Patients' Empowerment through Cultural Mediators in Healthcare Settings

by
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Abstract

The purpose of the present dissertation has been to provide insights into the role of cultural mediators in enhancing patients' empowerment medical encounters. Specific attention was paid to relations of power between mediators and heath staff understood in terms of the attribution of value to resources of knowledge.

The research takes a linguistic ethnographic approach to examining mediation within healthcare settings. Data-gathering techniques included recorded mediated interactions, interviews with healthcare staff and mediators, observations, analysis of hospital documents and visual material.

Findings show that mediators have a considerable impact on patients' empowerment. The data seems to confirm that mediators empower migrant patients in those cases when patients seek information and express concerns. Nevertheless, the research demonstrated that mediators prevent patients' participation and maintain the status quo of the healthcare system when patients make decisions and express refusals. The findings demonstrate the need to implement training programmes for both healthcare providers and mediators to become more aware of their role of coordinators in the interaction. Additionally, there is a need for heath staff to attribute a higher value to mediators' cultural capital and the need for healthcare institutions to recognise mediators as a professional group.

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Chapter One

Introduction

This study investigates the role of cultural mediators in enhancing patients' empowerment during medical encounters. It critically examines the use of mediators in response to the demands posed to healthcare services by the arrival to the city of Barcelona of migrants from various language and cultural backgrounds. The present chapter outlines the origin of this study and introduces the research questions before going on to detail the research aims and methodology.

Over the past two decades, globalisation has altered the face of social, cultural and linguistic diversity all over the world and new population flows have brought about major demographic changes. Populations have become more diverse as a result of increased migration and the territorial origins of migrants have become more varied. The increased diversity brings new challenges for contemporary societies, including the provision of health services, since the number and frequency of cross-linguistic and cross-cultural medical encounters increase considerably. In this study, then, I will explore the role of the cultural mediator within these socio-medical interactions.

Migrants' culture, traditions, religion, their way of understanding health and illness, language barriers and differences in life style, can make access to healthcare services for these groups more difficult. Migrants and ethnic minority groups are often more vulnerable than the average population, due to their lower socio-economic position and sometimes because of traumatic migration experiences and lack of adequate social support. One of the main challenges migrant healthcare users have to face is that they frequently lack language and socio-cultural knowledge required to fit into the healthcare institution.

A premise in this context would be the search and/or the creation of the necessary tools to guarantee adequate healthcare assistance for all these groups, taking into account their idiosyncrasies and cultural differences. In cultural and interlinguistic medical interactions when a common language is not shared, healthcare staff may rely on the help of cultural mediators to bridge the language and cultural gap between them and the migrant clientele. Cultural mediators are usually required when lack of cultural awareness and understanding of the system is the main impediment for the

migrant population to access and benefit from health services (Martín & Phelan, 2009). In addition to helping migrants access and use healthcare services, mediators can therefore play an important role in empowering patients by encouraging them to voice their needs.

Whilst there now exists a robust body of research on patient empowerment, there has to date been limited exploration of the role of mediators in this process. My aim is therefore to explore this role and the impact that mediators have on patient empowerment. Before moving on to outline the research questions and the aims of the study, it is important, first of all, to address the difference (if any) between the terms 'cultural mediator' and 'medical interpreter'. Since these are terms which are sometimes used interchangeably, this clarification is needed to avoid confusion, in particular to medical staff who may expect mediators to perform tasks that are outside their role boundaries.

1.1 Differences between Medical Interpreters and Cultural Mediators

Review from the literature reveals that medical interpreting and cultural mediation are sometimes considered separate concepts. For Martín and Phelan (2009), the roles of the medical interpreter and cultural mediator are complementary and distinct. They argue that, while the role of medical interpreters is to bridge the language barriers, which involves conveying the information transmitted in one language as accurately and as completely as possible into another, cultural mediators are seen to act as cultural brokers who bridge two different culturally specific views (that of the doctor and of the patient) of health and healthcare. Martín and Phelan (2009) also believe that mediators often have to provide cultural explanations (to explain, for instance, why a patient is unwilling to participate), whereas interpreters only provide cultural explanations as a last resort. They argue that mediators are also a resource to inform patients of the way the health system works and how it should be accessed.

However, according to other scholars (Katan, 2004; Rudvin and Tomassini, 2008; Taft, 1981; Verrept, 2008) mediators and interpreters are equivalent terms. For Rudvin and Tomassini (2008, p.261), the notions of mediation and interpreting are inextricably intertwined. Interpreters and cultural mediators can be expected to coexist, side by side, most likely in a constructive, complementary relationship. They state that:

Mediators are professionals with expert knowledge of both cultures, capable of recognising and understanding the speakers' cultural references and then of either openly explaining them to their listener or of 'absorbing' them into their translation whilst adapting it to the culture of the listener. In this way they could convey what they interpret as the actual meaning of the discourse, beyond the single words.

In the same vein, Katan (2004) and Taft (1981) consider mediation and interpreting as the same concept. Katan (2004) discusses that, since interpreters and cultural mediators include culture as part of their remit, there is therefore no difference between interpreting and mediation. In his contribution to Bochner's (1981) volume *The Mediating Person*, Taft (1981, p.53) also states that the cultural mediator's role is the same as that as the interpreter and he defines the role of the mediator as follows:

A cultural mediator is a person who facilitates communication, understanding and action between persons or groups who differ with respect to language and culture. The role of the mediator is performed by interpreting the expressions, intentions, perceptions and expectations of each cultural group to the other, that is, by establishing and balancing the communication between them.

For Verrept (2008), the terms 'medical interpreter' and 'cultural mediator' are often used in an inconsistent way and their tasks and roles vary considerably across different projects, local or regional contexts and even across countries. Therefore, since mediators and interpreters need to undertake a variety of overlapping tasks and roles, it is often difficult to pin down a precise task description for cultural mediators. For the purpose of this study, there is no difference between medical interpreters and mediators and I agree with the scholars who consider both terms as equivalent (Katan, 2004; Rudvin and Tomassini, 2008; Taft, 1981; Verrept, 2008).

The staff of the clinic where the study was based seemed to consider mediators and interpreters as different professions and doctors often used the term "mediator" in juxtaposition with what is perceived as the more prestigious role of "interpreter". Before moving onto the research questions, I present an overview of the role

description of cultural mediators in healthcare settings and in the Catalan healthcare context in particular.

1.2 Role Description of Cultural Mediators in Healthcare Settings

Despite the difficulty in identifying a professional profile for mediators based on a sum of the abovementioned diverse tasks, some scholars have developed programmes which include complete role descriptions. In this vein, the Interpreter Cultural Mediator (ICM) model developed by Jackson-Carroll et al. (1997) at the Harborview Medical Center in Seattle, Washington, provides a comprehensive overview of the responsibilities of the cultural mediator. The cultural mediators' summary position description developed by Jackson-Carroll et al. (see Table 1 below) highlights in particular the mediator's task as cultural broker, where they are in charge of removing cultural barriers and providing explanations about cultural differences that may hinder communication with migrant patients.

✓ **Interpret and mediate for families and providers in primary care clinics**
✓ **Focus on cultural and social circumstances that may impact care, as well as basic health information during the patient-mediator-doctor interaction**
✓ **Provide cultural information to the clinic providers and staff**
✓ **Work with the clinic quality improvement committees to remove linguistic and cultural barriers to care for the target communities**
✓ **Work as a team member with the directors, program coordinators, community advisors, health providers and other participants**
✓ **Provide explanations about cultural differences that may hinder communication with migrant patients**

Table 1. Cultural mediators' summary position description

In Catalan healthcare settings, cultural mediators are usually called to be present in medical consultations when doctors are unable to make themselves understood by patients and cannot get the information they need in order to reach an accurate diagnosis and recommend a treatment. Very often, they are called on in the middle of a consultation when communication has broken down and doctors feel they have not been understood and therefore cannot do their job properly. Cultural mediators often perform administrative work, they often work at the hospital reception area, making

appointments for migrant patients, answering queries either on the phone or face-to-face, programming patients for specific blood or X-ray tests and providing information about how to obtain a medical card, etc.

Some of the activities in which they are frequently asked to engage involve spending a considerable amount of time outside of the consultation room to explain to patients how the health system works and the reason behind the tests they may have to undergo. Although some mediators undergo specific training to become certified cultural mediators, very often unqualified cultural mediators, who share a common cultural and language background with the migrant clientele, are amongst those who are employed to improve the quality of communication between healthcare providers and ethnic minority patients.

1.3 Research Questions and Aims

By recognising mediated medical encounters as a complex phenomenon that requires participants to negotiate meaning, a number of questions are addressed. Firstly, the broad research question this thesis aims to answer is whether cultural mediators in healthcare interactions allow migrant patients to be empowered. More specifically, it seeks to discover what strategies (if any) mediators use to foster patients' empowerment. In this study, patient empowerment is understood as "a process whereby patients have the knowledge, skills, attitudes and self-awareness necessary to influence their own behaviour and that of others in order to improve the quality of their lives" (Funnell et al., 1991, p.37). Empowerment is also understood as those "activities on the patient´s side, such as communicating effectively with providers, receiving and understanding useful health education, understanding explanations of treatments and being able to ask questions and discuss implications" (Bischoff, 2006, p.82).

Secondly, I intend to consider what the mediators' perception of their own role is in relation to empowering patients. My focus is directed to the main practices they claim they perform and the subsequent consequences of these practices on patients'empowerment.

Thirdly, I seek to determine to what extent mediation is an effective way to change the status quo of social systems or if it mainly serves the purpose of supporting doctor-centred communication.

My aim is to generate a rich description of the mediating process, in order to gain an in-depth understanding of what occurs regarding patients' empowerment in medical encounters where the mediator is an active participant. Through providing a fine-grained linguistic analysis of mediated interactions, based upon an ethnographic approach to data collection, the study seeks to make connections between the tensions that occur on a micro level, to the wider social and ideological accounts that frame the mediated events. The sociolinguistic investigation reported here integrates different levels of analysis and enquires into the ways in which these different domains bear upon one another. On a macro level, it is concerned with the issues of power, social inequality and ideology. To understand macro-level social processes, the present thesis draws on concepts from the sociological models of Bourdieu (1977, 1991) and Giddens (1979, 1984). The approach to the understanding of the micro-level is critical and is particularly influenced by Goffman's (1981) analytical model of participation framework.

1.4 Methodology

In order to provide a contextually rich account of the processes involved in mediation in a health institution, I undertook an ethnographic study over a six-month period. The detailed experiences collected during these six months gave me a rich understanding of complex phenomena that occur within this particular healthcare environment.

Data for this research were collected in two stages. In the initial stage, interviews were conducted with mediators and health staff (5 mediators, 8 doctors, 1 nurse) in order to obtain their insights into their daily practices with migrant patients. Audio recording of mediated medical interactions formed the second stage of data collection. In addition, the empirical basis on which claims are made consists of six-month participant observation and visits to the hospital where fieldwork material was collected.

1.5 Thesis Structure

So far, in this chapter, I have outlined the origin of the study, highlighted the research questions and aims and have briefly described the data upon which I intend to draw. Chapter Two describes the theoretical framework that has been applied in the study and reviews the relevant literature relating to cultural mediators and patients' empowerment. This chapter also examines key studies on interpreting in medical settings and discusses definitions of the role of cultural mediators in healthcare settings.   An overview of power relations in monolingual and bilingual medical encounters is presented together with a review of Giddens' (1979) concept of *agency* as a means of understanding mediators' role in patient empowerment.   The chapter concludes with a discussion of the definition of empowerment and a review of patients' empowerment in monolingual and bilingual healthcare encounters.

Chapter Three discusses the methodology used in the study and outlines the data collection process. The setting and participants are presented. In this chapter, I address the challenges of obtaining access to the research site and the sensitive nature of conducting research in healthcare settings. I also present the various qualitative data collection methods, beginning with the interviews.   I then detail the collection of the audio-recorded data and the difficulties posed by the transcription of mediated interaction are highlighted.

Chapter Four is the first of the two findings chapters and presents the data gathered from the interviews, which are thematically analysed. My approach in this study was to take the articulations of patient empowerment elicited in the interviews with mediators and healthcare staff and contrast them with the interactional data from mediated medical encounters.

In Chapter Five, the second findings chapter, the recorded data from medical encounters are analysed and discussed. This chapter provides insights into patient empowerment in situations where patients seek information, express concerns and make decisions. It analyses the extent to which the claims that mediators and doctors made in their interviews match the actual practices undertaken in medical encounters.

In Chapter Six, I review the two sets of data. I show that the presence of cultural mediators has considerable implications on the empowerment of patients, despite the fact that they have to deal with institutional constraints and power imbalances. This chapter also presents the key contributions of this thesis and a discussion of the opportunities for further research that emerged from this work.

1.6 Significance of the Study

This thesis illustrates that the issue of patients' empowerment through the mediator is linked directly to questions of how healthcare professionals actually consider the mediator's role. Mediators' lack of specialised medical knowledge places them in a potentially less powerful position, and healthcare staff, as a result, question their role. My study demonstrates the complexities of empowerment in cross-cultural and cross-language medical interactions, where different cultural expectations, different standards of knowledge of medical language and different levels of power potential in the negotiation for consent are at play.

As my study will show, the contribution of mediators in these complex situations is indispensable if patients are to be empowered. However, institutional constraints may lead to mediators' disempowerment, thus not allowing them to always empower patients. This represents one of the key findings from my research.

1.7 Concluding Remarks

This chapter has provided background information relating to the origin of the present study and has introduced the research questions. The aims of the study have been outlined and an overview of the thesis structure has been detailed. I have suggested that this study will contribute not only to knowledge in community interpreting studies, but also in the sociolinguistic aspect of institutional discourse. This thesis addresses to a variety of readers, such as researchers, healthcare staff, policy makers and mediators. Researchers concerned with mediation may make the most use of the bibliography of this study, while healthcare staff may gain valuable knowledge of some of the challenges of working through mediators. It might also help policy makers dealing with healthcare for migrant clientele to implement measures for

achieving greater linguistic diversity, while mediators may find useful insights about their daily and complex practice.

The following chapter will outline the main issues regarding the empowering role of cultural mediators in interlinguistic interactions in healthcare services.

Chapter Two

Critical Literature Review

This chapter seeks to provide a background to the study and will outline the main issues pertinent to the role of cultural mediators in relation to empowering patients in interlinguistic interactions in healthcare services. Patients' empowerment is a complex process aimed at increasing the patient's capacity to make autonomous, informed decisions and the exploration of this process in the healthcare domain means that the relevant literature is necessarily inter-disciplinary. The points I make in this section will remain relevant to the key areas identified earlier in Chapter One, considering the primary parties engaged in the mediated interaction.

The chapter is divided into four main sections. In order to place the current research in context, i begin in Section 2.1 by considering some of the most notable studies on interpreting in medical settings. This section will also examine Goffman's (1981) analytical model of participation framework and his concepts of frame and footing will serve as a useful tool to understand the three-way exchange between the mediators and those for whom they are interpreting. It is therefore essential to explore the mediated interaction order where mediators might be seen to shift footing within an exchange to better understand their contribution to patients' empowerment.

