five month
16OBSf: four mon- four month and a half but not every
every woman
17ADHm: u[hm?]
18OBSf: [has] the same [day?]
19ADHm: [uhm]
20OBSf: ((laughter)) [the same]
21ADHm: [uh?uh]
22PATf: uhm
23ADHm: o[kay]
24PATf: [°ye]ah°
25OBSf: sì
26OBSf: s[ì:]
27ADHm: [questo è]
28ADHm: tutto esami?
29OBSf: o:k[ay] ecco allora guardiamo i tuoi esami I take your test
30OBSf: o.k[ay]
31ADHm: [uhm]
32OBSf: ecco allora guardiamo i tuoi esami I [take]
33ADHm: [uhm]
33OBSf: your test
34ADHm: uhm uhm
35OBSf: to see
36OBSf: the appointment? for ecography i:s:? [not this?]
37ADHm: [eh: (not thi-)]
38ADHm: diciannove? septembre

39OBSf: o:ka:y?
40ADHm: villave:rdi
41OBSf: oka[y ye]s
42ADHm: [sì.]
43ADHm: villaver[di (uhm uhm)]
44PATf: [(??)] (??)
45ADHm: villaverdi oh
46OBSf: yes
47ADHm: okay

In turn 7 the ad hoc interpreter aligns with the doctor, excluding the patient from the exchange: OBS: 'early [yes]' ADHm: '[uhm] I agree [ah:]. However, in turn 29 the physician completely ignores the ad hoc interpreter's question in turn 28 'tutto esami?'. By saying: 'o:k[ay] ecco allora guardiamo i tuoi esami I take your test' not only does she overlook the ad hoc interpreter's question, thus disregarding his rightful role as an active speaker, but also translates what she means to say, in order to make sure that the patient properly understands her utterance. On the other hand, by turn 32, the ad hoc interpreter still has not translated one single turn. It is impossible to establish whether the doctor(s) or midwife/ves act in the above mentioned way because of a lack of trust in the ad hoc interpreter or because they actually want to build rapport with the patient. It also has to be considered that, when it is difficult for them to establish a direct verbal contact with the patient, they prefer to talk to the ad hoc interpreter, using the third person to refer to the patient and they do not address the patient directly. In this example the obstetrician keeps talking in (bad) English even though the husband has tried several times to switch back to Italian. The frequent overlaps between physician and ad hoc interpreter indicate a series of turn-based actions, which are meant to exclude one of the speakers: the midwife positions herself as the main speaker while positioning the ad hoc interpreter as a 'secondary speaker, i.e. a participant who is not so important for the development of the interaction, and the patient as her main interlocutor, even though in this transcript the patient has only three turns. At the same time, the ad hoc interpreter positions himself as a rightful speaker (for instance in turn 11: ADHm: 'io ho già de[tto a lei:' and in turn 38: ADHm: 'diciannove? septembre',

the patient as a 'non-participant' (as he never talks to her), and the physician as a simple source of information, rather than an active participant in the conversation, as can be noticed in turns 16 and 17: OBS: 'four mon- four month and a half but not every woman' ADHm: 'u[hm?]' . On the other hand, through her low level of participation, the patient positions herself as a minor participant.

It is possible to observe how, in these data, the more indirect and non-obvious linguistic actions performed by the participants in the interaction not only position them in a certain way, but also position the other speakers, and significantly affect the whole interaction. For example, in the above-mentioned extract, the obstetrician's 'silent' action of ignoring the ad hoc interpreter's utterance, acquires a particular significance, in that it may not show up as an immediate discernible communicative strategy, however it has the clear result to affect the interaction in general and the other participants' turns in particular, by selecting the patient, not her husband, as the main interlocutor.

4.1.3 Reassuring patients

One aspect which the interactions I am analyzing with an ad hoc interpreter and with a cultural mediator have in common are the high number of non-renditions throughout the development of the interaction. The number of non-renditions is higher in those interactions where the ad hoc interpreter is present, but they frequently occur also when a cultural mediator mediates the medical encounter. This is evident also when it is necessary to reassure the patient. However, the action of reassuring the patient occurs in two different ways in these two types of interaction, as suggested by the following two extracts.

ExtractA
1OBSf: [y]ou have a lo:w risk
2ADHm: [ah:]
3OBSf: [to have a] baby with problem
4ADHm: (lo:w)
5ADHm: ah[:]

6OBSf: [oka]y?
7ADHm: okay
8OBSf: low.
9PATf: °low°
10ADHm: low? low
11OBSf: low risk.
12ADHm: o:kay
13OBSf: do you understand?
14PATf: okay
15OBSf: okay

In this conversation, words repetition plays a fundamental role in order to let the conversation flow. It may be argued that, in fact, repetition is the key for the correct development of the adjacency pair, highlighting at the same time the preferred action turn shape. Interestingly, in turn 14 the patient understands and speaks English and the husband is not acting as an interpreter in this sequence. He is one of the parties directly involved in the diagnosis. Three words are primarily repeated by the ad hoc interpreter in this extract: 'low' (turns 4 and 10), 'okay' (turns 7 and 12) and 'ah' (turns 2 and 5). The main aim of the three is to make sure he understood the obstetrician's comment properly, even though it is possible to detect some slight differences. In turn 4, the word 'low' includes implicitly the other part of the syntagm, 'risk'. That is, repeating 'low' means making sure that there will be no high risk, thus confirming what the obstetrician said. The double repetition in turn 10 reinforces this strategy, following the 'low' uttered by the patient. It can be detected a preferred action turn shape, because all the participants have agreed on the degree of the risk, that is, the baby is healthy and has no malformations. The repetition of 'okay' has the same aim of reassurance, but in turn 7 it is a sort of self-reassurance of the ad hoc interpreter, who understands the utterance of the obstetrician. In turn 12, instead, 'okay' seems to summarize all the conversation, following a little exchange between the obstetrician and the patient (turns 8-9). The repetition of the word 'ah' might be analysed from a similar perspective. It has a strong phatic function: before being sure about reassuring his wife, the ad hoc interpreter lets the

conversation flow with less certainty than in the 'okay' case. However, his final goal is to understand properly in order to reassure himself and his wife. At the same time, the obstetrician wants to make sure that both the patient and her husband have understood the meaning of the words she had previously uttered in English, as can be observed in turns 8-11-13-15. Conversely in turn 10 the obstetrician state her diagnosis, whereas in the rest of the conversation she follows the reassuring strategy by repeating words and, in turn 13, summarizing all with a clear question 'do you understand?' followed by two positive answers. In conclusion, this extract shows that repetition may be a useful tool to the development of the adjancency pair and the preferred action turn shape.

In Extract B, something similar happens in the interaction where a cultural mediator plays the role of the interpreter. Nonetheless, many elements of the conversation, and indeed many conversational strategies, appear to be very different from extract A:

ExtractB

1DOCf: in base alla densità quindi come comincia: (??) il riscontro con la visita nel collo ute:rino si decide di mettere un gel: (.) a livello vagina:le oppure l'ossitocina a livello venoso (poi) più avanti. Però (.) eh: sicuramente bisogna dirle (.) che non è tutto scontato cioè non è che siccome lei ha partorito una volta in un attimo si sbriga. [ogni donna è diver]sa [[(??) è una storia]]
(according to the density, therefore, the acknowledgement of the visit of the ce:rvix it is decided to put a gel: (.) in the vagina, or oxytocin in the veins (then) afterwards. But (.) eh: for sure it is necessary to tell her (.) that not everything is predictable meaning it is not that because she gave bith once she will do everything in no time. [every woman is differ]rent [[(??) it is a story]])

2MEDf: [sì infatti][[sì certo]]
([yes, as a matter of fact] [[yes of course]])

3DOCf: a sé *(by itself)*

4DOCf: [quindi non si deve demora- (??) tempi di]ve:rsi dipende da come inizia il travaglio cioè non si

de:ve demoralizzare né deprimere se vede che (.) i miei colleghi le metteranno prima un gel poi di nuovo un'altra (sedazione) dopo sei otto o:re [[e valuteranno lo]]ro
([so she doesn't have to demora- (??) different tim]me:s it depends on how labor starts meaning she does't have to demoralize nor get depressed if she sees that (.) my colleagues will put a gel beforehand then another (sedation) after six eight hou:rs [[and they will jud]]ge

5MEDf: [(e poi il bambino) (??)]
[(and the baby then (??)]

6MEDf: [[(sì certo)]]
[[(yes of course)]]

7MEDf: sì
yes

8DOCf: *anche il fatto che la rivisitano e le rimettono un gel e la reinducono non vuol dire che è fallita l'induzi[one]*
also the fact that they examine her again and put a gel again and re-induce her doesn't mean that the induction fai[led]

9MEDf: [(eh)]

10DOCf: vuol dire che ci vuole un po' di te- è raro che dopo il primo gel [parte]
it means that some time is necess- it rarely happens that after the first gel she [starts]

11MEDf: [parte]
[starts]

12DOCf: e [ini]zia il travaglio o[[kay?]]:
so [lab]or starts o[[kay?]]

13MEDf: [sì]
[yes]

14MEDf: [[(sì)]]
[[(yes)]]

15MEDf: so: as I said to you before now tomorrow if you come (.) now (??) parto (??) with induction. You when you come (??) they will now put gel on it on inside your vagina to help you have strong contractions. (.) some women (.) if you give them once they don't go immediately. (??) for they will give once two three times before the: the effect to come. so if they are doing it tomorrow don't have any fear. don't be afraid that oh this is going and disturb you. no? they are only trying to help you. do you understand? If they carry it all out and it it doesn't work they they need to do it and continue the (??). after six hour (.) you'll come and give

you another one. it's painful but you have to
resist. (??) this like women always give birth. So
after (??) if it doesn't work let's (make) it work.
they will now put drip. that drip that put
injection inside. the the injection also (??) cause
induction and give you more contractions after
that you can deliver (.) okay?

16H: so they want they want (that the baby come)
tomorrow

17MEDf: yes: (1,5)

18MEDf: 'cause the risk is too high (1,4)

19MEDf: so: you understand? as you are coming t-
tomorrow prepare yourself (.) before you come (.)
prepare yourself. (that's it) (.) (arrange)
everything. bring your baby (thing suit). bring (??)
what you want. (bring them) (??). bring your
(night gown) what you need to change.
bring if you: if you want stockings one stocking.
the husband (.) keeps them for you (they bring)
(??) uhm? (??)

20PATf: okay

21MEDf e:

Before exploring the conversation, some preliminary considerations are necessary. The doctor’s turn is much longer than in extract A, and it is uttered in Italian. It is possible to see that the doctor is producing one long turn while the mediator produces two acknowledgements/reinforcements which the doctor does not perceive as interruptions. This is shown by the fact that the doctor does not stop speaking, nor does she leave the floor to the mediator This is probably due to the different role of the mediator and leads to the different doctor’s attitude: she knows she can speak for a longer time – in comparison to extract A – and in Italian. The mediator’s answer underpins this assumption: the turns 1 - 15 are all in Italian and, additionally, the amount of information given by the doctor is more than in extract A – as turns 1 and 4 demonstrate.

After these introductory reflections, it is possible to go deeper into the conversation. It may be argued that the doctor wants to reassure the patient

about what will happen on the following day with the help of the mediator. The mediator's strategy may be considered similar to the one carried out by the ad hoc interpreter of extract A. This can be inferred in the last intervention of the mediator, in which many reassuring elements appear. First of all, the turn duration: the mediator speaks much longer than the time needed for a mere translation. Secondly, and consequently, the use of precise expressions which are useful to reassure the patient. The negative imperative ('don't have any fear, don't be afraid') used as a warm suggestion to calm down the patient; the contrast between the personal deictic 'they' – which identifies the medical personnel – and 'you'. It is also to be noted how this last personal pronoun is associated with the hyperonym 'women'. The broad semantic field of this term is useful to include the patient in a wide group of people who have been in the same situation. This way, the role of the (general and unidentified) medical personnel is preserved – they are forced to apply a procedure – and, simultaneously, there is a sort of identification of the patient in a group; that is, the other women who have already given birth in similar circumstances. The last strategy is related to the use of a precise range of terms with a negative connotation ('fear', 'afraid', 'disturb', 'painful') which are always accompanied by a strong reassurance ('they are only trying to help you', 'but you have to resist. (??) this like women always give birth'). There is a double aim in all these strategies: on the one hand, to prepare the patient for the physical pain and the peculiarities of the cure; on the other, to legitimize the role of the medical personnel based on what they are going to do. This process is clearly evident also in other utterances, when the cultural mediator in turn 15 explains to the patient what will happen on the following day, when the healthcare personnel will have to induce birth: 'so: as I said to you before now tomorrow if you come (.) now (??) parto (??) with induction. You when you come (??) they will now put gel on it on inside your vagina to help you have strong contractions. (.) some women (.) if you give them once they don't go immediately. (??) for they will give once two three times before the: the effect to come. so if they are doing it tomorrow don't have any fear. don't be afraid that oh this is going and disturb you. no? they are only trying to help you. do

you understand? If they carry it all out and it it doesn't work they they need to do it and continue the (??). after six hour (.) you'll come and give you another one. it's painful but you have to resist. (??) this like women always give birth. so after (??) if it doesn't work let's (make) it work. they will now put drip. that drip that put injection inside. the the injection also (??) cause induction and give you more contractions after that you can deliver (.) okay?' This turn is full of empathic expressions on the part of the mediator. 'so if they're doing it tomorrow don't have any fear' is clearly a conversational contribution of the mediator, because it is not present in the doctor's previous turns. The mediator here is clearly aiming at reassuring the patient that she needs to stay calm and not worry about the future events. Another example is the following expression: 'don't be afraid that oh this is going and disturb you. no? they are only trying to help you. do you understand?' The mediator shows her apprehension at the thought of what could happen to both the healthcare staff and the patient on the following day from an emotional point of view. Therefore, she is trying to prevent the patient from getting frustrated with the medical personnel if she feels pain. Lastly: 'it's painful but you have to resist' clearly shows an emotional connection between the mediator and the patient, since the former empathizes with the painful and difficult delivery the latter will have to endure.

To summarize, the action of providing psychological support and reassurance to the patient by the doctor is different compared to the action undertaken by the ad hoc interpreter in Extract A. While the ad hoc interpreter comforts his wife through the repetition of a specific term, the last excerpt shows that the doctor's soothing action is performed by employing specific expressions and utterances, which the mediator did not reproduce accurately and faithfully in language and register terms, but adhered to in terms of their spirit of reassurance. It is not a fully autonomous initiative: the choice of the language is autonomous, but the reassurance was contained in the doctor's turn. Moreover, the doctor is not only explaining the procedure, but also encouraging the patient to consider it as a normal procedure and not a failure,

as shown by turn 8: 'also the fact that they examine her again and put a gel again and re-induce her does not mean that the induction fai[led].

4.1.4 The role of emotions throughout the development of the interaction

As we have previously seen, it is possible to detect a clear difference between mediation and interpreting, whereby the first term identifies an action in which the emotional sphere is much more involved than in the second. In fact, interpreters are often seen as tools that simply transfer information, according to the so-called conduit role – whose main advantage is to guarantee the neutrality of the interpreter's performance.
On the other hand, the task of the mediator is much more related to the overcoming of cultural barriers. The conduit role is not as fundamental as it is for the interpreter. This is also due to the context in which the mediator usually works: hospitals, medical or immigration centers, for example. Since the mediator normally deals with immigrants, the role of nationality is, therefore, central in her/his activity.
The task of the mediator is considered to be related to both cultural barriers and to other communicative tasks. In this last case the conduit role seems to be not as fundamental as it is for the interpreter. Since the mediator normally deals with immigrants the role of nationality is, therefore, central in his/her activity. Interestingly, Baraldi and Gavioli (2012) point out that many studies on cultural mediation present the issue of emotions either from an institutional point of view or from a perspective which focuses on the mediator's ability to deal with a particularly emotional situation. The authors remark that only a few of these studies focus on the cultural aspect related to the issue of emotions within the construction process of the interaction, concluding that, considering emotions play a fundamental role during a mediated interaction, might imply the mediators' empathic dedication, but certainly depends more on the cultural mediator's participation. (Baraldi and Gavioli: forthcoming) The interactions analyzed in this work show two different attitudes towards the expression of emotions, depending on whether the interpreting service is performed by a

cultural mediator or by an ad hoc interpreter. However, the cultural aspect discussed by Baraldi and Gavioli in relation to emotions plays a significant role in both types of interaction, in that they are strictly bound not only to personal relationships (as can be the case with a foreign patient who is helped by an ad hoc interpreter who is also her husband), but also particularly by the countries or continents the cultural mediator, the ad hoc interpreter and the foreign patient come from. This aspect can be observed in the following two extracts. In Extract 7 the doctor's effort to answer the patient's question is expressed through the use of simple terms and expressions. The mediator, who comes from the same continent where the patient was born and lived before moving to Italy, provides simple explanations to the patient's questions:

Extract 7

1PATf: I have a question °question° the meaning of
placenta previa
2OBSf: uhm?
3MEDf: [(??)]
4OBSf: allora placenta previa vuol dire che è praticamente
davanti al bambino
so placenta previa means that it is practically in
front of the baby
5OBSf: quindi e. se rimane così bisogna fare il cesareo se
invece risa:le non si fa niente (.) quando hai avuto
la me[struazione?]
so and: if it stays like this it is necessary to have a
c-section if it goes ba:ck up we do nothing (.) when
did you have your period?
6MEDf: [(you had)] (??)
7PATf: dicio:tto maggio.
May 18th
8OBSf: diciotto di ma[ggio?]
May [18th?]
9MEDf: [(you know)] placenta is supposed to be (??) is bad
now. the baby will come out first before the
placenta
will come out
10PATf: uhm uhm
11MEDf: do you understand?
12PATf: mh mh?
13MEDf: but now the placenta is in the front
14PATf: uhm [uhm uhm]
15MEDf: [maybe be]fore you give birth (.) if the placenta

goes up [then you can]
16PATf: [uhm uhm]
17MEDf: deliver like this. they will control you in ecography
18PATf: uhm uh[m?]
19MEDf: but if it remains like that in the front (.) you don't the placenta does not come up before [you give birth (before Tuesday) then there will be an operation]

In the first extract (7) the information requested by the patient is provided by the doctor in an almost business-like manner, and is rendered by the cultural mediator through the occasional use of simpler terms and expressions, such as: 'placenta is supposed to be (??) is bad now. the baby will come out first before the placenta' and 'do you understand?' The first formulation– that is, the responsive action «which make[s] confirmation by the producer of the original version relevant» (Depperman, 2011: p. 117), of the doctor's explanation is clearly a simplified version of the conveyed message, as the mediator uses the general expression 'is bad now' in order to explain the meaning of 'placenta previa'. The mediator, who comes from the same geographical area where the patient grew up, wants to make sure that the patient understands the doctor's explanation. As a matter of fact, in her following turn (turn 11), the mediator asks the patient: 'do you understand?' The mediator probably understands the patient's communicative difficulties, thus demonstrating empathy towards the patient, because most likely she has experienced them as well, and this is clearly shown in the sequence. Therefore, the cultural aspect does play a fundamental role in the structuring process of the interaction, overlapping with the emotional factor and contributing to the construction of the mediator's rendition. In fact, the culture closeness between the patient and the mediator affects not only the translational element (in that the cultural mediator might choose to add, ignore, or significantly modify the doctor's utterances, thus coordinating the medical encounter), but also the actions undertaken by the speakers which constitute the very nature of the construction of conversation.

In Extract 8, after two turns in which a sort of hesitation can be detected (2-3), the doctor starts speaking in Italian in order to answer. From this moment on, it is the husband who answers the doctor's questions, without rendering them in the patient's native language. Therefore, it may be argued that the language-switch of the obstetrician implicitly guides the development of the conversational turns. The language used by the doctor and the ad hoc interpreter is not as formal as that used when a cultural mediator is present during the medical encounter, as demonstrated by some adverbs whose function is mainly phatic ('allora', 'praticamente') and the verbs which have a broad semantic field ('fare'). Moreover, the husband asks the doctor some questions, which is his own communicative initiative, since the patient does not intervene in the conversation. This shows the undeniable co-construction of the conversation: if the first actor to change the development of the interaction is the doctor through a code-switch (induced by the patient's question), then the mediator contributes to the construction of the conversational turns:

Extract 8

1DOCf: [eh:] lei sente muovere be?ne tutti i giorni[:]
[eh:] does she feel the baby move well everyday[y?]

2ADHm: [°sì°]
[°yes°]

3DOCf: ca[lci] sì (.) ha anche dei dolori alla pancia [[op]]pure no?
ki[cks] there are (.) does she feel stomach pains as well [[o]]r not?

4ADHm: [°sì°]
[°yes°]

5ADHm: [[s]]

6ADHm: dolori sì ogni tanto: [ne accusa un po']
pains every once in a while: [she feels some]

7DOCf: [ma se cammina?] s[e si stanca?]
[but if she walks?] i[f she gets tired?]

8ADHm: [sì quando cammina] (??) accusa sempre sotto la pancia e se[nte (??)] (??) °sì sì°
[yes when she walks] (??) she feels them under the stomach and fe[els (??)] (??) °yes yes°

9DOCf [un po']
[a little bit]

10DOCf: °okay°
11DOCf: °allora° siamo aspetta che mi sono un attimo per- (.) mh eh:
°well° we are wait I got a little los- (.) mh eh:
12DOCf: okay (2) .h t-°tua moglie ha delle cose da chiedermi?°
okay (2) .h t-°your wife has something to ask me?
13ADHm: sì
yes
14DOCf: °eh°
15ADHm: eh:m (.) ogni tanto quando lei adesso (.) sta sta succedendo spesso quando lei t- to- tossisci
eh:m (.) every once in a while when she now (.) it is often happening when she c- co- coughs
16DOCf: ah ah [perde la pipì]
ah ah [she pees]
17ADHm: [perde la pipì] (°eh°)
[she pees] (°eh°)
18DOCf: ah: ((laughter)) .h que[sto]
ah: ((laughter)) .h th[is]
19PATf: [((laughter))] ((laughter)) [[mi vuoi da]]re [l'acqua?] ((laughter)) [((laughter))]
[((laughter))] ((laughter)) [[do you want to gi]]ve me the [water] ((laughter)) [((laughter))]
20ADHm: [[((laughter))]]
21DOCf: [(??2syll)]
22DOCf: [((laughter))] puoi dire puo?i dire [((laughter))] [[puoi]]
[((laughter))] can you say ca?n you say [((laughter))] [[can you]]]
23ADHm: [[uh]]
24DOCf: di[re] [[puoi di?re]]]
sa[y] [[can you sa]y]]]
25PATf: [(this is [[what happens)]]]
26ADHm: [[((laughter))]]
27PATf: it's normal [though ((laughter))]
28ADHm: [ah: it's normal?]
29PATf: it's [normal]
30DOCf: [sì]
[yes]
31ADHm: [I was ((laughter))]
32PATf: [the pressure eh: the p]ressure (is that) the baby is big
33ADHm: ah[:]
34PATf: [so the the]

35PATf: pressure is that it is sitting on top of the(.) the: the urine [bag]
36ADHm: [(there)] oka[:y]
37PATf: [eh:] so when eh hey (is like)
38ADHm: (is so) pushe[s]
39DOCf: [mh]
40PATf: pushes [[[(at all)]] (??) to push ahead (the baby.)]
41PATf: [pushes]
42ADHm: [(uhm)]
43PATf: [[(at all)]]
44DOCf: [[sì]]
[[yes]]
45DOCf: eh:m siccome la bambina è giù con la testa [a]desso [[penso eh:]]m: (.) appunto schiaccia
eh:m because the baby's head is down [n]ow [[I think eh:]]m: precisely it presses
46ADHm: [mh]
47ADHm: [(°okay°)]
48ADHm: [[(°uhm okay°)]]
49ADHm: °uhm [uhm uhm (okay uhm uhm) uh uh]
50DOCf: [con la testa verso il basso .h]
[with the head pointing downwards]
51DOCf: quando soprattutto si muove è molto facile che le donne a questo [momento di gravi]danza perdano la pipì ((coughing)) [[((coughing)) se toss]]iscono se sal[[[tano]]]
at this point of pregnancy it is [easy fo]r women to pee in their pants ((coughing)) [[((coughing)) if they co]]gh if they ju[[mp]]
52ADHm: [°uhm uhm°]
53ADHm: [[°okay°]]
54ADHm: [[[°(okay)°]]]
55ADHm: ah[:]
56DOCf: [questo]
[this]
57DOCf: non preoccupar[ti]
don't worr[y]
58PATf: [eh:]
59DOCf: eh? [don't worry poi]
eh? [don't worry then]
60ADHm: [°..h° uhm]
61DOCf: spari[sce [[((laughter))]]]
it disapp[ears] [[((laughter))]]
62PATf: [(yeah) [[((laughter))]]] [[[((laughter))]]]
63ADHm: [[((laughter))]] [[[((laughter))]]]
64DOCf: [.h] di solito s[parisce]
[.h] it usually d[isappears]

65PATf: [((laughter))]
66DOCf [[ma tu sei una ragazza giovane per cui dop]]o
[[but you are a young girl so after]]wards
[(eh eh)]
67DOCf: [[(??)]]
68ADHm: [uh uh]

The cultural aspect in sequence 8, which sees the participation of an ad hoc interpreter, develops throughout the sequence and intermingles with the emotional involvement of the speakers in a different way. First of all, the answers to the doctor's questions are not provided by the patient, but by her husband. This happens from the very beginning of the conversation: the doctor asks if the patient feels the baby move well everyday. It is interesting to notice that the doctor addresses the patient in the third person, as if she already expected the ad hoc interpreter to answer directly, without rendering the question in English. This is precisely one of the most interesting and characterizing aspect of medical interactions with a foreign patient and an ad hoc interpreter: the language used is more colloquial and less institutional than the one employed in medical interactions with a cultural mediator. However, the patient is often treated as an 'invisible' party by the other participants, while she, on her part, does not show a strong willingness to be involved in the conversation. As suggested by Extract 8, the ad hoc interpreter not only answers the doctor's questions but also takes the initiative to asks questions himself, as shown in turn 15, when he asks the doctor if it is normal for his wife not to be able to control her bladder. Interestingly, the ad hoc interpreter-husband feels the right to ask a very personal question (which is also medically relevant) regarding his wife to the doctor, and his wife 'reacts' by showing to know the answer, as it is evident in turn 27: 'it's normal [though ((laughter))]'. It is interesting to notice that, after the ad hoc interpreter has asked the question, the patient immediately mitigates the embarrassing effect produced by it by declaring that it is normal. In other words, the patient provides 'remedial work':

> Goffman (1971) in his book *Relations in Public* identifies a social activity called *remedial work*. In his definition, the function of 'remedial work' is to change the meaning that otherwise might be given to an act , transforming what could be seen as offensive into what can be seen as acceptable. (Wadensjö 1998)

Therefore, the ad hoc interpreter's question is actually answered by his wife first, and by the doctor only afterwards. After turn 27 the patient goes on explaining to her husband the dynamics of her problem and the reasons why it is showing. Therefore the patient momentarily positions the doctor as a secondary speaker, herself as the source of information, and her husband as the recipient of the message, instead of the interpreter. For their part, both the doctor and the ad hoc interpreter accept the positioning proposed by the patient: the former by not interrupting the patient's explanation and by not addressing the ad hoc interpreter, by not producing any utterance, the latter by producing utterances which simply show understanding of the patient's explanation, such as: 'ah' in turn 33, '[(there)] oka[:y]' in turn 26 and [(uhm)] in turn 42 and by never directly addressing the doctor. The doctor, on her part, starts talking and explaining what is happening to the patient only after the patient's explanation is over and the ad hoc interpreter has shown to have understood it, first by saying: '[[yes]]' in turn 44, and then continuing her explanation in turn 45: 'eh:m because the baby's head is down [n]ow [[I think eh:]]m: precisely it presses', as well as in turn 51: 'particularly when she moves at this point of pregnancy it is [easy fo]r women to pee in their pants ((coughing)) [[((coughing)) if they co]]gh if they ju[[mp]]'. It can be easily noticed that, at this point, the doctor completes her explanation by reassuring the patient about her condition, as it happens in turns 59: 'eh? [don't worry poi], 61: 'it disapp[ears[[((laughter))]]]', 64: '[.h] it usually d[isappears] and 66: '*[[but you are a young girl so after]]wards'.* It can therefore be concluded that, in this sequence, with his actions the ad hoc interpreter proves not to be able to properly coordinate the turn-taking procedure, thus acting more like a curious relative of the patient, instead of an actual interpreter. On the other

hand, the frequent overlaps suggest a more relaxed and familiar atmosphere, compared to the one which characterizes those interactions where a cultural mediator plays the role of the interpreter.

4.2 Dealing with a problem and finding a possible solution

Baraldi and Gavioli (forthcoming) highlight the fact that several analyses conducted on interactions prove that it is actually impossible to separate the interpreting action from mediation, in that the latter is part of the former. (Baraldi and Gavioli (forthcoming) As a matter of fact, the interpreter, by encouraging a cultural dialogue between the two parties, helps to bridge the gap between the different cultures involved in the interaction. A possible outcome of this form of interpreting activity could be a better mutual understanding of the other speakers' culture, as well as a real contribution to the formation and organization of multicultural societies. (Baraldi and Gavioli (forthcoming) The authors point out that one possible explanation of the combination of the interpreting action and mediation is the concept of coordination introduced by Wadensjö (1998), according to whom, the interpreter is an active participant within the communicative context who significantly affects the interaction while amending it, therefore also creating a shared communicative goal and supporting the interaction's objectives. (Baraldi and Gavioli (forthcoming) Coordination is shown in different kinds of renditions, such as, for instance, expansions, which can be produced as non-renditions, namely actions concentrated on the structure of the interactions, such as, for example: 'requests for clarification, comments, requests to comply with the conversational order, invitations to start or continue talking.' (Baraldi and Gavioli (forthcoming) Lastly, the authors remind the reader that coordination creates both interpreting and a number of cultural mediations through the utterance negotiation process during the interaction, in order to allow all participants to reach comprehension and to establish a relationship. (Baraldi and Gavioli (forthcoming) This implies that speakers, through conversation, jointly construct the interaction, and that its meaning is both

constructed and constantly negotiated. Therefore, the process of creation of meaning is collaborative and interactive, and it is based on the participants' mutual understanding of the nature of understanding. (Turner and Merrison 2016: 137) This means that the interpreting action performed by cultural mediators is characterized by a bridging process between the two cultures to which the other speakers belong. The cultural aspects, then, play a fundamental role in the creation and coordination process of conversational turns, since they represent part of the identity of the speakers, which inevitably emerges throughout the interaction. Thanks to the interpreter or the cultural mediator, cultural aspects are clearly explained and, at the same time, they intermingle and become more understandable for doctor and patient. In the following extracts it is possible to observe that, in those interactions where a cultural mediator is present, the doctor relies heavily on her in order to bridge the cultural gap and to achieve the communicative goal. Conversely, in the extract where the ad hoc interpreter translates for the patient, the doctor shows no trust in his work which pertains to the cultural aspect and to the solution of the clinical problem.