Section 2.2 examines the role of the cultural mediator in healthcare settings and presents research that reinforce the view of the mediator as an active third participant in interpreted interactions. Detailed attention is paid to the specific ways in which mediators can influence the discourse event and the impact that they have on primary participants. In an attempt to explain the performance of mediators, basic concepts of Bourdieu's social theory such as field and habitus applied to interpreting are also explored.

Section 2.3 presents an overview of power relations and distribution of power in monolingual and bilingual medical encounters. From the perspective of interpreting as a socially-situated activity, this section also looks at Bourdieu, Giddens and Fairclough's concepts of power as useful analytical tools to understand the power

exercised by the mediator in medical encounters. Bourdieu's concept of resources and the attribution of different value to different resources of knowledge will also be reviewed in an attempt to understand how power is exerted in healthcare communication processes. The section ends with a review of Giddens' concept of agency to help understand how mediators are capable of empowering patients to exercise their responsibility and make decisions for themselves.

I conclude my review in Section 2.4 with a critical review of the literature on empowerment. This section focuses on the concept and characteristics of empowerment and organises patient empowerment indicators into three main categories: Provision of Information, Expression of Emotions and Decision Making. The mediator's role as an empowerment figure is outlined as well as his/her capability of empowering patients to exercise their responsibility. The section ends with a review of patients' empowerment in monolingual and bilingual healthcare encounters. In Section 2.5, I conclude with a summary of the issues that have been examined in this chapter.

2.1 Studies on Interpreting in Medical Settings

Early studies on healthcare interpreting and interpreting studies more generally were focused on the accuracy and completeness of the interpreters´ renditions and the nature of any deviations or errors (van Dijk, 1997). The error model tended to view the interpreter as a conduit as opposed to a meaning conveyer (Reddy, 1979) where communication is seen as the transfer of information from a sender to a receiver and assumes that the speaker creates meanings. This model considers human interaction as a 'unidirectional process of transfer' from one person to another. The model is *monologic*, which means that language is regarded from the perspective of the speaker and co-present people (including interpreters involved in the conversation) are seen as recipients of the units of information prepared by the speaker (Wadensjö, 1998).

In the conduit model, interpreters are taught to achieve neutrality by remaining passive, allowing the speakers to do the talking, thinking and negotiating. This model assumes that the interpreter does not have any communicative goals or personal agenda. As Hsieh (2009, p. 135) puts it:

Interpreters have been traditionally conceptualised as conduits, invisible non-thinking language modems that allow providers and patients who do not share a common language to communicate with each other.

For Hsieh (2009), there are three main reasons behind the popularity of the conduit model: (a) interpreters traditionally have been expected to claim an invisible role, (b) a conduit model appears to be an easy way of interpretation and requires minimal training and (c) the conduit model suggests that the speakers are the only persons to have control over the process and content of communication, therefore it assumes that interpreters say exactly what they said.

The idea of the interpreter as a translating machine, neutral and invisible is one that still informs the understanding of both interpreters and service users (Roy 1993; Dean & Pollard 2005; Moody 2007). However, the interpreter as active third participant, with "the potential to influence both the direction and outcome of the event" (Roy, 1993, p.151) has seen a turn towards a model of the interpreter as someone who is actively engaged in coordinating and negotiating meanings in triadic interaction (Mason 1999; Turner, 2007b).

However, there has been a move away from the earlier focus on errors in the interpreting product and the interpreters as a conduit, to a concern with the interactional role played by interpreters in interpreter-mediated interactions, where they are seen as active participants and *co-constructors* to the interaction (see Berk-Seligson, 1990; Metzger, 1999; Roy, 1989, 2000; Wadensjö, 1992, 1998).

The interpreter as a co-participant in the interpreted communicative event has been studied extensively using discourse analysis (Davidson 1998, 2000, 2001; Metzger 1999; Roy 1989, 2000; Wadensjö 1995, 1998). Davidson (2000, 2001) and Metzger (1999) challenge the notion of neutrality, while studying the participation of interpreters during interactions.

Following Bakhtin's (1979,1986) interactionistic view of language, Wadensjö (1998) suggests a new direction for research on interpretation based on a *dialogic* (rather than *monologic*) view on language, and she understands interpreter-mediated interactions in terms of "a communicative pas de trois, where the primary parties, as well as the

interpreter, may occasionally mobilize various levels of understanding" (Wadensjö, 1998, p.153). In these interactions, the lack of communicative contact between two parties not talking each other´s language and not sharing the same culture is overcome by the presence of the interpreter.

Angelelli has demonstrated that the interpreters' visibility means that "their role goes beyond simply encoding and decoding other people's messages cross-linguistically to bridge a communication gap, but instead that they exercise agency within the interaction" (Angelelli, 2003, p.13). In the same vein, Stewart et al. (1998) suggest that all participants engaged in interpreted interaction are responsible for communication. The following section explores the different roles that interpreters and mediators, as active co- participants, do play in healthcare multilingual interactions.

There is now a significant body of work that looks at interpreting through this interactional lens and specifically in the field of medical interpreting (see Angelelli, 2004; Athorp and Downing, 1996; Bolden, 2000; Davidson, 1998, 2000, 2001; Downing, 1991; Kaufert and Koolage, 1984; Kaufert and Putsch, 1987; Metzger, 1999 and Wadensjö, 1998).

All these interaction-oriented studies on medical interpreting have emphasised the crucial role that interpreters play in managing communication between doctors and their patients. All these works share in common the view that interpreters do not merely convey messages; "they shape, and, in some very real sense, create those messages in the name of those for whom they speak" (Davidson, 2000, p.382)

Among studies of language and discourse that have turned their attention to the nature and consequences of the interpreter's role, we find Kauffert and Koolage's (1984) as a significant one. Their work focuses on the cultural complexities involved in the interpreter´s tasks and highlights the crucial role that interpreters play as cultural brokers. In her study of the role of medical interpreters in structuring interaction between healthcare providers and their patients, Bolden (2000) dismantles the image of interpreters as 'non-participants'. She demonstrates that medical interpreters share the doctors' normative orientation to obtaining objectively formulated information about relevant biomedical aspects of patients' conditions.

In the same vein as Bolden, Angelelli's (2004) *model of visibility* portrays interpreters not only as linguistically visible, but also "visible with all the social and cultural factors that allow them to co-construct a definition of reality with the other co-participants to the interaction" (Angelelli, 2004, p.9). Also focusing on interactional issues, Davidson (2000) goes one step further and argues that there is a gap between what interpreters are officially asked to do and what they are really doing in daily practice, which allows the interpreting practice to continue unmonitored and unevaluated.

Many interpreting scholars who have looked at medical interpreting through the international lens have drawn on Goffman's (1981) analytical model of *participation framework* and his 1961 theoretical model of social interaction. Goffman's framework (1961) understands encounters as socially complex productions where participants constantly define and redefine the situation as part of an on-going interaction. He stresses the reciprocal impact of interactional behaviour on the individual actors of a group and on the group as a whole.

His notions of 'footing' (Goffman, 1974, 1981) and 'face-work' (Goffman, 1956, 1967, 1981) are significant in order to understand the theme of mediated roles since they concern the ways in which people participate in social interaction and take account of the other in the moment-by-moment production of talk. 'Footing' is "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" (Goffman, 1981, p.128). 'Footing' brings out how interactants are simultaneously positioned. The communicative phenomenon identified as 'face-work' by Goffman (1967) makes reference to the action taken by a person to make whatever he is doing consistent by face. Face-work serves to counteract communicative incidents and it is performed to counteract the risk of hurting others´ feelings with disrespectful behaviour and further losses in self-respect.

Goffman understands the interaction order as a "moral one in that people show or mask feelings, offend or comfort others" (Goffman, 1967, p.12). This moral nature of interaction is reflected in his definition of 'face' as "a positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact. Face is an image of self, delineated in terms of approved social attributes" (Goffman, 1967, p. 5). Originally derived from Goffman's (1967) notion of

face, Brown and Levinson (1978, 1987), in their foundational works on politeness, assume that all competent adults belonging to a society are rational agents who have a positive and a negative face. They conceive this double-featured face as the public self image that every individual, every member of a society, wants to claim for himself or herself. It consists of two related aspects. The negative face is the basic want of freedom from imposition, whereas the positive face is the basic desire of appreciation and approval of his or her wants.

Drawing on Goffman, Wadensjö (1998) shows that interpreters co-construct meaning together with the interlocutors and also perform on their interlocutors' behalf activities such as persuading, agreeing questioning, claiming, coordinating interaction and so forth. In line with Kaufert and Putsch, Wadensjö also highlights the social skills used in interpreting that had been traditionally ignored in some of the earlier interpreting literature. Similarly, Metzger (1999) applies Goffman's concept of footing to analyse the interpreter's influence on interpreted interactions. She concludes that interpreters can misrepresent the source message footings by using their own renditions, thus giving them powerful influence over the discourse that is interpreted. Section 2.2.2 will further explore in detail additional studies on interpreting in medical settings that analyse the *role* of interpreters in interactions between medical practitioners and their patients.

2.2 The Role of the Cultural Mediator as an Active Participant

The active interactional role played by medical interpreters is a characteristic also shared by cultural mediators, who also play a similarly active role in medical settings. As discussed in 2.1, interpreters play a role as cultural brokers not only in translating the words, but also the cultural context and bringing their knowledge of that to the interaction. As such, interpreters can be defined as cultural mediators and often perform that role. Therefore, as stated in section 1.1, medical interpreters and cultural mediators are in fact one in the same thing since they play out a similar role and bridge the language and cultural gap between the health staff and the migrant clientele.

Along with Goffman's model of participation framework, Bourdieu's theory of social production and his notions of *habitus* and *field* have also been applied across a

range of interpreting contexts to explain the role and performance of interpreters and mediators (for example Hermans, 1996; Inghilleri, 2003; Simeoni, 1998)

Bourdieu's theory of social reproduction (1977) and specifically the notions of *field* and *habitus* lend theoretical support to the view of interpreting as a socially constituted activity and can serve as a starting point for socially-informed interpreting research. Fields (legal, political, educational, healthcare) are viewed as autonomous structures in social space, each with its own set of values and regulative principles. Fields are occupied by different individuals and groups with different *habitus*, or set of dispositions to act in particular ways. These social agents also compete for the field's material and symbolic resources. Fields operate with their own rules and the agents in these fields have *habitus* incorporated with them.

Habitus are internalized dispositions and ways of perceiving the world that are generated within specific fields. It refers to the ways that individuals construct their reality and is acquired through inculcation in a set of social practices experienced through participation in social institutions. Through the habitus, social agents are likely to reproduce the conditions of the immediate status with respect to existing social hierarchies. However, conflicting habitus or dispositions amongst different participants can alter power relations between groups. The habitus generates an infinite number of possible actions, thoughts and perceptions. These actions, thoughts and perceptions recreate or challenge culturally constructed meanings and values. For Bourdieu (1977), the social predates the individual and social agents are likely to reproduce the conditions of their immediate status with respect to existing field relations.

For interpreting scholars, the habitus of the individual interpreter and the field in which the interpreting activity takes place plays a crucial role in what counts as a 'legitimate' translation within a given context. Influenced by Bourdieu's notion of the centrality of the social in language, Inghilleri (2003) asserts that interpreters are positioned in certain ways in the production and reproduction of 'cultured' meanings, playing therefore a pivotal role in challenging or maintaining field practices of their profession. Before moving onto looking at crucial interactive role of interpreters' and mediators' in healthcare settings, I will build on the notion of role as discursive and interactional phenomena to examine the professional-client conduct within a given institutional order.

2.2.1 Dimensions of role

As already highlighted in the introduction to this section, interpreters and mediators play an active interactional role in multilingual encounters, bringing their language and cultural knowledge to the interaction. However, exponents of role-theory (for example Linton, 1936; Parsons, 1951; Merton 1961) have a deterministic version of roles that does not take into account the interactional and dialogic aspects of role negotiation. In the anthropological tradition, Linton (1936) described role as the activities holders would engage in, where they act as only in terms of the normative demands upon people on this position. However, this deterministic version of role-theory that does not consider the interactional aspects of role has come under criticism from social psychology (Billing, 1987) and from pragmatics (Goffman, 1959; Levinson, 1988, Sarangi and Slembrouck, 1996; Thomas, 1986)

Contrary to this deterministic version of roles, for Goffman (1959) role is not regarded as a fixed category, but as a resource which actors draw on to carry on in their everyday lives. He draws attention to the fact that a person who mediates between two parties who are in one another's presence displays behaviour that would have appeared rather strange if one of the two had been absent. The organization of a situation is therefore dependent on all parties involved and how they relate to each other.

He suggests that an individual actor will strategically adopt various production and reception roles to cope with conflicting demands. Goffman (1961) problematizes the notion of role as itself consisting of three aspects: *normative role, typical role* and *role performance*. He understands 'normative role' as what people in general think they should be doing when acting in a certain role. The notion of 'typical role' considers that the conditions for performing a certain role fluctuate in time and space, while 'role performance' includes aspects of the individual behaviour that stem from circumstances in the situation.

Drawing on Goffman's (1981) analytical model of *participation framework*, Wadensjö (1992, 1998) distinguishes between the interpreter's 'normative role', which presupposes a close translation of everything that is being said by each party, and the 'typical role', which the interpreter can adopt to coordinate the conversation. The

'normative role' of the interpreter is deeply influenced by the conduit model of communication, where interpreters act as conveyors of messages without themselves affecting this information.

The 'typical role' is influenced by the dialogical model, which "implies that the meaning conveyed in and by talk is partly a joint product" (Wadensjö, 1992, p.8).

2.2.2 Interpreters' and mediators' roles in *healthcare settings*

As highlighted in section 2.1, a body of research now exists on the role of interpreters in medical settings (Bolden 2000; Davidson 1998, 2000, 2001; Kaufert and Putsch 1997; Metzger 1999; Wadensjö 1998). In these studies, interpreters in healthcare settings acting were shown to play numerous types of roles including that of institutional gatekeepers (Davidson, 2000), co-diagnostician (Davidson, 2001; Hsieh, 2007), doctor assistant (Bolden, 2000), patient advocate (Haffner, 1992) and some variations of these roles (Hsieh, 2004).

In her study of medical interviews interpreted by spoken language interpreters, Wadensjö (1992) categorised their performances as *relying* and coordinating. Relying functions include conveying what the parties intended to say; while *coordinating* functions include asking for clarification and explaining what one party means or explaining that one party does not understand the other. Wadensjö concludes that interpreters co-construct meaning together with the interlocutors and all parties in the conversation share that responsibility during interpretation. Therefore, the interpreter is a responsible social agent who takes part in an interaction that is constrained by the institution in which it is embedded.

Wadensjö (1998) states that interpreters work at providing a particular *service* and, simultaneously, they exercise certain *control* over the interaction. There is a potential conflict between the service and the control aspects, which sometimes surfaces in dilemmas reported in the literature on institutional communication. Inghilleri also highlights the fact that interpreters can exercise control and "might dominate the interactional space through the recasting and/or omission of utterances' (Inghilleri, 2004, p. 75).