The interactions analyzed in this work present two different ways of dealing with a problem and finding the most proper solution to it, depending upon whether the interaction is mediated by a cultural mediator or an ad hoc interpreter. It is interesting to note that the focus on the problem and the process of searching and finding a solution to it are negotiated by the participants throughout the development of the interaction, as can be observed in the following sequences:

Extract 9

1DOCf: va beh allora ascolta ((tongue click))
okay so listen ((tongue click))
2DOCf: qui bisogna coinvolgere l'assisten[te sociale]
here we have to contact social [services]
3MEDf: [(la) (??) (esatt-)]
[(there) (??) (exact-)]
4DOCf: allora quindi faremo due cose una la mandiamo
di là per il ginecologo: per veder- .h quand'è che
hai avuto l'ultima mestruazio-]

so we are going to do two things the first one we send her there to the gynecologist: to se- .h when you had your last [menstruat-]

5MEDm: [your last me]nstruation (.) when was your last menstruation

6PATf: eh: that was eh: (.) .h November four

7MEDf: ((tongue click)) .h il quattro novembre
((tongue click)) .h November fourth

8DOCf: okay quindi siamo all'ini[zio]
okay so we are at the begin[ning]

9PATf: [uhm uhm]

10DOCf: allora adesso ti mandiamo di là (.) per eh: l'ostetrica per vedere un attimino per la gravidanza va be[ne?]
so now we will send you there (.) to eh: the obstetrician for the pregnancy ok[ay?]

11MEDf: [we se]nd you to the midwife

12DOCf: eh

13PATf: °okay°

14MEDf: okay?

15DOCf: poi[:]
then[:]

16MEDf: [(??)] the pregnancy

17DOCf: prendia[: mo l'a]ppuntamento con l'assistente sociale
we schedule[: an a]ppointment with social services

18PATf: [(??)]

19MEDf: and (then we'll) take appointment with the social service

20PATf: (??) °(okay)° [(okay)]

Extract 10

1DOCf: (??2syll) (.) °ah°

2DOCf: ((humming)) °qua°

3DOCf: ((humming))

4DOCf: hai qualcosa da chiedere intanto? do you want to ask (.) me (.) something?

5ADHm: ((tobetran))

6PATf: okay

7DOCf: (..h)

8PATf: eh eh eh in the nights [some]times I feel pains

9DOCf: [(uhm)]

10DOCf: here?

11PATf: eh

12DOCf: uhm

13PATf: ((tobetran))

14DOCf: when you turn [in the bed]

15PATf: [eh:]
16DOCf: ah[:]
17PATf: [when I] sleep like this
18DOCf: okay
19PATf: (eh sì)
(eh yes)
20DOCf: uh uh .h
21PATf: (i)
22DOCf: eh (.) but you? eh do you go to toilet every day
or not.
23DOCf: [la cacca]
[the poop]
24PATf: [uhm]: yeah
25DOCf: uhm
26PATf: (°I do°)
27DOCf: because sometimes
28ADHm: °eh°
29DOCf: eh is possible that: in you:r (.) intestino
eh is possible that: in you:r (.) intestine
30PATf: uhm:
31ADHm: o[kay]
32DOCf: [there is] a lot of air
33ADHm: ((tongue click)) [°(it's okay)°]
34PATf: [o:][[kay]]
35DOCf: [[and]] when there is a lot of air [eh]
36PATf: [uhm]
37DOCf: the intestino spinge su (.) [(sulla)]
the intestine pushes upwards (.) [(on the)]
38ADHm: [°okay°]
39DOCf: può [s:entire un po' dolo]re (??4syll)
she can [fe:el a little pa]in (??4syll)
40ADHm: [sentire: mh °(okay)°]
[feel: mh °(okay)°]
41PATf: ((tobetran))

In Extract 9, the goal of finding a realistic solution to the problems outlined in the interactions is expressed by both the doctor and the interpreter. The doctor clearly addresses one of the problems in turn 1 and 2: 'okay so listen ((tongue click))'; 'here we have to contact social [services]'. In turn 3 the mediator again talks to the doctor, with whom she aligns, while the patient is treated as a non-person. The doctor and the mediator talk about the patient in front of the patient using the third person pronoun. In turn 4 the doctor proposes a possible solution for each problematic situation only to the cultural mediator:

'so we are going to do two things the first one we send her there to the gynecologist: to se- .h when you had your last menstruat-]. The personal deictic 'we' addresses her intention, without involving all the participants. At this point in the conversation the cultural mediator interrupts the doctor and therefore aligns with what the doctor has just said, by immediately asking the patient when she had her last period. This whole sequence clearly shows how the cultural mediator coordinates the other speakers' actions and, at the same time, her actions are coordinated by the other speakers' moves. The patient actively collaborates to find a solution to the problematic situations, by promptly answering the doctor's questions rendered by the cultural mediator in English, as can be observed in turn 6: 'eh: that was eh: (.) .h November four'. Interestingly, in these sequences the doctor does not speak directly to the patient in English, as happens in Extract 10 where the ad hoc interpreter is present, but relies completely on the cultural mediator's linguistic help. In the second sequence it is possible to observe that, after having been ignored for several turns, the ad hoc interpreter repositions himself as a rightful participant to the conversation by uttering 'eh' in turn 28 and 'o[kay]' in turn 31. Even though the doctor never addresses him directly throughout the sequence, the ad hoc interpreter nevertheless answers as if he was playing the patient's role, thus insisting on being recognized as a rightful speaker by the doctor. Nevertheless, the patient of Extract 9 does contribute to the conversation by providing key information.

4.2.1 Finding solutions to patients' concerns

One of the problems, which can be faced during medical encounters where a pregnant patient is present is her weight. It seems to be a delicate matter, to be treated with a certain diplomacy. This is detectable in two excerpts from the corpus that has been studied; however, the strategy used to face this matter is different according to the type of mediation. In Extract 11 the patient shows little involvement in the conversations, as it happens in the other interactions analyzed in this work, more frequently where an ad hoc interpreter is present.

In extract 11, the ad hoc interpreter, tries to minimize the impact of the doctor's utterance.

Extract 11

151 DOCf è importante che tua moglie aumenti un po' meno di peso [quindi guarda]

152 ADHm [((laughter))]

153 DOCf .hh se mangia molti do:lci: [uhm: molte]

154 ADHm [eh: (??)] (.) swe[ets]

155 DOCf [mer]endi:ne [mol]ti po:cc[[i eh molte cose che non vanno]]

156 ADHm [mh mh]

157 [[((laughter)) no]]

158 DOCf bene [eh?.hh]

159 ADHm [sì sì ((laughter))]

160 DOCf può mangiare frutta [verdura]

161 ADHm [°(frutta verdura)°]

162 DOCf pesce [.h]

163 ADHm [o]kay (.) [fish fruits]

164 DOCf [non troppo riso]

165 PATf (??)

166 ADHm ah: e[cco]

167 DOCf che manger[ai molto]

168 ADHm [uhm uhm]

169 DOCf ri[so invece]

170 ADHm [eh eh]

171 DOCf immagin[o e]

172 ADHm [(??)]

173 DOCf e: e quello [non va tanto bene]

174 ADHm [(??)]

175 PATf [(??)] (??) [(??)]

176 DOCf [((tongue click))]

177 ADHm [[uh uh]]

178 DOCf [[lei gli esam]]i li ha appena [[[fatti quindi (??)]]] (??)

179 PATf [[[(??)]]]

180 ADHm   [[[sweets no (.) chocolates]]]

181 ADHm   eh eh eh:

182 PATf   ((laughter))

The role of laughter seems crucial in order to attenuate the recommendation of the doctor. It must be said that the doctor herself already uses a hedging strategy by introducing her advice with 'è importante che', thus underlining the medical importance of weight loss. By laughing, the husband adds an ironic element, which is unexpected: in fact, the doctor continues with her recommendations about avoiding sweets and eating other kinds of food (fruits, vegetables, rice). It may be inferred, then, that the sentimental proximity between the interpreter and his wife inevitably modifies the conversation, introducing a dispreferred adjacency pair. There is no translation of the doctor's turns, i.e. non-renditions are employed: on the one hand, the husband tries to minimize the matter of weight by laughing and, on the other, he just utters some brief turns ('ah: e[cco]' '[uhm uhm]') expressing his understanding and developing the phatic function of the dialogue. At the end of the conversation, he seems to share the weight issue with his wife. He just translates by summarizing (turn 180), and the wife's laughter may suggest that the weight problem is not something new in the couple.

A slight different strategy is detectable in the following excerpt, where the cultural mediator is present.

Extract 12

223 DOCf   quant'è alta la signora?
(0,6)

224 MEDf   do you know your height?

225 PATf   no
(0,7)

226 MEDf   ((laughter)) [((laughter))]

227 DOCf   [ne sai qualcosa vero]:nica?

228 MEDf   (sì adesso te lo devo dire)

229 DOCf   ((laughter)) [((laughter))]

230 MEDf   [((laughter))]

231 DOCf   .h più o meno quanto sarà alta uno e [sessantacin]que[[:]]

232 PATf   [(I don't know)]

233 MEDf   [uh]m

234 DOCf   ((throat clearing))

235 INTf   io sono uno e settantadue

236 DOCf   quindi (??) ah

237 Event   background voice(s)
(0,6)

238 DOCf   quindi:

239 MEDf   .h con i tacchi è uno:
(1,0)

240 DOCf uno e sessanto:tto [dai]

241 MEDf [sì] sì sì dai
(1,2)

242 DOCf okay

243 Event background voice(s)

244 DOCf questa è bella

245 MEDf ((laughter)) .h (.) no: nessuno guarda questo in Africa quanto è alta [quanto pesi no ne][[ssuno mai]]

246 INTf [[((laughter))]]

247 DOCf [[eh (uhm) però]] ((laughter)) .h [però è impor]tante [[per vedere se è in sovrappeso (??) (cioè)]]

248 MEDf [(??)]

249 [[sì: sì (cioè) eh]]

250 DOCf u- un peso può essere dive- in base al[l'alte:zza: può avere un]

251 MEDf [(??)]

252 DOCf significato dive:rs[[o]]

253 MEDf [[s]]ì

In this case, the doctor asks about the weight through an indirect question (turn 223), which is fully explained in turn 247. In fact, height is a means to deduce weight and, therefore, establish whether the patient is overweight. However, the laughter of the cultural mediator in turn 226 has a different connotation compared to the laughter of the previous extract. If the husband laughs to minimize the impact of the doctor's recommendations, in this case the cultural proximity is the key to understand the dialogue construction.

The mediator is fully aware of the delicacy of the issue: and also the doctor realizes this, as confirmed by the rhetoric question: '[ne sai qualcosa vero]:nica?'. This question corroborates the fact that the laughter designs the physician's reaction: she is now aware that the patient's denegation is somewhat justified. As a further confirmation, the mediator specifies that 'no: nessuno guarda questo in Africa quanto è alta [quanto pesi no ne][[ssuno mai]]'. In other words, the laughter in turn 226 is the result of a cultural sharing: the mediator knows that the negative response of the patient in turn 225 is mainly due to the fact that weight is a delicate argument in African culture. And her laughter implies this embedded knowledge, shared by the other two participants.

To conclude, it may be argued that, even starting from the same issue (weight), which produces a similar reaction (laughter), these two conversations develop differently according to the role of the interpreter. In the ad hoc case, the husband tries to lower the impact of the doctor's recommendation and simply summarizes her suggestions. The final laughter of his wife may confirm the mutual knowledge of the weight problem – an element that probably causes also the ad hoc interpreter's first reaction.

The cultural mediator's laughter, instead, stems from cultural proximity. The reason why the patient asserts she does not know her weight seems to be something related to cultural reasons: and the doctor immediately understands this. Therefore, all the conversation is held in Italian excluding the patient, in the attempt to deduce her weight starting from her height.

This leads to a final observation. If, compared to extract 11, extract 12 contains less medical information, actually all the discussion about the cultural issue aims at identifying the cause of the weight change – and, therefore, obtaining more information about the patient's health.

4.2.2 The presence of four participants

If the typical medical encounter analyzed in this work involves three participants – doctor, patient and interpreter – in the following two cases another person takes part in the interaction.

This causes a change in the structure of the conversation, which may lead to a change in the strategy of the interpreter.

Extract 13

051 DOCf la situazione è questa (.) eh:m: la signora è una presa in carico tardiva (.) .h è stata presa in [carica dal nos]tro s- dal nostro servizio il sedici gennaio a ventotto settimane .h lei aveva una visita a Napoli ma non ha: refertazione: (e così) uhm poi sarà stata molto (mh) credo (.) fatta da (Cigarini) uhm di supporto come ecografia e poi l'ha mandata .h a fare un'(eco) del terzo trimestre .h ((tongue click))

052 OBSf [(carica tardiva?)]
(0,6)

053 DOCf che era fatta a ventinove settimane allora io oggi chiaramente l'ho rivista eh:m: l'ho rivista e ho trovato un rallentamento di crescita

054 OBSf uhm uhm?

055 DOCf un rallentamento di crescita sulla circonferenza addominale le altre misure van bene: (la) lunghezza va bene (.) però di base in linea ho messo sul grafico le misure .h (.) con l'ecografia fatta a ventinove settiman[e]

056 OBSf [o]ka[y]

057 DOCf eh °ho sbagliato spetta ecco perché non mi tornava° ((tongue click)) (.) eh: (:) quindi la m- questa è: mh non c'entra perché questi sono incrociati

058 PATf °(uhm)° [(??)]

059 DOCf [°(??)°] .hh il: mh: (.) ((tongue click)) quindi la mia idea perché lei in realtà è già a trentaquattro settimane adesso hai capito?

060 OBSf uhm? uhm.

061 DOCf uhm: vorrei pe- no uhm: diciamo duecentotrentasette siamo a venticinque (.) venticinquesimo centimetro °(??)° .h

(1,0)

062 DOCf ed era già il venticinquesimo percentile anche allora perché [questo]

063 OBSf [okay]

064 DOCf eh è qua

(0,8)

065 DOCf quindi pensavo di farla tornare fra due tre settimane cioè di nonmandarla direttamente

066 OBSf   in [ospedale]

067 DOCf   [eh] ma cosa di[ci?]

068 OBSf   [ah] sì sì
(0,6)

069 DOCf   però bisogna che la mettiamo [(con chi c'è)]

070 DOCf   [possiam metterla] con la B[anf]i

071 OBSf   [eh]
(0,8)

072 DOCf   .h

In this extract, the midwife and the doctor talk about the patient's situation. There is no rendition at all by the ad hoc interpreter; we do not know the reason why, even though we may infer that there might be two causes. Firstly, the language used is very specific, with terms such as 'refertazione' 'rallentamento di crescita', 'circonferenza addominale', 'ecografia' that may be difficult to understand for him. Secondly, and consequently, the speed of talk and the next-turn proof procedure: the two interlocutors are sharing information useful for the diagnosis. This aim automatically excludes the patient, unless she or the ad hoc interpreter deliberately decide to intervene.

Something similar happens in the following extract, contained in the same conversation. Even though the structure of the excerpt is quite different, the ad hoc interpreter seems to assume a passive role and, at the same time, by not rendering what is being said to the patient, he positions her as non-existent, while the patient, on her part, decides not to intervene.

Extract 14

284 DOCf ti do (.) la (.) tua cartelli:na

285 OBSf [cartelli:na]

286 DOCf che porterai la prossima vo:lta

(1,5)

287 [uhm]

(0,9)

288 OBSf °(??)° così

(0,6)

289 l'ultimo controllo

290 ADHm quindi basta che vado lì do[po (con quello) (??)]

291 DOCf [con quello gli dai quello e] loro capiscono

292 ADHm okay

293 DOCf uhm [uhm]

294 OBSf [va] bene

295 DOCf questo pos[siamo togliere perché gli esami]

296 OBSf [questo lo possiamo togliere]

297 ADHm [[okay]]

298 DOCf [[li abbia]]mo già [visti]

299 OBSf [questo] te lo metto qui nella cartellina c'è scritto o[tto di]

300 ADHm [otto]

301 OBSf ma:rzo alle [quindici e venti okay lo metto]

302 ADHm [quindici e venti °okay (??)°]

303 OBSf lì dentro

304 ADHm va bene

305 OBSf okay?

306 ADHm °okay°

(0,6)

307 OBSf a te

(0,9)

308 ADHm graz[ie]

The husband simply confirms his understanding in two main ways: by a linguistic alignment (turn 290), or by expressing agreement, as can be seen in the repetition of the word 'okay' (turns 292, 297 302 and 306).

In fact, the ad hoc interpreter is just a receiver of instructions regarding the documents that the patient must take with her to the next medical encounter. The husband assumes this responsibility by directly addressing directly to the doctor and the obstetrician. It may be concluded that, in these two excerpts, his role is quite passive. The situation is considerably different when the cultural mediator is involved:

Extract 15

296 NURf chi è la signora che deve fare gli esami questa:? (??)

297 MEDf sì:
(1,3)

298 sì (??)

299 NURf (??)

300 MEDf (??)

301 NURf venga signora si avvicini qu[a]

302 PATf (okay)

303 MEDf come this way. bring bring that chair. (??)
(10,6)

304 so the child is coming (??) (.) there's no worry for the child. (.)
uhm? (.) do- dottoressa dopo fa °uhm uhm°

305 DOCf   sì [facciamo do]po [[(??)]]

306 MEDf   [(okay)]

307   [[ah o]]kay oka[y]

308 DOCf   [(??)] (??)

309 MEDf   ((laughter))
(3,5)

310 DOCf   allora

311 MEDf   °(come)°
(14,0)

312   I will come here tomorrow I come and see you

313 PATf   °(okay)°

314 DOCf   allora adesso facciamo gli esami

315 MEDf   sì

Also in this case there are four participants in the conversation. The nurse immediately asks a question which seems to be rhetoric. She knows who the patient is; she is just addressing the mediator using Italian as a shared language. The mediator answers: this attitude does not change in the conversation, that is, the presence of the mediator seems to be much more relevant to the context than the one of the ad hoc interpreter. Even when the patient responds to the nurse (turn 302), showing her understanding, the

mediator immediately translates the nurse's utterance, adding further information, 'bring bring that chair', and addressing the patient.

It is interesting to notice that this active role is confirmed in turn 304, when the mediator asks 'do- dottoressa dopo fa °uhm uhm°'. In this turn, she shows a sort of knowledge of what follows in the encounter, as demonstrated by the following overlaps in turns 305 and 306. In other words, in this extract the active role of the mediator is decisive to construct the conversation: she guides the next-turn proof procedure by interacting in Italian with the nurse and the physician, also adding information when she considers it to be necessary.

CONCLUSIONS

In recent years Europe has experienced an unprecedented wave of migrants who do not speak or only partially master the language of the host country. This has inevitably had an impact on the healthcare systems, which have had to provide not only medical assistance, but also an appropriate interpreting service. During the last decades in Italy there has been an unparalleled arrival of migrants coming mostly from Eastern European countries and from Northern and Central Africa. This substantial immigration flow has affected not only social and cultural structures, but also the healthcare system, which has to provide proper healthcare assistance not only to the Italian population, but also to foreign patients. These foreign patients speak little or no Italian and they are rarely able to understand the healthcare staff and to express themselves in the host country's language. Starting from the assumption that monolingualism is a dynamic system, which constantly changes, bilingualism then represents a further linguistic challenge, and it is of the utmost importance for the speakers to be able to coordinate between the two languages. This aspect plays a fundamental role in the interpreting services within the healthcare system provided to foreign immigrants in Italy. Unlike other European countries, which have a longer tradition in welcoming migrants, Italy does not have an established organization for Public Service Interpreting. The direct consequence of this situation is that cultural mediators are often employed as interpreters, and, occasionally, the patients' family members or friends do translate for the patient during the medical encounter. Even though the literature has discussed and analyzed the interpreting service provided by cultural mediators (Gavioli 2009) and by ad hoc interpreting (Meyer 2012), a comparison between the two forms of interpretations has not been, to the best of my knowledge, carried out yet. Therefore, two different forms of interpretation have been considered in this work: one provided by ad hoc interpreters, the other by cultural mediators. Because of cuts made by European governments to interpreting services over the last few years

(Gentile, 2017), ad hoc interpreting performed by family members within the Italian health care system is becoming more widespread, although cultural mediators, as distinguished from medical interpreters (Martín and Phelan, 2009), are still commonplace. The results of my research suggest that, when using ad hoc interpreters or cultural mediators, significant issues, such as privacy, emotional control, competence and efficiency, are indirectly raised during interactions. However, the only aspect interactions with an ad hoc interpreter and interactions with a cultural mediator seem to have in common is the willingness to reassure the patient. The original project included the plan of recording several interactions within the medical field, which would see, either a doctor, a foreign patient and a professional interpreter as the main protagonists, or a doctor, a foreign patient and a cultural mediator, or a doctor, a foreign patient and an ad hoc interpreter. The intention was to collect if not a rich, a considerable data set, which would allow not only a qualitative analysis, but also a quantative one. Therefore, the first year of this project was dedicated entirely to the search for medical hospitals and clinics, both private and public, which would allow the recordings of interactions. Unfortunately, this attempt has proved fruitless and unsuccessful. It was therefore decided, together with my tutor, to use the data already available in the University database, which had previously been recorded by other members of the staff and by other students. By focusing on two types of interpreting service (interpreting with a cultural mediator and interpreting service performed by an ad hoc interpreter), it was decided to focus on the ad hoc interpretations, which have not received as much attention as professional interpreting and cultural mediation by the academic community in Italy yet, and to compare them with certain interactions where a cultural mediator is present, in order to discover the differences and similarities between these two different types of services, with the ultimate goal to determine which one would be better in certain clinical settings. Even though the samples presented in this work might not be sufficient to support the following claim, they nonetheless seem to suggest that the issues which emerge in the interaction where an ad hoc interpreter is present tend to be more concerned with the patient's personal

and emotional circumstances, whereas the ones which occur in the interaction with a cultural mediator, are more related to the practical steps the patient has to take until the end of her pregnancy. Another interesting aspect which emerged during the analysis of the data was a fundamental difference between interactions where a cultural mediator plays the role of interpreter and interactions where an ad hoc interpreter is present: in those interactions with a cultural mediator all the participants orient themselves towards a recognition of the mediator as the interpreter in the interaction, whereas in the ad hoc interactions doctor and patient do not recognize the patient's husband as the interpreter at all, even though this may obviously not be the case in other interactions, since, as I have already often highlighted, for a number of unfortunate reasons, the data available to carry out this work is scant. To conclude, my findings indicate that further investigation of ad hoc interpreting and cultural mediation in the medical field is required, with the ultimate goal of improving the interpreting and medical services provided to foreign patients. It is therefore necessary to further explore interpreting practices, in order to better understand how communicative dynamics work and, consequently, really help patients in need.

TRANSCRIPTION CONVENTIONS

Phenomenon	Convention	Example
Speaker codes	OBS = obstetrician DOC = gynecologist OPE = operator INT = interpreter PAT = patient MED = cultural mediator ADH = ad hoc interpreter NUR = nurse f = female m = male	MED = for privacy
Turns	Numbering Overlaps [ ]	01. 02, 03 etc. 2DOCf: here we have to contact social [services] 3MEDf: [(lthere) (??) (exact-)]
What is being said	(.) pause that lasts less than half a second (0.5) pause that lasts half a second 1, 2, 3 pause that lasts one or more than a second .hh speaker's in-breath. The more h's, the longer the in-breath. (Hutchby and Wooffitt 2008) hh Out-breath. The more h's the longer the out-breath. (Hutchby and Wooffitt 2008) (( )) this is to indicate paralinguistic features, such as laughter (??) unclear utterance plea- word interrupted while being uttered no: colons indicate a prolonged sound ? question mark is used to indicate exclamation °eh° indicates that the	

	utterance is pronounced in a low tone of voice	

APPENDIX 1: AD HOC INTERACTIONS

CSFS3

001 DOCf però Victoria secondo me devi stare qui eh?

002 MEDf qui eh? [(va bene)]

003 DOCf [eh] sì eh [non è che]

004 MEDf [va bene]

005 DOCf eh [conversaz]ione non la fac[[cio da sola]]

006 MEDf [((laughter))]

007 [[°va bene°]]

008 DOCf .h [°quindi°.h] no stavo guardando che la signora è una presa in
carico- è arrivata un pochino tardi? (.) da noi? sì

009 MEDf [(°non ti preoccupare°)]

010 ADHm sì

011 MEDf uhm

012 DOCf ah eh eh: la prima visita l'ha fatta un [pochino tardi]

013 ADHm [sì un poco tardi] °sì°

014 DOCf °uhm uhm okay° (2) però prima eravate andati ho visto giù
all'ospedale di Napoli?

015 ADHm sì [è andato: a Napoli sì (eh)]

016 DOCf [è andato bene? (.) s]ì. (1) però non vi han[no lasciato niente vi
han]

017 ADHm [non hanno lasciato niente]

018 DOCf detto che andava tutto be[ne?]

019 ADHm [sì] sì sì andava tutto [bene]

020 DOCf [(oh)] °.h° e tua moglie fino adesso è stata bene?

021 ADHm sì [sì stata bene °sì sì°]

022 DOCf [in gravidanza?] a- all'inizio della gravidanza ha avuto nausea o

vomito?

023 ADHm no vo[mito no]

024 DOCf [nien]te

025 (4,5) spetta che guardo (ultimo) a che punto siamo per[ché non conosc]endola sto cercando di capire eh beh non manca tanto eh qua [[a momenti]]

026 ADHm [°((laughter))°]

027 [[((laughter))]]

028 DOCf partori[:sce (??2syll)]

029 ADHm [((laughter))] .h

030 PATf [uhm?] uhm

031 DOCf .h (2) °okay° sì: siamo di: trentaquatto setiimane [[fra un]]

032 ADHm [[uhm]]

033 DOCf mesetto[: (mi da]: il momento) buon[[o quindi va bene]]

034 ADHm [((laughter))]

035 [[((laughter))]] .h

036 Event typing

037 DOCf lei partorirà all'ospedale di Reggio?

038 ADHm di Reggio [sì]

039 DOCf [mh os]pedale grande?

040 ADHm °uhm°

041 DOCf °okay° (1) .h che il termine della gravidanza ve l'hanno detto è- (.) più o meno all'inizio di aprile

042 ADHm s[ì sì sì il tre]

043 DOCf il tre di aprile?

044 ADHm sì (la prima) la prima settimana (0,7)

045 PATf ..hh

046 DOCf .h quando ha fatto questa ecografia che era quella importante per
[gli or]gani così anche se fatta un pochino più avanti [[del
s]]olito però: va tutto bene

047 ADHm [uhm]

048 [[uhm]]

049 °o[kay°]

050 DOCf il bambino: sta bene [vi hanno]

051 ADHm [°mh°]

052 DOCf detto che cos'è? se è un maschio o una femmin[a? (??2syll)]

053 ADHm [sì è una] femmina

054 [s]ì è una femmina

055

056 DOCf °(non scegliete)°

057 ADHm uhm
(4,2)

058 Event typing

059 DOCf finisco di scrivere e poi andiamo a vedere

060 Event typing

061 chair noise

062 typing

063 PATf [..h]

064 DOCf [eh:] lei sente muovere be?ne tutti i giorni[:]

065 ADHm [sì]

066 DOCf ca[lci] sì (.) ha anche dei dolori alla pancia [[op]]pure no?

067 ADHm [°sì°]

068 [[s]]

069 dolori sì ogni tanto: [ne accusa un po']

070 DOCf [ma se cammina?] s[e si stanca?]

071 ADHm [sì quando cammina] (??) accusa sempre sotto la pancia e se[nte
(??)] (??) °sì sì°

072 DOCf [[un po']]

073 °okay°

074 (3,5) °allora siamo aspetta che mi sono un attimo per- (.) mh eh:
(1,5) okay (2) .h t-° tua moglie ha delle cose da chiedermi?

075 ADHm sì

076 DOCf °eh°

077 ADHm eh:m (.) ogni tanto quando lei adesso (.) sta sta succedendo spesso
quando lei t- to- tossisci

078 DOCf ah ah [perde la pipì]

079 ADHm [perde la pipì] (°eh°)

080 DOCf ah: ((laughter)) .h que[sto]

081 PATf [(laughter))] ((laughter)) [[mi vuoi da]]re [l'acqua?] ((laughter))
[((laughter))]

082 ADHm [[((laughter))]]

083 DOCf [(??2syll)]

084 [((laughter))] puoi dire puo?i dire

085 [((laughter))] [[puoi]]

086 ADHm [[uh]]

087 DOCf di[re [[puoi di?re]]]

088 PATf [(this is [[what happens)]]]

089 ADHm [[((laughter))]]

090 PATf it's normal [though ((laughter))]

091 ADHm [ah: it's normal?]

092

093 PATf it's [normal]

094 DOCf [sì]

095 ADHm [I was ((laughter))]

096 PATf [the pressure eh: the p]ressure (is that) the baby is big

097 ADHm ah[:]

098 PATf [so the the]

099 pressure is that it is sitting on top of the(.) the: the urine [bag]

100 ADHm [(there)] oka[:y]

101 PATf [eh:] so when eh hey (is like)

102 ADHm (is so) pushe[s]

103 DOCf [mh]

104 ADHm

105 PATf pushes [[[(at all)]] (??) to push ahead (the baby.)]

106 [pushes]

107 ADHm [(uhm)]

108 PATf [[(at all)]]

109 DOCf [[sì]]
(14,9)

110 eh:m siccome la bambina è giù con la testa [a]desso [[penso eh:]]m:
(.) appunto schiaccia

111 ADHm [mh]

112 [(°okay°)]

113 [[(°uhm okay°)]]

114 °uhm [uhm uhm (okay uhm uhm) uh uh]

115 DOCf [con la testa verso il basso .h]

116 quando soprattutto si muove è molto facile che le donne a questo [momento di gravi]danza perdano la pipì ((coughing)) [[((coughing)) se toss]]iscono se sal[[[tano]]]

117 ADHm [°uhm uhm°]

118 [[°okay°]]

119 [[[°(okay)°]]]

120 ah[:]

121 DOCf [questo]

122 non preoccupar[ti]

123 PATf [eh:]

124 DOCf eh? [don't worry poi]

125 ADHm

126 [°..h° uhm]

127 DOCf eh? [don't worry poi]

128 spari[sce[[((laughter))]]]

129 PATf [(yeah) [[((laughter))]]] [[[((laughter))]]]

130 ADHm [[((laughter))]] [[[((laughter))]]]

131 DOCf

132 [.h] di solito s[parisce]

133 PATf [((laughter))]

134 ADHm

135 [((laughter))]

136 DOCf [[ma tu sei una ragazza giovane per cui dop]]o [(eh eh)]

137 PATf [[(??)]]

138 ADHm [uh uh]

139 DOCf e: fai fatica a far la cacca?

140 ADHm   sì

141 DOCf   sì?

142   [uhm]

143 ADHm   [sì]

144 PATf   [[(??)]]

145 DOCf   [[.h anche]]

146   quello delle volte peggiora

147 PATf   mh

148 DOCf   la situazione della pipì [perché se lei]

149 PATf   [s:ì]

150 DOCf   deve spingere molto [non]

151 ADHm   [uhm]

152 DOCf   va bene [le posso]

153 ADHm   [mh mh]

154 DOCf   dare se fa molta fatica uno siroppo [per]

155 ADHm   [si:]

156   sì s[ì sì sì sì]

157 PATf   [(??)]

158 ADHm   (noi [non siamo])

159 DOCf   [okay]

160 ADHm   (ma[ke])

161 PATf   [(??1syll)] (??1syll)

162 ADHm   yeah yeah [ye- yeah (??2syll) for

163 PATf   [(per defecare)]

164 ADHm   constipation [yeah]

165 PATf [uhm] uhm

166 uhm (defecare:)

167 DOCf uhm ((tongue click))

168 PATf °(mh) uhm uhm°

169 DOCf mi to- bevi abbastanza acqua [però?]

170 ADHm [sì]

171 DOCf durante il giorno? [sì?]

172 ADHm [be]ve tanto [(??)]

173 DOCf °o[kay°]

174 PATf uhm uhm eh[:?]

175 ADHm [she] drinks a lot of water

176 PATf water (??3syll) right?

177 ADHm ye[ah]

178 PATf [that]'s because

179 ADHm (nothing[has got to do with this yeah])

180 PATf [(??)]
(3,1)

181 DOCf uhm ((tongue clicking)) allora gli esami vanno bene. eh?

182 ADHm °(okay)°

183 PATf °(yeah)°

184 DOCf l'unica cosa è che ha poco ferro (.) [nel sangue]

185 PATf [(??)]

186 DOCf [.h] eh:m: è una cosa molto frequente in gravidan[za pe]rchè il
bambino mangia il ferro?

187 ADHm [[°uh°]]

188 [mh]

189 [[°(okay)°]]

190 PATf °(uhm uhm)°

191 DOCf eh la mamma: rimane senza il bambino non rimane mai senza [quin]di
.h adesso eh proviamo a dare poi qualche cosa per vedere di tirare
un po' su

192 ADHm [(uh)]

193 un po' su

194 DOCf [eh pe]rché altrimenti arriva al parto che dopo è anche molto
stan[ca]

195 ADHm [(il ferro.)]

196 [uhm] [[okay]]

197 PATf [(??)] [[(??)]] (??)
(1,8)

198 DOCf (??) [(??)]

199 PATf [be]cause (??) syndrome (??) (given in the hospital) (.) (??)
syndrome (??)

200 ADHm oka:y

201 PATf (??) (1) (??)

202 ADHm oka[y]

203 PATf [(??)] (??) [(??)]

204 ADHm [o]kay

205 PATf (they told me taking them?`

206 ADHm no

207 PATf no

208 ADHm she's never taken [them]

209 PATf [uh]m
(1,6)

210 DOCf lei adesso non sta prendendo vitamine n[on sta pren][[dendo niente

no?]]