Angelelli (2004) proposes the term "visible co-participant" to describe the interpreter's role, in contrast with the invisible, completely neutral role traditionally ascribed to interpreters (see section 2.1). Following her research on language interpreters in a California hospital, she found that the interpreters both saw and conducted themselves as "co-constructors of the interaction" (Angelelli, 2004, p.7) rather than as invisible interpreters. The model of visibility that Angelelli (2004, p.9) proposes portrays interpreters:

> Who are not only linguistically visible, but who are also visible with all the social and cultural factors that allow them to co-construct a definition of reality with the other co- participants to the interaction. They are powerful parties who are capable of altering the outcome of the interaction, for example, by channelling opportunities or facilitating access to information. They are visible co-participants who possess agency.

Kaufert and Putsch found that interpreters expanded and adapted healthcare providers' communication, provided cultural explanations and "acted as advocates for patients" (Kaufert and Putsch, 1997, p. 77). Hsieh (2006) studied 26 professional spoken language interpreters who had completed 40 hours of training developed by the Cross Cultural HealthCare Program. She found that the interpreters saw themselves as part of the healthcare team, and tailored their communication strategies to the goal of diagnostic efficacy. When the provider left the room, interpreters often summarized, explained, or repeated previous information for the patient. Occasionally they even went so far as to volunteer information on their own, such as suggesting an alternate treatment or discussing their own experience with a disease. Hsieh (2006, p.23) concluded that:

> The interpreters were acting on their own preconceived notions of doctors as authority figures, rather than on an actual assessment of the current interaction, causing them to over-emphasize the information-gathering aspect of the encounter at the expense of the doctor's goal of establishing a relationship with the patient.

Additionally, Folberg argued that cultural mediators allow the participant parties to be self-empowered by taking the responsibility for the decision-making process (Folberg and Taylor, 1984). This method highlights the human agents in the

communicative process and situates the mediator as the skilled expert in facilitating the multi-party communication in which individuals may share competing or conflicting goals (McCorkle, 2005). Bolden (2000) goes further stating that far from being passive participants in the interaction, interpreters will often pursue issues they believe to be diagnostically relevant, just as they may choose to reject patients´ information offerings if they contain subjective accounts of their socio-psychological concerns.

In a similar setting, Davidson (1998) investigates medical discourse mediated by an interpreter. He presents data collected in the context of a U.S. healthcare system and concludes that the role of the interpreter as linguistic facilitator varies according to the parties to the interaction. According to him, doctors consider interpreters as instruments that keep patients on track, while patients tend to view interpreters as co-conversationalists. He also states that interpreters are not "neutral machines of semantic conversion, but active participants in the process of diagnosis" (Davidson, 2000, p.379). The interpreter therefore does not function as an "ally" of the patient or as a neutral conveyer of propositions, but rather as a convert co-diagnostician and institutional gatekeeper.

Based on the roles discourse participants assume and perform, certain expectations with regard to their roles might be yielded; however, these expectations might not always be met during the consultation. Various studies have addressed the issues of roles as expected, performed and perceived by discourse participants in mediated medical encounters where major discrepancies have been highlighted. In this respect, doctors expect interpreters and mediators to be a neutral conduit (Leanza, 2005), to alert them to potential miscommunication (Hale, 2007), to be a bridge without adding or omitting anything (Fatahi et al., 2008), or to edit patients´ utterances filtering out irrelevant information of non-medical nature (Davidson, 2001). Patients typically expect mediators to align with them and they see the interpreter as a co-conversationalist (Davidson, 1998).

According to Dysart-Gale (2005), mediators often report distress in their attempt to meet the divergent expectations raised by the other parties. Mediator might occupy multiple social roles, including translator, educator, advocate and link worker, and

they have to shift judiciously between these potentially conflicting roles. The roles mediators assume and perform during the medical encounter do have an impact on the outcome of the consultation, affecting power relations among discourse participants.

Given the presence of mediators is often essential to establishing communication amongst different participating parties who could otherwise not understand each other, they can thus serve to maintain and reinforce power relations in face-to-face interpreting events. The next section looks at different models of power and way mediators in medical encounters can potentially exercise it.

2.2.3 Power relations in monolingual and bilingual medical encounters

In an effort to illuminate dimensions of power in monolingual encounters in medical settings more specifically, Treichler et al (1984) undertook an analysis of routine clinic consultations between patients and doctors. They concluded that generally doctors and patients had different concerns. In particular, doctors´ emphasis on biomedical aspects, together with the style of interviewing, hindered a full expression of the patients´ concerns and the development of a mutually agreed-upon agenda for the consultation. In a typical monolingual medical consultation, the doctor is the participant holding most power. His power stems from his medical expertise, institutional affiliation and also from the high expectations patients have of him.

In bilingual medical consultations where an interpreter or mediator is present, the migrant patient is also seen as the least powerful participant in mediated encounters. Their language, cultural barriers along with unfamiliarity with institutional norms and values impede them from enjoying an equal status in the triad. In contrast, the cultural mediator possesses power which differs in nature from the doctors' power. In monolingual and bilingual encounters, doctors are normally seen as more powerful since they set the pace of the discourse, ask closed questions determining the issues that will be discussed and for how long the discussion will last (Davidson, 2001). However, in mediated encounters, cultural mediators can be seen to take over at least some of the doctor´s interrogating capacity either by monopolising the subsequent turns, initiating their own questions or answering the questions asked instead of rendering them to the other interlocutor (Briskina, 1996). By doing so, the

mediator claims more power often aligning with the doctor´s medical expertise and institutional status, resulting in the redistribution of power within the medical discourse.

2.2.4   Summary

This section has discussed the literature in relation to the role of mediators, clearly demonstrating that they play an active interactional role in multilingual encounters. In medical communicative interactions, mediators are full participants together with doctors and patients and their agency is always present. Their role expands beyond that of language switcher to active participant. Regardless of the role assumed by them in the cross-linguistic encounters, mediators have an impact on the outcome of the medical consultation and they bring their language and cultural knowledge to the interaction. I have suggested that they are positioned in the production and reproduction of cultured meanings and, as a consequence, they might play a crucial role in challenging or maintaining the status quo of social systems. This section has discussed the literature in relation to the role of mediators, clearly demonstrating that they play an active interactional role in multilingual encounters. In medical communicative interactions, mediators are full participants together with doctors and patients and their agency is always present. Their role expands beyond that of language switcher to active participant. Regardless of the role assumed by them in the cross-linguistic encounters, mediators have an impact on the outcome of the medical consultation and they bring their language and cultural knowledge to the interaction. I have suggested that they are positioned in the production and reproduction of cultured meanings and, as a consequence, they might play a crucial role in challenging or maintaining the status quo of social systems.

2.3 Perspectives on Power

Within the social sciences there have been various attempts to produce theoretical models of what power is, and these models have been based on some rather different conceptualisations. From the behavioural perspective of the early 1960s, power was a matter of individual agency, residing in individuals rather than in organization (Dahl, 1961). According to this model, power can be said to exist only in so far as

it is empirically observable and measurable according to people´s responses to it (Thornborrow, 2002). In contrast to this position is the structural model of power developed by Lukes (1974), in which power is conceptualized as ideological and hegemonic. This type of power shapes people´s perceptions and cognitions in such a way that social agents accept their role in the existing order of things.

Foucault's (1977) post-structuralist model moves toward a concept of power as a complex and continuously evolving web of social and discursive relations. According to Foucault's theory of the micro-physics of power, power is defined not as the traditionally dominating force of a particular group to control or rule, but as a kind of strategy 'that one such decipher in a network of relations, constantly in tension, in activity, rather than a privilege that one might possess' (Foucault, 1977, p.26). As Mason and Ren (2012) point out, the network of relations highlighted by Foucault operates at all levels and in all social groups and is a state of constant tension.

The ways in which the notion of power is conceptualised in this study will draw mainly on the work of Giddens (1979, 1984), Bourdieu (1982) and Fairclough (1989, 1992, 1995). Next sections review the concept of power developed by these scholars and outline issues of power inherent to the mediators' role.

2.3.1 Power according to Giddens and Bourdieu

Giddens (1979) understands power as intimately bound up with the idea of agency. He views power as a transformative capacity; it is the ability to get things done or to achieve outcomes. Nevertheless, power is not necessarily related to the idea of intentionality and any social actor can yield power without consciously intending to do so. This idea is crucial to understanding how power at the health clinic under study is wielded.

It is important, however, to include not only the immediate speech situation, but also the social institutions within which the linguistic communication takes place. Bourdieu (1991) offers crucial insights into this by pointing out that illocutionary force is invested in an utterance not by the words themselves or by any combination of them, but by the system of social relations which influences the production and reception of utterances in particular situations.   The relative power and status of

language users within social institutions exercise a determining influence not only on language forms, but also on the intended and perceived illocutionary force of utterances. As Fairclough (1985) has noted, lexical selection tends to be a reflection of social role and status, and alternative lexicalisations may emerge from different ideological positions.

A fundamental idea borrowed from Bourdieu (1991) is that language cannot be analysed or understood in isolation from its cultural context and the social conditions of its production and reception. According to him, "standard languages" are the product of complex social processes, generally bound up with a history of state formation and they are simply one version of a language. Language is firmly situated within social relationships and interaction and linguistic relations are always relations of power. Even the simplest linguistic exchange brings into play a complex web of historical power relations between the speakers, endowed with a specific social authority, and the audience, which recognizes this authority to varying degrees, as well as between the groups to which they respectively belong.

By trying to understand the power of linguistic manifestations, one forgets that authority comes to language from the outside (Bourdieu, 1991). There is a rhetoric that characterizes all discourses of an institution, the official speech of the authorized spokesperson expressing him/her in a solemn situation. The stylistic features which characterise the language of doctors, teachers, priests, and more generally, all institutions, stem from the position occupied in a competitive field by these persons entrusted with delegated authority. At the healthcare clinic under study, access to power is based on competence in the local languages (Spanish and Catalan) and mediators possess the language knowledge to fit into the established institutional ways of behaving. Therefore, their competence in Spanish and Catalan allow them to achieve a certain status within the institution.

The use of language, the manner as much as the substance of the discourse, thus depend on the social position of the speaker, which governs the access we can have to the language of the institution, that is, to the official and legitimate speech. It is access to the legitimate instruments of expression, and therefore the participation in the authority of the institution, which makes all the difference between the straightforward imposture of masquerades, who disguise a performative utterance as a

descriptive or constative statement, and the authorized imposture of those who do the same thing with the authorization and the authority of an institution.

Bourdieu (1991) highlights the idea of doctors having 'scientific' authority'. The doctor accrues power from the ability to create 'objective' representations of the patient´s health or illness. For Weber (1968), domination in modern societies is a special case of power and is closely linked to an actor´s possession and use of knowledge. The doctor-patient exchanges epitomize this view of power because the doctor is viewed as possessing the power to heal or prevent death. Special knowledge enhances power, and the authority to employ this knowledge in doctor-patient circumstances favours the professional´s ability to create and influence courses of action. Bourdieu's (1991) concept that some resources of knowledge are more valued than others helps us to understand how power is exerted at the clinic under study. This will be further discussed in subsection 2.3.3.

In a similar line of thought than Bourdieu, Heritage emphasizes the epistemic statuses of the speaker and hearer as fundamental and unavoidable element of the construction of social action (Heritage, 2012). A person's epistemic domain comprises his or her knowledge and personal experiences (Heritage, 2012). Within medicine, patients' and physicians' epistemic domains are complementary: Patients have primary epistemic rights to knowledge about their experience of symptoms, preferences and life-world circumstances, while physicians have primary epistemic rights to knowledge about diagnoses, treatments etc.

A person's rights to knowledge within a certain domain can be described as *epistemic status*, and in conversation, speakers rely on their relative statuses as interactional resources (Heritage, 2012). Deontic rights on the other hand relate to someone's right to determine future actions. While in traditional medicine this has been seen as the physicians' responsibility (i.e. the notion of "doctor's order"), based on their medical expertise and experience (epistemic status), contemporary guidelines for patient-centered approaches recommend a more even distribution of these rights, acknowledging also patients' deontic rights. As a consequence, the epistemic status associated with medical knowledge has traditionally given physicians superior deontic rights, i.e. the right to decide what treatments to choose. Patients' epistemic and deontic rights on the other hand, have traditionally *not* been acknowledged, although

this is currently undergoing change due to the movement of patient-centered care which encourages patients to become equal partners in the decision-making based on their expertise on their own health and a recognition of patient autonomy.

2.3.2 *Fairclough's and CDA's concept of power*

One of the most comprehensive attempts to develop a theory linking discourse, power and social structure was undertaken by Fairclough (1985, 1989, 1992). He developed Critical Discourse Analysis (CDA) as an analytical framework for studying connections between language, power and ideology. Although the present thesis does not fall into the category of CDA studies, Fairclough's concept of power will be useful in understanding how power relations are played out in the interpreted-mediated interactions being investigated in this study.

Critical Discourse analysts focus on relations between discourse, power, dominance and social inequality (van Dijk, 1993) and how discourse (re)produces and maintains these relations of dominance and inequality. Critical Discourse Analysis (CDA) addresses broader social issues and attends to external factors, including ideology, power, inequality, etc. and draws on social theory to analyse written and spoken texts.

There is not just one way of doing CDA and the various methodologies reflect the theoretical orientations of different researchers (Fairclough, 1992; van Dijk, 1993; Wodak, 2001). Fairclough argues that the task of CDA is to identify how relations of domination and inequalities are produced and reproduced in discourse. Van Dijk has developed a social-cognitive framework that theorises the relationships between social systems and social cognition, while Wodak´s (2001) discourse-historical approach centres on political issues such as racism.

According to CDA researchers, research into aspects of institutional life must be founded on a critique of institutions with a view to unmasking those relations of domination embedded in them (Sarangi, 1999). CDA is concerned with social life and with the role of discourse in social life. Fairclough (2003c) points out that CDA developed as a response to the traditional divide between linguistics and areas of social science. Whereas linguistics traditionally focused on the microanalysis of texts and interactions, social science was concerned with social practice and social change.

One of the identifiable characteristics of theoretical positions adopted in CDA research is that CDA considers discourse as socially constitutive as well as socially conditioned (Blackledge, 2005). It is constitutive since it helps to sustain and reproduce the status quo and in the way it may contribute to transforming it (Fairclough and Wodak, 1997). A second relevant feature is the particular interest CDA takes in language and power. It tries to increase awareness of how language contributes to the domination of some people by others (Fairclough, 1989).

In CDA power is conceptualized both in terms of asymmetries between participants in discourse events, and in terms of unequal capacity to control how texts are produced, distributed and consumed in particular social contexts (Fairclough, 1985). According to Blackledge, CDA is centrally interested in language and power because it is usually in language that discriminatory practices are enacted, in language that unequal relations of power are constituted and reproduced, and in language that social asymmetries may be challenged and transformed (Blackledge, 2005).

In one of Fairclough´s analyses of institutional spoken discourse, where he analyses a transcript of a medical interview taken from Mishler (1984), Fairclough describes it as a typical 'standard' medicine practice, where the doctor is in control of the interactional organization of the interview, he controls the way turns are distributed in the talk, he initiates the cycle of questions that the patient has to answer and he also controls the topics, pursuing medical detail rather than other problems alluded to by the patient. According to his analysis, it is the doctor, the institutional 'voice', who ensures that the interview with the patient proceeds along these lines and the doctor does the controlling through his institutionally established discursive role as questioner and topic selector (Thornborrow, 2002).