211 PATf [no]

212 ADHm [[niente nien]]te

213 PATf (??3syll)
(19,8)

214 uhm

215 ADHm ((tobetran))

216 PATf °(uhm uhm uhm)°

217 DOCf tu da quanto tempo è che sei in Italia?

218 ADHm quasi tredici anni

219 DOCf e lei invece?

220 ADHm lei invece dal duemiladodici

221 DOCf ah un pochino meno [((laughter))]

222 ADHm [((laughter))] [[((laughter))]]

223 PATf [((laughter))] [[((laughter))]] ((laughter))
(4,5)

224 DOCf .h ehm: gli esami anche: gli infettivi [vanno]

225 ADHm [sì]

226 DOCf tutti bene eh? [mh?]

227 ADHm [ah] grazie a Dio

228 DOCf uhm tutti a posto

229 ADHm ((laughter))
(2,0)

230 (we can) (??2syll)

231 PATf (I know eh)
(1,0)

232 DOCf uhm
(1,4)

233 uhm (.) va bene no l'unica cosa è proprio il discorso del [ferro]

234 ADHm [del fe]rro [okay]

235 DOCf [e basta] solo quello .h [man]gia: poca carne? (.) tua moglie?

236 ADHm [(??)]

237 uhm: (0,5) no no tanto poco

238 DOCf non [tanto poco]

239 ADHm [(non mangi:)] ogni tanto mangi mangia: (.) [mangia nor]male

240 PATf [(uhm)]

241 DOCf .h ver[dura ne mang]ia?

242 ADHm [(??)]

243 sì

244 DOCf sì?

245 ADHm °mangia anche verdura°
(1,0)

246 DOCf perché il ferro è dentro

247 ADHm uh[m]

248 DOCf è dentro sia alla c[arne] ma anche alla verdura [[quindi:]]

249 ADHm [(uhm?)]

250 [[°(uhm okay)°]]

251 DOCf può mangiare (.) un po' di [tutto eh in gravidanza]

252 ADHm [°(okay)°]

253 [°(okay)° uhm okay]

254 DOCf bisogna mangiare un po' di tutto [((laughter))]

255 ADHm [((laughter))] (got it) (??4 syll)
(0,7)

256 PATf °(okay)°

(0,6)

257 ADHm (??)

258 Event stapler noise

259 DOCf allora (.) .h ti provo la pressione ade[sso]

260 ADHm [°(oka]y)° (1) pressure

261 PATf (..hhhhh)
(6,4)

262 °(??)°

263 DOCf eh? guarda appoggia così anche se ti fa un pochino male perché
°altrimenti°
(1,0)

264 aspetta proviamo a appoggiare il braccio così perfett-
(4,6)

265 le mani i piedi si sono gonfiati?

266 ADHm no

267 DOCf no

268 ADHm n- n- non lo vedo tanto gonfiato [no]

269 DOCf [no] ma non mi sembra da vedere anche a me

270 Event pressure measuring noise

271 DOCf pressione va bene? (.) centoventi ottanta va bene (.) okay

272 Event pressure measuring noise

273 pressure measuring noise

274 DOCf saliamo sulla bilancia eh?

275 Event scales noise

276 DOCf questo è sempre un problema invece eh? mh ((laughter))

277 ADHm ((laughter))

278 Event unidentified noise

279 DOCf sei ottantaci:nque sei tutta vestita sarai un pochino meno [sarai ottanta]quattro [[però sei aum]]entata [[[eh .h uh:m]]]

280 ADHm [sì esatto]

281 [[(??)]]

282 [[[sì tanto]]]

283 [[[sì tanto]]]
(0,7)

284 DOCf .h sei aumenta[ta tanto esatto sei aumentata]

285 ADHm [((laughter))]

286 DOCf tanto

287 ADHm ((laughter)) (.) .h

288 PATf (??)

289 DOCf adesso hai più fame forse anche

290 ADHm eh eh adesso mangia anche tanto

291 DOCf uhm [infatti]

292 ADHm [(what?)]

293 PATf [(??)] (??)

294 ADHm you eat

295 PATf (no I don't know)

296 DOCf perché

297 Event typing

298 DOCf da quando siete venuti qua che era: genna[io]

299 ADHm [ge]nnaio

300 PATf (??)

301 DOCf risulterebbe aumentata di sei chili

302 PATf (??)

303 ADHm ma mia?

304 DOCf ed è: (1) troppo [((laughter))]

305 ADHm [((laughter))] six kilos (no thank you)
(0,5)

306 [from January]

307 PATf [(??)]

308 Event typing

309 ADHm [infatti (io)]

310 DOCf [(ma sì)]

311 ADHm (gli) ho detto di ogni- perché siccome che sta a casa io ho detto
[che ogni tanto (beve)]

312 DOCf [sì ma è poc]o

313 ADHm sì eh

314 DOCf eh infa[tti]

315 ADHm [sce]ndi e fai- n- fai una camminata no?

316 DOCf è quello il problema anche perché siccome lei è spesso in c[asa]

317 ADHm [in cas]a [°(okay)°]

318 DOCf [semmai] un po' mangia
(33,2)

319 vieni Elena che andiamo a vedere

320 Event stapler noise

321 ADHm (??)
(1,7)

322 PATf grazie (??)
(1,7)

323 DOCf allora intanto scopri solo la pancia

324 ADHm ((tobetran))

325 PATf (??)

(3,4)

326 (??)

327 DOCf se vuoi tuo marito può venire a vedere eh? (1) [(vedete voi)]

328 ADHm [((laughter))] (0,5) sì ((laughter)) ((laughter))
(2,0)

329 (uhm)
(4,6)

330 DOCf °okay°
(19,2)

331 sì dimmi?
(24,6)

332 Event ultrasound device noise

333 PATf (??)
(10,5)

334 Event ultrasound device noise
(10,6)

335 DOCf la testa è qua? [(??)]

336 ADHm [°(uhm uhm okay)°]

337 DOCf [appo]ggia da questa parte questa è la schiena?

338 ADHm la schiena?

339 DOCf cuore?

340 ADHm uhm
(1,0)

341 PATf °(that's it)°
(0,6)

342 ADHm that's it

343 PATf °(??)°

344 Event ultrasound device noise
(19,9)

345 DOCf si muove senti come sta dando i calci [(??2syll)]

346 ADHm [((laughter))] ((laughter))

347 DOCf muoversi si [muove]

348 ADHm [(it moves)]

349 PATf sì
(22,5)

350 Event ultrasound device noise

351 PATf (??)

352 Event ultrasound device noise

353 ADHm °mh mh°
(11,9)

354 PATf °(uhm)°

355 DOCf le gambe (son qua in alto)

356 Event ultrasound device noise
(1,0)

357 ADHm le gambe?

358 DOCf sono in al[to]

359 ADHm [ah] [[in alto]] ah okay

360 PATf [[°(in alto)°]]
(0,5)

361 °(??)°

362 ADHm °(??) (it's perfect)°

363 PATf °(??) [(??)]°

364 ADHm [(??)] (??)
(19,8)

365 Event ultrasound device noise

366 ADHm °okay°
(3,9)

367 DOCf allora la bimba è lunga ma non è (proprio) grassa [((laughter))]

368 ADHm [((laughter))] ((laughter)) .h (??2syll) .h
(1,4)

369 (1) °(in the throat) (0,5) (??) (.) (the baby) (1) (??)°

370 PATf (I see)
(19,4)

371 Event ultrasound device noise

372 PATf °(??3syll) (have you told me?)
(4,7)

373 Event ultrasound device noise

374 PATf (??4syll)
(5,1)

375 Event ultrasound device noise
(6,5)

376 ultrasound device noise ultrasound device noise
(4,6)

377 ADHm ((tongue click))

378 DOCf (niente) mh deve bere anche abbastanza acqua [eh lei mi] raccomando
[[di bere]]

379 ADHm [((tongue clicking)) °(okay)°]

380 [[°(okay)°]]

381 DOCf dell'acqua

382 ADHm °(okay)°
(3,1)

383 (??)

384 PATf (??)

385 DOCf (??3syll) una bottiglia tutti i giorn[i eh:?]

386 ADHm [°uhm uhm°] °(okay)°
(8,8)

387 ..h
(27,2)

388 DOCf allora (il bimbo è) circa due chili

389 PATf °(okay)

390 DOCf adesso

391 ADHm [((tobetran))]

392 PATf [((tobetran))] ((tobetran))
(17,0)

393 ADHm (??)
(49,1)

394 PATf °okay°
(0,7)

395 DOCf bene

396 quindi mi dicevi scusa tua moglie adesso sta prendendo: vitamine fer[ro: non sta prendendo niente]

397 ADHm [no non sta prendendo (nien-)] nulla

398 PATf (that's right)

399 DOCf adesso allora ti do qualche cosa da dare (intanto) asciugati pure

400 ADHm (??)
(8,4)

401 (??)
(4,6)

402 DOCf (??)

403 ADHm ((tobetran))

404 PATf ((tobetran))

405 ADHm ((tobetran))
(0,6)

406 ((tobetran))
(2,0)

407 ((tobetran))
(0,8)

408 PATf (..h .h)

409 ADHm ((tobetran))

410 PATf ((tobetran)) [((tobetran))] ((tobetran))

411 ADHm [((tobetran))]

412 Event background voice(s)
(4,0)

413 DOCf eh

414 ADHm °(??)°

415 PATf (??) °(okay)°

416 ADHm (??)

417 PATf .h
(3,5)

418 DOCf .hh allora questo?

419 ADHm °o[kay]°

420 DOCf [è] uno sciroppo che serve ad andare in bagno (far la cacca)

421 ADHm a (fare) [°cacca°]

422 DOCf [uh?]

423 ADHm okay

424 DOCf lei può prendere (.) tutte le sere

425 ADHm °okay°

426 DOCf un cucchiaio da minestra

427 ADHm uhm

428 DOCf uhm?

429 ADHm °(uhm)°

430 DOCf tutte le sere [eh?]

431 ADHm [utte le se]re u[no?]

432 DOCf [(no)] uno non è che (.) ti faccia andare subito in bagno

433 ADHm uhm

434 DOCf però devi prenderlo tutte le sere [hai capit]o? e bere [[dopo l'acqua]]

435 ADHm [°okay°]

436 [[dopo dopo dop]]o basta

437 DOCf (d-) lon[tano dai pasti sì]

438 ADHm [(dopo) (??) °okay°]

439 DOCf lontano n- non a stomaco pieno

440 ADHm °o[kay°]

441 DOCf [cioè] un cucchiaio al giorno quando vuole [eh? però]

442 ADHm [uhm okay]

443 DOCf lontano dai pas[ti]

444 ADHm [°lo]nta[no dai pasti okay°]

445 DOCf [uhm? .hh] questa invece è l'altra cosa che le do da prendere che si chiama ferro
(1,2)

446 ne prendi una compressa al giorno

447 ADHm (uhm) [°(okay)°]

448 DOCf [dopo man]giato [eh?]

449 ADHm [okay] °okay°

450 Event background voice(s)

451 DOCf (??)
(0,6)

452 (??)
(8,0)

453 ADHm cioè una al giorno può prendere mattino pomeriggio o la [sera (??)]

454 DOCf [stesso no ha impor]tan[za]

455 ADHm [°(okay)°]
(4,8)

456 DOCf .h ..hh
(9,1)

457 ADHm this one is for your constipation
(0,7)

458 and this one is for the ferro (.) the iron
(1,1)

459 (what is it?)

460 PATf (uhm uhm?)

461 PATf (uhm uhm?)
(17,0)

462 DOCf (uhm? mh.)
(9,9)

463 allora (.) [vi:]

464 ADHm [(..h)]hh

465 DOCf vi farò tornare prima del parto [comunque]

466 ADHm [°(okay)°] °okay°

467 DOCf eh: perché eh dobbiamo controllare come cresce la bam[bina umh?]

468ADHm [la bambina okay]

469 DOCf .h mentre come prossimi esami saranno quelli che farà: il prossimo mese che sono direttamente quelli che servono per (.) il pa[rto]

470 ADHm [il par]to [°(okay)°]

471 DOCf [(uhm) .h] adesso controllo un attimo per l'accrescimen[to]

472 ADHm [..h]

473 DOCf °aspettate°
(2,3)

474 °(ah eh) questa l'hai fatta il ventino:ve: (uhm)°
(1,1)

475 duecentotrentasette
(8,6)

476 (.h) (.h)
(14,7)

477 ((tongue click)) (.) sì anche in questa ecograf[ia]

478 ADHm [°(uhm uhm)°]

479 DOCf che avevi fatto [eh:]

480 ADHm [uhm uhm]

481 DOCf la bambina era lunga mh

482 PATf (??)

483 ADHm uhm [uhm]

484 DOCf [.h] e magra

485 ADHm ((laughter)) .h ((laughter)) .h

486 DOCf era così come l'ho trova[ta anch'io oggi]

487 ADHm [come tu adesso] uhm uhm
(4,9)

488 slim and tall
(27,9)

489 DOCf sì continua con il suo tipo di cre[scita]

490 ADHm [cresci] ta °uhm okay°
(24,2)

491 DOCf .h
(11,1)

492 .h
(0,7)

493 ehm:
(3,8)

494 ADHm °(non facciamo) (??) [(??)°]
(3,8)

495 DOCf (.hh) °okay°

(1,0)

496 OBSf °sì cinquantuno°
(2,7)

497 ADHm (.h ..hh)
(1,3)

498 Event unidentified noise
(46,2)

499 ADHm .h ..hhh

500 PATf (??)
(2,2)

501 DOCf questa ecografia (era) stata fatta il: diciotto gennaio (.) .h
(19,7)

502 ADHm .h ..h

503 DOCf (eh) chiamo un attimo l'ostetrica

504 ADHm okay
(1,8)

505 DOCf va bene?

506 PATf (??) [(??)]

507 DOCf [(??)] (??) [(??)]

508 ADHm [(??)] (??) appointment

509 ((tobetran)) [((tobetran))]

510 DOCf [.hhh allora] ..h
(1,5)

511 la situazione è questa (.) eh:m: la signora è una presa in carico
tardiva (.) .h è stata presa in [carica dal nos]tro s- dal nostro
servizio il sedici gennaio a ventotto settimane .h lei aveva fatto
una visita a Napoli ma non ha: refertazione: (e così) uhm poi sarà
stata molto (mh) credo (.) fatta da (Cigarini) uhm di supporto come
ecografia e poi l'ha mandata .h a fare un'(eco) del terzo trimestre
.h ((tongue click))

512 OBSf [(carica tardiva?)]
(0,6)

513 DOCf che era fatta a ventinove settimane allora io oggi chiaramente l'ho rivista eh:m: l'ho rivista e ho trovato un rallentamento di crescita

514 OBSf uhm uhm?

515 DOCf un rallentamento di crescita sulla circonferenza addominale le altre misure van bene: (la) lunghezza va bene (.) però di base in linea ho messo sul grafico le misure .h (.) con l'ecografia fatta a ventinove settiman[e]

516 OBSf [o]ka[y]

517 DOCf eh °ho sbagliato spetta ecco perché non mi tornava° ((tongue click)) (.) eh: (:) quindi la m- questa è: mh non c'entra perché questi sono incrociati

518 PATf °(uhm)° [(??)]

519 DOCf [°(??)°] .hh il: mh: (.) ((tongue click)) quindi la mia idea perché lei in realtà è già a trentaquattro settimane adesso hai capito?

520 OBSf uhm? uhm.

521 DOCf uhm: vorrei pe- no uhm: diciamo duecentotrentasette siamo a venticinque (.) venticinquesimo centimetro °(??)° .h
(1,0)

522 ed era già il venticinquesimo (centile) anche allora perché [questo]

523 OBSf [okay]

524 DOCf eh è qua
(0,8)

525 quindi pensavo di farla tornare fra due tre settimane cioè di non mandarla direttamente

526 OBSf in [ospedale]

527 DOCf [eh] ma cosa di[ci?]

528 OBSf [ah] sì sì
(0,6)

529 però bisogna che la mettiamo [(con chi c'è)]

530 DOCf [possiam metterla] con la B[anf]i

531 OBSf [eh]
(0,8)

532 DOCf .h

533 Event background voice(s)
(6,8)

534 DOCf ((tongue click)) (??) °non trovo nien-°
(3,9)

535 °settanta settantasette centotrentasette è perfetto°
(0,5)

536 eh[mh:]

537 OBSf [(eh) ma se lei è] trentaqua[ttro (??)]

538 DOCf [e l'altra cosa che mi chiede]vo gli esami prericovero [[semmai glieli faccia]]mo fare la prossima vol[[ta]]

539 OBSf [[glieli facciamo fare]]

540 [[[sì]]]

541 DOCf che viene?
(1,4)

542 OBSf eh[: poten][[do]]

543 DOCf [(io qui ho finito)]

544 PATf [[(alright)]]
(3,2)

545 DOCf uhm
(1,4)

546 [allora]

547 OBSf [noi] la facciamo prenotare
(1,7)

548 (??) perché adesso [mi dicono]

549 DOCf [non so]

550 OBSf che è di trentaquattro

551 DOCf lei è di trentaquattro settimane

552 OBSf (mh)

(1,4)

553 DOCf °dove sono i nostri codici? (??)° (di venti pagi[ne])

554 OBSf [lì] lì sotto alla cartellina
(2,0)

555 allora oggi: abbiamo detto che è il ven[ti:]

556 ADHm [il ven]ti

557 OBSf venti

558 ADHm sì
(0,6)

559 OBSf quindi se oggi è trentaquattro
(2,1)

560 °(okay) trentaquattro° trenta[ci:n]que

561 ADHm [(uhm uhm)]
(9,2)

562 DOCf lei deve tornare per un controllo della: biometria [e (un con)]

563 OBSf [(??) (e un] telefono forse quella che tu sta aspettando)

564 PATf (ah) sì sì sì sì
(4,4)

565 DOCf °(uhm uhm) va bene°

566 PATf (??)
(19,5)

567 °(??)°
(1,0)

568 OBSf (??)

569 PATf °(in your country)°
(15,2)

570 ADHm (I thought you can see) (??) (as the right) (??4syll)
(1,2)

571 PATf ((tobetran))

572 ADHm °(so welcome aga:in (.) slightly open (.) until) (.) was that (??)

((tobetran)) the last appointment (there) the last appointment
((tobetran))

573 PATf ri[ght]

574 ADHm [take] the appointment before (.) say that you have to ((tobetran))

575 PATf °uhm uhm°

576 ADHm ((tobetran)) [((tobetran))]

577 PATf [°(uhm)°]

578 ADHm °appointment (.) two or three weeks (.) from now ((tobetran))
appointment for (.) say that you have ((tobetran)) appointment
((tobetran))

579 PATf uhm [mh]

580 ADHm [((tobetran))] ((tobetran))
(2,8)

581 OBSf .hh allora eh: l'otto è troppo avanti vediamo (??) l'otto
(0,7)

582 DOCf facciamo?

583 OBSf allora
(2,1)

584 ventotto di giu:gno
(0,7)

585 °ventotto di gi[ugno?]

586 DOCf [(impegno)]
(0,7)

587 OBSf l'otto
(1,7)

588 di ma:rzo
(0,7)

589 sarebbe trenta[sei più qua]ttro (.) eh? (.) può andare?

590 PATf [(??)]

591 DOCf ((tongue click)) va bene

592 OBSf perfetto
(0,7)

593 allora vi do
(0,8)

594 il controll:o
(1,2)

595 ADHm (??) (quando?)

596 OBSf il controllo l'otto con martedì pomeri[ggio può andare bene?]

597 ADHm [martedì pomeriggio] sì martedì [pomeriggio]

598 OBSf [okay]

599 ADHm perfe[tto]

600 OBSf alle quindici e venti [vi do l'a]ppuntament[[o?]]

601 ADHm [e ve-]

602 [[o]]kay

603 OBSf okay?

604 ADHm e ce[rto]

605 OBSf [ci sarà un'a]ltra dottoressa che potrà fare [l'ecografia come ha fatto]

606 ADHm [(??) okay]

607 OBSf adesso la dottores[sa]

608 ADHm [oka]y
(0,7)

609 DOCf perché dobbiamo: (.) controllare soprattutto [quello allora]

610 ADHm °uh okay°

611 DOCf è importante che tua moglie aumenti un po' meno di peso [quindi guarda]

612 ADHm [((laughter))]

613 DOCf .hh se mangia molti do:lci: [uhm: molte]

614 ADHm [eh: (??)] (.) swe[ets]

615 DOCf [mer]endi:ne [mol]ti po:cc[[i eh molte cose che non vanno]]

616 ADHm [mh mh]

617 [[((laughter)) no]]

618 DOCf bene [eh?.hh]

619 ADHm [sì sì ((laughter))]

620 DOCf può mangiare frutta [verdura]

621 ADHm [°(frutta verdura)°]

622 DOCf pesce [.h]

623 ADHm [o]kay (.) [fish fruits]

624 DOCf [non troppo riso]

625 PATf (??)

626 ADHm ah: e[cco]

627 DOCf che manger[ai molto]

628 ADHm [uhm uhm]

629 DOCf ri[so invece]

630 ADHm [eh eh]

631 DOCf immagin[o e]

632 ADHm [(??)]

633 DOCf e: e quello [non va tanto bene]

634 ADHm [(??)]

635 PATf [(??)] (??) [(??)]

636 DOCf [((tongue click))]

637 ADHm [[uh uh]]

638 DOCf [[lei gli esam]]i li ha appena [[[fatti quindi (??)]]] (??)

639 PATf [[[(??)]]]

640 ADHm [[[sweets no (.) chocolates]]]

641 eh eh eh:

642 PATf ((laughter))

643 ADHm biscuit[s (sugar) (??)]

644 DOCf [non glieli]

645 faccio [fare]

646 ADHm [(??)]

647 DOCf gli es[ami?]

648 ADHm [(uhm) no] (.) because of (??) [(??)]

649 PATf [(??)]

650 OBSf °(allora) [(??) (abbiamo) già fatto fa:re]°

651 ADHm [((tobetran)) uh?]

652 OBSf °(chi lo sa)°

653 DOCf [dunque lei considera che gli esami (gli unici) (??) che ha fatto
sono dell'otto genna:io]

654 ADHm [(??)]

655 PATf [(??)]
(0,8)

656 (??)
(2,0)

657 OBSf ah (.) [(??)]

658 DOCf [perché non è che]

659 se lei mangia tanto bambina cresce di più

660 ADHm °e[cco]

661 DOCf [delle vo]lte le [mam] crescono tante

662 ADHm [uhm]

663 e la [bi]mba [[(??)]] [[[(??)]]]

664 DOCf [e]

665 [[bambine n]] [[[o]]]

666 OBSf [[[(io)]]] [rifarei sta qua]

667 DOCf [(ah ecco qua)] [[(attenta)]]

668 ADHm [((tobetran))] [[((tobetran))]]

669 [((tobetran))]

670 PATf [((tobetran))] ((tobetran))

671 ADHm ((tobetran)) [((tobetran))]

672 DOCf [sì]

673 ADHm ((tobetran)) [((tobetran))]

674 OBSf [quindi?]

675 DOCf [[dalle dal quattro]]

676 ADHm [[((tobetran))]]
(0,6)

677 ((tobetran)) [((tobetran))]

678 DOCf [poi il quattro marzo]

679 ADHm [[((tobetran))]] ((tobetran)) [((tobetran))]

680 PATf [((tobetran))]

681 OBSf che così almeno

682 DOCf °(ripete)°
(3,0)

683 allora ques[ti sono gli esam]i che servono per il parto u[[hm?]]

684 ADHm [°(??)°]

685 [[°(okay)°]]

686 DOCf che facciamo abitualmente in gravidanz[a .hh]

687 ADHm [°(okay)°]

688 DOCf sono da preno[tare]

689 ADHm [°(??)°]

690 DOCf però a differen- uhm: [a differenza]

691 ADHm [°(??)°]

692 OBSf

693 DOCf

694 PATf

695 ADHm

696 PATf

697

698 OBSf questo te lo do in in[glese eh?]

699 ADHm [((luaghter))] [[.h]]

700 DOCf [[così]] adesso andiam (??)
(0,6)

701 OBSf (??)
(3,4)

702 DOCf uhm (??) [(??)]

703 OBSf [potete an]darci anche stamattina adesso

704 ADHm [(??)]

705 DOCf [se][[nti un po']]

706 OBSf [[quando esci]] da qua se hai temp[o puoi an]dare in osped[[ale]]

707 ADHm [[uhm]] uhm

708 OBSf e (.) che così (.) ti danno l'appuntamen[to]

709 ADHm [o]ka[y]

710 OBSf perché [come ti]

711 ADHm [ma]

712 OBSf diceva la dottoressa sono da prenot[are]

713 ADHm [da preno] tare mag mag (.) che: che parte si preno[ta (questa)]

714 OBSf [(??)]

715 DOCf dove si fa: il prelievo

716 ADHm ah dove fanno il prelievo dove: [am]bula- poliambulato[[(rio allora:) (okay uhm)]]

717 DOCf [sì]

718 [[sì proprio lì]]

719 con questo foglio [che è come]

720 ADHm [uhm uhm]

721 DOCf una ricetta

722 ADHm oka[y]

723 DOCf [lo]ro ti daranno l'appuntament[[o come ho scr]]itto dopo il quattro di marzo

724 ADHm [[°(uhm uhm)°]]

725 uh

726 DOCf ((tongue click)) sono gli stessi esami praticamente che hai fatto l': che ha fatto l'altra volt[a in]

727 ADHm [uhm uhm]

728 DOCf più c'è un altro esame che si chiama tampone vaginale (che è un)a (.) specie di cotton fioc [[(eh?)]]

729 ADHm [°okay°]

730 [[o]]ka[y]

731 DOCf .h sotto che prendono quelle secrezioni bianche[:]: che: ha insomma che tutte le donne [[hanno]]

732 ADHm [uhm]

733 [[okay]]

734 DOCf okay non è doloroso [(però)]

735 ADHm [((tongue click)) però]

736 DOCf eh serve .h (.) per (.) evitare le infezioni del bambino quando na[sce]

737 ADHm [quando] nasce o[kay]

738 DOCf [uhm uhm] .hh

739 ADHm va be[ne]

740 DOCf va bene mh?

741 ADHm (ti mandiamo adesso a prende[re)]

742 DOCf esatto dovremmo: a questo punto aver messo: un pochino: in fila le co[se ((lauhter))]

743 ADHm [(??) oka]y
(1,7)

744 DOCf ti do (.) la (.) tua cartelli:na

745 OBSf [cartelli:na]

746 DOCf che porterai la prossima vo:lta
(1,5)

747 [uhm]
(0,9)

748 OBSf °(??)° così
(0,6)

749 l'ultimo controllo

750 ADHm quindi basta che vado lì do[po (con quello) (??)]

751 DOCf [con quello gli dai quello e] loro capiscono

752 ADHm okay

753 DOCf uhm [uhm]

754 OBSf [va] bene

755 DOCf   questo pos[siamo togliere perché gli esami]

756 OBSf   [questo lo possiamo togliere]

757 ADHm   [[okay]]

758 DOCf   [[li abbia]]mo già [visti]

759 OBSf   [questo] te lo metto qui nella cartellina c'è scritto o[tto di]

760 ADHm   [otto]

761 OBSf   ma:rzo alle [quindici e venti okay lo metto]

762 ADHm   [quindici e venti °okay (??)°]

763 OBSf   lì dentro

764 ADHm   va bene

765 OBSf   kay?

766 ADHm   °okay°
(0,6)

767 OBSf   a te
(0,9)

768 ADHm   graz[ie]

769 PATf   [(??)]

770 DOCf   [[bene]]

771 PATf   [[(??)]]

772 ADHm   [(??) (zie)]

773 PATf   [(??)]

774 ADHm   arr[ivederci ((laughter))] [[((laughter))]]

775 DOCf   [cia:o arrive[[derci]]]

776 OBSf   [[ciao arrive]]derci

A0020830

001 OBSf   come stai?

002   come stai?

003 PATf   °(thanks)° (1) oh: [oh]

004 OBSf   [((laughter))] brava ((laughter)) [((laughter))]

005 ADHm   [s]ì adesso[:]

006 OBSf   [.h]

007   [.h] [[.h]]

008 PATf   [[((laughter))]] ((laughter))

009 OBSf   qualche parola [(attenzione) (??3syll)]

010 ADHm   [eh sì: piano p]iano [(così)]

011 OBSf   [(sì)] sì. ci vuole: [molta pazienza]

012 ADHm   [((laughter)) .h]

013 OBSf   ma poi: piano pia[no]

014 ADHm   [pia]no piano

015   [pia]no piano (0,5) (eh) (.) hai tempo eh?
(2,8)

016 OBSf   allora. cominciamo a scrivere?

017 ADHm   mmh
(1,9)

018 OBSf   il vostro bimbo sta bene?

019 ADHm   sì:

020 PATf   .h ..hhh
(4,6)

021 OBSf   allora oggi è il giorno trenta? agosto

022   allora oggi è il giorno trenta? agosto. (.) (facciamo) i conti?

023 ADHm uhm

024 OBSf ventotto apri::le la mestrua[zione.]

025 ADHm [zione] (uh)
(1,1)

026 OBSf allora la tua gravidanza [oggi] è di

027 ADHm [mh]

028 mh uhm?: quante eh set[timana?]

029 OBSf [dicias]se:tte [settimane? p]iù? [[quattro]]

030 ADHm [settim:ana]

031 [[uhm?]]

032 OBSf giorni t[ra]

033 ADHm [uhm]

034 OBSf tre giorni è dicio[tto]

035 ADHm [ciotto] uhm [°uhm°]

036 PATf [sì]
(2,0)

037 OBSf okay
(0,7)

038 non hai ancora cominciato a sentire muovere? don't you: feel your baby move?

039 PATf [uhm uhm uhm]

040 OBSf okay it's possible because it's (.) early

041 ADHm so:

042 OBSf early [yes]

043 ADHm [uhm] I agree [ah:]

044 OBSf [yes] [[°yes yes°]]

045 PATf [[(yeah)]] (okay)

046 OBSf .h

047 ADHm io ho già de[tto a le:i.]

048 PATf [(it was sta]rt four time)
(0,7)

049 OBSf (which month?)

050 PATf °(come here)°

051 OBSf at five month (1,5) four mon- four month and half but not every woman

052 ADHm u[hm?]

053 OBSf [has] the same [day?]

054 ADHm [uhm]

055 OBSf ((laughter)) [the same]

056 ADHm [uh? uh]

057 PATf uhm

058 ADHm o[kay]

059 PATf [°ye]ah°

060 OBSf sì

061 s[ì:]

062 ADHm [questo è]

063 tutto esami?