Therefore, from the critical discourse analytic perspective, all talk, be it every day conversation, a doctor´s consultation or a political interview, is viewed as taking place within social structural parameters and accordingly to conventions of social and discursive practices. For Fairclough (1985), all interaction is subject to the social and institutional constraints of the context in which it is produced, constraints that lead to the reproduction of existing relations of power and status.

2.3.3 Attribution of value to capital (resources)

As discussed in 2.3.1, Bourdieu's (1991) concept of capital (resources) and the attribution of different value to them allows us to understand the ways in which cultural mediators and patients' access to forms of resources is prevented and/or encouraged through talk. A field (legal, educational, political) is a structured system of social positions, occupied either by individuals or institutions, the nature of which defines the situation for their occupants (see section 2.2). In Bourdieu's sense, field is a social arena within which struggles take place over specific resources and access to them. According to Bourdieu, there are different forms of capital: economic, social (various kinds of valued interactions with significant others), cultural (legitimate knowledge of one kind or another) and symbolic (prestige and social honour).

Bourdieu's concept of capital highlights the ways in which individuals' opportunities for social actions are constrained by their limited access to certain forms of capital. Resources are fundamental social structuring devices and they are often unequally distributed among social actors; as a consequence, not all social actors have the same opportunities for action. Resources are unequally distributed in ways that position people differentially in terms of their access to them, and the spaces where they are produced, where their circulation is regulated and their meaning and value are defined (Bourdieu,1991). Therefore, for Bourdieu, power in interaction is related to the ability to mobilise appropriate resources.

Bourdieu uses a market metaphor as an alternative to the notion of field. As arenas of struggle over valued resources, fields are markets regulated by a relationship between *supply* and *demand*, which allows the mobilisation of notions such as *price* and *cost* in relation to the strategies of agents engaged in competition within the field.   This marketplace notion, where different resources have different values, is connected with Giddens' (1984) idea that the connections of experiences of individuals across time and space provide structured distributions of resources: not everybody has access to the same resources to mobilise interactions.

While Giddens evokes the ways in which institutions are key forms of social organization of knowledge and resources, Cicourel (1983) has empirically tracked how

those processes actually work in specific sites, ranging from education to health. His approach regarding the construction of socially distributed knowledge in institutions represents one of the most notable contributions to the understanding of the processes of social structuration. He has been concerned with the social construction of knowledge and with showing how crucial it is to go beyond analyses of specific interactions in order to understand that process (Cicourel, 1973, 1992; Knorr-Cetina and Cicourel, 1981). For Cicourel, to find out how knowledge is implicated in the dimensions of structuration we have to analyse (1) the way in which institutions act to produce and distribute valued resources, (2) what control they exercise over these resources and (3) what value they attribute to them.

According to Cicourel, distributed knowledge is the knowledge understood as organized sets of discourses with organic connections among each other that take shape as a function of how institutional processes are organised and how actors are involved in the production and circulation of resources. Discursive spaces have their own histories and trajectories, as do the social actors who participate in them. What gets constructed as knowledge is not neutral, it reflects the interests of some participants more than others, and certainly more likely of those who have access to those spaces than of those who are excluded. Distributed knowledge takes the shape it does because interests surrounding both its forms and its circulation, and because of the ability of participants to mobilize resources in those spaces in ways that have consequences for their own access to what goes on there and for the access of others.

To summarise, Bourdieu's (1991) idea that some resources of knowledge are more valued than others can help us to understand how power is exerted at the clinic under study. In the field of healthcare examined in my study, access to power is partly based on competence in the local languages (Catalan/Spanish) and specialized professional knowledge. The knowledge of local languages constitute a valued resource or form of capital that migrant patients do not have and which might constrain their opportunities for action. Mediators can be seen to possess the local languages and socio-cultural knowledge that fit into the established institutional ways of behaving (Heller, 2007). However, their lack of specialized medical knowledge is a valued resource that they do not have and places them in potentially less powerful position. As a consequence, their role might be questioned by healthcare staff and, as a result, get positioned in a disempowering role.

Having reviewed the different notions of power conceptualized in this study and Bourdieu's (1991) concept of capital and resources, I will conclude this section with a discussion of how it relates to Giddens' (1979) notion of agency. Agency is linked to the concept of power and this will be used to help us to understand mediators as agents who are able to exert power and produce effect on the interaction.

2.3.4 Giddens' concept of agency

As discussed in subsection 2.3.1, Giddens (1979) understands power as intimately bound up with the idea of agency. For our purposes here, agency is understood as the intention to act or do something and also as the capability a person has of doing things in the first place, which is informed by Giddens' (1984) s*tructuration theory.* For Giddens, agency is not related to considerations of intentionality. Agency refers not to the intentions people have in doing things, but to their capability of doing those things in the first place, which is why agency implies power (the agent is the one who exerts power or produces an effect). Agency concerns events of which an individual is the perpetrator, in the sense that the individual could have acted differently. An agent is the perpetrator of an activity, independent of whether or not s/he is aware of the consequences of his/her actions. As Angelelli (2004) highlights, interpreters are visible co-participants who possess agency and are capable of altering the outcome of the interaction. In the healthcare context explored in the current study, mediators exercise agency and power, which materialize through different behaviours that might alter the medical interaction.

Giddens (1984) links agency to structure through his discussion on rules and resources. The s*tructuration theory* was developed as an attempt to address the micro-macro, structure-agency binary in sociology and as a response to the structuralist determinism of some social theorists (such as Bourdieu) who overstress the imposition of social structures on human action. In the same line than Bourdieu, Giddens' theoretical framework attempts to integrate the individual and the societal within one single paradigm and defends the position that individual actions shape the social world. Whereas Bourdieu emphasizes the importance of the structure in social

processes, Giddens theory underscores the local nature of social life, which can be attributed to the influence of Goffman's micro-sociology in Giddens' work. For Giddens (1984) the social order is not seen as external to or imposed on social action, but as both shaped by and shaping social action.

This understanding of the dialectic relationship between agency and structure has important implications for the way participants are conceptualised too. Participants are seen as social actors who actively adjust, change and transform their available semiotic resources in their interactions with others (Tsitsipis, 2007; Lytra, 2011). Central to his theory of structuration is the understanding that people´s actions are shaped by the very social structures that those actions then serve to reinforce or reconfigure (Ahearn, 2001). Actions are influenced by social structures and social structures are (re)created by actions.

Giddens' arguments about agency and structure

Giddens´ notion of agency can help us to understand how institutional resources like cultural mediators, who are incorporated to manage communication between interlocutor from different linguistic and cultural background, might produce unintended consequences for migrants who come in contact with the healthcare system. The consequences of what actors do, intentionally or unintentionally, are events that would not have happened if that actor had behaved differently, but which are not within the scope of the agent power to have brought about, regardless of what the agent's intentions were. The implication of human agency in the continuity of social life does not mean that social actors set out to create social systems intentionally. Their agency role resides in their ability to reproduce social systems through their routine participation in social events.

For this reason, Giddens´ notion of agency bears directly upon the current study as it is the institution that decides what the multilingual language needs of the organization are as well as the resources that are mobilised. They do so to secure the smooth running of the clinic in the face of challenging conditions of linguistic diversity. From the perspective of the institution, migrants are construed as persons with limited agency; their agency is limited because they lack the language and cultural knowledge to fit into the established institutional ways of behaving (Cicourel, 1973; Heller, 2007).

The agency of migrants does not give them power over others on whom they need to depend and it could be said that cultural mediators also have limited agency because of their lack of specialised medical knowledge. Yet it is hard to claim that this situation is all created intentionally. Health staff implement a series of linguistic routines which have unintended effects, but which sometimes may reinforce their powerful position in this institutional context. It could also be argued that the institution itself is affected by the broader societal context. There are many cases when institutions try to give agency to migrant patients, but are restricted from doing so by broader societal constraints such as anti-immigration policies or lack of government support.

However, as Mason and Ren claim (Mason and Ren, 2012, p.243), 'the presence of an interpreter may bring change to the original network of power relations". This is precisely where the interpreter and mediator's agency is at its most apparent. Due to their unique access and understanding of the language and cultural background of both parties at work, mediators are capable of empowering weaker parties (patients) to exercise their responsibility to make decisions for themselves. The following section will therefore explore the concept of empowerment and focuses on the mediator's role as an empowerment figure in bilingual and multilingual healthcare encounters.

2.3.5   Summary

This section presents the ways in which the notion of power is conceptualised in this study based on the work of Giddens (1979), Bourdieu (1982) and Fairclough (1989). While Giddens understands power as intimately bound up with the notion of agency, Bourdieu highlights that power and authority comes to language from the position occupied by a person in a field. The notion of resources and the attribution of different value to them is equally important to understand how mediators' opportunities for action are constrained by their limited access to certain forms of capital. This is particularly important at the site examined, where mediators lack of specialised knowledge places them in a less powerful position and might influence their ability to further empower patients.

2.4 Concept of Empowerment

The concept of empowerment is frequently viewed as being too abstract and lacking a usable definition (Chang, 2004). Despite its ambiguity and lack of a broadly accepted definition among professionals (Ackerson & Harrison, 2000), many researchers view empowerment as multidimensional, noting its various psychological, political, economic, organizational and social dimensions (Berton, 1994; Cowger, 1997; Rappaport, 1987). Empowerment entails different personal factors, including the ability to make personal decisions, to exercise critical thinking and to access relevant resources (Wallerstein, 1992). Empowerment can also be understood as a social action process that promotes the participation of people, organizations and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life and social justice (Wallerstein, 1992).

The roots of the empowerment concept can be traced back to Freire (1993). His view of education as an instrument to facilitate integration of individuals into society provides the basis for a definition of empowerment that is in line with the approach adopted in the present study. Freire viewed empowerment as both a process and an outcome. According to him, empowerment is a process whereby the purpose of an educational intervention is to increase one's ability to think critically and act autonomously.   Alternatively, empowerment is an outcome when an enhanced sense of self-efficacy occurs as a result of the process. In a healthcare setting, the outcome component occurs when there is a measurable increase in the patient's ability to make autonomous, informed decisions.

In the same line than Freire, Jones et al. (1993) stated that the concept of empowerment refers to both a process and an outcome: a developmental potential and a process of becoming (Jones et al., 1993), enabling individuals to change a situation, given the skills, resources, opportunities and authority to do so. Having described the roots of the concept of empowerment, the factors that it entails and the different dimensions viewed by researchers; in the following section I will turn specifically to the notion of empowerment within the field of healthcare and the definition of patient empowerment.

2.4.1 Empowerment within the field of healthcare

In the medical literature, a widely accepted definition of empowerment remains elusive and there are many interpretations of the term empowerment based on the different understandings of the concept (Gibson, 1991). The foundation of the medical literature on empowerment can be found in the work of Rappaport (1984). He regards empowerment as easy to define in its absence: powerlessness, helplessness, alienation, and loss of sense of control. In a general sense, he considers empowerment as a process through which people gain mastery over their own lives and individuals become empowered as they learn skills for influencing life events (Rappaport, 1984). Empowerment can therefore be taken as a concept referring to individuals' rights and possibilities; it focuses on people's strengths, rights and abilities, as opposed to paternalism where others take the liberty of decisions (Gray, 1999).

In the field of healthcare, empowerment has been acknowledged as an alternative to compliance in order to guide the provider-patient relationship. The empowerment-oriented approach views patients as being responsible for their choices and the consequences of their choices (Laverack & Wallerstein, 2001). There was an attempt to clarify the concept of empowerment by Gibson (1991). Her analysis shows that a great number of characteristics are associated with the concept of empowerment, making it difficult to think of empowerment consistently and in operational terms. Gibson states that empowering involves helping patients to gain awareness of their own values related to health as well as their beliefs, perceptions and relationships vis-a-vis the environment. Gibson also suggests that, although the healthcare provider should be involved in the decision-making process, the final determination of what is best for the patient is both the right and responsibility of the individual (Gibson, 1991).

According to the empowerment model in Piper's (2009) health promotion framework, empowerment fits conceptually with informed choice, partnership working, patient participation and involvement in shared decision making, where the doctor's control is reduced and patient knowledge has greater influence and more of a bottom-up impact. These concepts are equally contestable and, according to Cribb and Duncan (2002) when empowerment is applied to healthcare practice the key is how much power is devolved by healthcare practitioners (HCPs).

Empowerment is used by Bush and Folger (1994) in a way that differs from common usage. It does not mean power-balancing or redistribution, but rather, increasing the skills of both sides to make better decisions for them. Specifically, Bush and Folger use the term empowerment to mean "the restoration to individuals of a sense of their own value and strength and their own capacity to handle life's problems" (Bush and Folger, 1994, p.2). Through empowerment, disputants gain "greater clarity about their goals, resources, options, and preferences and they use this information to make their own "clear and deliberate decisions" (Bush and Folger, 1996, p.264). Empowerment can be seen to occur in transformative mediation when the mediator watches out for opportunities to increase the parties' clarity about or skills in these areas. The transformative mediator aims to foster parties' clarity and skills in a way that allows the parties to maintain control of both the process and the substance of the discussions. Unlike problem-solving mediators, transformative mediators are careful to take a secondary role, rather than a leading role in the process. It is said that they *follow the parties around*, and let the parties take the process where they want it to go.

One central theme of empowerment is nevertheless that it obviously concerns power (Gilbert, 1995). Rogers (1979, as cited in Gilbert 1995) claims that empowerment occurs when an individual gains increased personal power. The intention of patient empowerment is, therefore, to increase the personal power that patients have in relation to their health and healthcare. This includes issues of control and choice, such as increasing the control that patients have over their health, the choices that they can make, and the power that they hold in relation to decision-making. This needs a change in the power differential that has traditionally existed between patients and professionals (Christensen and Hewitt-Taylor, 2007).

As well as issues of power and control, patient education is also an essential feature of empowerment. According to Feste and Anderson, empowerment is defined as "an educational process designed to help patients develop the knowledge, skills, attitudes, and degree of self-awareness necessary to take effective responsibility for their health-related decisions" (Feste and Anderson, 1995, p.139). Being empowered means that patients have learned enough about their disease and health to be able to judge the benefits and costs of adopting a wide variety of healthcare recommendations, that

they have the knowledge required to make informed decisions, and enough control and resources to implement these decisions (Gibson, 1995). Central to empowerment is increased personal knowledge and development where problem solving ability is enhanced by asking persons to identify their own problems to a precise self-care aspect and consider possible solutions to their problems. For Anderson and Funnell (2005, p.155), the empowerment approach requires:

> A change from feeling responsible *for* patients to feeling responsible *to* patients. This means acting as collaborators who provide patients with the information, expertise and support to make the best possible self-management decisions based on the patient's own health priorities and goals.

However, they believe that patient empowerment is often perceived as an assault on deeply embedded professional roles and responsibilities. According to Lewin and Piper (2007), the four dimensions of empowerment frequently identified in the literature include: (1) individual patients' beliefs and abilities to have power, influence and control, (2) the willingness and commitment of health professionals to empower patients, (3) a perceived change in the power or control over their care by the patients and (4) equality of opportunity and freedom from discrimination. All four dimensions have to be addressed in order to obtain complete empowerment (Byrt and Dooher, 2002). Empowerment is thus shifting practice away from 'top-down' based on assessment of need from a professional perspective to promoting patient-led, more 'bottom-up' decision-making. For Gibson (1991) and Piper and Brown (1998), it is concerned with fostering a more collaborative, less hierarchical and power-sharing partnership based on mutual trust and respect.

Following Funnell et al., patient empowerment is understood in this research as "a process whereby patients have the knowledge, skills, attitudes and self-awareness necessary to influence their own behaviour and that of others in order to improve the quality of their lives" (Funnell et al. 1991, p.37). Empowerment "covers activities on the patient´s side, such as communicating effectively with providers, receiving and understanding useful health education, understanding explanations of treatments and being able to ask questions and discuss implication" (Bischoff, 2006, p.82).

2.4.2 *Characteristics of empowerment*

As highlighted in section 2.4.1 above, there are many interpretations of the term empowerment (Gibson, 1991) and the defining characteristics of empowerment vary considerably among different scholars. Having reviewed the literature on empowerment, I identified three broad characteristics of empowerment, namely Provision of Information, Expression of Emotions and Decision-Making. These are summarized in Table 2.1.

Category	Indicators
Provision of Information	Provide patient with information and facilitate informed choice (Piper, 2010)
	Patient has information to be able to make decisions (Feste and Anderson, 1995)
	Provide patient with information regarding diagnosis, pathology, treatment and prognosis (Rodwell, 1996)
	Respond to patient's needs for information (Mead and Bower, 2002)
	Interventions with information giving are not about empowerment as there is no devolution of power from doctors to patients (Jack, 1995)
	Answer clinical questions (Anderson and Funnell, 2010)
Expression of emotions through active listening	Elicit and acknowledge patient's beliefs, priorities and fears (Aujoulat, 2007)
	Address patients' emotional concerns (Anderson and Funell, 2010
	Pay attention to the patient's priorities and concerns through active listening (McWilliam et al., 1997; Paterson, 2001)
	Listen carefully to the patient's perception of his/her problems (Piper, 2010)
	Mutual participation and active listening (Ellis-Stoll et al., 1998)
	Allowing patients to express their emotions and paying attention to their concerns through active listening, checking patients' feelings and appreciating patients' self-expression (Bush and Folger, 1994).
	Checking patients' feelings and active listening to patients (Bohm, 1996; Pearce and Pearce, 2003).
Decision Making	Decision aids provided, mutual decision-making, freedom to make choices and accept responsibility (Rodwell, 1996)
	Patient decides for himself (Gibson, 1991)
	Allow patient to take the necessary time to make decisions (Paterson, 2001)

Table 2.1. Patient Empowerment Indicators

Provision of Information

As can be seen in Table 2.1 above, in terms of the provision of information, for Jack (1995) interventions concerned with information giving are not about empowerment as there is no real devolution of power from doctors to patients and no challenging of social inequalities or doctor–patient hierarchies. In contrast, Piper highlights that "information giving is not empowering per se, but it is an important starting point and patients cannot be empowered without information" (Piper, 2010, p.176). If knowledge is a tool of power, then the knowledge or information that patients have will affect their power.

In the same vein, Feste and Anderson state that "patients being empowered means patients having information, so as to know enough about health and disease to make decisions about the variety of options available to them" (Feste and Anderson, 1995, p.140). In the same line of thought, Rodwell (1996) emphasizes as a key feature of patient empowerment the need for the caregiver to provide the patient with information regarding diagnosis and treatment. He states that the defining attributes of patient empowerment include a helping process, a partnership which values self and other, mutual decision making using resources, and freedom to make choices and accept responsibility.

Expression of Emotions

For category two, the expression of emotions, McWilliam et al. (1997) believe that an empowerment process occurs when the patient tells his/her story and the healthcare provider facilitates the understanding. Both McWilliam (1997) and Paterson (2001) stress that the patient and the professional are changed as a result of the empowerment process, since an empowering relationship implies that professionals have to unlearn being in control. Piper (2010) also highlights the importance that healthcare practitioners listen carefully to the patients' perception of their problems, particularly those with a chronic problem who have developed expertise about their disease. Ellis-Stoll et al. (1998) find mutual participation and active listening as the main characteristics of the empowerment process, while Aujoulat (2007) stresses the importance of the healthcare provider to elicit and acknowledge patient's priorities and fears.

Decision-Making

In terms of decision-making, Rodwell (1996) and Gibson (1991) provide defining features of patients' empowerment. For Rodwell (1996), mutual decision-making and freedom to make choices and accept responsibility are the main defining attributes of patient empowerment, while Gibson (1991) highlights how doctors must surrender their need to control and decide for patients and they should instead learn to be observers.

Having organized the indicators of empowerment into these three main categories, the next step was to operationalize them for the purpose of my analysis. The identification of indicators would allow me to identify instances of patients' empowerment in the mediated medical encounters recorded. These categories occur in the presence of one or more of the following processes: (1) patients receive individualised information, clarification and advice when they seek it, (2) patients are allowed to express emotions and concerns and are actively listened to, and (3) patients have the authority to set the agenda for the meeting and freedom to make choices. I am aware that these categories might sometimes overlap. In fact, there are excerpts that might present instances of more than one category (or even the three categories combined). However, they provide a useful starting point for the purposes of the analysis.

CATEGORY 1: *Patients receive information, advice and clarification upon request.*

The indicators for this particular category include instances when patients request information and actually receive advice and/or clarification from the cultural mediator. The information patients receive generally includes details regarding diagnosis, pathology, treatment and care. Cultural mediators usually invite patients to speak and help them to seek advice. A further indicator of the present category includes those cases where mediators adjust the scientific doctors' language to make it more available to patients, facilitating patients' understanding of the medical dialogue and allowing patients to carry on asking for additional information. Of particular relevance is to check whether mediators deliver or omit the information provided by doctors to patients. An additional indicator includes cases when the mediator

checks the patient's understanding using invitation formulas such as 'Do you understand?' and/or 'Do you want to ask about anything else?' offering patients the possibility to request further information.

CATEGORY 2: *Patients are allowed to express emotions and concerns and are actively listened to (attention to patients' concerns through actively listening).*

The type of examples which will be identified in this category include instances where patients are able to express their experiences or emotions with expressions such as "I don't know if I'm doing the right thing", "I am really afraid", "I didn't know what to do" and cultural mediators are there as an emotional support, acknowledging patient's emotions. Checking and formulating patients' feelings are actions also included in this category.

The linguistic indicators which will be included in this category are similar to those suggested by Roberts and Sarangi (2005), where doctors and/or mediators use words such as "so" to elicit and address patients' concerns. Further linguistic indicators from this category will be those actions, as identified by Baraldi (2009), where mediators echo patients' last utterances, encouraging them to continue speaking on and to express their concerns. Some expressions such as "OK/ I see/ Right" uttered by mediators are identified as indicators that patients are being actively listened to (Roberts and Sarangi, 2005).

A further criterion of empowerment to be explored in this category includes those instances when mediators pay attention to psychological and social aspects of patients' health, such as the difficulty to buy the prescribed medication or concerns regarding their job contracts. This issue is quite significant, since migrant patients not only bring health- related problems to the medical consultation, but social problems too.

CATEGORY 3: *Patients have the authority to set the agenda for the meeting and freedom to make choices.*

This final category includes instances where doctors provide different options to the patient: instead of imposing a specific treatment or action to be taken, doctors suggest different possibilities and explain the advantages and disadvantages of each of them. Cultural mediators also show empathy, attempting to show solidarity with patients' opinions. The linguistic indicators that will be looked at include examples where doctors say "I understand how you feel" or "we'll try to make you feel better" used to eventually gain patient's cooperation in the decision-making process.

The examples that will be identified include those instances where patients are actively involved in negotiating the goals of their care plan. These will be used to examine whether or not mediators allow patients to take the necessary time to make decisions. Additionally, I will check whether patients have a final word in the conversation, rather than following the instructions of those in authority. Examples may also include those instances where the mediator decides for the patient, with those considered as potential cases of disempowerment. In the data I will look for instances where patients can negotiate medicine taking and treatment, where they provide consent before a clinical procedure is carried out and where they are allowed to take the initiative to make health- related decisions, such as the suggestion of a particular treatment or the request of additional tests.

2.4.3 Empowerment in monolingual and bilingual encounters

The literature on individual patient empowerment in monolingual encounters has mostly focused on empowering individuals with chronic conditions. Anderson and Funnell, (1991, 2000, 2005, 2010) and Adolfsson (2004) have published extensively on empowering diabetes patients, while Hage and Lorensen (2005) work with empowerment of frail elderly patients and Chang et al (2004) have researched with cancer patients. Patient empowerment in monolingual practices has also been researched in other healthcare contexts, such as mental health, the empowerment of people with AIDS, asthma, heart failure, and people with disabilities among others (Rodwell, 1996; Hayes, 2007; and Mola 2008).

According to Anderson and Funnell, for most doctors, embracing empowerment means making a shift which is really difficult because their training and socialization is embedded in a traditional approach to care. During their professional education, doctors are "socialized to a set of responsibilities and expectations that define their professional identity, with these responsibilities and expectations so embedded in their identity that they do not consciously think about them" (Anderson and Funnell, 2010, p.278). In a study with European diabetes doctors to understand how doctors and nurses view the implementation of empowerment group education (EGE), Adolfsson et al. (2004) showed that although diabetes doctors knew their role in the traditional approach, they had problems when trying to implement actions that might lead to the empowerment of patients. As their role had changed from being an expert to being a facilitator, there was a conflict in roles. "As experts they felt secure, as facilitators they needed support in their educational process" (Adolfsson et al., 2004, p. 319).

In a further study conducted by Kilian et al. (2003), they studied empowerment and disempowerment in terms of the way persons with persistent schizophrenia evaluated their psychiatric outpatient treatment. Only a minority of patients who participated in the study perceived their treatment as an empowering process through which they gained control over decisions and actions affecting their health. It was found that a majority of patients tend to describe their treatment as being reduced to drug treatment and that they feel helpless rather than actively involved in the treatment process.

Wahlin et al. (2006) have studied patient empowerment specific to an intensive care situation. Their research was based on interviews with eleven patients in two intensive care units in southern Sweden. Results showed that patient empowerment in intensive care consist of strengthening and stimulating the patients' joy of life and will to fight. The study also showed that ICU patients were empowered when they were confirmed as valuable by health staff and relatives. Wahlin's results share similarities with other studies, as the one carried out by Bulsara (2004) with cancer patients, where different ways in which empowerment occurred were identified: (a) the need to have power within oneself in terms of fighting spirit, and (b) acceptance of the illness.

Lewin and Piper (2007) demonstrated that empowerment issues involving the rights of coronary care patients to be primary decision makers and managers of their illnesses were of minimal concern to all but a few. In their exploratory study, which aimed to investigate coronary care patients' perceptions of their care and interventions related to empowerment and strengthening patient choice, almost 90% of patients were happy to entrust their care to health professionals based on their confidence in the clinical expertise of the medical staff.   The findings of this particular research are compatible with Henwood et al (2003), who contend that some patients wish to adopt a passive role in relationships with their general practitioner and opt to devolve responsibility for decision making to their medical practitioners.   These results contradict the received wisdom that patients necessarily wish to be empowered. The drive for empowerment may be contradicted by patients being comfortable with leaving decision-making relating to the management of their illness to doctors.

Empowerment in bilingual encounters

Empowerment in bilingual encounters replicates many of the characteristics found in monolingual encounters. One of the most relevant contributions to the literature in the field is the work undertaken by Kaufert and his colleagues. A large ethnographic study with Canadian aboriginal patients (Kaufert; Lavallee and Koolage, 1996) concluded that in order to establish meaningful communication, the interpreter must mediate between the clinician´s biomedical explanations of illness and proposed treatment, and the culturally based framework that the minority patient uses to interpret his or her problem. According to Kaufert et al (1996), in cross-cultural and cross-language interactions there are different cultural expectations and concepts, different knowledge of medical language, different knowledge of types of conversations, different notions of negotiation and different power potentials in the negotiation for consent.   In these situations, the contribution of intermediaries (interpreters or mediators) acting as advocates is indispensable if patients are to be empowered (Kaufert, 1990).   As a consequence, the interpreter cannot be seen as a black-box language-switcher, but instead as having an important role in empowering patients.

Of particular relevance is also the research work undertaken by Bischoff (2004) where he investigates the practice of cultural mediation in public institutions in the health, educational, social and legal services sector in the cities of Geneva and Basel. Bischoff underlines that cultural mediators are often used to convey information to the migrant but in one direction, from the institution to the client. The main expectation attached to this transfer of information is that migrants will change their behaviour accordingly and adapt. At the same time, interpreting and mediation can sometimes become a form of self- protection for the representatives of the institution, almost a 'legal' insurance, so that the institution cannot be called to account. In such cases, the doctor will not be accused of having given the migrant patient too little information and cultural mediation serves almost as a defence against pluralism and as a form of self-protection (Bischoff, 2004).

Theoretically, mediators act as communicative resources that give migrants the opportunity to participate in the production of institutional discourse and to negotiate their position in the medical encounter. However, access to valuable resources such as cultural mediators is strictly surveyed and controlled by the institution, thus potentially limiting migrants´ opportunities for action. It is the institution and, at the micro-level, the doctor, rather than the migrant, that has the power to decide whether an interpreter or cultural mediator should be brought in. The institutions therefore hold the key to whether the migrant patient understands what is being said and they decide how the linguistic and cultural differences will be dealt with. The option of involving a cultural mediator is usually only taken up if and when the institution can no longer do what it needs to do (Bischoff, 2004). Furthermore, Baraldi (2009) finds that the interactional conditions for promoting the migrant patients' voices are not easy to construct within medical systems, although he states that patients' empowerment is achievable "if mediators' actions combine the support of patients' self expression with its formulation in translation, involving doctors in triadic interactions" (Baraldi, 2009, p.134).

2.4.4   Summary

This section has discussed the medical literature in relation to empowerment, demonstrating that there are many interpretations of the term. I have suggested that empowerment is a process where patients have the knowledge and skills necessary to

influence their own behaviour and to make decisions for themselves. This section also presents the organisation of the indicators of empowerment into three main categories, which I have developed to make the concept consistently and manageable in operational terms.

2.5 Concluding remarks

This chapter has foregrounded the interdisciplinary nature of the theoretical framework that is to be used to answer the research question which addresses the role of mediators in facilitating migrant patients' empowerment. Current literature on interpreting and mediation in medical settings has been revised to allow my ethnographic data to be meaningful. The role of the mediators in relation to the interaction between healthcare staff and migrant patients has been discussed with an emphasis placed on the active and visible position that mediators occupy in multilingual interactions. I have highlighted that mediators play a role as cultural brokers not only in translating the words, but also the cultural context and bringing their knowledge of that to the interaction. I have also shown that mediators are agents who are able to exert power and produce effect on the interaction. However, although they possess unique access and understanding of the language and cultural background of both parties at work, their agency is limited because of their lack of specialised medical knowledge. This fact places them in a potentially less powerful position and might constrain their abilities to further empower patients.