064 OBSf o:k[ay] ecco allora guardiamo i tuoi esami I take your test

065 o:k[ay]

066 ADHm [uhm]

067 OBSf ecco allora guardiamo i tuoi esami I [take]

068 ADHm [uhm]

069 OBSf your test

070 ADHm uhm uhm

071 OBSf to see
(0,7)

072 the appointment? for ecography i:s:? [not this?]

073 ADHm [eh: (not thi-)]

074 diciannove? septembre

075 OBSf o:ka:y?

076 ADHm villave:rdi

077 OBSf oka[y ye]s

078 ADHm [sì.]

079 villaver[di (uhm uhm)]

080 PATf [(??)] (??)
(1,1)

081 ADHm villaverdi oh

082 OBSf ye[s]

083 ADHm °okay°
(1,1)

084 OBSf so
(3,8)

085 do you feel pain? (.) stomach pain?

086 PATf y:e:s more pain.

087 y:e:s more pain.

088 OBSf eh. (.) every day? o:r? only sometimes

089 PATf sometime

090 OBSf sometimes

091 today for example? do you feel [pain?]

092 PATf [yeah]

093 OBSf yes
(4,6)

094 do you work? (.) are you working?

095 ADHm [°(uhm uhm)°]

096 PATf [no.]

097 OBSf [no]

098 ADHm [no]: ((laughter)) [((laughter))]

099 OBSf [at] home?
(0,6)

100 [(at home?) eh:]

101 ADHm [at home (ah yeah)]

102 at ho- ((laugher)) me

103 OBSf [do you] work a lot at home? or not. okay
(1,0)

104 ADHm [(at home)]

105 OBSf [when you fe]el?

106 when you feel pain is that that you:? (s:tay.)

107 PATf ((tobetran)) [((tobetran))]

108 ADHm [((tobetran))]

109 ((laughter))

110 OBSf .h okay °uhm°

111 PATf okay
(2,8)

112 OBSf allora la dottoressa ha scritto: (molto) bene eh eh eh eh:m (0,5)

113 oka[:y] (0,5) diciotto ve:nti e va bene perfetto

114 ADHm [uhm]
(5,9)

115 OBSf okay

(2,1)

116 (uhm u:hm?)
(20,6)

117 did the vomit stop?
(0,8)

118 PATf ye[ah]

119 ADHm [y]es

120 OBSf or not?

121 ADHm stop

122 OBSf (eh già)

123 ADHm uhm (??)
(5,9)

124 PATf ((tobetran))

125 ADHm no:
(0,7)

126 PATf ((tobetran)) (0,5) ((tobetran))
(2,8)

127 ((tongue click)) [((tobetran))]

128 ADHm [no:]
(1,5)

129 OBSf °allora°

130 ADHm [no:]
(10,6)

131 OBSf okay
(2,9)

132 ((humming))
(2,4)

133 this test? [is]

134 ADHm [(uhm)]

135 OBSf about ci-to-me-ga-lo-vi-rus it's a (.) sickness

136 ADHm ah o:

137 OBSf it's okay

138 ADHm oh

139 OBSf °(eh)°
(6,2)

140 °okay°
(3,5)

141 ((humming)) .h (are you heard? test?) about a:hm:

142 PATf (about) ((tobetran))
(1,6)

143 ADHm is

144 OBSf (??) test about malformation of baby is okay mh mh

145 ADHm a[:h ok]ay

146 OBSf [uhm?]

147 °okay°

148 PATf °okay°

149 OBSf .h eh:

150 eehh
(0,6)

151 ADHm questa è[:]

152 OBSf [y]ou have a lo:w risk

153 ADHm ah:

154 OBSf [to have a] baby with problem.

155 ADHm [(lo:w)]

156 ah[:]

157 OBSf [oka]y?

158 ADHm okay

(1,9)

159 OBSf low.

160 PATf °low°

161 ADHm low? low.

162 OBSf low risk.
(0,7)

163 ADHm o:kay.

164 OBSf do you understand?

165 PATf okay

166 OBSf okay
(7,1)

167 abbiamo ancora molte proteine nella pipì
(0,5)

168 ADHm quando sei lo:w vorrei dire che è bene bene. bene.

169 OBSf uhm

170 ADHm uhm
(1,1)

171 PATf (??2syll)
(1,5)

172 (??2syll)
(2,2)

173 ((tobetran))

174 ADHm (that's a fashion museum)
(1,4)

175 PATf (let your father come)
(1,4)

176 (I listen)
(2,6)

177 (??)
(1,3)

178 (up here) (??)
(3,5)

179 ADHm (oh uhm)
(13,3)

180 (??2syll)

181 OBSf eh:m
(0,8)

182 vorrei sapere se tu senti bruciore quando fai la pipì (0,5) do you feel burn pain when you piss

183 PATf no:

184 OBSf no.

185 never?

186 PATf no:

187 OBSf okay
(17,2)

188 uhm?
(10,6)

189 °eh°
(3,8)

190 ADHm ((tobetran))
(16,2)

191 ecco (prendi)
(4,6)

192 (stop beat) °(??2syll)° (yeah)
(1,5)

193 uhm
(2,0)

194 (??) [(stop sto)]p okay

195 OBSf [can I see]

196 sorry mh

197 ADHm °mh°

198 OBSf ((laughter)) (.) sorry baby

199 ADHm uhm uhm (0,5) sorry sorry so?r[ry.]

200 OBSf [o]kay. (.) voglio vedere questi esami

201 ADHm ah[:]

202 OBSf [o]kay]
(2,0)

203 okay questi: (0,5) sì a giugno?
(2,5)

204 (un certo) (??2syll) perfe:tto (1) ((humming)) mh c'è sempre
cinquanta only (??)
(4,4)

205 ADHm uhm

206 OBSf °good° ((humming)) [((humming))] ((humming))

207 PATf [((tobetran))]

208 ADHm °((tobetran))°
(3,2)

209 OBSf questo si può (0,5) °(cinq-)°

210 ADHm questo: secondo mi: ricevuta (oggi)
(0,6)

211 OBSf mh
(3,1)

212 uhm
(0,7)

213 questo si può b[utta]re. [[già fatto]]

214 ADHm [sì]

215 [[(sì sì)]] sì già fa:tto.

216 OBSf solo test che [hai già fa]tto (1) okay (1) bene (0,5) controlliamo
il peso

217 ADHm [uhm]

218 sì

219 OBSf come with me
(1,6)

220 we check your weight

221 ADHm uhm weight sì eh eh ((laughter)) .h
(3,6)

222 OBSf okay (.) seventy-two
(0,7)

223 ADHm quan-

224 OBSf .h settantadue

225 ADHm ah allora: [allora (inso]mma vanno:) (.) avanti piano pia:no

226 OBSf [seventy-two]

227 eh sì [((laughter))] sì sì

228 eh sì [((laughter))]

229 ADHm [eh sì:]

230 OBSf sì sì (2) [settantadue. (.) (uno) in meno?] qua]ttro (.)siamo al
diciasse:tte [[.h]]

231 ADHm [eh sì:]

232 [o:kay settantadue uhm uhm]

233 [[°(uhm uhm)°]]

234 OBSf (0,5) sì adesso stai [cominciando ad aumentare]

235 ADHm [(uhm uhm sì cominciando)] sì (2,5) perchè prima è problema di
vo:mito. [eh:]

236 OBSf [eh s]ì
(1,1)

237 ADHm eh:? (4,5) no no no

238 OBSf però sei aumentata bene l'ultima volta eri sessantotto e adesso sei
aumentata quattro chi:l[i norm]ale

239 ADHm [quattro chili]

240 [quattro chili]

241 o[kay]

242 OBSf [sì] (.) è oka:[y]

243 ADHm [a]:lright
(2,5)

244 PATf (??)
(1,3)

245 ADHm no

246 [no no]

247 OBSf [è cambiato] (mh?) ((laughter)) (0,7)

248 questo è importa:nte

249 ADHm uhm sì [però-]

250 OBSf [anche] tu ti senti più fo:rte? do you feel you: (.) yourself better?(.) [than bef]ore?

251 PATf [yeah] (0,5) ah yes
(4,9)

252 OBSf °o:ka:y.°
(1,6)

253 ci ricolleghiamo qua (.) (ecco) si è perso il collegame:nto
(1,6)

254 ((humming))
(2,4)

255 ((humming))
(24,0)

256 ADHm °(piano dai)° (1) piano no no

257 OBSf °(ecco:)°

258 PATf °(scusa)°

259 ADHm °(o:kay)°
(2,1)

260 OBSf °(oka:y)° allora (2) I write your

261 ADHm uh[:m]

262 OBSf [da]te

263 [da]te

264 ADHm o?kay

265 OBSf .h ((humming))

266 ADHm ventinove?
(0,8)

267 OBSf °(okay)°
(1,5)

268 PATf °(stop it)°

269 ADHm °okay.° (0,7) vento:tto
(8,1)

270 OBSf °mh° .h (0,5) °uhm°
(4,4)

271 ADHm no:
(8,1)

272 no:
(1,6)

273 no:
(1,7)

274 no:
(9,5)

275 no:
(3,9)

276 no:
(16,4)

277 OBSf .h ((throat clearing))
(3,6)

278 ADHm no (0,5) °(no)°
(3,3)

279 OBSf .h allora ho bisogno di chiedere una cosa (.) quando hai raccolto la
pipì per far l'esame ti sei lavata prima? (1) when you did your
test- urine test (.) the last urine test. did you wash before- (.)
eh: catch the piss? or [not]?

280 PATf [mh mh] (.) [[(uhm)]]

281 ADHm [[yeah]] yeah [yeah (yeah uhm)]

282 [[yeah]] yeah [yeah]

283 OBSf [sì?]

284 ADHm ye[ah °(okay)°]

285 OBSf [okay] °(uhm)°
(6,9)

286 ADHm no:
(1,0)

287 no:
(0,9)

288 no:
(1,2)

289 OBSf okay (.) I check your blood pressure.

290 ADHm uhm uhm
(1,2)

291 no:

292 PATf (??) (??) (.) f:a

293 ADHm (dai dai) (??) [((laughter))]

294 (fa- father)

295 fa- father

296 OBSf i bambini si stancano ad aspetta:re

297 ADHm uhm (1,5) vuoi provare (anche i tre?)
(0,9)

298 no:? aspe-
(2,2)

299 OBSf I realize your case the last time the docto::r?

300 (I realize your case)

301 ADHm okay

302 OBSf .h the last time the docto:r? [e]:mh ga:ve you only this test. (.) that you did.

303 ADHm [uh]

304 ye[ah yeah yeah only]

305 ye[ah yeah yeah only]

306 OBSf [yes? (.) okay.]

307 ADHm (??)
(26,4)

308 OBSf (no tato) ((laughter)) [((laughter))]

309 ADHm [((laughter))] ((laughter))

310 OBSf .h please baby [don't touch hear because I]: don't hear very well. [[okay?]]

311 ADHm [°(??)° okay]

312 [[uhm uhm]]
(0,9)

313 OBSf wait a moment

314 ADHm mh
(18,1)

315 OBSf okay
(1,3)

316 it's okay
(0,8)

317 ADHm uhm uhm
(5,3)

318 it's oka?y (.) [°(??)°]

319 OBSf [.h okay] (.) if you feel pain stomach pain I have to visit you (.) to:

320 ADHm   ye[ah]

321 OBSf   check if [the ne] ck of the womb is closed (0,5) okay?

322 ADHm   [the baby]
(1,1)

323 PATf   (go)

324 OBSf   °(??)°

325 PATf   (??)
(1,4)

326 ADHm   (basta dai)
(4,2)

327   (..h)
(6,1)

328   (ah ah)

329 OBSf   mh [mh]

330 ADHm   [o]kay

331 OBSf   good

332 ADHm   lascia al dotto:r

333 OBSf   okay ((laughter)) [((laughter))]

334 ADHm   [((laughter))] (0,5) okay? (0,5) (??)
(4,2)

335   (muh:)
(2,2)

336   aspett[a]

337 OBSf   [eh:] (.) no per favore (.) mh? (0,5) allora.

338 ADHm   (??) (.) [uhm uhm]

339 OBSf   [uhm uhm] (0,5) okay (.) sit down and put your (.) legs
(1,2)

340   oh [bene]

341 ADHm [uhm uhm uhm]
(0,8)

342 OBSf (??) (1) [o?:kay]

343 ADHm uhm (.) (eh eh)

344 OBSf try to relax

345 PATf yeah

346 OBSf and open your vagina (.) umh?

347 ADHm u[hm uhm]

348 OBSf [are you rea]dy?

349 PATf (°??°)

350 OBSf okay.
(7,1)

351 ADHm (??)

352 OBSf uhm

353 ADHm (??)

354 OBSf I will select the room if it's okay.
(3,0)

355 do you feel? (.) where do you feel pain.

356 PATf (??) (yeah here) (.) (uhm uhm)

357 OBSf .h only in the evening or- or also in the morning?
(2,7)

358 PATf sometimes I'm in pain °sometimes I'm-°

359 OBSf uhm
(1,6)

360 I want to: (.) feel the (.) heart rate of the baby

361 PATf (uhm yeah)
(0,6)

362 ADHm uh[m]

363 OBSf [wa]it a moment please

364 ADHm uhm uhm
(4,0)

365 uhm uhm
(54,2)

366 OBSf this is the heart rate of the baby.

367 PATf okay. (1,3) okay. (.)

368 ADHm (??)
(1,0)

369 OBSf it's (.) quick.
(3,3)

370 okay.
(1,6)

371 °yes°
(1,8)

372 PATf °(uhm? uhm.)°

373 OBSf allo[ra]

374 ADHm [eh] (f) (0,5) [°(eh)°]

375 OBSf [°(uhm)°] (here your paper)
(1,6)

376 PATf °(??2syll) is ok°
(2,3)

377 ADHm I think everything is okay

378 OBSf yes ye[s]

379 ADHm [u]h okay.

380 OBSf at the moment? yes. [(??3syll)] (??) (0,5) sì

381 ADHm [(uh)]

382 PATf (we are doing that?)

383 ADHm [alright]

384 PATf [(??)]

385 OBSf it is okay
(1,0)

386 ADHm uhm uhm o?kay?
(1,5)

387 OBSf the neck of the womb? is closed

388 ADHm uh? okay

389 OBSf the baby? is o[kay]

390 ADHm [it's oka]y uhm uhm

391 OBSf the baby move? and (.) we he[ar (.) the heart rate]

392 ADHm [(??) it's okay] okay ((laughter))
(1,5)

393 °(okay)° (??) is oka[y? o]kay? (2,5) (okay?) (1,5) so?rry

394 PATf [((laughter))]

395 (??)
(15,5)

396 ((laughter))

397 ADHm so?rry? (1) sorry? (2) sorry? (2,5) okay. °sì sì sì° sì sì (2) (??)
(1) (??) (1,5) (??)
(7,3)

398 PATf °(??)°

399 ADHm [come come] come? (.) ((laughter))

400 OBSf [I write]

401 I write the visit (.) .h [.h] (.) °ah°

402 ADHm [°come°]

403 are you ready (ready) again

404 PATf (I don't know)
(4,4)

405 ADHm come? uhm uhm [uhm uhm uhm] (1,5) uhm? uhm.

406 PATf [(??)]
(2,7)

407 OBSf ((humming))
(1,0)

408 ADHm all[ora c]uore di: bim

409 OBSf [(??)]

410 sì

411 ADHm sono: [okay]

412 OBSf [sì sì] tutto okay

413 ADHm °(it's okay)° (4,5) no [no no °no°]

414 PATf [(??)] (it's not that)
(1,7)

415 ADHm (c'è un bagno là)

416 OBSf .h vorrei sapere una cosa (??)

417 ADHm uhm uhm

418 OBSf in questo momento proprio at this moment (.) now (.) you are feeling pain? or not.
(1,0)

419 PATf it's small [it's-]

420 OBSf [s]mall? now?
(0,6)

421 PATf it's like eh: (1) mestruating

422 OBSf uh[m (.) mh (.) o]kay .h ah: (1) you- do you go to toilet every day?

423 PATf [today is- it feels like-]
(0,6)

424 (okay)

425 OBSf uhm uhm

426 ADHm every day (0,5) no: not e[very]

427 OBSf [((laughter))]

428 ADHm nah

429 OBSf no?

430 ADHm not every day

431 PATf [(??)]

432 OBSf [how many days? don't you go.]
(2,5)

433 ADHm [uhm]

434 OBSf [how] many days don't you go to toilet
(0,6)

435 PATf oh: (0,5) mh.

436 ADHm maybe [you go (one twice)] uh: (it might)

437 PATf [that's (a) once a week]

438 OBSf once a week? maybe

439 PATf mo:re?

440 OBSf ah[:]

441 PATf [I] go (but) one day just-

442 OBSf ah[:]

443 PATf [a] day [(??)]

444 OBSf [okay okay]

445 PATf (??)

446 OBSf I understand il contrario ((laughter)) [((laughter))]

447 ADHm [eh sì eh]

448 OBSf okay (0,5) (??)
(7,6)

449 ADHm (??)
(3,0)

450 PATf (??)

451 ADHm uhm uhm

452 PATf (??)
(0,7)

453 OBSf .h

454 PATf (??) [(??)]

455 OBSf eh: I want to know if there is som- something. (0,5) eh: (0,5)
((tongue click)) qualcosa ci sono delle cose che ti fanno venire più
dolore? (1) is there something who grow up your pain? or not.
(1,5)

456 ADHm ((tobetran)) [((tobetran))]

457 PATf [((tobetran))]

458 ADHm ((tobetran))

459 OBSf no (0,5) oka[y]

460 ADHm [n]o perchè lei non lavoro non[: non fac]cio in tem°po a [[fare le
cose° (??]]

461 OBSf [non fate le cose?] (0,5) [[.h è un d]]olore che tu senti dopo che
fai l'amore?
(1,0)

462 ADHm ah[:]

463 OBSf [it's a] pain that you feel after making love? (.) or not.

464 PATf no no [no]

465 OBSf [no] (0,5) okay (0,5) .h try to rest (.) uh:m in (.) in the days
when the pain is: (.) is in try to rest more (.) [uhm?]

466 ADHm [mh.] (eh)

467 PATf °(uhm uhm)°
(2,5)

468 OBSf .h (.) ah:m (.) don't you feel more pain when you pi?ss for example.
(0,5) no (0,5) okay
(4,9)

469 (??)

(4,4)

470 ADHm no:

471 OBSf ((laughter))

472 ADHm (??2syll) (2) °(??)° (2) °o?kay.°
(8,7)

473 OBSf °okay°

474 ADHm °okay°
(2,4)

475 OBSf °uhm°
(19,3)

476 ((tongue click)) ahm (.) I want to know another thing [.h]

477 ADHm [uhm]

478 OBSf (.) ah:m (0,5) ((toungue click)) (0,5) you breast f:eed your baby?
(.) .h (.) [ah for some]

479 PATf [(??)]

480 OBSf weeks? [(or if)]

481 PATf [(no)]

482 OBSf .h eh why? (.) do you know? (.) why don't you: can (.) can you to[:]

483 PATf [no] (??)

484 OBSf uhm uhm
(2,4)

485 ADHm that's is why.
(1,3)

486 OBSf it was not [enough f]or you .h or did you feel pain at your [[no
ni]]pple

487 ADHm [not eno- uhm uhm]

488 PATf [[no]] °(no)° [no]

489 [[no:]]

490 (oka[y)]

491 OBSf   [uhm?] no (2,5) °oka:y° (1,5) so .h
(0,7)

492 ADHm   uhm
(1,3)

493 OBSf   hai: (.) hai tanti new test [to do]

494 ADHm   [uhm] (1) okay.
(0,9)

495 OBSf   do you have [som]ething to ask me?

496 PATf   [(??)]
(1,5)

497   [((tobetran))]

498 ADHm   [((tobetran))] ((tobetran))

499 PATf   uhm?
(1,1)

500 ADHm   (??) (question here)

501 PATf   (blood press)
(1,5)

502 ADHm   ((tobetran))

503 PATf   (no? I'm not saying that I didn't blood.)
(0,8)

504 OBSf   blood test? (0,7) .h ah:m yes one is (.) blood because you are toxo:
te:st negative and every .h th- thirty forty (.) days we have to
repeat this test
(0,9)

505 ADHm   uh[m]

506 OBSf   [to] be s[[ure that the s]]ickness doesn't come during this
pregnancy (.) okay?

507 ADHm   [[(make sure that)]]

508 PATf   (uhm)

509 ADHm   uhm uhm

510 OBSf do you understand?

511 ADHm o?kay
(1,2)

512 OBSf do you understand (me)?

513 do you understand (that)?

514 PATf (no)
(1,0)

515 OBSf no? ((laughter)) (.) .h my English is not ver[y:]

516 PATf [oh?] okay.

517 ADHm [(no?)]

518 OBSf ((laughter)) (2) .h dobbi[amo ri-]

519 ADHm [sem]pre sempre lì (0,5) [((laughter))]

520 OBSf [dobbiamo ripet]ere (.) uhm: beh potete .h[:]

521 ADHm [uh]m

522 OBSf è scomodo per voi andare lì?

523 ADHm sì sì è comodo lì (.) [°s- sì°]

524 OBSf [va bene?]

525 ADHm sì va b[ene]

526 OBSf [okay]
(4,5)

527 PATf °(??)°

528 OBSf °(ventotto:) quattro ..h° (.) °sette° allora questi li hai fatti (.)
il (.) sette di agosto possiamo (fare dopo) il diciassette di
settembre

529 ADHm diciassette?

530 OBSf dopo (.) adesso guardiamo che giorno è [diciassette]

531 ADHm [perchè:] (.) diciannove c'ha appuntamento di ecograf[ia]

532 OBSf [o]kay

533 ADHm dopo (.) perchè bisogna portare tutto: insieme per vedere

534 OBSf sì

535 ADHm allora mi fai prima: di
(0,8)

536 OBSf gli esami per me basta che li facciate [dopo il di]ciassette ma
adesso vi do l'appuntamento [[eh aspetta un at]]timo che

537 ADHm [uhm]

538 [[(uhm uhm)]]

539 PATf [[(??)]] (??)
(0,5)

540 OBSf °uhm: toxo°
(2,0)

541 PATf (??) (0,7) (??)
(10,7)

542 OBSf °okay°
(13,4)

543 ADHm ma (.) ma (.) m- ma questo noi c'è precedenza o: bisogna (.) fare il
turno (.) perché[:]

544 OBSf [n]on c'è ancora [precedenza]

545 ADHm [non c'è pre]cede[n]

546 OBSf [ho] paura di no mh (2,5) .h potete andare a pieve (.) al ce[ntro
prelievi di pieve]

547 ADHm [sì pieve sì] sì pie[ve (là)]

548 OBSf [là] (.) si: aspetta un po' meno che in ospedale (.) ospedale tre
ore là un'ora e [mezza]

549 ADHm [no da]i va bene tranquill[o di più di Santa Maria]

550 OBSf [((laughter)) .h] tu puoi chiedere (.) tu dici lei è incinta (.) un
po' comincia a vedersi la pancia ma (.) s- c'è sempre precedenza
quando: le donne sono negli ultimi due mesi there is always eh:m
precedenza when the wom[en .h]

551 ADHm [(perf-) ah:]

552 OBSf are (the) seven month of pregnancy (:)

553 ADHm ah[: ho capito]

554 OBSf mh? but you can (.) as[k can try to ask?]

555 [uhm? but you] can: as[k]

556 ADHm [(??)] (??) [(??)] ehm: eccetera ci penserò (??) no eccetera accidenti ma però: no no no no- non è un problema se non c'è [[precedenza no]]

557 OBSf [can try to ask]

558 [[voi chiedetel]]o

559 ADHm [ah]

560 OBSf [quando anda]te a fare esami voi chiede[te]

561 ADHm [uh uh]

562 OBSf se potete passare perché lei è incinta tu lo- tu parli un po' italiano?

563 ADHm sì [uhm]

564 OBSf [glielo] chiedi [all'infermiera (.) okay?]

565 ADHm [ah (.) uhm mh mh]
(1,1)

566 OBSf vediamo

567 ADHm °sì sì°
(1,4)

568 OBSf allora uhm: ..h

569 ADHm giorni?

570 OBSf adesso (0,5) °te li dico°
(0,7)

571 PATf (tell please) (0,5) I want to ask in Africa in Ghana when you are pregnant

572 OBSf uhm

573 PATf they give us (.) eh: (medicine)
(0,7)

574 OBSf uhm:

575 PATf when you visit the hospital every Monday [(??)]

576 OBSf [umh umh umh] .h [but]

577 PATf [(but)] (the eh[:)]

578 OBSf [.h] now it's not necessary

579 PATf uhm

580 OBSf .h the last eh: next time when you: when we (.) see the next test we
decide if you need m- of medicine or not [okay?]

581 PATf [°okay o]kay°
(6,8)

582 ADHm (??)
(8,9)

583 OBSf ((humming))
(12,4)

584 ..hh

585 ADHm (??)
(2,9)

586 OBSf uhm siamo arrabbiati

587 ADHm uhm uhm

588 OBSf allora possiamo fare ventisette septembe twenty-seven of September
the next visit here

589 ADHm ah[:]

590 OBSf [.h] (.) eh (.) l'orario.
(0,5)

591 ADHm orario: mh mattina c'è: posto di mattin[a?]

592 OBSf [n]o ..hh mattina [no]

593 ADHm [p]omerig[gio?]

594 OBSf   [.h] pomeriggio? comincio alle due e un quarto

595 ADHm   allor[a sì]

596 OBSf   [se per] tu se per voi va bene possiamo fare alle due e un quart[o]

597 ADHm   [s]ì due e un quarto.

598 OBSf   cercavo però la mia agenda prima di darvi degli appuntamenti

599 ADHm   sì eh

600 OBSf   allora vorrei essere sicura di darvelo senza doverlo spostare per telefono

601 ADHm   o?kay
(1,3)

602 OBSf   ventisette [dai] ventisette settembre due e un quarto oppure alle sei?

603 ventisette [dai]

604 ADHm   [uhm uhm]
(0,6)

605 OBSf   ventisette settembre due e un quarto oppure alle sei? [o alle tre o alle quattro (.) due e un quarto ok]

606 ADHm   [no due due due] e un quarto [sì due e un quart]o sì

607 OBSf   [due e un quarto okay]
(7,6)

608 ((humming))
(3,2)

609 ADHm   °perché la sera qualche volta io non ci sono: andato al lavoro allora è meglio che°

610 OBSf   (ah: sì?)

611 ADHm   °fai il pomeriggio così mh?°

612 OBSf   va bene. (.) mh
(2,0)

613 PATf   (??)
(1,0)

614 OBSf cosa c'è?
(3,6)

615 ADHm ((tobetran))
(0,5)

616 PATf ((tobetran))

617 OBSf c'è [qualcosa che n]on va dimmi

618 ADHm [ah:]

619 no ma eh quello lì eh (.) è data di (.) prelievo eh
(1,1)

620 OBSf sì [uhm uhm]

621 ADHm [il gior]no è quando?
(0,7)

622 OBSf allora
(0,6)

623 ADHm diciasse- quest[o è di settembre one]

624 OBSf [l'appuntamento the appointment is] twenty-seven.

625 ADHm uhm [uhm]

626 OBSf [so] .h il prelievo lo potete fare dopo il diciassette quando
[volete]

627 ADHm [ah quello lì] dipende da me?

628 OBSf sì [.h]

629 ADHm [ah]: ah non [c'è]

630 OBSf [tu] eh il sabato mattina lavori?

631 ADHm sab- eh: dipende:

632 OBSf ah [non sai?]

633 ADHm [qualche volt]a io comincia: mattina qualche volta [comincia]

634 OBSf [ho capito]

635 ADHm pomeriggio allora: (mh) sì

636 OBSf allora l'appuntamento [sarà il vent]isette settembre alle due e un quarto del pomeriggio qua

637 ADHm [già prossima]

638 uh uh [due e un quarto okay.]

639 OBSf [okay .h] gli esami (.) dopo il diciassette settembre puoi andare quando vuoi

640 ma non il sabato perché il sabato ci vuole l'appuntamento

641 ADHm ah .h eh b- dopo di diciasset[te]?

642 OBSf [do]po di diciassette

643 ADHm ah: [diciotto]

644 OBSf [okay]

645 ADHm di[ciannove v- ah]

646 OBSf [sì quando vuoi]

647 ADHm okay

648 OBSf sì

649 sì

650 ADHm va bene
(1,7)

651 okay okay
(1,5)

652 OBSf ma non on [Sat- (.) on Saturday]

653 ADHm [non (.) sì on Sat]urday [o?kay uhm uhm (sì) o]kay

654 OBSf [perché ci vuole l'appuntamento il sabato]
(0,7)

655 allora (.) sangue e pipì sempre

656 ADHm ah okay
(1,5)

657 OBSf questi sono gli esami da fare
(0,7)

658 ADHm uhm
(0,9)

659 mh

660 OBSf anche stavolta also (.) next time when you piss here before (.) piss you wash your[self]

661 ADHm [ah]

662 PATf okay

663 OBSf (out) [uhm:? .h]

664 ADHm [before you piss]

665 OBSf eh: clean?

666 PATf okay.

667 OBSf and then the first piss via go out (.) [to:]

668 ADHm [go:?]

669 OBSf the[: water (cl]ose) (0,5) eh: in the next piss you put [[inside]]

670 ADHm [ye okay]

671 [[yeah]]

672 OBSf

673 PATf ok[ay]

674 OBSf [d]on't touch inside the box [okay?]

675 PATf [yeah] okay

676 ADHm [yeah]

677 [yeah]
(0,7)

678 o?kay
(0,6)

679 PATf (well)
(8,6)

680 (what's this?)
(2,3)

681 okay (??) °okay°
(14,0)

682 OBSf per le: vitamine aspettiamo perchè i tuoi esami vanno bene adesso non ce n'è bisogno (.) okay?

683 PATf okay
(0,6)

684 OBSf for medicine? we (.) wait.

685 ADHm uhm

686 OBSf next control (1,5) okay (9,5) °(uhm uhm)° (0,5) °(okay)°

687 ADHm (uhm)
(10,1)

688 OBSf ((humming)) (1) avete qualcos'altro da chiedere?
(0,7)

689 ADHm ((tobetran)) [((tobetran))]

690 PATf [oh]:

691 ADHm (??) (questions) (??) (we can:)

692 PATf (??)

693 OBSf mh?

694 PATf ((tongue click)) ah: ah I drink (.) (??) (.) (??)

695 OBSf month? what is. (.) is

696 ADHm sono vita: vitaminerali eh (.) sono: (.) eh:m come si chiamo (.) come come come: come ciucculato

697 OBSf come cioccolato?

698 ADHm sì [come (??)]

699 OBSf [e come si chiam-] molt proprio si [chiama?]

700 ADHm [vit]amod sì vitamod (1) [vita]

701 OBSf [dove lo] trovi al supermerc[ato?]

702 ADHm [trovi] supermercato sì
(0,6)

703 OBSf mh

704 ADHm (??) c'è un: [c'è ta]nti di là sì

705 OBSf [okay]

706 eh: (.) e stai meglio a:

707 PATf °(okay)°

708 OBSf a mangiare questo?
(0,8)

709 ADHm ((tobetran))

710 PATf ye:ah it's okay (but I don't trust) (??) (1) (??) because if when
(??) you can feel a lot of blood
(0,8)

711 OBSf a lot of?
(0,6)

712 PATf blood (.) san?gue

713 ADHm sangue sangue

714 OBSf non ho capito allora when you take mot?

715 PATf eh: [(??)]

716 ADHm [lei sta (??) healthy (??)]

717 quando bevi quello è mo?rt[o]

718 OBSf [do] you feel be?t[ter]

719 ADHm [f]eel better

720 OBSf .h eh: I don't know? (.) eh: (.) what (.) is inside (the mod)

721 PATf [there is]

722 ADHm [there is a]:

723 PATf °(eh: uhm)°

724 ADHm uhm inside there come me- mais come ma[is che loro fanno]

725 OBSf [ok try] to read (.) .h eh[:]

726 PATf [(??)]

727 OBSf because if it's possible to eat for a pregnant woman is okay but if
it's better (or not) to: drink eh is written (.) eh: over (.) the[:
the box][[:]]

728 PATf [no (??)] [[(??)]] [[[(??)]]]

729 ADHm [[(??]] [[[(??)]]]

730 OBSf ok, non c'è scritto [niente che non va]

731 ADHm [vita- vi]ta[mod]

732 PATf [(yeah)]

733 ADHm me me me me mi dai biro per s[(crive così tu)]

734 OBSf [sì okay] perfetto

735 ADHm per c[on-]

736 OBSf [s]crivimelo qua dietro così (0,5) io contro[llo si i]nternet

737 ADHm [uhm uhm]
(0,6)

738 PATf yes?
(3,5)

739 (??)
(0,7)

740 ADHm °vitamod (vita)° (1) °mod mod°

741 OBSf adesso controlliamo
(3,1)

742 ADHm così (0,5) si chiamo così vitamod
(0,6)

743 PATf (??)

744 OBSf ok proviamo a guardare allor[a]

745 ADHm [u]hm:

746 OBSf uhm?

747 ADHm ok così vediamo [che]

748 OBSf [sì] esatto

749 ADHm °uhm°
(2,0)

750 OBSf cosa c'è[:]

751 ADHm [(??)]

752 OBSf vuoi un foglio? per disegnare?

753 ADHm sì for-
(3,1)

754 OBSf pre?ndi (.) baby.
(0,9)

755 ADHm tieni
(1,0)

756 English (Italian American)

757 OBSf allora vita (.) molt?

758 [allora vita?]

759 ADHm (Italia) (??)

760 OBSf mol[t?]

761 ADHm [(??)] °(niente)°
(1,5)

762 meno male (Italian) [(??)] English (??) italiano (??)

763 PATf [((laughter))]
(3,2)

764 OBSf vitama:lt

765 ADHm sì ehm eh: va bene per: donna incinta

766 [ecco] è qu[esta sì]

767 OBSf [è questa?]

768 PATf [yeah]

769 ADHm [[ecco]]

770 OBSf [[((laughter))]] ((laughter))

771 ADHm °(eh)° (.) ((laughter))

772 OBSf uhm: mh .h

773 ADHm perchè computer c'è tutto eh (.) c'[è tu?tto.]

774 OBSf [okay] proviamo a guard- sì infatti c'è [tutto]

775 ADHm [uhm uhm]

776 OBSf °hai ragione°
(1,4)

777 °(vitamalt)° adesso guardiamo se me lo apre

778 ADHm uhm
(3,6)

779 OBSf questo è un sito di vendita?
(13,5)

780 ((humming))
(4,1)

781 there is not alcohol (.) [inside oka:y]

782 ADHm [no no no non alcoholic] non alcoholic
(1,2)

783 senza alcohol

784 OBSf °okay°
(5,2)

785 okay

786 ADHm uh[m]

787 OBSf [.h] ahm ..h there ares eh (.) a lot of: (.) [commer]cial site

788 ADHm [uhm]

789 [uhm] commer- ah ((laughter)) [(??)]

790   commer- ah eh ((laughter)) [((laughter))] .h

791 OBSf   [°((laughter))°]

792   .h [so eh]:m?

793 ADHm   [(??)]
(2,0)

794 OBSf   I take eh: (.) a little [time to see.]

795 ADHm   [a little time] to see [okay.]

796 OBSf   [if there] is a problem I phone to you [I will phone]

797 ADHm   [okay ah okay okay okay]

798   [okay]

799 OBSf   to [you okay but I]

800 ADHm   [(ah) okay okay (no prob-)]

801 OBSf   think there is [no problem okay?]

802 ADHm   [no (there's no- (??) yeah)] only suga:r a:n[:d]

803 OBSf   [yes] eh: a lot of sugar is not very good for you ok[ay? remember]

804 PATf   [no: it doesn't] contain (a lot-)

805 OBSf   o?k[ay]

806 ADHm   [uh]m
(0,9)

807 OBSf   so
(1,8)

808   eh: after seventeen of[: eh:]

809 ADHm   [uhm]

810   [uhm]

811 OBSf   September y- you will go to do: blood [test and urine test]

812 ADHm   [(??) °(okay)°] (eh)

813 OBSf the nineteenth the ecogr[aphy to Villaverde .h]

814 ADHm [(??) uhm uhm]

815 OBSf and the s- uh tw[enty-seventh?]

816 ADHm [twenty-seventh]

817 OBSf in the [afternoon here]

818 ADHm [afternoon here]

819 OBSf to see all (.) u[hm mh]

820 ADHm [okay]

821 PATf okay

822 ADHm que[sto? (.) sì]

823 OBSf [dì?] (.) sì] (.) qua sotto?
(0,6)

824 ah: ah ah ah ah [c'è anche una]

825 ADHm [°(okay)°]

826 OBSf macchina lì [((laughter))]

827 PATf [(uhm uhm)]

828 OBSf .hhh allora okay (.) here there is a question for a problem before
you can [(phone to)]

829 ADHm [(call)]

830 OBSf me okay?

831 PATf okay

832 ADHm that-? that you know t- eh: oggi (io ha chiamato) questo nu?mero.

833 OBSf eh

834 ADHm (eh eh) eh:m:

835 OBSf sì [hai parlato] con me?

836 sì [hai parlato]

837 ADHm [(a posto)]

838 OBSf con me

839 ADHm ah sì?

840 OBSf sì ma io là non avevo: l'agenda e il calendario

841 ADHm ah: perché io ha chiamato questo [nume]ro

842 OBSf [sì]

843 hai chiamato:

844 ADHm m[a uh uh]

845 OBSf [sì dopo] mia collega mi ha passa[to questo]

846 ADHm [tu- ah:] ah [okay]

847 OBSf [sì]

848 ADHm °(if you say so)°

849 OBSf io ero qua
(0,6)

850 ADHm ah: ah

851 OBSf mh
(0,6)

852 PATf mh

853 ADHm okay
(1,7)

854 OBSf (vanno) bene quei numeri lì?

855 ADHm ma ma c'è sempre eh: qui oh: (.) qualche volta perchè se c'è se: ehm
noi bisogno qualcosa così io chiamo a questo numero ma s- tutti i
giorni fino venerdì

856 OBSf no io non ci sono mai martedì mattin[a]

857 ADHm [(na)] ah [okay]

858 OBSf [mai]

859 ADHm mar[tedì]

860 OBSf [.h] gli altri giorni sono o qui o in via Monte San M[ichele]

861 ADHm [(ichele)]

862 OBSf a quei due numeri lì però [i nume]ri sono quel[[li]]

863 ADHm [ah:]

864 [ah] ah:

865 OBSf quindi se hai bisogno tu [chiama lì: e dopo lì] trovi qualcuno che mi passa se non sono lì okay?

866 okay? quindi se hai bisogno tu [chiama lì:]

867 ADHm (no:)

868 PATf (??) [(??)]

869 OBSf [e dop] o lì trovi qualcuno che mi passa [se non sono lì okay?]

870 ADHm [(that's good uh uh o]kay)

871 PATf o?kay
(1,2)

872 ADHm ma n- noi no[n abbiamo]

873 OBSf [tell me]

874 ADHm lasciato qualcosa [qui? °(yeah okay) (??)°]

875 OBSf [no no questo è il mio]

876 ADHm è il mio

877 OBSf eh[: sì]

878 ADHm [ah (o-)] (.) a [posto (al-)]

879 OBSf [no direi] di no che è [tutto lì]

880 ADHm [uhm]

881 OBSf sì
(1,3)

882 PATf (anything?)

883 ADHm (yeah) (??)

884 OBSf è: [qua dentro]

885 ADHm [ah (??)] (??) [no questo (che è?)]

886 OBSf [..h sì uhm la] tes[sera è importante sì hai ragione ((laughter)) .h]

887 ADHm [perché è importante ((laughter))] .h (.) [(??)]

888 OBSf no no è lì è lì

889 ADHm o:kay
(1,2)

890 allora a posto?

891 OBSf a posto sì [((laughter))] ((laughter))

892 PATf [((laughter))]

893 ADHm ventisette ci vediamo venti[sette?]

894 OBSf [(okay)]

895 PATf (uhm uhm uhm)

896 OBSf va b[ene]

897 ADHm [grazie]: [(Christine)]

898 OBSf [h. niente [[ciao:]] ciao:]

899 ADHm [okay [[niente cia]]o]

900 PATf [[(ciao)]]

901 ((laughter))

902 ADHm ciao (Chris[tine)]

903 OBSf [ciao]
(0,5)

904 ADHm ecco apri capo apri
(0,6)

905 PATf [(??)]
(0,7)

906 ADHm   apri:

907 PATf   ((laughter)) (??) [°(ciao)°]

908 ADHm   [cia:o]

909 OBSf   ciao:

910 ADHm   say ciao no no say ciao dop-
(0,9)

911 PATf   ciao

912 ADHm   cia[:o]

913 OBSf   [ciao piccolo (??)] ((laughter)) but

914   [cia:]o pi[ccolo cia:o ((laughter))] ((laughter))

915 ADHm   [ciao piccolo]

916   ciao (Ch[ristine)]

917 OBSf   [ciao]:

918 ADHm   okay ciao
(1,0)

919   [(??)]

920 OBSf   [(allora eh)] uhm uhm:
(2,3)

921 PATf   (ah ah)

A0030830

0001 DOCf allora? come stai.
(1,0)

0002 PATf b[ene]

0003 DOCf [how] are you [((laughter))]

0004 PATf [I'm fine]

0005 DOCf .h (??) [(??)]

0006 PATf [(??) ye]s
(0,6)

0007 DOCf allora oggi è il trenta?
(1,4)

0008 di agosto

0009 ADHm uhm uhm
(0,7)

0010 DOCf can I (give)? [okay.]

0011 ADHm [(yeah)]

0012 PATf °(okay)°
(5,1)

0013 Event unidentified noise

0014 DOCf ..h

0015 Event unidentified noise

0016 DOCf do you feel move your baby? or not.

0017 Event background voice(s)

0018 PATf yes the nights

0019 DOCf yeah t[he night?]

0020 yeah t[he night? ah:]

0021 PATf [°(yeah yeah)°]

0022 DOCf yes becau[se you a]re more quiet

0023 ADHm [(uhm)]

0024 PATf uh[:m:]

0025 DOCf [you rest and you] can feel tha[t]

0026 PATf [a]h:

0027 DOCf when you walk when you do your things it's more difficult to[: to
feel] the baby.

0028 ADHm [(??)]

0029 PATf [(??)]
(3,4)

0030 DOCf now because the bab[y is (??)]

0031 PATf [(??)] when the baby is moving

0032 DOCf ye[s]

0033 PATf [(do you)] feel feel pains right?

0034 DOCf .h no[:]

0035 PATf [cause] yesterday night I fee?:

0036 DOCf pain?

0037 PATf eh: as- it was just walki[:ng and (?]?)

0038 DOCf [ah ah °ah°]

0039 and do you feel [pain pa]in? [[(or a little)]]

0040 PATf eh:

0041 [[not only pain]] eh[:.h (??) it's moving]

0042 DOCf [or something (that's strange)]

0043 PATf (beca[use) [(??)]

0044 DOCf ah: okay yes yes .h but (.) eh do you feel also pain?

0045 PATf no no no [not only]

0046 DOCf [okay]

0047 PATf pain

0048 DOCf mh (.) .h yes because the baby eh: gro:w (.) [up]

0049 PATf [(yeah)]

0050 DOCf and then you feel better [to e]at ((laughter))

0051 PATf °(okay)°

0052 DOCf .h som- sometimes when (.) ((tongue click)) you will be: uh in
pregnancy of eight month

0053 PATf u[hm]

0054 DOCf [nine] month

0055 PATf uhm

0056 DOCf maybe i:s possible to feel so a little pain because the baby is
[(??) ((laughter)) [[((laughter))]]]

0057 ADHm [(??) oka[[y]]]

0058 PATf [[o]][ka:y]

0059 DOCf [now is] the baby is: (??) [(??)]

0060 ADHm [(??)] [(??)]

0061 PATf [(yeah)] ((laughter))

0062 DOCf allora oggi siamo a diciannove più due tre (.) quattro
(1,2)

0063 l'ecografia l'hai già fatta?

0064 ADHm sì là

0065 DOCf ah ecco quando è fatto?

0066 ADHm ieri

0067 DOCf ah: bene.

0068 ADHm uhm
(1,2)

0069 Event unidentified noise
(1,9)

0070 DOCf and what the doctor (.) say- did say [to you?]

0071 ADHm ha d[etto:]

0072 DOCf [to you]
(0,6)

0073 ADHm ha detto tutto be- [tutto bene]

0074 DOCf [tutto bene?]

0075 ADHm ah. anche ha detto: (mh uhm) dal peso un po': però normale però un po': un po' più

0076 DOCf ..h

0077 ADHm °(uhm uhm)°
(0,6)

0078 DOCf voi avete capito [quello che vi ha de]tto: doctor? [[did]]

0079 ADHm [uhm uhm]

0080 [[°sì°]]

0081 DOCf you understand what the doctor said to [you yes]terday yes?

0082 PATf [(stand?)]

0083 yeah

0084 DOCf ah? okay.
(1,5)

0085 okay yes it's all

0086 ADHm °(okay)°

0087 Event unidentified noise

0088 ADHm [(??)]

0089 DOCf [eh] (.) la terra ferma tutto [noi diciamo]

0090 ADHm [((laughter))]

0091 DOCf in Italia

0092 ADHm ((laughter))

0093 DOCf the earth stop? (.) all (the) things

0094 Event unidentified noise

0095 DOCf allora (.) mettiamo i: le misure su questo grafico

0096 ADHm uhm uhm?

0097 DOCf diciannove più due quarantaci:nque mh. mh. mh. °e uno qua°
(0,9)

0098 (cc) sedici die:ci?
(2,9)

0099 okay
(1,9)

0100 (ca a tredici e no:ve)
(2,1)

0101 oka:y
(0,7)

0102 Event unidentified noise

0103 DOCf (??) trentaquattro
(3,6)

0104 (no) it's long

0105 PATf uhm [mh]

0106 DOCf don't you are (??)

0107 PATf [((laughter))]

0108 ADHm [((laughter))]

0109 PATf (yes she's ready)

0110 DOCf ((laughter))

0111 ADHm anche lei ha detto così

0112 DOCf [((laughter)) sì]

0113 PATf [((laughter))] mh
(0,5)

0114 DOCf va bene [il resto]

0115 ADHm uhm uhm

0116 DOCf tutto okay

0117 ADHm ((tongue click)) °okay°

0118 DOCf the head the s[tomach it's]

0119 ADHm [uhm uhm]

0120 DOCf all okay

0121 ADHm °mh mh°

0122 DOCf mh mh

0123 PATf (really? fine)

0124 DOCf mh mh very important. .h do you have: test to see me or [not
°(okay)°]

0125 ADHm [no no]

0126 PATf no no

0127 ADHm last time we said no test for now

0128 PATf eh[:]

0129 DOCf [o:]ka[y]

0130 ADHm [u]hm uhm
(1,7)

0131 DOCf (??)

0132 Event unidentified noise

0133 DOCf .h

0134 PATf (uhm)

0135 DOCf eh (.) we check your weight [controlli]amo il tuo peso [[vieni]]

0136 PATf [okay]

0137 [[va bene co]]sì [((laughter))] ((laughter)) (.) .h eh

0138 DOCf [mh mh?]

0139 ADHm [(??)]

0140 Event unidentified noise
(1,1)

0141 DOCf uhm uhm

0142 ADHm ha mangiato troppo

0143 DOCf mangiato troppo?

0144 ADHm °(man[gio) (??)°]

0145 DOCf [((laughter))]
(0,6)

0146 Event unidentified noise

0147 DOCf sessantanove

0148 Event background voice(s)

0149 DOCf (parecchio)

0150 ADHm sixty-nine?

0151 DOCf six[ty-nine]

0152 PATf [yeah I wa]s (??)

0153 ADHm uh [uh]

0154 DOCf .h

0155 PATf that's too much yeah (.) [((laughter))] ((laughter))

0156 ADHm [(??)]

0157 Event background voice(s)

0158 DOCf anche il marito? [((laughter))]

0159 PATf [((laughter))] ((laughter))

0160 DOCf .h

0161 PATf uhm uhm

0162 Event unidentified noise

0163 mouse click

0164 PATf uhm:
(2,2)

0165 Event mouse click
(3,0)

0166 mouse click
(1,6)

0167 DOCf contento o no.

0168 Event unidentified noise

0169 unidentified noise

0170 mouse click
(0,6)

0171 ADHm uh?

0172 DOCf ((tongue click)) contento oppure no adesso pens[o]

0173 ADHm [e]h io [gliel'ho detto sei stata (assente)?]

0174 DOCf [((laughter))] .h

0175 PATf (??)

0176 Event mouse click

0177 ADHm (sette se:tte)

0178 PATf (otto sette s-)

0179 ADHm (??)

0180 Event unidentified noise

0181 typing

0182 PATf o:kay

0183 Event typing

0184 ADHm bene ..h

0185 Event unidentified noise
(0,6)

0186 ADHm (respiro) va bene
(0,7)

0187 Event typing

0188 DOCf ..h
(0,8)

0189 ADHm (??) [(??)]

0190 PATf [(??)]

0191 (??)

0192 Event typing

0193 ADHm ((tobetran))

0194 Event typing

0195 PATf eh

0196 ADHm mh

0197 Event typing

0198 typing
(1,2)

0199 typing

0200 PATf (today is) (??)

0201 Event typing
(0,7)

0202 background voice(s)

0203 typing
(1,3)

0204 DOCf ma in gravidanza è normale [during the]

0205 ADHm [uhm uhm]

0206 DOCf preg- the [pregnancy i]s (.) quite no?rmal

0207 ADHm [uhm uhm]

0208 Event typing

0209 PATf uhm uhm

0210 DOCf okay sessantanove .h allora son più ci:nque e siamo a cinque
me:si: bah
(0,8)

0211 °okay°
(1,0)

0212 it's good
(3,4)

0213 ADHm uhm

0214 Event paper noise

0215 DOCf it's good
(2,0)

0216 okay bene .h we check your blood pressure?
(0,5)

0217 ADHm lei lei ha detto non ha ancora cinque mesi

0218 DOCf manca ancora eh: quattro giorni

0219 ADHm sì sì ha [detto però:]

0220 DOCf [(??) un po']

0221 [un po']

0222 ADHm eh:

0223 Event unidentified noise
(0,8)

0224 unidentified noise
(1,6)

0225 unidentified noise

0226 DOCf °okay°

0227 Event pressure measuring noise

0228 pressure measuring noise

0229 DOCf ((tongue click)) °relax°

0230 PATf mh
(0,6)

0231 Event unidentified noise
(8,7)

0232 pressure measuring noise

0233 DOCf okay

0234 va bene

0235 cento? massima e cinquantacinque la minima.

0236 ADHm uhm

0237 DOCf one-hundred the maximum and fifty-five the mi[nimum]

0238 ADHm [uhm uhm]

0239 DOCf it's okay

0240 PATf °okay°

0241 DOCf very good (.) .h
(1,7)

0242 °okay°

0243 Event unidentified noise
(1,2)

0244 printing noise

0245 ADHm .h so how many hour do you work a day.

0246 DOCf uhm?

0247 ADHm .h how many hour do you work a day.
(0,7)

0248 DOCf how many ho[ur?]

0249 ADHm [ho]urs do you work a day.

0250 DOCf (you?) I don't [(understand)]

0251 PATf [((laughter))] [((laughter))]

0252 ADHm [quante ore] lavorate: lavor[(??)] [[(??)]]

0253 DOCf [ah:]

0254 PATf [[(??)]]

0255 DOCf we work .h

0256 PATf [mh] mh mh [mh]

0257 DOCf [ah]: depend- it depends. some days six hours?

0258 ADHm °okay°

0259 DOCf other days eh: nine hours ((laughter)) ten ho[urs]

0260 PATf [(??)]
(0,6)

0261 DOCf (depend)
(2,0)

0262 oka:y
(0,9)

0263 today I begin: at half past eight

0264 ADHm uhm [uhm]

0265 DOCf [and I] stop (and sit) for fo?rty minutes

0266 ADHm °o:kay°
(0,9)

0267 DOCf ((tongue click)) okay
(0,6)

0268 .h when did you feel when (do) begin to feel the baby move?
(1,0)

0269 how many days [(??)]

0270 PATf [°I] don't [know°]

0271 DOCf [do you unders]tand?

0272 PATf don't know [(no)]

0273 DOCf [no?] ..hh
(5,3)

0274 °okay°

0275 Event unidentified noise
(2,8)

0276 DOCf bene

0277 .hh qui ..h here the heart rate of the baby
(1,2)

0278 come
(3,4)

0279 PATf ..h
(2,7)

0280 DOCf have you: (.) see blood from (??) vagin[a?]

0281 PATf [uhm] (no okay)

0282 DOCf °(come)°

0283 Event unidentified noise

0284 DOCf the doctor say to you if
(0,5)

0285 there is a: (.) male or a female?

0286 PATf she said it's a female.

0287 DOCf ah:

0288 PATf ((laughter)) .h

0289 DOCf (uhm uhm uhm)

0290 ADHm mh

0291 Event unidentified noise

0292 DOCf (??)
(3,5)

0293 PATf (..h)
(2,2)

0294 ADHm dopo lei mi può tornare a casa solo che c'ha i soldi (.) .h sennò?

0295 PATf ((laughter)) [((laughter))]

0296 ADHm [((laughter)) oh] no ((laughter)) (??) ((laughter))

0297 DOCf [chis]sà?

0298 ADHm eh[:]

0299 DOCf [nes]suno lo può sapere

0300 ADHm eh ((laughter)) lo so (??)

0301 DOCf ((laughter))

0302 ADHm ((laughter))

0303 Event ultrasound device noise

0304 DOCf chissà come sarà la sua vita

0305 ADHm (eh) così.
(2,8)

0306 (solo sp- solo spero.)

0307 DOCf mh?

0308 Event ultrasound device noise

0309 ADHm .h

0310 DOCf bè prima è importante anche che stia be?n[e]

0311 ADHm [s]ì sì sì sì

0312 Event ultrasound device noise

0313 DOCf spetta perché non ci sto

0314 Event unidentified noise

0315 DOCf okay relax your stomach? (.) okay

(0,9)

0316 so

0317 Event ultrasound device noise

0318 ADHm (perché) qua c'è (.) testa

0319 DOCf uhm uhm?

0320 ADHm qua:
(1,0)

0321 qua (.) c'è: gambe

0322 Event ultrasound device noise

0323 DOCf adesso (lei) è molto piccolo e si sposta s- in continuazione .h
the baby is very (.) [li]ttle [[and]]

0324 ADHm [°sì°]

0325 [[°(ah okay)°]]

0326 DOCf he move itse[lf (??)]

0327 ADHm [okay (it moves) okay ((laughter))]
(0,8)

0328 it is (??)

0329 DOCf sì [(sì)]

0330 ADHm [(ah)] sì?

0331 DOCf °uhm uhm?°

0332 Event ultrasound device noise

0333 DOCf beh ma guarda (.) sta così (??)

0334 Event ultrasound device noise

0335 DOCf allora
(0,7)

0336 (??) (they come)

0337 Event background voice(s)
(1,4)

0338 DOCf (devo) sentirlo qua

0339 Event ultrasound device noise

0340 DOCf (??)

0341 ADHm °(uhm uhm)°

0342 DOCf quando si muove si fa più fatica a senti:re?

0343 PATf (.h °((laughter))°)

0344 DOCf questi sono [i movimenti]

0345 ADHm [(??)] (eh it's what I told you)

0346 PATf [ah]

0347 DOCf (era da tanto) si muove (.) è più difficile sentirla °qui°

0348 ADHm uhm

0349 Event unidentified noise

0350 DOCf (you are very good thank)

0351 PATf (??)

0352 Event ultrasound device noise

0353 DOCf qua

0354 ADHm °okay°

0355 PATf °o?ka:y.°

0356 DOCf °this is the (.) heart of the baby°

0357 PATf ((laughter)) [((laughter))]

0358 DOCf [((laughter))] ((laughter))

0359 °(..h)°

0360 okay

0361 PATf uhm [uhm]

0362 DOCf °(okay)°

(1,2)

0363 °tieni ancora carta°

0364 Event unidentified noise
(1,2)

0365 DOCf °tieni thank you°

0366 Event unidentified noise

0367 DOCf ((humming))

0368 Event unidentified noise

0369 DOCf °allora°

0370 Event typing

0371 DOCf guardiamo se c'è già: apposto per appuntamento di altra ecografia

0372 ADHm uhm uhm (.) °(eh eh)° lei ha fatta
(1,1)

0373 DOCf ha già fatto?

0374 ADHm non lo so però (ha detto fai- vuole fai) vedere te:: (3) sss
[(??)] qua

0375 DOCf [(non ha)]

0376 Event unidentified noise

0377 DOCf fine ottobre

0378 ADHm °(okay)°
(0,6)

0379 DOCf alla ventottesima

0380 ADHm °ah okay° ventiotto?

0381 DOCf ventotto sì (.) allora adesso aspetta che vediamo eh (.) guardiamo
se c'è posto [(già che)]

0382 ADHm [uhm uhm]
(1,7)

0383 DOCf oh
(0,7)

0384 °uhm°
(0,6)

0385 ADHm (??)

0386 DOCf no quella è penultima dopo ce n'è un'al[tra]

0387 ADHm [ah] sì?

0388 DOCf mh?

0389 Event typing

0390 DOCf .h però non c'è mh: va tutto bene quindi: non so perché ve la fa fare secondo me- (.) per maggiore scrupolo forse

0391 ADHm uhm uh[m]

0392 DOCf [no]n ve la fa fare perché c'è un problema

0393 ADHm uhm mh

0394 DOCf è un controllo
(1,7)

0395 ADHm poi vuole fare [un] altro?
(1,1)

0396 DOCf quella: di fine ottobre è un'ecografia in più
(0,7)

0397 ADHm ah::

0398 DOCf normalmente noi facciamo tre ecografie

0399 ADHm s[ì]

0400 DOCf [al] terzo al quinto e all'ottavo (.) usually we do three ecography

0401 ADHm uhm uhm?

0402 DOCf ah (.) at the month number thre[e number] five number eigh[t]

0403 ADHm [mh mh?]

0404 [e]ight

0405 DOCf mh? .h eh this is the e:cography number seven [month] of pregnancy

0406 ADHm [uhm]

0407 ye[ah]

0408 DOCf [o]kay?
(0,5)

0409 but eh. there is n- no problem mh? it's only for a control
(1,1)

0410 PATf (??) the next one.

0411 DOCf nex[t one] eh at the end of October yes

0412 ADHm [uhm]

0413 [(allora)]

0414 DOCf [I want to] see if there is a place

0415 ADHm o?kay

0416 DOCf .h quindi la fate ma non c'è un problema è un controllo che ha
deciso di fare la dottoressa

0417 ADHm okay
(1,0)

0418 DOCf è chiaro oppure no

0419 ADHm no no è:: (3) you know what [(??)]

0420 DOCf [è chiaro an]che per te?

0421 ADHm (??) norma?le

0422 PATf uhm

0423 ADHm (??) [(??)]

0424 DOCf [it's all ok]ay

0425 PATf uhm

0426 ADHm the (tenth) month the fifth month and eighth [month]

0427 PATf [(it)] okay

0428 ADHm (for this reason) they wanna do:: (??)

0429 DOCf uh

0430 ADHm in più. (.) però (ogni) quindici gio- they wanna do (so control)
(??) with every (??6syll)

0431 PATf okay

0432 ADHm eh
(1,0)

0433 PATf ((??8 syll))[((??5syll))]

0434 ADHm [that's what she say]

0435 it's supposed to be

0436 PATf seven

0437 ADHm the eighth month ((??4syll))

0438 PATf oka[y]

0439 ADHm ((??9syll))[((1syll))]

0440 PATf uhm? uhm?

0441 Event typing

0442 ADHm that's what she said

0443 PATf (oh)

0444 Event typing

0445 DOCf (??3syll)

0446 ADHm uhm [uhm]

0447 DOCf [o]kay?

0448 Event typing

0449 DOCf o-

0450 Event unidentified noise

0451 DOCf l'appuntamento? the appointment is here.
(0,6)

0452 ADHm okay

0453 DOCf l'avete fatta qua ieri o in via Monte S. Michele

0454 ADHm eh qua

0455 DOCf okay

0456 ADHm uhm

0457 DOCf smpre qua (allor-)

0458 ADHm sempre

0459 Event unidentified noise

0460 ADHm (??2syll) che loro fanno là

0461 DOCf sì si fa anche là

0462 ADHm °okay°
(0,5)

0463 DOCf siamo- è sempre la stessa dottores[sa che la fa] sia qua che là

0464 ADHm [dottoressa okay]

0465 (è) sempre lei?