The concept of empowerment is frequently viewed as too abstract and lacking a broadly accepted definition among scholars. For the purpose of my study, I understand empowerment in healthcare settings as the process through which people achieve more control over decisions with influence their health. In an attempt to make the concept of empowerment more manageable, three main categories were identified –Provision of Information, Expression of Emotions and Decision-Making- and their corresponding indicators were included.
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Chapter Three

Ethnographic Context, Data and Methods

The present study is an ethnography of a multilingual healthcare centre in Barcelona, which is institutionally bilingual Spanish/Catalan. One of the multilingual practices implemented in response to the demands posed by the arrival of migrants from various language and cultural backgrounds include the use of cultural mediators. As one of the resources mobilized by the clinic, my focus is on how multilingualism is managed through cultural mediators and whether their presence empowers the migrant clientele in a meaningful way. It is my intention also to examine the use that health staff made of mediators and to infer from observations of mediated-encounters whether patients are empowered. This particular health centre was chosen as the study site because of its linguistic and cultural diversity. Ethnographic fieldwork extended over a six-month period. Data-gathering techniques included recorded interactions, interviews with healthcare staff and mediators, observations, analysis of hospital documents and visual material.

I begin in section 3.1 with an overview of the neighbourhood and the site, followed by a description of the mediating staff and some considerations regarding the process of gaining access to the centre. Section 3.2 considers my position within the research process, reflecting on my connections with the participants who agreed to take part in my study. Then, Section 3.3 examines the data-collection techniques used that allow for a description of the mediation process. These include interviews, audio-recording and field notes. Section 3.4 focuses on the process of transcription and coding, and Section 3.5. presents concluding remarks where some potential limitations and weaknesses of the methodology are identified.

3.1 Description of the Setting: An Ethnographic Overview of the Healthcare Centre

3.1.1 The neighbourhood and the site

The healthcare centre is located at south of the city of Barcelona, in a relatively poor and marginal area where the migrant population has a prominent presence. It is

historically a neighbourhood that hosted many people coming from outside Barcelona. These include people who migrated in the 50s from other parts of the Spanish state and the 80s had witnessed the arrival of a large number of foreign migrant citizens. In 2012, 49.2% of the district's population was of foreign origin, a percentage that had increased by 3.5% since

2007.

The health centre was built in 1987 and is operated by the Catalan Institute of Health (ICS). Pursuing its mission to provide healthcare services of excellence to the population and to develop teaching and research in the health sphere in Catalonia, the ICS aims to make responsible provision to meet users' needs and expectations, ensuring quality services whilst seeking a balance between sustainability and value. With a budget of 3,069 million euros for 2010 and total staff of over 41,000 professionals, 20,000 of them in Primary Care, the ICS is the largest public healthcare provider in Catalonia. The ICS serves 5,774,142 users, a figure representing 75.5% of all those insured in Catalonia. The clinic is made up of family practitioners, social workers, specialists in paediatrics, gynaecology, cardio-vascular, urology, trauma and dental care, home help and a tropical diseases unit.

The community that utilises the services of the clinic reflects diverse ethnic and socio- economic pool of residents. 70% of the population served by the health centre are migrants, of which 59% come from Pakistan, India and Bangladesh, with the Pakistani population the largest group. The estimated population coming to the clinic for healthcare is around 40,000, of which 4,200 are children.

 "Public Health for all" is the motto appearing on the colourful handwritten poster hanging on the front door of the hospital. It is written in Spanish and Catalan, but also in Urdu and Punjabi. The centre opens from 8am to 8pm. Its team is made up of 24 doctors, 24 nurses and 20 administrative staff.   57% of the population visiting the centre are migrants. In paediatrics, the number rises to 83%.

On entering the main door of the clinic premises, the Customer Service Unit (CSU) is located on the right hand side. This unit is a medium-size room with two employees working behind an information desk. It is opened on weekdays from 9am to 1pm and from 3pm to 7.30pm. CSU assists customers who require access to services at the

clinic. It is also a service to voice patients' opinion about any aspect of the clinic care or services. Complaints management for all the complaints received at the clinic is a crucial function of the CSU, together with the management of patients' suggestions, ideas or other feedback.

There is a sheet hanging on a wall of the CSU with information regarding the mediators' schedule. There are also some leaflets on a shelf on the front part of the information desk. These leaflets are in different languages including English, Arabic, Hindi, Spanish and Catalan, and they include information regarding how to prevent and cure certain diseases (see Appendix E for example of leaflet about Tuberculosis). Of particular importance is the leaflet created and supplied by the Catalan based NGO Salut i Familia (Health and Family) with information regarding the clinic's mediation service. This leaflet is in English, Arabic, Spanish, French, Urdu, Chinese and Romani (See Appendix E).

As can be seen in the English version of the leaflet provided below, not only does the healthcare centre acknowledge the presence of migrant patients, but also the need they might have to be assisted by someone speaking their own language.   Through the information on the leaflet, the healthcare centre explicitly encourages migrants to request the service of a mediator if needed; explaining how to proceed with the request of asking for a mediator either before seeing a doctor or during medical consultation. As we can see, the leaflet includes information regarding the specific tasks mediators might undertake, which may help patients who have never heard about the figure of mediators to have a clearer idea of the services they offer.

Leaflet with information regarding mediation service in Customer Service Unit

The information provided in this leaflet positions this healthcare centre as an organization that has developed certain modalities of communication, such as the provision of mediators, oriented to a migrant clientele.

Once passed the CSU there is a big glass door that patients have to cross to arrive to the main reception. On the right hand side of the reception desk there are two lifts to access the different floors. The centre has seven levels. On all floors there are information posters displayed on the wall (see Appendix E), some of them near the lifts, on the corridors and close to the doctors' consultation door. These posters are in Catalan, Spanish and Urdu and contain different kind of messages: from recommendations to pregnant women to consult their dentist to warnings to diabetic patients requesting to bring their medical cards in order to obtain their glucose test' strips.

Each floor has a reception desk where patients can make appointments with their GPs. However, the seventh floor's reception desk, where patients have to come to process

their medical cards, and the fourth floor's reception desk, where the Paediatrics service is located, receive a more significant number of patients. Karim and Seema, the two mediators who took part in the recorded encounters in this study, worked in level seven and four. These two mediators worked at reception desks as administrative staff. It was quite common for them to leave their seat in reception when they were called to assist in a doctor's consultation.

3.1.2   The mediating staff

The mediating staff at the clinic consisted of four part-time Urdu/Punjabi/Hindi/English cultural mediators and a part-time French/Arabic mediator. Of the four part-time Punjabi interpreters, two were on duty between 8:00am and 2:00pm and two were on duty between 3:00pm and 8:00pm. The French/Arabic mediator worked on Tuesdays and Thursday from 8:00 to 2:00 and from 3:00 to 8:00 on Mondays and Wednesdays. All mediators were hired by the two NGOs in charge of supplying mediators to the clinic.

Table 3.1 illustrates the mediators' demographic data. The ratio of females to males is three to two, with an average age of 30 years old. Mediators are contracted and paid by two NGOs, with these NGOs responsible for supplying staff with the language combination required by the clinic. Mediators have been living in Spain for an average of eight years, except Seema (who is now in her 20s) who has lived for ten years and Shazia (who is in her 40s) who has been there for fourteen years.

The background of the mediators who work at the clinic varies widely, from high school graduates to those with engineering degrees, although very often their degrees are not formally recognized by the Spanish educational system. In fact, many of them were drawn to this profession because the job offers on the market for migrants were not congruent with their high qualifications. Many of them end up in this job just by chance, through friends, casual translation work as voluntary mediators. None of them has previous health-related experience in mediation, two have experience as administrative assistants, one as an engineer, one as a shop assistant and one has no previous experience at all and this was her first job.

Seniority does not correspond with age. For instance Barahim has five years of experience and is in his 30s, while Shazia, who is second-highest in seniority with four years experience is in her 40s. Karim and Seema are the youngest mediators and they have worked at the health centre for an average of two years

Mediators Pseudonym	Age	Seniority in mediation	Education	Previous Experience	Ethnic background
Karim	20s	3	High School	Administrative	Pakistan
Seema	20s	1	High School	No previous experience	India
Shazia	40s	4	BA. Mediation course	Shop Assistant	Pakistan
Fatima	30s	3	Degree in Psychology. Mediation training course	Administrative	Alger
Barahim	30s	5	Degree in Engineering. Mediation training course	Engineer	Pakistan

Table 3.1. Mediators' demographic data

Like most of cultural mediators working in Spain, none of the mediators working at the centre have received formal education in medical interpreting. Three out of the five have undergone specific training (a four week course) provided by an NGO to become certified cultural mediators.

3.1.3 Gaining access

One of the major difficulties in the present study was gaining access to the research site. What made my research project particularly difficult was the nature of the social setting chosen, since a healthcare clinic is a highly sensitive institutional context where patients' confidentiality has to be protected. The practicalities of conducting interviews and audio- recording medical encounters required thorough planning. For a couple of months, I made various visits to the clinic to establish contact with Nuria, the

senior manager, to introduce my research project and get permission to access the site. This face-to-face approach enabled me to work through any concerns she had and issues she wished to rise. A written informed consent form where I requested the collaboration of the institution in carrying out my research was issued (see Appendix D) and submitted to Nuria. Following telephone calls and e-mails with the hospital, I finally received a positive response from her, where she showed no objection to carry on my research proposal at the clinic.

After a couple of months, I was informed by the clinic´s manager that obtaining ethical approval from the clinic´s Local Research Ethics Committee was not necessary for my study. Nuria took the responsibility to inform all parties involved about the main aim of my research and my presence at the health centre. She was basically making a decision for the group and gave me permission to access the centre. Nuria was very cooperative at all times and she introduced me to the cultural mediators and health staff. She also advised me to undertake observation work if possible in the paediatrics unit, since the relationships established with mothers in these types of encounters could be of interest for my research.

Participation in the research was by voluntary informed consent, obtained by me prior to commencement of the interview/medical encounter. Patient consent was solicited at the beginning of each encounter. This was obtained through the mediator, who introduced me as an experienced university researcher and explained to them the purpose of my research. Doctors, nurses and mediators had been explicitly informed beforehand about the nature of the research by the senior manager and I assumed the responsibility of soliciting consent before recording encounters. Data collected were treated in the strictest confidence and only the director of my research group (CIEN) and I had access to the data.

3.2 Positioning the Practitioner-Researcher

The present study uses qualitative methods of data collection and the approach to the analysis of the data gathered is interpretative. Although researchers must ensure that their presence, values, and behaviour do not influence participants and outcomes, the very nature of ethnographic methodology means that they inevitably form part of, and

shape, the research that is being produced (Tusting and Maybin, 2007). Researchers´ subjectivities influence the design and goals of their investigations. Their influence needs to be acknowledged and explained (Codó, 2003). In line with this approach, the aim of this thesis is to provide an account of social reality as experienced by participants themselves.

The dynamic between researcher and participant has become a key focus for academic attention over recent decades, and qualitative researchers have critically examined the epistemological, methodological and ethical issues associated with this. Whether the researcher is an insider, sharing the characteristics or experience with the participants, or an outsider to the commonality shared by participants, the personhood of the researcher is an essential and ever-present aspect of the research. There appear to be many arguments for outsider and insider research as against. As Adler & Adler (1987) claimed, the insider role status provides researchers a certain amount of legitimacy and/or stigma. According to them, while the complete membership role allows researchers more complete acceptance by their participants, outsiders might see this role as creating a heightened level of researcher subjectivity that might be detrimental to data collection and analysis.

In examining the issue of the researcher positionality, Kanuha (2000) has suggested that, although being an insider researcher enhances the depth of understanding a population, questions about objectivity and authenticity of a research project might be raised because the researcher may be too similar to those studied. In the same vein, Asselin (2003) has pointed out that, although role confusion can occur in any research study, there is a higher risk when the researcher is familiar with the research settings or participants through a role other than that of researcher. For the purpose of this study, I understand that the researcher would have to maintain a satisfactory degree of distance with the research setting. As Corbin (2009) claims, "although a shared status can be beneficial as it afford access, it has the potential to impede the research process as it progresses" (Corbin, 2009, p.58).

It is necessary to take into account the ways in which my own particular background has impacted on the research process (Robson, 2002). There are different ways in which my subjectivity and background experience has shaped the present study. The most immediate influence is the choice of topic. The main reason underpinning my

choice is that I have always had an interest in healthcare settings, since hospitals both reflect and reinforce dominant social and cultural processes of a given society. As sites where society comes face to face with manifestations of illness and experiences of suffering, and as organisations that demand highly elaborate and resource-intensive means to treat disease, hospitals and clinics are in effect emblematic of how societies treat life and death (Helman, 2000). This is where my initial interest and motivation to undertake this research reside.

Additionally, as a member of an international research group [1] at the Universitat Autònoma de Barcelona, I had the opportunity to become familiar with different institutional practices and discourses including those of telecommunications, non-profit organizations and healthcare. This sparked my interest and made me reflect on the day- to-day practices in healthcare multilingual and multicultural settings. These reflections lead to the development of my study and have also influenced my decision-making process in the selection and analysis of the data. My main objective was to make a positive contribution to clinics dealing with linguistic and ethnic diversity and to bring about change in institutional practices.

Due to the multilingual and multicultural characteristic of the clinic, the centre was used to the presence of scholars conducting research there. Staff were also accustomed to having journalists around conducting interviews to publish articles in local and national newspapers. This was both an advantage and a disadvantage to me. On the one hand, they knew how to deal with researchers and they were quite receptive to my requests to conduct interviews and to record encounters; on the other hand, they were suspicious in case I was the "typical" researcher going there to collect my material and disappearing once I had all the data needed. They were willing to participate, but some doctors expressed their will to be informed about the results of my research. I committed myself to give insights to the research staff which may be applied to their work settings.

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[1] *CIEN or Comunicació Cultural i Estratègies de Negociació (Cultural Communication and Strategies of Negotiation) research group. It is an interdisciplinary team formed by researchers from different Catalan and Canadian universities.*

The commitment that I made to share research findings and to work with health staff and mediators to develop better working practices was a major factor in gaining the agreement of all participants. The importance of establishing an ongoing relationship with participants, making sure that they were fully aware of what the research was about, and also satisfied with the feedback that they will receive, cannot be underestimated (Stubbe, 1998). I did not have any former links with the clinic or any experience working in a healthcare organisation. None of the participants in the study knew me. Although the senior manager, the person who gave me access to the clinic, had already informed the health staff about the aim of my research, one particular doctor was concerned with what I might do with the data. He expressed some doubts just fearing that I wanted to uncover "bad" practices and he revealed his concerns about the consequences of my presence there. That is why it was crucial for me to explain the objectives of my research and to make it clear that criticising the institution was not my intention.

Apart from this doctor, the rest of the health staff displayed a positive attitude to my presence. They saw my research as an opportunity to make the Catalan Health Department aware of their need to have more resources available in order to deal with their diverse clientele. I developed an almost immediate rapport with the mediators. They perceived me as someone who was interested in their job. They agreed to co-operate since this represented a good opportunity not only to express their views, but also to make society aware of how important their work was. They expressed their gratitude for being heard, as if this were the first time someone was paying attention to them and their relevant task.