0466 DOCf sì

0467 ADHm °mh mh°
(8,5)

0468 però quando noi è venu- qua prima non è lei che ha fatto quello prima

0469 DOCf .h no la prim[a la fan]no anche degli altri medici [[ma la seconda]]

0470 ADHm [°okay°] [[°okay°]]

0471 DOCf e la terza di solito le [[[fa le:i eh?]]]

0472 ADHm [[[lei okay]]]
(0,6)

0473 DOCf (??4syll) (1) il trentuno di ottobre alle tre e un quarto del pomeriggio thirty-one of October at [fifty]

0474 ADHm [(alle tre o)] (quattro)

0475 DOCf ah esatto tre e un quarto [tre e quindici]

0476 ADHm [uh u][[h]]

0477 PATf [[th]]ree fifteen

0478 ADHm °ah ah°

0479 DOCf fifty past three

0480 [(??3syll)]

0481 ADHm [(??)] sì sì uhm

0482 DOCf oka[y]?

0483 ADHm [.h] (a che) non si può va bene

0484 DOCf ah (.) vuoi un altro ora- mh non c'è un altro orario

0485 ADHm va beh lascia stare

0486 DOCf ..h

0487 PATf (what do you want?)

0488 DOCf è un mercoledì [it's a Wednesday yes]

0489 ADHm [mercoledì yeah]
(1,2)

0490 ((tobetran))
(0,9)

0491 eh:: se no lascia lavoro alle tre (.) uhm:

0492 DOCf è scomodo.

0493 ADHm sì sì sì [(l'ho detto)]

0494 DOCf [eh lo so] solo che:

0495 ADHm (no) va bene uh

0496 DOCf (as) mh: non riesco a darvi un altro:: perchè quell'ecografia lì
le fa solo a quell'ora lì

0497 ADHm va bene va bene va bene alle (??) facciamo
(1,6)

0498 DOCf ci guardo aspetta eh

0499 ADHm uhm uhm

0500 DOCf però temo proprio di no (.) (??10syll) (.) allora può esserci
anche alle quattro e un quarto o alle quattro e quarantacinque
cosa è meglio?
(0,8)

0501 ADHm (facciamo alle) quattro e un quarto

0502 DOCf quattro e un quarto è meglio?

0503 ADHm °va bene°

0504 DOCf o alle quattro e quarantacinque?

0505 ADHm basta che lei eh: (.) °eh°
(0,8)

0506 DOCf (??5syll)

0507 ADHm [(??2syll)] (.) (??3syll)

0508 DOCf (??1syll)
(1,9)

0509 ADHm ((tobetran))

0510 DOCf [tre] e quarantacinque quattro e quindici e quattro e
quarantacinque
(1,0)

0511 ADHm facciamo: quattro e quindici

0512 DOCf quattro e quindici?

0513 ADHm ((tobetran))

0514 PATf oh

0515 ADHm ((tobetran))

0516 PATf okay

0517 DOCf s:o allo[ra.]

0518 ADHm [va bene] quattro e quindici va bene

0519 DOCf aspetta che dobbiam rifarlo un po' tu?tto

0520 ADHm uhm

0521 DOCf adesso ne ha un po'
(0,7)

0522 °okay°
(1,0)

0523 ((humming))
(0,6)

0524 ((humming)) °qua°
(1,5)

0525 ..h (??)
(1,8)

0526 (??)
(1,0)

0527 Event typing
(6,2)

0528 DOCf ..h ((humming))
(1,4)

0529 ((humming)) altrimenti

0530 ADHm mh

0531 DOCf l'alternativa è (.) in via Monte San Michele le fa il: martedì (.)
però sempre con gli stessi orari

0532 ADHm va bene faccia[mo: (sì)]

0533 DOCf [va bene qua?]

0534 ADHm (??2syll)
(1,9)

0535 però anche mercol (martedì o mercoledì) martedì

0536 PATf (°yes°)

0537 DOCf qui è mercoledì [sì]

0538 ADHm [no] mercoledì va bene (martedì no) martedì:

0539 DOCf mh

0540 ADHm c'è da far[e]

0541 DOCf [a]lle quattro e un quarto allor[a?]

0542 ADHm [va b]ene sì
(10,1)

0543 DOCf trentun? quattro (qua)
(4,0)

0544 ecco
(0,5)

0545 okay [è corre]tto

0546 PATf [(yeah)]

0547 (yeah)

0548 ADHm (uhm)
(0,8)

0549 DOCf lo metto qua
(3,1)

0550 ADHm °perfetto°
(24,9)

0551 DOCf ((coughing))
(0,8)

0552 ADHm °((humming))°
(4,5)

0553 DOCf questa è (??7syll) okay be?ne

0554 ADHm okay
(4,7)

0555 DOCf allora
(0,7)

0556 ti scrivo gli esami da [fare la prossima]

0557 ADHm [(da fare)]

0558 DOCf volta

0559 ADHm o:kay
(0,9)

0560 DOCf (??2syll) (.) °ah°
(1,1)

0561 ((humming)) °qua°.
(4,9)

0562 ((humming))
(2,8)

0563 hai qualcosa da chiedere intanto? do you want to ask (.) me (.) something?
(0,7)

0564 ADHm ((tobetran))
(1,2)

0565 PATf okay
(1,3)

0566 DOCf (..h)

0567 PATf eh eh eh in the nights [some]times I feel pains

0568 DOCf [(uhm)]

0569 here?

0570 PATf eh

0571 DOCf uhm

0572 PATf ((tobetran))

0573 DOCf when you turn [in the bed]

0574 PATf [eh:]

0575 DOCf ah[:]

0576 PATf [when I] sleep like this

0577 DOCf okay

0578 PATf (eh sì)

0579 DOCf uh uh .h

0580 PATf (i)

0581 DOCf eh (.) but you? eh do you go to toilet every day or not.
(0,8)

0582 [la cacca]

0583 PATf [uhm]: (.) yeah

0584 DOCf uhm
(0,6)

0585 PATf (°I do°)
(7,9)

0586 DOCf because sometimes

0587 ADHm °eh°

0588 DOCf eh is possible that: in you:r (.) intestino

0589 PATf uhm:

0590 ADHm o[kay]

0591 DOCf [there is] a lot of air

0592 ADHm ((tongue click)) [°(it's okay)°]

0593 PATf [o:][[kay]]

0594 DOCf [[and]] when there there is a lot of air [eh]

0595 PATf [uhm]

0596 DOCf the intestino spinge su (.) [(sulla)]

0597 ADHm [°okay°]

0598 DOCf può [s:entire un po' dolo]re (??4syll)

0599 ADHm [sentire: mh °(okay)°]

0600 PATf ((tobetran))

0601 ADHm ((tobetran)) the intestine sometimes ((tobetran))

0602 PATf ah:

0603 ADHm ((tobetran)) [((tobetran))] eh perchè qua è scritto con cinese:

0604 PATf [yes]

0605 DOCf ((laughter)) [.h]

0606 ADHm [eh eh ah] che non scrive c[on (cinese)]

0607 PATf [everyday]

0608 DOCf ah questo non serve a niente

0609 ADHm lo so perché [(no)]

0610 DOCf [(.h)]

0611 ADHm puoi chiedere sempre qua sempre: non è solo qua

0612 DOCf mh

0613 ADHm (loro scrivono) in cinese: anch[e ara]b (.) ogni tanto inglese
loro non si scrive perché

0614 DOCf [((laughter))]

0615 PATf °uhm°
(0,6)

0616 DOCf eh alcune cose le abbiamo scritte in inglese altre cose no

0617 ADHm uhm uhm

0618 DOCf because in: in inglese ci possiamo capire anche sui numer[i]

0619 ADHm [s]ì

0620 DOCf i cinesi invece umh: fanno più: fati[ca i numeri]

0621 ADHm [fatica]

0622 DOCf sono diversi

0623 ADHm (anche coi numeri è diversi?)

0624 DOCf anche i numeri [possono essere]

0625 ADHm [ah:]

0626 DOCf diversi sì (.) .h eh: (.) °(mh)° (.) però se vuoi te lo scrivo in
inglese

0627 ADHm no? [dai s- ((laughter))]

0628 DOCf [((laughter))]

0629 ADHm .h °(eh)° non vuoi?

0630 DOCf .h se proprio [mi dispiace]

0631 ADHm [((laughter))] no no °(no no)°

0632 DOCf .hh

0633 ADHm (se vuo-) vuoi: sapere se qualcosa: in più per fare quello non è che se

0634 DOCf mh
(0,6)

0635 (uhm)
(2,4)

0636 PATf .h sorry eh: eh I want to ask (.) ((tongue click)) (.) there's (mo:re eh for any pregnant woman they don'ts give them a drugs to be taken)

0637 DOCf medi[cine]

0638 PATf [for] the growth of the child?

0639 DOCf ehm no mh mh mh: now it's not necessary [we will (day)]

0640 PATf [ah ah]

0641 DOCf (eh:) next test (.) and after I see the next [test .h]

0642 PATf [okay]

0643 DOCf I decise if give you vitamin [(??1syll) because]

0644 ADHm [((tobetran))]

0645 DOCf at the moment it's not nece[ssary]

0646 ADHm [(nece)]

0647 PATf [ah] [[°okay°]]

0648 DOCf [[.h]] do you eat eh: vegetables fruit
(0,6)

0649 PATf uh uh?
(0,7)

0650 DOCf what do you eat?

0651 PATf ((laughter)) [((laughter))]

0652 ADHm [((laughter))]

0653 PATf ((laughter)) [(okay) ((laughter))]

0654 DOCf [try to tell me (.) try]

0655 PATf .h eh eh fruits

0656 DOCf fruits

0657 PATf uhm

0658 DOCf mh and then?

0659 PATf vegetable but not often
(0,5)

0660 DOCf uhm: [.h]

0661 PATf [not] often not all the time

0662 DOCf eh eh: today in the: uhm (.) a mezzogiorno eh: ((laughter))
[((laughter))]

0663 ADHm [sì] eh eh this afternoon
(0,6)

0664 PATf okay this afternoon?

0665 DOCf what did you: [eat.]

0666 PATf [(what I do)] (.) rice

0667 DOCf rice? and then?
(1,0)

0668 PATf then in the morning I ate (.) custard and beans:

0669 DOCf uhm .h this is very very okay

0670 PATf okay

0671 DOCf uhm [.h]

0672 PATf [okay]

0673 DOCf rice also but .h what do you put (.) into the rice

0674 ADHm ((tongue click)) [.h]

0675 DOCf [wi]th the rice what do [you stew in)]

0676 ADHm [eh pom-] pomodoro:

0677 DOCf ah

0678 ADHm ah eh: anche un po' di spinaci

0679 DOCf ah vege[tables]

0680 ADHm [(beh)] sì anche:
(0,9)

0681 eh eh galline dai chicken [soltan]to: meat (??) [[dipende]]

0682 DOCf [sì sì sì]

0683 PATf [[°(uh uh)°]]

0684 DOCf (ma) eh: pomodori e spinaci sono vegetable[s]

0685 ADHm [s-] eh okay

0686 DOCf a te non piacciono? don't you like?

0687 ADHm yeah

0688 PATf ((tobetran)) [tomato?]

0689 ADHm [((tobetran))] tomatoe[s]

0690 PATf [o]kay o[kay]

0691 ADHm [uh] yeah [(we'll eat) ((tobetran))] [[((tobetran))]]

0692 DOCf [(do you eat rice?)]

0693 PATf [[(the same)]]

0694 DOCf ah [okay]

0695 PATf [uhm]

0696 ADHm eh (tutti la cosa da fare tutto da sugo [tanto usare) tomat]oes

0697 DOCf [ah okay]

0698 u[hm]

0699 PATf [but also] plantain?

0700 ADHm [°uhm°] °uhm°
(0,5)

0701 DOCf plantain? what is?

0702 ADHm eh:
(0,5)

0703 °(eh eh)° quello è[: s-]

0704 PATf [not banana]

0705 ADHm (eh beh sì)

0706 PATf (the) plan[tain]

0707 ADHm [plan]tain

0708 DOCf plantain

0709 ADHm lo sai eh: come si [chiama]

0710 DOCf [scrivi per piacere] dopo io cerco su inter[[net]]

0711 PATf [((laughter))]

0712 ADHm [[o]]kay
(3,1)

0713 DOCf uhm

0714 ADHm plantain
(0,7)

0715 pla
(2,4)

0716 tain

0717 PATf uhm

0718 DOCf (??1syll)

(1,4)

0719 ADHm c- c- come qua eh ((tobetran)) [((tobetran))]

0720 DOCf [((humming))] [[((humming))]] [[[((humming))]]]

0721 PATf [[plantain this]] [[[((tobetran))]]]

0722 ADHm [[[((tobetran))]]] sì

0723 DOCf °(okay)°
(0,8)

0724 ((humming)) plantain?

0725 PATf uhm uhm
(1,8)

0726 ADHm no

0727 PATf no:

0728 DOCf no
(0,5)

0729 ah ah ho sbagliato io [((laughter))]

0730 ADHm [ah]

0731 DOCf sorry pla[:] n:

0732 PATf [pla:n]

0733 ADHm uh uh

0734 PATf ta:in
(0,6)

0735 DOCf [(??2syll)]

0736 PATf [no]:

0737 DOCf [(??)]

0738 ADHm [no]

0739 a[h]

0740 PATf [n-] e: i

0741 ADHm (ancona)

0742 DOCf (pe) a

0743 ADHm non lo scr- [(??6syll) sì?]

0744 DOCf [a planta:] e:

0745 ADHm (i) (.) no imola
(0,7)

0746 DOCf i

0747 ADHm eh

0748 there (.) è [questi]

0749 DOCf [uh]m

0750 ADHm questi qua

0751 DOCf plantain?

0752 ADHm eh

0753 PATf °((tobetran)) plantain°

0754 DOCf [plantain traduz]ione [((laughter))]

0755 ADHm [((tobetran))]

0756 [(??4syll) sai] se c'è qua (.) c'è?

0757 DOCf banana o legu[me?]

0758 ADHm [sì]

0759 ba[nan- sì ((laughter))]

0760 DOCf [((laughter))]

0761 PATf ((laughter)) [((laughter))]

0762 DOCf [it's] like banana?

0763 ADHm [sì quello gro?sso.]

0764 PATf [(??3syll) no not- not banana] eh eh

0765 DOCf [not tha:t sweet]

0766 ADHm eh eh:

0767 DOCf o?kay?

0768 PATf you [fry]

0769 DOCf [ye?s]

0770 PATf fry it [((tobetran))]

0771 ADHm [((tobetran))]

0772 DOCf [uhm uhm uhm mh]

0773 ADHm [((tobetran))]

0774 DOCf the (frieds?)

0775 PATf ye[s]

0776 DOCf [f]ri?tte

0777 ADHm sì

0778 DOCf the (frieds) food is not very very good

0779 ADHm o[°kay°]

0780 PATf ye[ah]

0781 DOCf [som?]times yes but not all days.

0782 ADHm o[kay]

0783 DOCf because (frieds) is very very (.) fat

0784 ADHm fat yeah

0785 PATf o[kay]

0786 DOCf [and it's] not (.) a good thing. [because the-]

0787 PATf [uhm:]

0788 DOCf this fat (.) f- cooked fat is not very good [is]

0789 ADHm [okay]

0790 DOCf bette:r .h °eh° not cooked fat.

0791 ADHm uhm is [fried fat]

0792 PATf [o?ka:y]

0793 DOCf [o]kay

0794 PATf [fried] ah ah

0795 ADHm [uh]
(0,6)

0796 PATf .h o?kay.

0797 DOCf mh
(0,6)

0798 (.h eh eh) °mh° voglio vedere
(2,5)

0799 no

0800 ADHm °non è quello°

0801 DOCf °non è quello°
(2,5)

0802 °ah:° (.) forse qua

0803 ADHm no

0804 DOCf no?

0805 ADHm spetta
(1,6)

0806 qua

0807 DOCf questo è (il) [(??3syll)]

0808 ADHm [sì]

0809 DOCf .h solo con le banane ho [capito:]

0810 ADHm [eh- eh:]

0811 DOCf sì quelle un po' con [gli angoli]

0812 ADHm [eh sì sì] sì eh:

0813 DOCf okay

0814 ADHm quello più grosso così

0815 DOCf sì

0816 ADHm però anche [se:]

0817 PATf [(??2syll)]

0818 DOCf con la buccia [(vera)]

0819 PATf [(??)] [the green plantain]

0820 ADHm [sì sì sì sì] però anche [(questa qui)]

0821 DOCf [not yel]low

0822 PATf uh[m]

0823 ADHm [p]erò the yellow th- that's what she eat th- aft- eh (.) qu-
quello c- che yel[lo:w]

0824 PATf [uhm]

0825 DOCf

0826 are more sweet

0827 ADHm [sì]

0828 PATf [uhm] yes [yes]

0829 ADHm [(??2syll)]

0830 DOCf (this is) (??)

0831 ADHm

0832 this is [(that's) not sweet]

0833 PATf [(??)] (??)

0834 ADHm this one (anche lo so posso) fare: fried

0835 DOCf ma si possono fare anche: in altro modo o solo (frieds) .h

0836 ADHm sì sì si può far cucinare

0837 DOCf cucinare in other w- w:ays? [not only]

0838 ADHm [sì sì sì]

0839 DOCf

0840 (frieds)

0841 PATf [(okay)]

0842 ADHm [sì sì sì sì]

0843 [puoi cucinare:] normale:

0844 DOCf [okay]

0845 [okay va beh] allora[: sì]

0846 ADHm [(??3syll)]

0847 [uhm uhm]

0848 DOCf così va bene

0849 ADHm mh mh?
(1,5)

0850 DOCf ((tongue click)) va bene allora questi sono gli esa:mi gli esami
li (avevate) fatti lì all' (??2syll) [(??2syll)]

0851 PATf [wha-] w- what about egg?
(1,0)

0852 DOCf e:gg:?

0853 PATf egg

0854 ADHm uova

0855 DOCf ah yes (.) it's oka:y

0856 PATf °it's okay°

0857 DOCf yes
(2,3)

0858 not more one (.) in a day

0859 ADHm [uhm]

0860 PATf [o-] (uh) one a day.

0861 DOCf .h yes but °eh° to you can to eat eh- also two? (.) [in a days .h]

0862 ADHm [mh mh °(okay)°]

0863 DOCf but (.) the day after not only [not al-]

0864 PATf [all the time]

0865 ADHm al[ways eh sempre]

0866 DOCf [(oh yeah) not all]

0867 PATf [(always) (??3syll)]

0868 DOCf [days (??2syll)]

0869 ADHm [((laughter))]

0870 PATf [((laughter))]

0871 DOCf .h

0872 PATf mh mh

0873 DOCf but i:s good
(2,8)

0874 allora eh: qui siamo a po:sto °eh:° (??) ventiquattro (??3syll)
dopo il
(1,4)

0875 settembre già dalla prossima settimana
(0,7)

0876 ADHm okay
(1,4)

0877 DOCf °mh°
(1,5)

0878 so .h uhm: il ti:mbro? (..h)
(9,1)

0879 the prescription for blood and urine test

0880 ADHm ah okay

0881 PATf °okay°

0882 DOCf (ah:m)
(6,5)

0883 °okay°

0884 PATf okay

0885 okay
(5,3)

0886 sorry I I. I wanted to ask (although) I forgot to bring it (.) I
have a folic (.) acid

0887 DOCf uhm?

0888 PATf can I (.) take any?

0889 DOCf eh: you can wa:it (.) and we wait the: the next blood te[st]

0890 ADHm [tes]

0891 DOCf .h [because the]

0892 PATf [okay]

0893 DOCf folic is very important before pregnancy (.) and during the first
first [weeks of pregnancy]

0894 PATf [o?ka:y]

0895 ADHm [o]kay

0896 DOCf to avoid (.) problem of the baby [of the:]

0897 PATf [yeah:]
(0,6)

0898 DOCf colonna ver[tebrale non so come si dice]

0899 ADHm [uhm-mh [[uhm]] uhm]

0900 PATf [[yeah]]

0901 DOCf of the baby

0902 ADHm uhm

0903 DOCf eh: but next in: at eh: an- ..h in the four five [six seven]

0904 ADHm [(six) seven]

0905 DOCf mon[th .h]

0906 PATf [uhm]

0907 DOCf

0908 can be important for the anemy but we can see if you have anemy after next [test okay?]

0909 ADHm [(the results) okay uh uh]

0910 PATf °okay°
(3,5)

0911 DOCf .h if you ea:t eh green vegetable[s]

0912 PATf [mh]

0913 DOCf .h you can find folic [i:n vegeta][[bles]]

0914 ADHm [acid okay]

0915 PATf [[okay]]

0916 DOCf uhm? [(??2syll)]

0917 ADHm [però come sala-] salate o[:]

0918 DOCf [s]pina[ci:]

0919 ADHm [spinaci]

0920 DOCf bietole:

0921 ADHm però con gli spinaci (??3syll) (qua lei non si) piace [(non lo so)]

0922 DOCf [non gli] piace

0923 ADHm quello che: già: (.) [(??3syll)] [sì sì sì]

0924 DOCf [(??4syll) però]

0925 ADHm sì

0926 DOCf prendi quelli crudi

0927 ADHm va bene

0928 DOCf sì quelli crudi sì li: li [lavi bene:]

0929 ADHm [sì ah °(okay)°]

0930 DOCf poi li puoi mangiare
(4,0)

0931 allora vediamo quando fare il prossimo controllo qui abbiam
[scritto]

0932 ADHm [°okay°]

0933 DOCf tutto (??2syll) tutto oggi (proprio ah ah ah) sì (.) okay (.)
salva (baila) stampa
(9,7)

0934 °okay°
(3,1)

0935 ADHm (quello esame lei) quando deve fare

0936 DOCf allora si possono già fare la prossima settimana ma adesso aspetta
che te lo di[co così]

0937 ADHm [okay] okay

0938 DOCf li fate:
(1,4)

0939 vicino alla prossima (.) data.
(1,3)

0940 mh °uhm°
(1,8)

0941 ventiquattro ventise:i
(28,0)

0942 ((tongue click)) allora potete farli già dopo il: mh: (.) dieci
[di: settembre]

0943 ADHm [o:kay]

0944 DOCf .h (.) allora vi darei appuntamento
(1,1)

0945 uhm o il ventisette di settembre?

0946 ADHm °okay°

0947 DOCf oppure i:l quattro ottobre

(0,7)

0948 on the twenty-seven of September

0949 ADHm uhm uhm

0950 DOCf or the four of October

0951 PATf m[h]

0952 DOCf [wha]t do you prefer
(0,6)

0953 it's a Thursday in the afternoon [(??2syll) Thurs]day yes

0954 ADHm [Thursday okay?]

0955 fa:i: settembre (plea[se)]

0956 DOCf [set]tembre (.) twenty-seven

0957 ADHm uhm uhm

0958 DOCf mh?
(0,8)

0959 okay .hh
(0,6)

0960 so (.) there is place a:lle due e quarantacinque oppure se vuoi
venire tardi anche alle sei o alle [cinque e mezzo]

0961 ADHm [va ben- mh] va va va vai a cinque e mezzo

0962 DOCf cinque e mezz[o? s]ei è troppo tardi

0963 ADHm [mh] m[h]

0964 anche sei va s- depende (dipende) te

0965 DOCf io alle sei è l'ultimo appuntament[o]

0966 ADHm [va] bene dai (.) uh [uhm uhm]

0967 DOCf va bene? (.) okay allora facciamo qua
(1,6)

0968 PATf when is that
(0,7)

0969 ADHm twenty-seventh

0970 PATf okay ((tobetran))

0971 ADHm ((tobetran)) (.) uhm

0972 PATf °okay°
(3,1)

0973 DOCf °okay°
(8,9)

0974 ecco
(1,7)

0975 gli esami li fate dopo il dieci [di:]

0976 ADHm [okay]

0977 DOCf settembre e il ventisei li portate [io ho scritto (du[e o tre)
però va]

0978 ADHm [questi? okay]

0979 DOCf bene (anche dopo il) dieci

0980 ADHm (°ah okay°)
(2,4)

0981 DOCf (ec[co])

0982 ADHm [vu]oi fare undici:

0983 DOCf sì (.) dopo dopo fai la carta [lì?]

0984 ADHm [sì] sì sì [sì]

0985 DOCf [(be]ne)
(7,7)

0986 ADHm (°this would be that°)

0987 DOCf (mh)
(0,6)

0988 ADHm °(??)°
(1,3)

0989 DOCf °okay°
(1,7)

0990 bene

0991 PATf ((tobetran))

0992 ADHm after ((tobetran))

0993 PATf oka:y (.) [(after:)]

0994 ADHm [((tobetran))]

0995 DOCf after [°yes°]

0996 ADHm [after (ten]th)

0997 PATf °(o:kay okay)°

0998 ADHm after the ten you can do it: a[n:d (??2syll)]

0999 PATf [°okay°]

1000 Event unidentified noise

1001 ADHm ((tobetran)) [((tobetran))] ((tobetran))

1002 PATf [o:kay?]
(0,5)

1003 DOCf se cè problema prima mi cercate a [questo eh?]

1004 ADHm [okay] okay
(2,0)

1005 .h (.) siamo a posto?
(0,8)

1006 [può andare?]

1007 DOCf [sì sia][[mo a posto]]

1008 PATf [[((laughter))]]

1009 [((laughter))]

1010 ADHm [allora grazie mi]lle

APPENDIX 2: INTERACTIONS WITH A CULTURAL MEDIATOR

Voce 32

001 Event background voice(s)
(2,9)

002 DOCf non so se le spieghi il discorso della privacy?

003 MEDf sì

004 DOCf possiamo parlare (poi semmai) con la famiglia e col marito che [così]

005 MEDf [sì]

006 DOCf le chiedo anche la firma [grazie]

007 MEDf [okay]
(1,1)

008 Now what is the problem. the doctor says that
(0,8)

009 she will let you sign for

010 for privacy
(0,6)

011 that is in case of any problem they can talk with your husband (.) and maybe if your friends or your family (.) come here to look for you they will tell them that th- (.) you have said that.
(0,8)

012 PATf so I'm not going today

013 DOCf ((laughter))

014 MEDf ((laughter))

015 PATf ((laughter)) [((laughter))]

016 MEDf [if you're go]ing today you want to ask first? ((laughter)) (baby) don't worry you will soon go.

017 PATf ((laughter))

018 MEDf are you pregnant?

019 PATf uhm
(0,6)

020 MEDf your pressure is high

021 PATf uhm

022 MEDf eh that one is very dangerous in pregnancy.
(0,9)

023 DOCf okay allora eh: mi serve la lista per il loro titolo di studi [il loro]

024 MEDf [okay]

025 DOCf lavoro e i numeri di [telefono]

026 MEDf [are you working.]
(0,5)

027 PATf no

028 MEDf then your husband is working

029 PATf mh
(0,5)

030 MEDf marito operaio
(0,6)

031 DOCf okay? (.) quando si sono sposati?

032 MEDf when did you: (.) you have (wedded) already (.) did you married already when?
(0,7)

033 PATf two eleven
(0,6)

034 MEDf two thousand and eleven

035 DOCf mh u[mh?]

036 MEDf [(duemil)]aun

037 DOCf sì?
(0,5)

038 e: un: recapito telefo[nico anche del marito?]

039 MEDf [telephone number give] your: your husband's.
(2,5)

040 Event background voice(s)

041 PATf ((tobetran))
(4,3)

042 MEDf allora

043 Event background voice(s)

044 MEDf allora

045 Event unidentified noise

046 MEDf oh sorry (1) sei due sette?

047 DOCf sì?

048 MEDf due quattro uno

049 DOCf sì?

050 MEDf sette sei tre tre
(1,2)

051 DOCf kay?

052 Event   unidentified noise
(2,4)

053   background voice(s)

054 MEDf   ((tobetran))

055 PATf   ((tobetran))

056 MEDf   ((tobetran))

057 DOCf   okay non ha firmato per la privacy?

058 Event   background voice(s)

059 MEDf   you sign here for privacy
(1,0)

060 Event   background voice(s)

061 MEDf   (yeah)
(2,7)

062 Event   background voice(s)

063 DOCf   e: nella sua famiglia c'è qualcuno che s- che la si[gnora?]

064 MEDf   [in your] family anybody with high blood (pressure) diabetes?

065 PATf   (no)

066 DOCf   [malformazioni congenite]?

067 MEDf   [(don't worry any sickness)?]

068 DOCf   [[cancro?]]

069 PATf   [[uhm uhm]]

070 DOCf   informazioni (??5syll)

071 MEDf   any: sickness familiar family sickness

072 PATf no no

073 DOCf problemi ematologici tipo emoglobinopatie

074 Event background voice(s)

075 MEDf ((tobetran)) anybody with blood sickness ((tobetran))

076 PATf (no:one)

077 MEDf nessuno
(5,4)

078 Event background voice(s)

079 MEDf ((tobetran)) [((tobetran))]

080 DOCf [lei ha detto che non ha: allergie]:? [giusto?]

081 MEDf [are you alle]rgic to any drugs.
(0,7)

082 PATf no:

083 DOCf [no] (.) le malattie dell'infanzia le ha avute?

084 PATf [no]

085 MEDf did you have the: (.) the infants' sickness like measles chicken pox
(0,6)

086 PATf eh eh eh eh eh eh [eh]

087 MEDf [you had it] (??1syll)

088 sì le ha avute
(0,6)

089 DOCf o[kay?]

090 MEDf [(??2syll)]
(0,7)

091 DOCf malattie infettive?
(0,8)

092 PATf (so early) so

093 MEDf have you got an infective err:

094 PATf disease?

095 MEDf eh:

096 PATf no

097 MEDf no

098 DOCf no?
(0,6)

099 mai avuto interventi chirurgici?

100 MEDf solo l'appendicite (.) have you done any operation apart from appendi-

101 PATf °no°

102 MEDf no
(2,9)

103 DOCf quando l'ha avuta?

104 MEDf when did you do it?

105 PATf °ninety-six (.) ninety-seven°

106 MEDf °novantasette°
(1,8)

107 DOCf okay?

108 problemi a parte la pressione alta che l'abbiam[o trovata noi prima della gravi]danza

109 MEDf [apart from this high blood pressure]

110 [are you havin-?]

111 DOCf [cuore polmoni] fegato tiroide?

112 MEDf before this pregnancy. did you have any of this high blood pressure
(0,5)

113 PATf no

114 DOCf [uhm uhm mh]

115 MEDf [you don't have problem with] the hearts?

116 PATf °eh no°

117 MEDf (and when is tha:t?)
(1,9)

118 DOCf (uhm esatto)
(2,6)

119 MEDf così tanto alta (.) dottoressa?

120 DOCf eh: era: (sui) novantacinque cento allora le abbiamo dato [un po'
di (??)]

121 MEDf [centonovanta]cinque

122 DOCf no [è a]: centocinquanta [[centosessanta]]

123 MEDf [ah:]

124 [[ah ok]]

125 DOCf su novanta[cinque]

126 MEDf [sì]

127 DOCf a volte cent[o e]

128 MEDf [eh] [[uhm]]

129 DOCf [[con gli e]]sami ha: molte proteine: [nelle urine]

130 MEDf [(alright alright)] ho capito

131 DOCf e quindi[: abbiamo]

132 MEDf [mh mh]

133 DOCf impostato una terapia

134 MEDf °o?kay.°

135 DOCf e: lei fuma?
(0,7)

136 MEDf °non penso° but did you smoke.

137 PATf no

138 MEDf °ah°

139 DOCf non beve alcolici che farmaci ha assunto in gravidan[za]

140 MEDf [duri]ng this pregnancy what type of drugs do you take

141 PATf only: (taccaprine)

142 DOCf °okay°

143 MEDf (??) should take (??4syll) [(??)]

144 DOCf [acido foli]co solo?

145 PATf (didn't take) no

146 MEDf [no tachi]pirina [did you?]

147 DOCf [neanche?]

148 [uhm uhm]

149 MEDf take the: (.) folic acid
(0,9)

150 PATf that one they give us (.) eh: (.) from beginning [(??)]

151 MEDf [exa]ctly that's it.

152 PATf eh yes

153 MEDf (??3syll) [°okay°]

154 DOCf [l'ha] preso?

155 MEDf sì

156 DOCf oka[y?]

157 MEDf [what] about (??6syll)
(1,0)

158 PATf only that one [I take]

159 MEDf [so in that wa]y you have the: eh: something [(??)]

160 DOCf [quanto] pesava prima di rimanere incint[a?]

161 MEDf [be]fore the pregnancy do you remember your weight?
(1,4)

162 PATf eighty

163 MEDf °ottanta.°

164 DOCf quanto è alta?
(0,6)

165 MEDf your height?

166 PATf uhm (.) I don't know that one

167 DOCf °of course°

168 MEDf non si ricorda sua al[tezza]

169 DOCf [più o meno]

170 MEDf maybe it's in your ID card
(1,1)

171 stand up and let me see

172 Event stapler noise

173 DOCf e quanti chili ha preso in gravidan[za?]

174 MEDf (??4syll) your height (that's why) uno e sessantotto? sessantacinque? cosa pensi dottor[e.]

175 DOCf [s]ì: [più]

176 MEDf [eh]

177 DOCf o meno
(0,9)

178 e quanto: ha preso in gravidanza? adesso quanto [pesa?]

179 MEDf now did you know (how many you weigh?) (.) did they use to weigh you in the cons[ultorio]

180 PATf yeah they weighed (.) ninety this morning

181 MEDf ninety.
(4,2)

182 DOCf durante la gravidanza è sempre andato tutto bene?

183 MEDf before you come to this hospital. (.) [the pregnancy (now the pregnancy) was regular? You have not gone]

184 DOCf [mai venu- mai venuta in pronto socco:rso:]

185 MEDf to the hospital before? this is your [first]

186 PATf [(yeah)]

187 MEDf time. (.) for this pregnancy
(0,5)

188 DOCf [eh: un attimino]

189 PATf [well I've been going to:] (.) (that one)

190 MEDf that one is the consultorio the one you go for check-up [(??)]

191 PATf

192 [yeah]

193 MEDf did you go to hospital?
(0,6)

194 PATf [the hospital]

195 MEDf yeah (well here) signora

196 PATf (why) (??6syll)

197 MEDf [qua è la prima volta]

198 DOCf [(quindi) tutto: sì tutto] bene okay e: niente oggi le facciamo
l'ecografia per controllare il liquido perchè era ridotto?

199 MEDf uhm uhm

200 DOCf okay e poi: vediamo come vanno gli esami (per caso) abbiamo mandato
giù la (pro tempore) delle ventiquattro [o:re per]ché se il liquido
è ulteriormente ridotto e se gli esami non vanno bene allora
induciamo il parto

201 MEDf [okay?]

202 ok[ay (°quante settimane?°)]

203 DOCf [se no invece possiamo aspett-]are le cinque

204 MEDf [(??)] c'è: c'è il problema now you will do SCAM (.) they will
control the water that is the amniotic liquid to see how it is

205 PATf °mh mh°

206 MEDf she said how that it was reduced a little bit so they will control it (.) to see. if it is reducing more more that means they have to push to force labour.
(0,6)

207 PATf uhm?

208 MEDf if the water has reduced more they will put you to force labour
(0,9)

209 PATf (no my time is ready?)

210 Event telephone rings

211 MEDf °uhm°

212 DOCf (??2syll)

213 MEDf because the water is where the baby stay (.) in the womb

214 PATf ((tobetran))

215 MEDf (??) yo (2) Gladys. (1,5) yes (6,5) (well then sixth) floor don't worry stay there stay in the room there (1,5) (??4syll) don't call me again I'll come and meet you okay?
(2,4)

216 DOCf uhm (3,5) e: (da quando) (??5syll) [uhm]

217 MEDf [eh eh] (1) (??2syll) [(??2syll)]

218 DOCf [(d'accordo?)] (2) e: mi ha fermato una collega (per una signora che è stata) ricoverata qui (.) ah benissimo perché è arrivato anche il marito e anche la mediatrice (2) sesto piano ingresso uno (appena usciti) dagli ascensori a destra (.) grazie (1.5) benissimo benissimo grazie

219 MEDf (it was?) (2) chiamo al telefono?

220 DOCf no

221 MEDf ah

222 DOCf per questo- (.) noi siamo a pos[to:?]

223 MEDf [okay.]

224 DOCf e stanno arrivando i consulent[i c'è anche]

225 MEDf [uhm uhm]

226 DOCf vari dotto[:?ri]

227 MEDf [lei] sta: pensando: quando va a casa [((laughter))]

228 DOCf [eh vediamo. (.) ved]iamo dall'ecografia [come va]

229 MEDf [okay] (.) let them do the SCAM first okay? [After the] SCAM they will know what to do. No worry just relax your mind okay?

230 PATf [°okay°]

231 °okay°

232 DOCf °okay°

233 il marito se lei (??4syll) fuori [faccio qualche domanda]

234 MEDf [eh. he stays] there.
(3,6)

235 DOCf [(ah ah)]

236 MEDf [((tobetran))]

237 PATf [((tobetran))]

238 MEDf ((tobetran))
(1,2)

239 uhm [mh be] cause

240 DOCf [eh] eh:

241 MEDf ((tobetran))

242 DOCf [allora il nome se- le puoi chiedere?]
(2,2)

243 (yeah) allora (mi chiedi a) lei [se fuma] se prende di solito i (??2syll) se beve alcolici quanto pesava prima della gravidanza? quanto pesa adesso? e quanto è alta?

244 MEDf

245 [uhm]

246 ((tobetran))

247 PATf no[:]

248 MEDf ((tobetran))

249 PATf ((tobetran))

250 MEDf uhm[:]

251 PATf [((tobetran))] ((tobetran))

252 MEDf ((tobetran)) [((tobetran))]

253 PATf [((tobetran))] ((tobetran))

254 MEDf ((tobetran))

255 PATf ((tobetran))

256 MEDf ((tobetran))
(0,7)

257 PATf ((tobetran)) [((tobetran))]

258 MEDf [uhm] uhm

259 PATf ((tobetran))

260 MEDf ((tobetran))
(0,5)

261 PATf ((tobetran))

262 MEDf [uhm uhm]

263 [uhm]

264 ((tobetran))

265 PATf ((tobetran))
(0,7)

266 MEDf prima della- prima gravidanza

267 DOCf uhm. (.) [no prima]

268 MEDf [(la) prima]

269 DOCf (è questa)

270 MEDf prima di que?sta. (.) perchè lei [dice. (.) prima?]

271 DOCf [sì (.) (okay)]

272 MEDf della prima [pesava s]ettanta[[sei]]

273 DOCf [lo so]

274 [rimane] questa

275 MEDf dopo che hai pa[rtorito eh pesava-] (.) pesava s[[ettantasei?]]

276 DOCf [sì? (??) okay?] (1) [[°uhm° sì?]]

277 MEDf dopo un po' [è calata (.) calata e cont]inuava a calare un po'?

278 DOCf [è calata tantissimo (.) okay?]

279 o p[rima di questa?]

280 MEDf [adesso] pes- pesa: (.) eh[: no sixty (weight) (??2syll)] (??)

281 DOCf [prima di questa gravidanza]

282 no

283 MEDf uhm

284 PATf ((tobetran))

285 MEDf (°that's it°)

286 PATf °uhm?°

287 MEDf prima della- questa [gravidanz]a era sessant- settantasei.

288 DOCf [sì?]

289 uhm

290 MEDf poi dopo è calato? è arrivato a settanta (1) dopodichè è calato di nuovo è arrivato cinquanta

291 DOCf sì ma [(??4syll)]

292 MEDf [adesso?]

293 DOCf qua- in quanto tempo è calata venti chi[li]

294 MEDf eh da un bel po' (.) [eh: ((tobetran))]

295 DOCf [eh no infatti lei è a nove settimane] lei è di nove [settimane]

296 PATf [uhm uhm uhm]

297 DOCf (è) [(??3syll)]

298 MEDf ((tobetran)) [((tobetran))] [[((tobetran)) allora]]

299 PATf [°uhm uhm°]

300 DOCf [due mesi f]a quanto pesava prima di sapere di essere incinta?

301 MEDf ((tobetran))

302 PATf ((tobetran))

303 MEDf ((tobetran)) be[cause (th-)]

304 PATf [(it's n]ot good)

305 MEDf eh non lo sa ha dett[o]

306 DOCf [no]n lo sa.

307 MEDf °mh°
(1,1)

308 DOCf eh: durante questa gravidanza non ha ancora fatto nessun tipo di esam[e?]

309 MEDf [no] è venuta da noi (1) consultorio?

310 DOCf sì[:?]

311 MEDf come lì non è che: le fanno gli esami così [il do]ttore (italiano) ha detto vai in ambulatorio fai gli esami della gravidanza?

312 DOCf

313 uhm

314 MEDf poi lo portiam lì per far ve[dere: che]

315 DOCf [ce:rto?]

316 MEDf (che era lì per fare dei giri) però lei non sentiva (.) [bene e non è venuta a portare]

317 DOCf [ah? ho capito quindi è venut]a da poco [in consultorio quindi per il]

318 MEDf [sì sì sì]

319 DOCf momento non ha fatto [esami non ha fatto niente okay e non sapevo questo]

320 MEDf [no no no no doveva portare: esami (.) eh] doveva portare ieri e non stava bene non ha venuto

321 DOCf e quindi non li ha fatti

322 MEDf no ha fatto gli esami della gravidanza

323 DOCf dove li ha fatti?

324 MEDf eh[:]

325 PATf [e quan] e quan e: quan- eh ieri anche lunedì

326 MEDf mh

327 ((tobetran)) [((tobetran)) ambula]tory ((tobetran))

328 DOCf [(??)]

329 PATf the pregnancy

330 DOCf yes

331 MEDf eh:

332 PATf eh[:]

333 MEDf [uhm uhm]

334 PATf mh

335 MEDf cercato in ambulatorio
(0,7)

336 DOCf °(e quale ambulatorio?)°

337 MEDf ambulatorio delle: a rotonda

338 DOCf [ah: (.) test di gravidanza e basta? cioè gli esami]
infettivolog[ici toxo?]

339 MEDf [test di gravidanza (gliel')avevano scritto sì. (.) sì?]

340 [no? doveva portare ie]ri a far vedere ginecologa così [continua]

341 DOCf [era gr]avida [e quell'altro] è (??2syll) [[(??3syll) ho capito adesso perchè s'è sentita male]]

342 MEDf [eh]

343 [esa?tto non è venuta perché non stava bene es]atto
(1,4)

344 DOCf okay
(24,4)

345 MEDf because (the)- ((tobetran))
(1,1)

346 PATf ((tobetran))
(2,2)

347 DOCf (no ma il) [gruppo]

348 MEDf uhm?

349 DOCf sanguigno probabilmente lo riesco a trovare: da noi perché ha partorito qua

350 MEDf eh sì ha [fatto tutto qua sì sì.]

351 DOCf [(fatto tutto bene sì ci siamo)] okay eh:m (1) possiamo andare (aspett- stiamo) arrivando [quindi secondo]

352 MEDf uah

353 DOCf me ti conviene aspettar[e: °quando° eh? (ti ric-) benissimo?]

354 MEDf [e io guardo in ostetricia uno a fare: (.) uhm]

355 DOCf (.) [e ap]pena arrivano stanno salend[[o: ti]] richiamo

356 MEDf [[(quan)]]

357 [[o?kay]]

358 (sì)

359 PATf ((tobetran)) [((tobetran))]

360 DOCf [(ah beh (.) venga vicino italiano?)]

361 Event background voice(s)

362 PATf

363 MEDf [(??3syll)]

364 DOCf [ciao:]:
(0,7)

365 Event background voice(s)

366 DOCf ma tu sei grandi?ssimo hai un anno e mezzo e già cammini così?

367 MEDf secondo me (??5syll) [(??2syll) ((laughter))]

368 DOCf [(??) i dottori:] e quelli che l'hanno vista [[(??)]]

369 MEDf [[amo:re]]

370 DOCf (??) (risposto ti) hanno già telefonato [(??)] okay.

371 MEDf [dai tesoro]

372 DOCf stanno arrivando così parliamo anche con lui (sul-) sul da farsi
(.) [va bene? per te va bene?]

373 Event background voice(s) background voice(s)

374 MEDf [((kissing))]

375 ((tobetran)) [((tobetran))]

376 DOCf [(and what?)] ma tu sei bellissi[[mo:]]

377 MEDf [[((laughter))]] [[[((laughter))]]]

378 DOCf [[[come ti chiam]]]i?

379 Event background voice(s)

(1,4)

380 DOCf uhm

381 Event background voice(s)

382 MEDf (you see that) [(?? crying)] [[(??)]]

383 DOCf [((tongue click)) oh:]

384 PATf [[((laughter))]] [[[((laughter))]]]

385 DOCf [[[da:i se mi f]]]ai un sorriso ti faccio [vedere la mia lingua]

386 MEDf [dai fai (il) sorriso] fa?i il sorriso alla dottoressa [[dai (.)
dai so]]rrisino ((kissing)) ((laughing))

387 DOCf [[(bra:v- guarda)]]

388 (ma) [(guarda)]

389 MEDf [(uhm)]

390 DOCf

391 (oh)
(2,5)

392 è grande come t[e]

393 MEDf [eh] (??2 syll) [(??1syll)]

394 DOCf [hai visto:?]
(0,9)

395 (parlami io comincio)

396 MEDf ((laughter)) [((laughter))]

397 DOCf [(stai quieto?)]

398 Event background voice(s)

399 MEDf ((laughter)) ((tobetran))

400 DOCf mi arrangi[o]

401 PATf [(??1syll)] (??2syll)

402 MEDf ((tobetran)) [((tobetran))]

403 DOCf [va bene]

404 Event background voice(s)

405 MEDf ((tobetran))

406 DOCf e: quando (??5syll)

407 Event background voice(s)

408 MEDf ((laugher))

409 PATf ((tobetran))

410 Event background voice(s)

411 MEDf big boy (1) big boy ((laughter))

412 Event background voice(s)

413 background voice(s)

414 MEDf no you (work like that.) eh: (for me)

415 PATf ((tobetran))

416 MEDf for me eh? (3) wait

417 PATf °okay°
(1,2)

418 MEDf for me (yeah you know- you accept that) (.) do you understand me?
do the: do the tests (2,5) and see that's (??) what (has) with you
for (??)

419 PATf ((tobetran))

420 MEDf for me (.) ('cause) I don't know [(how)] (??6syll)

421 Event background voice(s)

422 PATf (no more it's not a) (??3syll)

423 MEDf (no matter does it work) (??)

424 Event background voice(s)

425 PATf (°uhm°)

426 MEDf (the birth) induction (.) they call it induction (.) they'll give you (??2syll) force labour giving you something to force you to fall into labour (you know that)

427 Event background voice(s)

428 MEDf no no (I told you you haven't anything to do with it (??) you leave) (??6syll) (.) any forced labour is forced (??) because you (walk)

429 PATf °u:hm°

430 MEDf at the end they will not say there's proble:m (.) (??4syll) way they (will not hurt you) so (.) just take it easy when (??)

431 Event background voice(s)

432 MEDf I just want to tell you (actually:) take it easy [with that]

433 PATf [uhm]

434 MEDf when you [do the sca]n (.) tell them you [don't want to (fall)]

435 PATf [uhm]

436 [uhm? uhm.]

437 MEDf (you don't want) (??) [(hospital)] (.) (you want to be put into labour by the third time you did that) because they want to make

sure that (.) you feel the baby is moving everytime that is (??) if you if you are very careful and you know the baby is moving everytime (.) (??) pregnancy. oka[y?]

438 PATf [(hospital)]

439 (fine)

440 MEDf okay (??)

441 Event background voice(s) background voice(s)

442 MEDf ((tobetran))

443 Event background voice(s)

444 DOCf sì [sì]

445 MEDf [(??)]

446 DOCf

447 MEDf (??)

448 DOCf °(??)°

449 Event background voice(s)

450 MEDf (??)

451 DOCf amo:re [((laughter)) dove vai?]

452 MEDf [((laughter))]

453 DOCf ((laughter)) dove vai amo[:re]

454 MEDf [((laughter))] ((laughter))
(1,3)

455 DOCf amore (.) ciao

456 PATf (??) ((laughter))

457 MEDf mh (.) mh mh mh

458 Event background voice(s)

459 PATf °(??)°

460 DOCf eh ciao amo[re:]

461 MEDf [(??)] (??) [(??)]

462 DOCf [ciao amore ((laughter))] ((laughter))

463 Event background voice(s)

464 DOCf (e lei può stare)

465 Event background voice(s)

466 MEDf (before first pregnant) (.) (if you are going once before now) (??) (.) (because at the first time) (.) it's very difficult like that.

Osp4_010105

001 OBSf (dove hai detto dove vivi?)
(10,8)

002 MEDf (dove dicevi) [(??)]

003 OBSf [non a Mo]dena?

004 PATf no

005 OBSf Savignano?

006 MEDf uhm uhm

007 PATf uhm
(13,0)

008 OBSf mi ha detto il numero?

009 PATf trenta uno ottantadu:e
(8,1)

010 MEDf senti (.) sapete quali sono le ditte pe:r che si paga meno per le:
uhm

011 OBSf (meno)?

012 MEDf qual'è?
(1,1)

013 uhm?
(0,5)

014 OBSf cioè il telefono quello di casa di[ci?]

015 MEDf [uhm] uhm

016 OBSf paghi meno che il cellulare
(0,8)

017 se tu usi il cellulare per eh:m telefonare paghi un sacco di sol[di]

018 MEDf [mh.] voglio dire perché perché [io]

019 OBSf [inve]ce con con il: il telefono di casa (.) paghi me:no (uhm?)

020 MEDf sì no sapete un sistema che costa mo- me:no de:l de:l teleco[m?]

021 OBSf [(allora)] [(??)]

022 [(allora)] [(??)]

023 INTf teledue

024 MEDf teledue
(0,6)

025 tele[due?]

026 OBSf [di]cono °non lo so°
(1,1)

027 MEDf (allora)

028 OBSf uh:m
(1,0)

029 INTf sennò c'è infostra[:d-]

030 OBSf [do]ttoressa (??) vero ti se:gue? la dottoressa del consultorio?
(0,9)

031 (allora) [(the doctor)]

032 MEDf [(ah)] the doctor that is taking care of you in er: Savignano

033 PATf a[h ah:]

034 MEDf [signora]:

035 OBSf (??)

036 MEDf (were you listening?)
(3,0)

037 PATf (??) (??) Roberta

038 OBSf ah la (??) [(??)]

039 PATf [uhm] uhm

040 OBSf l'ostetrica [però la dotto]ressa [[è:]]

041 MEDf [uhm uhm]

042 [[the doc]]tor

043 PATf   ah:
(1,3)

044   °non lo so°
(1,4)

045 OBSf   dottor (??) (0.5) mi aveva chiama:to
(2,6)

046 MEDf   [(??)]
(11,4)

047 PATf   I have a question °question° the meaning of placenta previa
(2,3)

048 OBSf   uhm?

049 MEDf   [(??)]

050 OBSf   allora placenta previa vuol dire che è è praticamente davanti al bambino
(0,6)

051   quindi e: se rimane così bisogna fare il cesareo se invece risa:le non si fa niente (.) quando hai avuto la me[struazione?]

052 MEDf   [(you had)] (??)

053 PATf   dicio:tto (.) maggio.

054 OBSf   diciotto di ma[ggio?]

055 MEDf   [(youknow)] placenta is supposed to be (??) is bad now. the baby will come out first before the placenta will come out
(2,5)

056 PATf   uhm uhm

057 MEDf   do you understand?

058 PATf   mh mh?

059 MEDf   but now the placenta is in the front

060 PATf   uhm [uhm uhm]

061 MEDf   [maybe be]fore you give birth (.) if the placenta goes up [then you can]

062 PATf   [uhm uhm]

063 MEDf deliver like this. they will control you in ecografia

064 PATf uhm uh[m?]

065 MEDf [but] if it remains like that in the front (.) you don't the
placenta does not come up before [you give birth (before Tuesday)
then there will be an operation]

066 OBSf [(??)] (??)
(0,6)

067 MEDf venti?

068 OBSf no qui dice dociotto e qua:ttr[o]

069 MEDf [uhm] sì

070 OBSf no diciotto maggio apri:le
(0,9)

071 PATf ah l'ultima mestrua[zione no]

072 OBSf [eh:]

073 PATf a [aprile]

074 OBSf [aprile]
(36,0)

075 quindi (Marisol) (??)
(0,7)

076 MEDf certo
(1,5)

077 OBSf ah ecco quindi l'orologio

078 MEDf sì:?

079 OBSf uhm
(1,6)

080 (??)
(0,6)

081 MEDf (??)
(1,7)

082 OBSf eh no quello lì è un orologio perché quando ho fatto il prelievo no

[(??) lo levo]

083 MEDf [eh:]

084 OBSf faccio il prelievo allora metto l'orologio

085 faccio il prelievo allora metto l'orologio [dopo un'ora]

086 MEDf [ah:]

087 OBSf mi suo[na]

088 MEDf ah [ah:]

089 OBSf [allora] tutte le volte di guardare l'ora (anche perché poi) no? ti passa l'ora:rio [eh?]

090 MEDf [uhm] vero

091 PATf uhm

092 OBSf allora (??)
(1,2)

093 INTf poco
(0,9)

094 OBSf anche quello la dottoressa si farà poi la cartella: di nuovo
(5,0)

095 quindi se oggi è mercoledì eh ci vediamo eh:m:
(2,0)

096 venerdì
(0,8)

097 PATf venerdì [eh?]

098 OBSf [ve]nerdì
(1,1)

099 ah: no venerdì no che c'abbiamo: abbiamo il congresso. lunedì allora torni lunedì per fa:re di nuovo la flebo

100 PATf ah[:]

101 OBSf okay?
(0,8)

102 PATf °yeah°

103 OBSf come va lì?
(0,9)

104 (sei più bella?)
(0,8)

105 PATf (sì sì)
(1,5)

106 OBSf devi mangiare eh? devi mangiare.

107 MEDf (why? thank you)
(1,1)

108 grazie eh
(1,6)

109 OBSf perché secondo me non mangia tanto [lei]

110 MEDf [(??)] you don't eat? you need to (??) the better for your blood
(.) you can't eat (??) (fresh vegetables) I told [you (??)] (??)
[[(??) eat]] fish fresh fruit (??)

111 PATf [yes]

112 [[okay]]

113 uhm uhm

114 MEDf uhm?

115 uhm? cook that fish

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001 MEDf mi ha detto che: solo quella lì però: la mamma finora non ne hai più
(0,6)

002 DOCf cioè quando ha avuto la pressione [alta la mamma]

003 MEDf [when did she] (??)
(1,0)

004 PATf (??)

005 MEDf u[hm?]

006 PATf [(??)] (??)

007 Event background voice(s)

008 MEDf (??) (qui gli esami)

009 INTf è andata a lezio:ne

010 Event background voice(s)

011 MEDf è avuto per soli due anni poi dopo: non ha più °non ha più:°

012 DOCf altri tipi di malattie [in famiglia non ce ne sono problemi]

013 MEDf [no niente nien-]

014 DOCf di cuore di [diabe]te malformazioni in famiglia[[:]]

015 MEDf [no]

016 [n]o dir[ei n]o

017 DOCf [niente]
(0,7)

018 okay (.) lei è nata a termine di un parto normale? [sua mamma]

019 MEDf [sì]

020 DOCf gli raccontava poi se ((laughter)) [se non lo sa]

021 MEDf [whe- when] (??) your mother gave birth to you. it was up to nine
months.

022 PATf °yes°

023 DOCf uhm uhm? .h eh: (.) beh loro i- io ogni volta che lo chiedo fanno
fatica a ricordarselo gli esantemi cioè il morbillo rosolia
vari[cella loro]

024 MEDf [did] you have these children e: child sickness like the measles
(.) chicken pox (.) ano[ther]

025 PATf [no] (??) [(??)]

026 MEDf [did you have them?]

027 PATf (I don't know) [(??)] (??) [[(??]] (uhm)

028 MEDf [(??)]

029 [[the injections? the vaccinations?]]

030 [no]

031 DOCf [non se] li ricor[[da]]

032 MEDf [[no]]

033 DOCf invece mal[aria?]

034 MEDf [uhm]

035 DOCf ha mai avuto episo:di?

036 MEDf have you had any malaria before?

037 PATf no.

038 MEDf n[o]

039 DOCf [no]:?

040 MEDf no.

041 DOCf o:kay
(1,3)

042 ha mai avuto interventi chirur[gici?]

043 MEDf [did done] operation bef[ore?]

044 PATf [n]o.

045 MEDf no.

046 DOCf mai? ap[pendi]cite tonsille n[[iente?]]

047 MEDf [mai]

048 [[mai]]

049 DOCf eh?
(1,9)

050 °okay°
(1,3)

051 °va bene° fuori (.) dalla gravidanza (.) uhm?

052 MEDf apart from the (grav-) the: preg[nancy]

053 DOCf [nella] vita norma[le (Victoria) sta bene o:]

054 MEDf [(??) (apart from when you are)] pregnant. you are always well you
don't have any [problem]

055 PATf [°yeah°]

056 DOCf non deve prendere delle medici:ne [non ha]

057 MEDf [(even)]

058 DOCf problemi di [tiro:ide]

059 MEDf [even when you are not] pregnant

060 PATf ah: sometimes I have (headache)

061 MEDf sometimes you have it. (.) no e: ogni tanto: c'è mal di testa
(0,7)

062 DOCf ogni tanto mal di test[a]

063 MEDf [s]ì

064 DOCf la tiroide lo stomaco il fegato è tutto a po[sto?]

065 MEDf [sì] sì

066 DOCf mh (.) va bene. (.) sa di essere allergica a qualche farmaco?

067 MEDf (did) you allergic to anything?
(2,1)

068 PATf °(uhm no mh)°

069 MEDf (is there any medicine you take) (??) that caused you problem?
(0,6)

070 PATf yeah

071 MEDf which one?

072 PATf clorochina in Ghana [uhm]

073 MEDf [cloro-]

074 DOCf clorochi[na] eh

075 MEDf [eh:] sempre quel[la]

076 DOCf [oka]y

077 trasfusioni di sangue le ha mai [avute?]

078 MEDf [you (don't)] have blood before they don't give you blood [before]

079 PATf [no:]

080 DOCf [[o]]kay. (.) ascolta (e- e:) se mi puoi aiutare a trovare gli
esami quelli dell'infettivologi[[[a (??) (la tox)]]] l'HIV
l'epatite quelli [[[[là]]]]:

081 MEDf [[no]]

082 [[[(??)]]]

083 [[[[sì]]]]

084 okay

085 DOCf poi guardiamo le cose (.) allora il primo tu hai avuto una
gravidanza? (.) giusto? [il pa]:rto[[:]]

086 MEDf [sì]

087 PATf [[(??)]] (??)

088 MEDf you had one pregnancy

089 DOCf [o no]

090 PATf [(this one)]

091 MEDf one child. how many pregnancy have you had?
(0,9)

092 PATf this one

093 DOCf sì questa è la second[a?]

094 MEDf [(what] abou the other?)

095 DOCf [e come hai]

096 PATf [°yeah°]

097 DOCf partorito?

098 MEDf (what year did you give birth the first time?)

099 PATf °ninety-six°

100 MEDf novantasei
(0,6)

101 DOCf nel novantase:i

102 MEDf sì

103 DOCf com'è andata la gravidanza la [prima?]

104 MEDf [how was] this? (??) [(??)]

105 PATf [yeah]

106 MEDf

107 DOCf [ha]i partorito a te:rmine a fi[:ne:]

108 MEDf [did you give] birth normall[y?]

109 PATf [ye]s

110 DOCf okay
(1,0)

111 non il taglio per giù

112 PATf [(yeah yeah)]

113 MEDf [sì sì no é]: per giù

114 DOCf	io parlo in [termini molto ((laughter))]

115 MEDf	[((laughter))]

116 DOCf	elementa:ri però .h okay (.) e: maschio o femmina?

117 MEDf	°femmina°

118 DOCf	una femmina quanto pesava?
(0,8)

119 MEDf	you know his weight when you gave birth to [him]

120 PATf	[no]:

121 MEDf	to her

122 PATf	(??)

123 MEDf	(can't remember)

124 Event	background voice(s)

125 MEDf	[(it was up to three kilo)]

126 DOCf	[tre due non ti ricor]di?

127 Event	background voice(s)

128 DOCf	no

129 MEDf	you can't remember

130 PATf	(no)
(4,7)

131 DOCf	okay (.) va bene (.) questa gravidanza com'è andata?

132 MEDf	this birth eh io lo so (professoressa) perché lo ve[do al
con]sultorio

133 DOCf	[eh?]

134	dimmi (co[m'è andata)]

135 MEDf	[eh: è andat]a così così perché: per gravidanza è andata bene. cioè
certo punto: e: dottoressa ha fatto: l'ecografia e visto che no:
bambino [non è cresciuto bene]

136 DOCf	[(non cresceva bene)] eh adesso p[oi vediamo intanto] guardo gli

esami

137 MEDf [poi mh]

138 sì
(2,0)

139 (??) I said (??) that I know you right from [the day you] started
(??) (sent to her)

140 PATf [uhm uhm]
(1,7)

141 DOCf °(??)°

142 MEDf °ti interessa anche ecografia dottores[sa?]°

143 DOCf [sì]: sì sì sì °(??) il dieci di aprile (.) (??)° e: dimmi (.)
quindi c'è stata questa: quest'ecografia [che era]

144 MEDf [sì]

145 DOCf un po: [(??2syll)]

146 MEDf [sì:] sì (.) poi: l'ha mandata qua per fare (esa-)

147 DOCf sì
(1,5)

148 ma lei è stata bene?

149 MEDf sì è stata più bene però non mangiava: non mangiava bene: n[o:]

150 DOCf [quant]o pesava prima della gravidan[za?]

151 MEDf [befo]re this pregnancy how many of we- what was your weight?

152 DOCf ah: dammi a me (??2syll) [(così io non)]

153 MEDf [ah okay]

154 DOCf ti faccio perdere del tem[po]

155 MEDf [((laughter))] ((laughter)) sì
(0,7)

156 eighty
(0,7)

157 no: before the pregna[ncy. before the pregnancy]

158 DOCf [prima prima di diventar] grass- (.) [no]

159 MEDf [when] you were pregnant (??) eighty? (.) are you sure?
(0,8)

160 DOCf no: [troppo]

161 PATf [ottant]ta

162 MEDf it can't be (.) it can't be eighty (.) °no no no°
(5,5)

163 DOCf beh? quanto pesavi?

164 MEDf can't remember

165 DOCf ma forse c'è scritto sulla cartellina:?

166 MEDf °eh sì°

167 DOCf l- nella prima visita:

168 MEDf prima visita: [è qua]

169 DOCf [°ci dovrebbe essere] scritto il peso in chilogrammi°
[ottantasette?]

170 MEDf [ottantasette]

171 DOCf e adesso quanto pesi?

172 MEDf adesso è: uhm è diminui:to. l'ultimo: ottantacinque: (.)
cinquecen[to]

173 DOCf [cioè in] gravidanza sei sei dimagri:ta:?
(0,9)

174 uhm mi sembra un po' strana la [cosa]

175 MEDf [eh:] sì (??)
(0,9)

176 qua c'è scritto la prima è: no- nove settimane già ottantasette:
(.) chili.
(1,3)

177 DOCf e adesso quanto pesa?
(1,0)

178 MEDf now how many are you weight?
(0,6)

179 DOCf (prendila)

180 MEDf (dai vuoi [vedere?)]

181 DOCf [(la pe)]siamo [sì]

182 MEDf [do]po (??)
(35,9)

183 mah se noi togliamo un chilo pe:r le scarpe: ottantacinque

184 NURf eh (volevo) parlare col consultorio in via padova. (.) grazie.
(3,4)

185 MEDf (??)

186 DOCf senti a me sembra molto strano che lei sia dimangrita di: un chilo:

187 MEDf °perché non mangiava no[n mangia:va°]

188 DOCf [perché non mangiav]a

189 MEDf °eh: la diceva proprio non riu[sciva (proprio)°]

190 DOCf [è depressa lei?]

191 MEDf vomita:va

192 DOCf è depressa:? (.) lo vuole questo bambi[no?]

193 MEDf [sì]: vuole
(1,8)

194 DOCf [e]

195 MEDf [non ma]ngi[a:va]

196 DOCf [sei sicu]ra che non ha problemi di gestazione?

197 MEDf no:?
(4,5)

198 non mangiava no:n diceva che non riu- quando mangia vomita.
se:mpre? (.) dall'inizio a: fino a o:ra (.) (tu vomiti) (.) vuoi il
numero vuoi? [(??)]

199 NURf [(??)]

200 MEDf dai dimmelo direttamente
(0,8)

201 eh? (.) vuoi il numero [direttamente del consultorio?]

202 NURf [no no (mi arrangio io)]
(1,4)

203 NURf2 ma: sai (qualcosa)
(1,3)

204 ma sai sai qualcosa della signora G. che non è andata a fa:re: la consule:nza?

205 DOCf per la tiroide:? (.) mah io qua ce l'ho: mah lei mi aveva detto di:
(1,6)

206 quando doveva venire? (??)