Finally, I wish to address the degree to which I was a participant observer in the data collection process. Whilst not a participant in the truest sense of the word, the fact that I was present in the medical encounters and observing whilst collecting the audio-recorded data made me, to some extent, a participant in the situation. As Robson notes, once the participants are aware that they are being observed, the observer is inevitably a participant in the situation (Robson, 2002).

3.3 Data Collection

Data were collected at the primary healthcare centre over a six-month period between July 2007 and January 2008, after a preliminary contact with the site in May 2007. To ensure reliability and validity, triangulation methods were used in this qualitative study. Triangulation strengthens the present research by using multiple methods of data collection, such as interviews and recordings, which ultimately leads to more valid and reliable construction of realities. Research methods included a total of 224 minutes of fourteen audio-recorded semi- structured interviews with nine healthcare staff and five mediators and 117 minutes of audio recording of ten face-to-face mediated medical encounters. The combination of ethnographic description based on audio data from interviews and recorded medical encounters' observation provides a rich data set for investigating the issue of empowerment. Using both kinds of data was considered useful for the identification of both confirmatory and contradictory relationships between what participants say they do and the actual practices in which they engage in the consultation. In the following sections, I explain how the different sources of data were collected and coded.

3.3.1 Interviews

The literature on direct questioning of events provides different insights than observations.   As Codó highlights "interviews are employed either to obtain information which may otherwise be very difficult to gather or to explore issues that can only be accessed indirectly if interactional data is considered "(Codó, 2008, p. 161).

In this particular study, fourteen ethnographic interviews were conducted, including interviews with five cultural mediators and nine healthcare staff working at the healthcare centre.   Both doctors and mediators scheduled their interviews, although on some occasions these were delayed or postponed due to last minute patients' requirements. I interviewed three male doctors and six females. As shown in Table 3.2, all these were from Catalonia and their age range between 30s-50s.

Pseudonym	Occupation	Gender	Age	Country of origin	Seniority
Albert	Family Practitioner	Male	50s	Spain	25
Fidel	Family Practitioner	Male	30s	Spain	9
Miriam	Family Practitioner	Female	30s	Spain	10
Alicia	Paediatrician	Female	30s	Spain	10
Dolores	Paediatrician	Female	50s	Spain	28
Estefanía	Dentist	Female	50s	Spain	27
Adolfo	Family Practitioner	Male	40s	Spain	17
Victoria	Family Practitioner	Female	30s	Spain	8
Mercedes	Nurse	Female	40s	Spain	17
Karim	Cultural Mediator Administrative staff	Male	20s	Pakistan	3
Seema	Cultural Mediator Administrative staff	Female	20s	India	1
Shazia	Cultural Mediator	Female	40s	Pakistan	4
Fatima	Cultural Mediator	Female	30s	Alger	3
Barahim	Cultural Mediator	Male	30s	Pakistan	5

Table 3.2.   Interview participants

Seniority levels vary between 8 and 25 years of experience, with Dr. Albert showing highest number of years of experience.   Five out of nine doctors are family practitioners, two are paediatricians, and there is also a dentist and a nurse. As discussed above (Table 3.1) four out of the five mediators are from India and Pakistan, Urdu/Punjabi mother tongue and with an average age of 30 years-old.

Each interview lasted approximately twenty minutes and they were conducted in one session inside of the participants' working hours.   As initial words exchanged in an interview are important in terms of the definition of the communicative event, I tried to take advantage of the opening turns to start building rapport.   All interviews were of a semi-structured nature and the interview schedule followed a list of general questions related to the theme, even though I allowed for digressions from the topic. Participants' anonymity was guaranteed at the beginning of each interview.   Since I wanted interviewees to speak unconstrained, I let them choose the language of the interaction. Some doctors choose Spanish and others Catalan, with Spanish the language chosen by all mediators.

Questions were short and easy to understand and special attention was paid to avoiding ambiguity. The initial questions in the mediators' interviews took the form of life history narratives (See Table 3.5.3a in Appendix D) in order to find out who they were, when and why they arrived in Barcelona and how have they come to be mediators. As migrants themselves, I was interested in exploring their personal experiences and any event that might have shaped their lives. I also elicited information of the main challenges they have to face in their daily routine, their perception regarding doctors and patients' attitude towards their work and what they consider to be their role.

The basic themes discussed during the interviewing process with doctors (See Table 3.5.3b in Appendix D) related to the communication problems they have to deal with, the availably of resources to manage multilingual/multicultural diversity at work and their view of the role of mediators in the hospital settings. A complete transcript of interviews with healthcare practitioners can be found in Appendix B, while Appendix C contains transcripts of interviews with cultural mediators. Appendix D contains tables with a list of questions addressed to practitioners and mediators. The tapes containing the interviews were fully transcribed and then analysed for emerging patterns.

3.3.2   Audio recording of medical encounters

In addition to ethnographic interviews, research methods also included audio recording of mediated medical encounters. The selection of mediators to participate in the encounters was not random. As discussed in previous sections 3.1 and 3.3.1, there were two mediators, Karim and Seema, who worked at the reception desk and in assisting doctors' consultations. The fact that they were working at reception made it easier for me to interview them in the first place and to shadow and monitor them in medical encounters. I arrived at the health centre at 8:00am every day and went to the reception desk on floor seventh to spend the entire morning with Karim. The same procedure was repeated in the afternoon, where I went to the second floor to spend the afternoon shadowing Seema.

Karim and Seema were hired as administrative staff and that is how the centre could officially justify their presence in the clinic. However, similar to the rest of the mediators, they were paid by an NGO and they did not have any additional skills in comparison with their colleagues working there. As shown in Table 3.3., Karim participated in five out of the ten recorded encounters, while Seema took part in the remaining five. They were the young, both in their 20s, and they had varying degree of experience in acting as mediator. Karim had three years and Seema had one. They were from different cultural backgrounds, but both had Punjabi as their mother tongue. Both of them also participated in the interviews. A total of three languages were employed in the encounters, namely Catalan, Spanish and Punjabi.

Pseudonym	Occupation	Gender	Age	Country origin	Seniority	No. encounters (out of 10)	Interview Participant
Karim	Cultural Mediator Admin. Staff	M	20s	Pakistan	3	5	YES
Seema	Cultural Mediator Admin. Staff	F	20s	India	1	5	YES
Albert	Family Practitioner	M	50s	Spain	25	3	YES
Esther	Family Practitioner	F	30s	Spain	5	2	NO
Alexandra	Family Practitioner	F	30s	Spain	12	1	NO
Carmen	Paediatrician	F	40s	Spain	20	1	NO
Margarita	Dentist	F	30s	Spain	14	1	NO
Cristina	Otolaryngologist	F	40s	Spain	13	1	NO
Mar	Family Practitioner	F	30s	Spain	11	1	NO
Elena	Nurse	F	30s	Spain	5	1	NO
Montse	Nurse	F	50s	Spain	33	1	NO

Table 3.3. Mediators and Health staff participating in recorded encounters

In selecting health staff, it was my intention to select those doctors who took part in the previous interviews. However, since the mediators I was shadowing had to assist many different practitioners, I was only able to record those encounters where mediators were required. I did not want to miss the opportunity to record an encounter just because the doctor was not participating in interviews. Additionally, it

was not easy to adjust the mediators' schedule with the interviewed doctors' consultations. In the end, only one doctor, Dr. Albert, participated both in the encounters and the interviews.

Family practitioners' consultations (seven out of ten) were the most commonly required by migrant patients at the time of my research. As shown in Table 3.3. above, only one doctor, Dr. Albert, participated both in the encounters and in the interviews. He is a family practitioner who participated in three of the recorded encounters, followed by Dr. Esther who participated in two. In the remaining five encounters, five different doctors participated. Two nurses also took part in two different encounters. Seniority varies among health staff, ranging from the nurse Montse with 33 years experience to family practitioner Esther with five years experience. All staff were from Spain and had Catalan and Spanish as their mother tongue and were able to communicate in a very basic English.

Patients participating in the encounters were all Punjabi speaking. Some of them were able to articulate some basic words in Spanish such as "Yes", "No", "Here" or "Pain". As Table 3.4 shows, there were seven men and three women, all of them from Pakistan and India. Ages ranged from 30 to 50. All women were housewives and males were working in construction, unemployed or with unknown jobs.

Pseudonym	Occupation	Gender	Age	Country origin	Mother Tongue
Adil Tahir	Unemployed	Male	50s	Pakistan	Punjabi
Jaswinder	Not known	Male	40s	Pakistan	Punjabi
Mandeep	Housewife	Female	40s	India	Punjabi
Ahmed	Housewife	Female	20s	India	Punjabi
Rupinder	Not known	Male	30s	Pakistan	Punjabi
Gobind	Housewife	Female	20s	Pakistan	Punjabi
Rajinder	Not known	Male	30s	Pakistan	Punjabi
	Construction worker	Male	30s	Pakistan	Punjabi
Bishen					
Inderjit	Not known	Male	50s	India	Punjabi
	Received Disability Proposal	Male	50s	Pakistan	Punjabi

Table 3.4. *Migrant Patients participating in Recorded Encounters*

It was a common practice for doctors to be forced to call a mediator for an unscheduled interpretation. Consequently, mediators were normally running behind and postponing scheduled mediations. In my role as the mediator´s shadow, it was not an uncommon practice for me to enter with the mediator in the middle of a consultation to assist a doctor. Under these conditions, my opportunities to spend the desirable time to establish an adequate rapport with the doctors and patients were severely reduced.

Oral informed consent was obtained from health staff and patients before recording the encounters. The normal procedure for me was to enter in the doctor's room together with the mediator and ask the doctor whether (s)he agreed to allow me to record the medical consultation. When a response was affirmative, the mediator asked for permission from the patient. I thanked the doctor, the mediator and the patient for their co-operation and the voice recorder was left under the doctor's table. On many occasions, consent was quickly granted. At other times, either doctor or patient asked questions as to the nature of the research and explanation was offered. A confidential handling of the data was ensured and participants were told that recorded material was only to be used for research purposes. In addition, participants were reassured that anonymity was guaranteed and that pseudonyms would be used for identification purposes. Consent was never denied.

I paid attention to my role and how others perceived me. For this reason, I restrained myself from being a complete participant and I assumed what Duranti calls the status of a *professional overhearer* (Duranti, 1997), which implies finding out the least intrusive place where to sit or stand. I sat in the corner of the room to be as unobtrusive as possible and where the participants would not feel obliged to include me. I only used audio recordings, since they seemed less threatening to people's privacy than video recordings.

3.3.3   Field notes

Ethnographic notes can add dimensions of description that cannot be captured on tape and they may also be used to document information about the participants, including their age, profession and social status.   Notes were taken during the recorded mediated encounters as well as during the semi-structured interviews with mediators

and doctors. One of the most interesting observations made was the management of gaze. Gaze is one of the mechanisms whereby participants display their mutual engagement in focused interaction (Codó, 2003). During participant observation, I observed how doctors normally had eye-contact with the mediator when addressing the patients. This practice was appreciated in all interactions, except in paediatrics consultations, where doctors generally had eye-contact with mothers. It was also observed how doctors normally raised the tone of their voice when addressing migrant patients, as an attempt to be understood by them.

Notes were transcribed into computer files and organised into chronological documents. There were analysed for content and compared to recordings of medical encounters and interviews. The main purpose of these notes was to supplement the audio recordings and interviews and to capture in writing relevant verbal and non-verbal information. The information was placed in a table format, with the left column containing observational notes and the right column containing analytical notes (see Appendix E).

Of particular relevance were notes taken during interviews with Catalan Health Institute's (ICS) managers. These interviews were the very first exploratory step in my research and I conducted them even before obtaining consent for my study. My main aim was to have a broad view of the political discourse of the hospital Administration. I interviewed senior managers who were responsible for Mediation, Immigration and also responsible for Training and Development of Health Professionals dealing with migrant population. The information obtained was analysed and compared to recordings of medical encounters and interviews to identify gaps between the Administration discourse and the day-to-day reality.

3.4   Transcription and Coding

In many domains of social sciences where human interaction is of interest to researchers, the research method of choice involves audio or videotaped recordings of communicative interaction followed by verbatim transcription, coding and analysis to make sense of the data. Transcription is a pivotal aspect of qualitative research, as it can powerfully affect the way participants are understood and the conclusions drawn. It is the process of representing oral language with orthographic conventions, but the

outcome of rendering oral language into written form is not a neutral process of representation.   Researchers in the area of Conversation Analysis (Psathas and Anderson, 1990) point out that transcripts cannot be neutral and researchers employ selectivity in deciding what to include in a transcript.

The aim of transcribing is twofold: to provide representation of interactional materials for the purposes of observational analysis, and to represent the detail of participants' verbal and non-verbal conduct as far as is possible given the constraints and affordances of text (Ten Have, 1999; Roberts and Robinson, 2004).   Far for being a theory-neutral activity, transcription is theory (Ochs, 1979). The transcriptions are the researcher's data and what is on a transcript will influence what generalisations emerge. Transcription, as proposed by Ochs (1979), is a selective process relying on conventions and reflecting theoretical goals and definition. By being selective, transcription conforms to the classic definition of a *scientific method* because it helps us deal with problems and allows us to make sense of everything. Transcription helps us to develop partial theories, which is a reasonable goal in any scientific enterprise (Duranti, 2006).

The need to interpret talk becomes more acute in cases in which the researcher deals with foreign language talk in intercultural situations. This is the case in the present study. I shall dwell upon the difficulties encountered throughout the transcription process later in this section. For the purpose of my study, ten medical exchanges have been transcribed in full detail. Those interactions mainly involve speakers of Asian origin who employ Punjabi to communicate with the mediator.

The standard used for the transcription and coding of the ten medical encounters was LIDES (Language Interaction Data Exchange System).   LIDES is a data transcription system based on CHILDES (Child Language Data Exchange System) created by MacWhinney and Snow (1990). This system has been specifically developed to meet the need of researchers working with multilingual data and it is "the first coordinated effort in the field of bilingualism to provide a system whereby researchers can share their data" (Turell and Moyer, 2008, p.197).   The information transcribed from audio recording was organised in a coherent form. All transcriptions begin with a heading section that includes information on the participants in the

interaction (name, age, gender and occupation), languages involved, date of recording, and duration of encounters. Transcriptions read as follows:

@Begin

@Participants: Pedro, 50, Male, Catalan, Family Practitioner

                Karim, 24, Male, Punjabi/Catalan, Cultural Mediator

                Tariq, 54, Male, Punjabi, Construction Worker

@Date of Recording: January 22, 2008

@ Duration of encounter: 18m30s

A description is presented in Appendix A of the main constituent elements of LIDES transcripts. A complete list of the transcription conventions employed in this study is provided in Table 3.5 below.