207 NURf2 lei non si è presentata mercoledì perché nevica:va
(2,0)

208 NURf eh però: [(??)]

209 DOCf [a me non m'ha] chiamato forse ha chiamato Vale:ria
(34,9)

210 ok:a:y:
(1,3)

211 va bene. che: farmaci ha preso in gravidanza la signora?
(0,9)

212 che medicin[e?]

213 MEDf [the] medicine that you are taking you must (tell it to) the doctor (??)
(4,4)

214 DOCf °uhm° Buscopan (dopodiché)
(3,1)

215 MEDf you know that (??) you take it to vomit. you know ferro

216 PATf yes

217 MEDf okay? (??) down
(0,9)

218 PATf a:nd Buscopan

219 MEDf Buscopan

220 PATf yeah

221 DOCf Buscopan

222 MEDf uhm
(4,3)

223 DOCf quant'è alta la signora?
(0,6)

224 MEDf do you know your height?

225 PATf no
(0,7)

226 MEDf ((laughter)) [((laughter))]

227 DOCf [ne sai qualcosa vero]:nica?

228 MEDf (sì adesso te lo devo dire)

229 DOCf ((laughter)) [((laughter))]

230 MEDf [((laughter))]

231 DOCf .h più o meno quanto sarà alta uno e [sessantacin]que[[:]]

232 PATf [(I don't know)]

233 MEDf [uh]m

234 DOCf ((throat clearing))

235 INTf io sono uno e settantadue

236 DOCf quindi (??) ah

237 Event background voice(s)
(0,6)

238 DOCf quindi:

239 MEDf .h con i tacchi è uno:
(1,0)

240 DOCf uno e sessanto:tto [dai]

241 MEDf [sì] sì sì dai
(1,2)

242 DOCf okay

243 Event background voice(s)

244 DOCf questa è bella

245 MEDf ((laughter)) .h (.) no: nessuno guarda questo in Africa quanto è alta [quanto pesi no ne][[ssuno mai]]

246 INTf [[((laughter))]]

247 DOCf [[eh (uhm) però]] ((laughter)) .h [però è impor]tante [[per vedere se è in sovrappeso (??) (cioè)]]

248 MEDf [(??)]

249 [[sì: sì (cioè) eh]]

250 DOCf u- un peso può essere dive- in base al[l'alte:zza: può avere un]

251 MEDf [(??)]

252 DOCf significato dive:rs[[o]]

253 MEDf [[s]]ì

254 DOCf io però non riesco a capire questo fatto che è dimagrita non mi va giù sinceramente

255 PATf °no°

256 DOCf che in tutta la gravidanza lei è dimagrita di[: (??)]

257 MEDf [sì sem]pre così: (.) sempre
(2,1)

258 DOCf allora
(1,6)

259 anche nell'altra gravidanza era dimagrita?

260 MEDf when you were pregnant of the other baby were you like this this situation you are [now?]

261 PATf [no]

262 MEDf (??) no eh?

263 PATf (uhm uhm)
(0,9)

264 MEDf because you had birth in Ghana [at the time]

265 PATf [yeah uhm]
(0,6)

266 DOCf uhm uhm?
(0,6)

267 MEDf non era così
(0,6)

268 (dice lei)

269 DOCf allora (.) oggi le abbiamo fatto il tampone. okay
(43,1)

270 okay
(1,2)

271 allora
(12,8)

272 allora (.) e: (.) dunque domani (.) proveriam- proveremo a fare
l'induzione del pa:rto. tu sai bene com'è un'induzione [no?]

273 MEDf [(eh sì eh)]:

274 DOCf in base alla densità quindi come comincia: (??) il riscontro con la
visita nel collo ute:rino si decide di mettere un gel: (.) a
livello vagina:le oppure l'ossitocina a livello venoso (poi) più
avanti. però (.) eh: sicuramente bisogna dirle (.) che non è tutto
scontato cioè non è che siccome lei ha partorito una volta in un
attimo si sbriga. [ogni donna è diver]sa [[(??) è una storia]]

275 MEDf [sì infatti]

276 [[sì certo]]

277 DOCf a sé

278 [quindi non si deve demora- (??) tempi di]ve:rsi dipende da come
inizia il travaglio cioè non si de:ve demoralizzare né deprimere se
vede che (.) i miei colleghi le metteranno prima un gel poi di
nuovo un'altra (sedazione) dopo sei otto o:re [[e valuteranno lo]]ro

279 MEDf [(e poi il bambino) (??)]

280 [[(sì certo)]]

281 sì

282 DOCf anche il fatto che la rivisitano e le rimettono un gel e la reinducono non vuol dire che è fallita l'induzi[one]

283 MEDf [(eh)]

284 DOCf vuol dire che ci vuole un po' di te- è raro che dopo il primo gel [parte]

285 MEDf [parte]

286 DOCf e [ini]zia il travaglio o[[kay?]]:

287 MEDf [sì]

288 [[(sì)]]

289 so: as I said to you before now tomorrow if you come (.) now (??) parto (??) with induction. you when you come (??) they will now put gel on it on inside your vagina to help you have strong contractions. (.) some women (.) if you give them once they don't go immediately. (??) for they will give once two three times before the: the effect to come. so if they are doing it tomorrow don't have any fear. don't be afraid that oh this is going and disturb you. no? they are only trying to help you. do you understand? if they carry it all out and it it doesn't work they they need to do it and continue the (??). after six hour (.) you'll come and give you another one. it's painful but you have to resist. (??) this like women always give birth. so after (??) if it doesn't work let's (make) it work. they will now put drip. that drip that put injection inside. the the injection also (??) cause induction and give you more contractions after that you can deliver (.) okay?

290 H so they want they want (that the baby come) tomorrow

291 MEDf yes:
(1,5)

292 'cause the risk is too high
(1,4)

293 so: you understand? as you are coming t- tomorrow prepare yourself (.) before you come (.) prepare yourself. (that's it) (.) (arrange) everything. bring your baby (thing suit). bring (??) what you want. (bring them) (??). bring your (night gown) what you need to change.

bring if you: if you want stockings one stocking. the husband (.)
keeps them for you (they bring) (??) uhm? (??)

294 PATf okay
(0,9)

295 MEDf e:
(3,8)

296 NURf chi è la signora che deve fare gli esami questa:? (??)

297 MEDf sì:
(1,3)

298 sì (??)

299 NURf (??)

300 MEDf (??)

301 NURf venga signora si avvicini qu[a]

302 PATf (okay)

303 MEDf come this way. bring bring that chair. (??)
(10,6)

304 so the child is coming (??) (.) there's no worry for the child. (.)
uhm? (.) do- dottoressa dopo fa °uhm uhm°

305 DOCf sì [facciamo do]po [[(??)]]

306 MEDf [(okay)]

307 [[ah o]]kay oka[y]

308 DOCf [(??)] (??)

309 MEDf ((laughter))
(3,5)

310 DOCf allora

311 MEDf °(come)°
(14,0)

312 I will come here tomorrow I come and see you

313 PATf °(okay)°

314 DOCf allora adesso facciamo gli esami

315 MEDf sì

316 DOCf ora le diamo il foglio per andare al quarto pia:no [per fare l'ele]ttrocardiogramma poi lei può andare via

317 MEDf [pe:r]

318 okay

319 DOCf okay?

320 MEDf dopo lei [(dovrebbe:)]

321 DOCf [dovrebbe anda]re al qua:rto pia:no [che]

322 MEDf [sì]

323 DOCf adesso le diamo il foglio [e va a fare. e]

324 MEDf [(??) dottore-]

325 DOCf si presenta domani alle otto e mezza in sala parto

326 MEDf ah sala parto [sì?]

327 DOCf [sì] sì l'astanteria è di fronte deve [fare il]

328 MEDf [sì]

329 DOCf ricovero e poi va [in sala parto]

330 MEDf [ah okay]

331 DOCf subito

332 MEDf va be[ne]

333 DOCf [o]kay?

334 MEDf °va bene°
(67,3)

335 NURf allora
(0,9)

336 °sono qua eh?° [(??)]

337 NURf2 [vuole scrivere il nome] eh?

338 INTf sì sì sì compilo io

339 NURf °così facciamo prima°
(2,0)

340 allora mi da un braccio?
(1,0)

341 DOCf poi fa l'urina anche eh?

342 NURf (bene)
(3,0)

343 (mi dia pure il braccio)
(1,1)

344 mi da questo?
(0,8)

345 quello là no? (.) è più [comoda le]i

346 PATf [((laughter))]

347 ((laughter))
(1,8)

348 NURf (??) (aprirla)
(14,4)

349 MEDf pronto?
(1,6)

350 l'ospedale
(0,9)

351 (??)
(30,7)

352 NURf io sto diventando scema ti vogliono in ecografia veh
(0,8)

353 MEDf io?

354 NURf (ti) vogliono lì (??) [(??)]

355 MEDf [ah] °(okay)°

356 NURf (mh?)

357 DOCf okay spiegale che adesso v- va giù al quarto piano po va via e
torna doma:ni con que:sto fo:glio [miracco]mando

358 MEDf [°okay°]

359 okay

360 DOCf eh? oka[y?]

361 MEDf [n]ow eh?

362 DOCf alle in sala parto.

363 MEDf (let's see eh) you take this and (go to) (.) five er fourth floor
(.) you go and do a test

364 H (ok:ay)
(0,8)

365 MEDf bring this paper with you (.) then when it's finished you can go
home. tomorrow you come with this paper with all your (findings)
everything in sala parto (.) sixth floor (.) uhm?

366 H (??)

367 MEDf er: if you don't enter from the main entrance (.) you take the
first lift to sixth floor sala parto where did you go (.) [(??)]

368 DOCf [dove siete andati un sacco c'hanno tremi:la fo:gli al pronto
soc]corso [ci siete già andati (tante) vo]:lte

369 MEDf [uhm (??)]

370 (yeah?)

371 DOCf uhm uhm

372 MEDf °(okay)° (.) so (sister) (.) (tomorrow I will see you) (.) grazie
dottoressa

373 DOCf [grazie]

374 PATf [ciao]

375 DOCf [[a voi]]

376 H [[(??)]] (??)

377 MEDf (ma scherzi)

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Abstract

The thesis is about a topic of increasing interest in linguistic and social studies, that is interaction involving interlocutors of different languages, whose communication is achieved thanks to the work of a bilingual speaker providing interpreting. The work focuses on a particular setting, that of healthcare, and focuses on the comparison between the performance of "interpreters" with different competence and expertise: intercultural mediators, employed by healthcare services to interpret in bilingual talk, and so called *ad hoc* interpreters, i.e. bilingual relatives or friends accompanying patients to support them in communicating with doctors.

To date no comparative research has been undertaken on these two forms of interpreting. My research is based on an analysis of authentic interactions collected in Italian healthcare services in the areas of Modena and Reggio Emilia and the methods used are mainly derived from conversation analysis. My data are restricted to 6 encounters selected in a way as to be highly comparable: maternity check-ups with intercultural mediators (3 encounters) and *ad hoc* interpreters (3 encounters). The total amount of recording is approximately 45 minutes for the former set of data and 90 minutes for the latter.

The results are as follows:

- Participants in *ad hoc* interpretations created rapport through language shifting and mixing
- The actions of cultural/linguistic-mediators are more oriented to the institutional goals of the interaction (history taking, diagnosing, therapy provision).
- *Ad hoc* interpreters are more suited for relational tasks, e.g. putting the patients at ease or reassuring them
- Cultural-linguistic mediation is more appropriate for interaction centred on diagnosis and cure.

Probably not surprisingly, the conclusion is that ad hoc interpreting seems to be more suitable when the patient needs emotional help and support, whereas interpreting performed by cultural mediators is focused on providing care and instructions about how to deal with the therapies. A point of interest in the data is that while healthcare providers seem to trust cultural mediators and rely on them for interpreting, they tend to bypass ad hoc interpreters and "do without them" in an attempt to reach the patient directly. This suggests that: a. cultural mediators are in a better position to perform as interpreters, even when ad hoc interpreters are linguistically competent; b. that interpreting effectiveness does not depend on the interpreter alone.

Keywords: ad hoc interpreter, mediation, interaction, healthcare

La tesi riguarda una tematica il cui interesse, per quanto riguarda gli studi linguistici e sociologici, è in aumento: il fatto che la comunicazione che coinvolge lingue diverse si realizzi grazie al lavoro di un parlante bilingue che svolge il ruolo di interprete. Il lavoro si focalizza su un setting particolare, ovvero quello medico, e si concentra sul confronto tra i lavori di interpreti con gradi diversi di competenza e con esperienze diverse: mediatori culturali (assunti dai servizi sanitari per interpretare il discorso bilingue) e i cosiddetti interpreti ad hoc, cioè parenti o amici bilingue che accompagnano i pazienti per aiutarli a comunicare con i dottori.

Finora non è stata ancora svolta una ricerca su queste due forme di interpretariato. La mia ricerca si basa sull'analisi di autentiche interazioni registrate in diversi servizi sanitari italiani nella zona di Modena e Reggio Emilia e i metodi utilizzati per l'analisi derivano soprattutto dall'analisi della conversazione. I miei dati si limitano a sei incontri selezionati in modo da poter essere facilmente confrontabili: visite ginecologiche per donne in gravidanza con un mediatore culturale (3 incontri) e con un interprete ad hoc (3 incontri). Il tempo totale di registrazione è approssimativamente di 45 minuti per il primo set e di 90 minuti per il secondo.
I risultati della ricerca sono i seguenti:

- I partecipanti alle interazioni con interprete ad hoc creano una relazione attraverso i cambiamenti e i mix linguistici;
- Le azioni dei mediatori linguistici-culturali sono più orientate verso gli obiettivi istituzionali dell'interazione (storia clinica, diagnosi, impostazione della terapia);
- Gli interpreti ad hoc sono più adatti a svolgere compiti relazionali, ad esempio mettere i pazienti a proprio agio o rassicurarli;
- La mediazione linguistico-culturale risulta più appropriate per l'interazione che si basa fondamentalmente sulla diagnosi e la cura.

Probabilmente non sorprenderà il fatto che in conclusione, l'interpretariato ad hoc sembra essere più adatto quando il paziente necessita di aiuto e supporto emotivi, mentre l'interpretariato svolto dai mediatori culturali si concentra nel prendersi cura del paziente e nel fornirgli istruzioni su come gestire le terapie. Un aspetto interessante emerso dai dati è che mentre gli operatori sanitari sembrano fidarsi dei mediatori culturali e si affidano a loro per l'interpretazione, allo stesso tempo tendono a bypassare gli interpreti ad hoc e a "fare senza di loro" nel tentativo di raggiungere direttamente il paziente. Ciò suggerisce che: a. i mediatori culturali sono in una posizione migliore per svolgere il servizio di interpretariato, anche quando gli interpreti ad hoc sono competenti dal punto di vista linguistico; b. l'efficacia dell'interpretazione non dipende solamente dall'interprete.

Parole chiave: interprete ad hoc, mediazione, interazione, sanità

RELAZIONE SUI TRE ANNI DI DOTTORATO

La ricerca cominciata durante il primo anno di dottorato si proponeva di analizzare le modalità in base alle quali le strutture linguistico-discorsive che caratterizzano i saggi di divulgazione di concetti economico-finanziari scritti in lingua inglese siano cambiate, in certi casi radicalmente, successivamente alla Grande Recessione cominciata nel 2006 con la cosiddetta "crisi dei mutui sub-prime" negli Stati Uniti, e che si è in seguito diffusa globalmente.

Verso la fine del primo anno di dottorato, ha prevalso un interesse per un tipo di studio che avesse un radicamento nella traduzione e nella comunicazione tra culture diverse. La ricerca iniziale è stata quindi in larga parte abbandonata in favore di un progetto centrato sull'oralità, piuttosto che sulla scrittura, e sull'analisi del parlato. Si tratta di un tema che ha ricoperto un interesse crescente negli ultimi vent'anni, nella ricerca linguistica e sociale: l'interpretazione dialogica. La mia ricerca in particolare ha avuto lo scopo di determinare se e in quale misura la relazione che si instaura tra i partecipanti a un'interazione sia influenzata dall'identità e dal ruolo della figura che sta prestando servizio di interpretariato. Della vecchia ricerca rimane la prospettiva incentrata su un'analisi di un corpus di dati, sebbene in questo caso orali (conversazionali) e di diversa tipologia e tematica. L'obiettivo finale della ricerca è quello di riflettere sulle dinamiche discorsive attuate in tali interazioni per eventualmente fornire strumenti relativi alla formazione degli interpreti nella prospettiva di migliorare il servizio da loro prestato. Anche se la ricerca non arriva a coprire l'aspetto applicativo della formazione e si ferma a quello descrittivo (cioè come funzionano queste interazioni), gli spunti di riflessione sollevati possono rendere gli aspiranti interpreti più consapevoli dell'importanza giocata dal loro ruolo professionale e dalle implicazioni relazionali dei loro comportamenti che, inevitabilmente, esercitano un impatto notevole sia sui pazienti, sia sul personale medico.

Tutto l'ultimo periodo del primo anno di corso è stato dedicato alla stesura del nuovo progetto di dottorato a seguito dello studio di manuali atti a fornire una base strumentale per l'analisi di dati interazionali e bilingui. Tale progetto è stato presentato e accolto a metà settembre e il resto del mese è stato dedicato all'approfondimento della nuova disciplina e alla conoscenza della

nuova tutor e della sua équipe di lavoro della quale sono entrata a fare parte.

L'esigenza di redigere un nuovo progetto di dottorato partendo dal presupposto dell'analisi linguistica di due tipi diversi di interpretazione dialogica, ha sollecitato delle riflessioni sulle relazioni che si costruiscono nell'interazione (oltre a come si costruiscono) e su come queste svolgano un ruolo fondamentale nella comunicazione in questo particolare setting professionale.

Il secondo anno di dottorato in Scienze Umanistiche – lingua inglese è cominciato con il passaggio ad altro tutor e, di conseguenza, il lavoro di ricerca è proseguito sulla base di un nuovo progetto, dal titolo provvisorio: "L'interpretazione dialogica in ambito medico-sanitario: una prospettiva interazionale". Nel mese di ottobre sono stati inquadrati l'argomento e il punto focale del progetto stesso, ovvero il confronto delle dinamiche interazionali che si instaurano durante due tipologie diverse di scambio comunicativo tra medico, paziente e interprete: quella che prevede la presenza di un mediatore culturale perché medico e paziente possano interagire, e quella che vede come altro protagonista attivo dell'interazione, oltre al paziente e al medico, il cosiddetto interprete ad-hoc, vale a dire un parente o un conoscente del paziente. Il primo oggetto di riflessione del progetto è stato dunque costituito dalla raccolta dei dati. Si è ipotizzato di raccogliere dieci scambi che presentassero come interprete un mediatore culturale e altri dieci in cui il ruolo di interprete venisse svolto da un parente o conoscente del paziente. Nonostante le numerose richieste di collaborazione inviate a istituzioni sanitarie sia pubbliche che private, la raccolta dei dati per lo svolgimento dell'analisi interazionale si è rivelata infruttifera perchè le istituzioni interpellate non hanno dato il loro assenso. Nella maggioranza dei casi il rifiuto è stato motivato dal timore di ledere il diritto alla privacy dei pazienti e dell'istituzione, sebbene siano stati consegnati, a ciascuna struttura, i moduli di consenso che prevedono una sezione dove viene illustrata la tutela della privacy garantita a tutti i partecipanti. Si è pertanto proceduto all'accurata selezione delle interazioni già presenti nella banca dati del Centro AIM (http://www.aim.unimore.it/site/home.html), ottenendo dieci interazioni con mediatore culturale e tre interazioni con interprete ad-hoc.

Parallelamente alla ricerca e selezione dei dati si è lavorato alla familiarizzazione con il programma “Elan” che permette di trascriverli. Le difficoltà riguardanti l’acquisizione di dimestichezza con questo sistema di gestione dei dati linguistici hanno riguardato principalmente la comprensione del suo funzionamento generale, che si basa su diversi elementi dei quali l’utente deve tenere conto in ogni istante della trascrizione. Inoltre, la corretta segmentazione dei turni che presentano una sovrapposizione delle voci dei parlanti ha richiesto un certo periodo di rodaggio.

Contemporaneamente è stato affrontato lo studio dei manuali di analisi della conversazione, fondamentali per l’approfondimento della disciplina e per l’apprendimento della metodologia di trascrizione delle interazioni. Successivamente si è cominciato a selezionare e analizzare le fonti bibliografiche con il doppio obiettivo di stabilire una base concettuale per la stesura della tesi e di ampliare le prospettive utilizzando diversi punti di vista riguardo lo stesso argomento. A questo proposito sono stati scrupolosamente selezionati articoli e saggi riguardanti lo studio delle diverse forme di interpretazione linguistica e il loro impiego in ambito medico-sanitario, la rilevanza del contesto nello sviluppo dell’interazione (e viceversa), le dinamiche conversazionali presenti nell’interazione tra medico, paziente e interprete, nonché l’influenza degli aspetti interculturali e di medizione dialogica sulle interazioni.

Tra le attività del secondo anno di dottorato vi sono inoltre diversi incontri e lezioni. Le prime due lezioni alle quali ho preso parte sono state tenute dalla mia tutor, Prof.ssa Laura Gavioli e riguardavano la metodologia dell’Analisi della Conversazione. Questi incontri mi hanno permesso in parte di riassumere le conoscenze apprese dai manuali di analisi della conversazione, in parte di osservare dettagliatamente il funzionamento delle interazioni grazie alla spiegazione di numerosi esempi concreti. La partecipazione alla riunione AIM di dicembre 2016 ha reso possibile il contatto con persone provenienti da altre Università che si occupano delle stesse tematiche. Tale confronto ha stimolato la riflessione sui molteplici impieghi della disciplina di analisi della conversazione, le sue applicazioni e le diverse dinamiche che la caratterizzano. Contemporaneamente, in base a un’ipotesi scaturita dallo studio dei dati che si era cominciato ad analizzare, è stato realizzato un abstract per la proposta di una relazione al convegno IADA che si sarebbe tenuto a Bologna l’anno seguente (ottobre 2017). La proposta riguardava il confronto tra due interazioni registrate in un

ospedale del Nord Italia. Protagonisti di entrambe le interazioni erano un'ostetrica, una paziente in gravidanza e un interprete, ma nella prima interazione presa in esame, il lavoro di interpretariato è stato svolto dal marito della paziente (interprete ad-hoc), nella seconda da una mediatrice culturale. Si è osservato che, in entrambi i casi, le azioni dell'interprete sono state determinanti per coordinare l'incontro in modo tale da influenzare significativamente il rapporto tra i partecipanti, a loro volta co-costruttori attivi dell'interazione, ma anche che tale risultato è stato realizzato secondo modalità differenti.

Nello stesso periodo è pervenuta la comunicazione di accettazione ai due workshop "Beginners Conversation Analysis" e "Applied Conversation Analysis" presso l'Università di Loughborough (U.K.) tenuti, rispettivamente, dal Prof. Charles Antaki e dal Prof. Paul Drew insieme alla Prof.ssa Laura Thompson. Il workshop del Prof. Antaki si è rivelato particolarmente utile per comprendere a fondo la struttura dell'analisi della conversazione, evidenziando attraverso esempi concreti i meccanismi di questa disciplina, fondamentale per lo studio delle interazioni. Inoltre, il workshop del Prof. Drew e della Prof.ssa Thompson, attraverso l'osservazione di alcuni dialoghi svoltisi prevalentemente in ambito medico-sanitario, ha chiarito la funzione sociale dell'analisi della conversazione e le sue diverse applicazioni, sottolineandone l'utilità e il metodo di impiego. Queste due esperienze sono state basilari per l'apprendimento di una metodologia di analisi che potesse essere applicata ai dati della tesi. A seguito delle riflessioni maturate grazie alla partecipazione a questi workshops è stato inviato un secondo abstract con una proposta di partecipazione al convegno CACE che si sarebbe svolto presso l'Università di Bristol (U.K.) nel luglio 2017. Anche questo studio ha portato a riflessioni utili agli scopi della tesi.

In seguito, con il fine di approfondire ulteriormente e contestualizzare in ambito medico-sanitario quanto appreso a Loughborough, si è deciso di fare domanda per partecipare al workshop "CA Workshop on Diagnosis in Primary Care" tenuto dal Prof. John Heritage presso l'Università "La Sapienza" di Roma. I due giorni passati con il Prof. Heritage sono stati utili per comprendere a fondo i meccanismi interazionali che si attivano tra medico e paziente durante diverse tipologie di visite mediche, grazie anche alle registrazioni video effettuate presso una struttura sanitaria statunitense che, oltre a presentare il dialogo tra i partecipanti,

mostravano le espressioni facciali e la postura degli stessi durante lo svolgimento della visita. Inoltre, nel corso del seminario, sono state presentate sia la struttura della visita medica, che la storia degli studi compiuti per analizzarla. Un'ulteriore giornata di studio con il Prof. Heritage "Diagnosis in Primary Care Practice: Slots, Formats and Response and Patients" presso la medesima Università a Roma ha avuto come obiettivo l'illustrazione e la sintesi dei concetti espressi nel workshop precedente. Questo incontro, sostanzialmente riassuntivo, ha avuto la funzione di evidenziare le dinamiche conversazionali e sociali che si instaurano inevitabilmente nel setting sanitario tra medico e paziente, oltre ad aver garantito un confronto diretto con il Prof. Heritage. In quest'ottica è proseguito il lavoro di trascrizione e di analisi dei dati a disposizione, parallelamente alla preparazione della presentazione PowerPoint per il convegno CACE di luglio 2017.

A causa di gravi problemi di salute, per i quali è stato inaspettatamente necessario un intervento chirurgico in data 28/06/2017, purtroppo non è stato possibile prendere parte al convegno CACE. Durante la convalescenza si è cominciato a preparare la presentazione PowerPoint per IADA, ma l'esigenza di sottoporsi a un nuovo intervento chirurgico in data 20/09/2017 ha reso indispensabile sollecitare una sospensione di tre mesi dall'attività dottorale all'inizio di settembre, che è stata poi successivamente prolungata di altri due mesi per complicanze post operatorie.

Il terzo anno di dottorato si è concentrato sulla messa a punto di dati e bibliografia per la redazione della tesi finale, che prevede un'analisi di interazioni medico-paziente, a cui partecipa nel ruolo di traduttore un familiare del paziente, oppure un mediatore fornito dal servizio sanitario. L'anno è cominciato con una riflessione sui dati raccolti e trascritti fino al mese di ottobre 2018. Il mese di ottobre è stato caratterizzato dalla trascrizione delle ultime interazioni di ambito ginecologico, che vedono come protagonisti un interprete-familiare (cosiddetto interprete "ad hoc"), la paziente e l'ostetrica che la segue durante diverse fasi della gravidanza. Poiché queste interazioni sono piuttosto lunghe e caratterizzate da frequenti sovrapposizioni e interruzioni da parte di altro personale medico-sanitario, la loro trascrizione ha richiesto un notevole impegno in termini di tempo. Durante il mese di novembre si è svolta anche la trascrizione di un'interazione mediata da mediatore

semi-professionale. L'ambito è sempre quello medico-sanitario ginecologico, e l'incontro in questione vede come partecipanti all'interazione il mediatore culturale, una paziente in diversi momenti del processo di gravidanza e un'ostetrica con il compito di valutare lo stato di salute della paziente durante lo svolgimento della visita. Questa trascrizione ha rappresentato un impegno minore rispetto alle interazioni ad hoc: l'interazione trascritta e successivamente analizzata è infatti caratterizzata da una minore quantità di sovrapposizioni e interruzioni da parte di altre persone, è più breve e il linguaggio utilizzato risulta essere più professionale e meno confidenziale. Pertanto, il lavoro è stato meno impegnativo, sia intermini di tempo di trascrizione che di porcesso di analisi. Di pari passo alla trascrizione dell'interazione mediata si è cominciato un ripasso approfondito della bibliografia generale, con particolare attenzione ad autori che si sono occupati di interazione in ambito medico-sanitario. Poiché lo strumento metodologico utilizzato per l'analisi dei dati è basato sui principi fondamentali dell'Analisi della Conversazione, nel mese di dicembre si è proceduto a una revisione di tale metodologia, che si è sviluppata soprattutto su manuali dedicati all'illustrazione della stessa. Inoltre, nello stesso periodo, si è cominciata una schematizzazione della struttura della tesi e della sua suddivisione in capitoli al fine di mettere a fuoco il punto centrale quello del confronto tra le interazioni con interprete ad hoc e le interazioni mediate da semi-professionista, con l'obiettivo principale di capire quali aspetti hanno in comune, e da quali differenze sono caratterizzate. A questo proposito, durante le vacanze natalizie si è proceduto alla revisione sostanziale della bibliografia riguardante sia le interazioni ad hoc, sia quelle mediate e ad analizzare le caratteristiche dell'impiego dell'una o dell'altra forma di interpretazione. A inizio gennaio 2019 si è cominciata la stesura della tesi, partendo dal primo capitolo riguardante l'interpretariato ad hoc e la percezione generale dell'impiego di interpreti ad hoc negli Stati Uniti e in Europa. La redazione del primo capitolo ha richiesto circa un mese di tempo e il suo contenuto è stato caratterizzato da una grande quantità di informazioni nonchè dalla vasta gamma di punti di vista sull'utilizzo, da parte di diverse tipologie di istituzioni, di un parente del paziente per lo svolgimento dell'attività di interprete. Nel mese di febbraio si è revisionato attentamente il primo capitolo, concentrandosi principalmente sugli aspetti caratterizzanti l'interpretariato ad hoc in ambito sanitario. Inoltre si è sviluppata un'ulteriore riflessione

sulla letteratura disponibile in merito. Nella seconda parte del mese si sono analizzate le fonti bibliografiche riguardanti la mediazione culturale e l'angolatura concettuale che vede l'interazione tra l'interprete e gli altri due partecipanti all'interazione come una continua serie di azioni di coordinamento conversazionale. L'elencazione ed analisi delle suddette fonti avrebbero costituito il fulcro del secondo capitolo. Si è quindi proceduto alla stesura dello stesso che, oltre a trattare aspetti propri dell'interazione mediata, introduce anche certi concetti caratterizzanti l'analisi della conversazione, ovvero lo strumento metodologico utilizzato per l'esplorazione dei dati presentati. La stesura del capitolo si è rivelata particolarmente complessa, in quanto le fonti bibliografiche sono di difficile rielaborazione in relazione all'argomentazione presentata nella tesi. Pertanto, nel mese di aprile e di maggio si è rivisto il capitolo diverse volte, con lo scopo di connetterlo concettualmente a quello precedente e a quelli a seguire. Nel mese di giugno si è cominciato a redigere il terzo capitolo, che spiega la metodologia utilizzata per l'analisi dei dati, che avrebbe poi costituito il cuore del quarto e ultimo capitolo, nonchè quello della tesi. Tutto il mese di giugno e i primi giorni di luglio sono stati dedicati alternativamente ad una revisione dei concetti fondamentali dell'analisi della conversazione per poi proseguire con la spiegazione di tale metodo per l'analisi delle conversazioni raccolte. Durante il mese di giugno si sono esplorate le fasi storiche dello sviluppo dell'analisi della conversazione come strumento di osservazione ed è stata svolta un'analisi dei pattern propri dell'interazione tra individui, argomento che avrebbe poi costituito la parte iniziale del capitolo. Nel mese di luglio si è proceduto alla stesura della seconda parte del capitolo, che si focalizza sulle ragioni per cui si è scelto di optare per l'analisi della conversazione come strumento metodologico e sull'introduzione della natura dei dati che sarebbero poi stati analizzati nel quarto capitolo. Gli ultimi mesi, incluso quello corrente, sono stati interamente spesi sulla scrittura dei capitoli analitici della tesi, sull'applicazione dei concetti teorici e metodologici all'analisi dei dati e sulla riflessione che porta al confronto tra le due tipologie raccolte.

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