...	Pause
XXX	Inaudible passage
CAPITALS	Emphasis
:	Elongated vowel sound
( )	Hesitation
// //	Overlap (people speaking simultaneously)
■	Facing
[ ]	Non verbal information
((LF))	Laugh
¡ ¡	Rising intonation
! !	Falling intonation
Boldface	Catalan
Italics	Idiomatic translation from Spanish, Catalan and Punjabi into English
*	Background information Line in the transcript relevant to the point being made

Table 3.5. Transcription conventions

The level of detail in the transcriptions of the speech of doctors, patients and mediators includes the English translations (represented in italics) of Spanish, Catalan and Punjabi utterances. The transcription conventions adopted include square brackets to indicate instances of non-verbal information, dots to highlight pauses, and for overlapping utterances where people are speaking simultaneously.

To be able to interpret what is going on in the medical interactions examined in the study it is of critical importance to analyse contextualization cues. According to Roberts and Sarangi (2005, p. 634):

> Talk has only meaning in context and contextualization cues are the hidden underbelly of this meaning making. They are the signs that invoke the context that gives each utterance a specific meaning. They tend to be used unconsciously and their function in establishing or reinforcing social relations and negotiating shared meaning goes largely unnoticed.

These linguistic and prosodic signs include intonation, stress, pausing, rhythm of speech and expressions such as "so", "well" and "right". In this vein, an effort has been made to render prosodic information as accurately as possible. As indicated in Table 3.5, comments on paralinguistic phenomena are inserted by means of the symbols: "¡ ¡" for rising intonation, "! !" for falling intonation, "..." for pause , "( )" for hesitation and "CAPITALS" for emphasis.

At this point, some specific transcription practices which are of particular interest to the corpus of the present research are discussed in the following lines. One practice to be examined is the representation of gaze. Of particular relevance was highlighting whether healthcare professionals address the patients directly or if they talk to them 'through the mediator'. The solution adopted here has been to use the symbol ■ as code to indicate 'two people talking face to face'.

Other transcription issues that I have considered are vocalizations other than speech (e.g., laughing) and nonverbal interactions (e.g., smiling, pointing, head nodding, hand gestures,etc). Non-verbals constitute important conversational cues and therefore, transcribing these features of speech adds context and explanation. ((LF)) symbol is used for laughing.

As briefly announced above, during the transcription and coding process a number of difficulties were running into as a consequence of the foreign language nature of the data gathered. The complexities of this linguistic material can be spelled out by examining the concept of *foreign language talk*. This notion includes linguistic data from languages unknown to the researcher, such as Punjabi. Instances of this category occur in the data presented in this study since I had to handle linguistic data from a language, Punjabi, that was unknown to me. The complexities of the process of data transcription were enormous.

To assist with this, I engaged the assistance of a cultural mediator (Bishen) currently working in a different clinic who had Punjabi as a mother tongue. Bishen was external to my research and he did not take part in any of the recorded encounters. I instructed him on the transcription conventions employed so that the transcribed texts were consistent. In order to attain reliability and check the consistency of the transcription, the transcribed material was double-scored. A second transcriber, an experienced lecturer at the University of Delhi, transcribed the material following the same conventions, with 90% agreement between the two transcripts.

3.5 Concluding Remarks

As Morse et al. point out, "without rigor, research is worthless, becomes fiction, and losses its utility" (Morse et al., 2002, p.14), hence the importance of verification strategies used by the researcher so that reliability and validity are actively attained. Strategies to ensure rigor in the present study have included methodological coherence, sampling adequacy and theory development.

Regarding methodological coherence, my aim was to ensure congruence between the research questions, the method (ethnography), the data and the analytic procedure. The sample of mediators and healthcare practitioners selected to take part in interviews and medical encounters consisted of participants who have knowledge of the research topic. By selecting an adequate sample, I have tried to obtain sufficient data to account for all aspects of the empowerment phenomenon. In order to develop theory, I have moved between a micro perspective of the data and a macro conceptual understanding. All these verification strategies have contributed to and built reliability and validity, thus ensuring rigor.

In any research project it is important to acknowledge the specific weaknesses of the approach method used. In the case of the present study, the sensitive nature of the context studied led to significant methodological limitations. One of the most serious weaknesses of the present study is the absence of feedback data from migrant patients. Interviews with patients were not conducted and their point of view regarding empowerment was not gathered. Therefore, any future examination of patient' empowerment would benefit from patients' interviews, where information regarding their experiences at the healthcare centre, their linguistic difficulties and their views of cultural mediators and doctors' practices regarding empowerment can be gathered. These interviews could potentially uncover different mediators' working practices which might lead to patients' (dis) empowerment and would be a useful direction of travel for future research.

A further potential limitation refers to the length of time needed to conduct an ethnographic study. This form of research is extremely time-intensive and even more so if the process of negotiating access to an organisation is taken into account. That is the reason why it is be necessary to consider the pragmatic implications when ethnographic research is proposed.   However, the detailed experiences collected during these long durations give researchers a rich understanding of complex phenomena that occur within that specific social environment. The ethnographic approach provides a suitable research approach for the purposes of the study since it allows for a holistic perspective of the organization. It also allows for an appreciation of working practices in a real-world setting. Ethnographic findings uncover social patterns and individual forms of expression and relationships. They are valuable for illustrating and explaining various forms and significance of social interaction (Quimby, 2006).

A further weakness of the data presented has to do with the mediators´ working experience and level of training. Although some of the mediators interviewed were experienced in their job, those who took part in the recorded medical encounters only had three-year experience (Karim) and one-year experience (Seema) respectively. I am also aware that the medical encounters may have been different if those mediators taking part in the recorded communicative events were certified with specific training in cultural mediation.

As mentioned in section 3.4, the process of data transcription was complicated by the language combination used. However, the fact that I can not control the quality of the Punjabi transcriptions represents a limitation in itself, although every effort was made to achieve rigor, precision and accuracy.

In spite of the above acknowledged limitations, this study brings to light key interactional situations shaping the experiences of migrant patients, health professionals and mediators. By examining these realities largely unknown to the local population, the project aims to contribute our understanding of patients' empowerment through cultural mediation and, in doing so, to make recommendations for change in healthcare institutional practices.

Chapter Four

On how Cultural Mediators Perceive their Role in Empowering Patients

The combination of various data collection methods such as interviews and observations allows researchers to obtain rich and in-depth data on the behaviour of individuals (Hua and David, 2008). As outlined in the Methodology Chapter, the aim in this study was to analyse mediated recorded interactions and to capture whether the views expressed in interviews supported or contradicted mediated interactions. Although interview methods do not fully capture the actual social and linguistic practices in which research participants engage within their communities (Briggs, 1986), my approach in this study was to take the articulations of patient empowerment elicited in the interviews with mediators and health staff and contrast them with the interactional data from mediated medical encounters.

Interviews with cultural mediators and health staff were conducted before the recording of medical interactions, with each lasting approximately twenty minutes. They were all conducted in one session each within the working hours of participants. All interviews were of a semi-structured nature. The original Spanish quotes from interviews, which appear in italics and inverted commas, are translated into English and appear in square brackets. The research questions sought to identify the mediators' perception of their own role in relation to empowering patients and whether this corresponded with how mediators are perceived by doctors. I also wanted to find out what strategies were employed by mediators to empower patients and whether these had any impact on patient empowerment.

In the data set, a number of themes were identified. The recurring common themes that appeared in interviews with both mediators and healthcare staff included issues around power relations between mediators and healthcare staff, time as an institutional constraint, mediators sharing migrants' patients' background and the role of mediators. These themes will be analysed in this chapter. Section 4.1. looks specifically at power relations between cultural mediators and doctors and it pays particular attention to the consequences of mediators' lack of specialized medical knowledge. Section 4.2. examines the potential difficulties as a result of mediators sharing their background with migrant patients. Finally, section 4.3. examines the

cultural mediators' perception of their own role as providers of empowerment to patients, together with health staff's perception of the mediators' role. In doing so, the aim to identify potential divergences and/or common ground between both groups.

4.1 Power Relations Between Cultural Mediators and Doctors

In a typical monolingual medical consultation, doctors tend to hold most of the power. This power stems from their medical expertise and institutional affiliation. As discussed in section 2.2.3, doctors are the first to initiate questions, they set the pace of the discourse, ask closed questions determining the issues that will be discussed and for how long discussion will take place (Davidson, 2001). In bilingual and multilingual medical consultations where a mediator is present, doctors often have to rely on the mediator to establish communication and, in many ways, are often obliged to yield part of their interactional power. As Pasquandrea points out, in medical contexts "doctors must share responsibilities for the management of the interaction and they may not retain control on extended parts of the conversation with the patient" (Pasquandrea, 2011, p.456).

As discussed in section 1.1 of Chapter One, cultural mediation in Spain spans a much wider range of activities than what is generally meant by translating or interpreting. Interpreting is quite often one of the cultural mediator's many tasks, although they also perform additional tasks such as facilitating access to the Spanish medical service, helping with administrative practices and providing explanations about cultural differences that may hinder communication with migrant patients. The mediation market is not regulated and anyone can serve as a mediator on the basis of his/her alleged linguistic/cultural skills. There are few, if any, quality controls and many mediators are not trained and certified in mediation. This section analyses power relations between mediators and doctors and uncovers mediators' feeling of disempowerment as a factor that might ultimately constrain mediators' ability to empower patients.

As discussed in section 2.3.1, Bourdieu's (1991) accounts of power as 'symbolic capital', whereby some resources of knowledge are more valued than others. As Heller (2007) states, "different kinds of actors have access to different kinds of knowledge" (Heller, 2007, p. 639), both knowledge about the health centre as an institution and knowledge about the resources distributed there. At the clinic under study, access to power is partly based on competence in the local languages (Spanish and Catalan) and specialized professional/medical knowledge. Mediators can be seen to possess the language and socio-cultural knowledge of the host country and the healthcare institution to fit into the established institutional ways of behaving (Heller, 2007; Cicourel, 1973). However, their agency is limited because of the specialized medical knowledge they do not possess, which places them in a potentially less powerful position and their role may as a result be questioned by healthcare staff.

A further factor which might influence power relations is the fact that mediators are not recognised as professional groups and do not enjoy a high status. As Moyer points out "the lack of official recognition of interpreters from different language and cultural origins reflects the Catalan government's official non recognition of this professional figure" (Moyer, 2013, p. 201). In fact, this is not specific to Catalonia. Community interpreting in Spain is characterised by a lack of recognition as a professional activity more generally (Martin, 2006; Valero-Garcés, 1998).

Additionally, although mediators use language in the course of carrying out their duties, it seems that there is an absence of commoditisation or recognition of the economic value of their language competence. Mediators in the study are generally badly paid and their pay rates do not provide any evidence of economic compensation. This is in line with Heller's (2003) research on call centres, where workers are hired on the basis of their communicative competence, but not in a way that their language constitutes a commodity with an economic value. In the healthcare centre under study, it seems that the language component of mediators is not recognised in economic terms, which places them in a potentially less powerful position. As one of the doctor interviewed claimed, "mediators are full of good will, but they are paid a pittance", which seems to indicate that their role may be questioned by healthcare staff.

In the interviews, doctors often expressed mistrust of cultural mediators. This is likely to emerge as a consequence of mediators' perceived lack of medical knowledge. Concerns regarding trust have been identified in other institutional settings where mediators and interpreters are used. In their study on the Scottish police, Perez and Wilson (2007) observed that a primary area of concern for police officers was related to the accuracy of the interpreters' renditions, with these concerns closely linked to trust. According to Perez and Wilson, the main concern "appears to be the potential loss of information and the negative consequences this would have for police officers" (Perez and Wilson, 2007, p. 84). This is also applied to doctors at the clinic under study, where some doctors expressed concerns about *having to trust mediators' renditions",* which seemed to indicate doctors' perception of a surrender of control.

In his interview, Dr. Adolfo, a family practitioner with 17 years experience, claimed that he feels uncomfortable with this loss of control in the encounter, having to rely on the mediators' renditions. It seems that some doctors see the presence of mediators as an obstacle when it comes to ensuring that the medical encounter proceeds along the lines established by healthcare professionals. According to Moyer (2011), since doctors do not control the interpretation, they fear that mediators, as individuals with no medical background and members of the patients' own communities, are more aligned with the viewpoints of the patients than the *scientific* opinion of the doctors. As the excerpt below shows, Dr. Adolfo, for instance, claimed that, since the mediator and the patient speak a foreign language, he has no control over the information exchanged by them. He pointed out that he had no other choice but to trust in the reliability of mediator's rendition. This is seen as problematic as he is no longer in control of the exchange.

> *"Como no sabes ni lo que el paciente le dice a la mediadora ni lo que la mediadora le*
>
> *dice al paciente, pues te tienes que fiar, no te queda más remedio"*
>
> [Since you don't know what the patient says to the mediator or what the mediator tells
>
> the patient, you have to trust them, you have no choice but to trust].

The distrust of mediators expressed by doctors in this study is also confirmed by some of the mediators in their own interviews. Fatima, a certified mediator from Alger, highlighted that sometimes mediators feel disempowered by doctors due to their lack of trust in them. She pointed out that there were occasions when doctors believed that the mediators were talking about other issues with patients and that they were not translating the medical instructions being imparted by the doctor. As she claims:

"Quizás el paciente nos está contando sus síntomas y el médico piensa que estamos hablando de otra cosa y no estamos traduciendo las instrucciones médicas al paciente. Y me pregunta ¿qué estáis diciendo?"

[Perhaps the patient is telling us his symptoms and the doctor believes we are talking about something else. He thinks that we (mediators) are not translating the medical instructions to the patient and we are talking about other issues instead. And he (the doctor) asks me: what are you talking about?]

As a result of unequal power relations between doctors, cultural mediators seem to be disempowered in their role. Some mediators in their interviews also express this and it could be said that their feeling of disempowerment might ultimately constrain their ability to actually empower patients. Shazia, a certified mediator from Pakistan, states that there are doctors who she thought dislike mediators, but "they have to put up with them," she says because patients insist on having their services while in the consultation. She pointed out that:

"Hay médicos a los que no les gustan los mediadores y entonces nos tienen que aguantar
a nosotros cuando los pacientes insisten en que nosotros estemos"

[There are doctors who do not like mediators and they have to put up with us when patients insist on having us there].

Although she stresses that only a third of doctors have this attitude, she feels that mediators bother doctors since they interfere with the encounter. Patients are also seen to bother doctors because they have not learned the host country language and, as a consequence, have to request the assistance of mediators. As she puts it herself:

> *"Nosotros molestamos porque estamos en medio y los pacientes porque no han aprendido el idioma"*

> [Mediators bother doctors because we are in the middle and patients bother doctors because they have not learned the language].

What is interesting in Shazia's remarks is that she expresses the denigrated position of the mediator and the patient, where both parties 'bother' the doctor for different reasons.

Expressions of mistrust of cultural mediators were also voiced by doctors who claimed that health information ''filtered'' through a mediator could distort doctors' medical instructions. The prevailing view among doctors was that they only need interpreters to translate their words and the patients' words, and mediators' interventions were regarded as unnecessary interferences. This idea is expressed clearly in the words of Dr. Victoria, a female family practitioner with eight years experience. Although she acknowledged at the beginning of her interview that mediators do good work at the clinic, there are conflicting views in her position and during our discussion she showed some distrust of mediators. She claims that she does not need the interpretation of a third person and does not want any interference between her and her patients, fearing a mediator might alter the patient's message. What is interesting in her comment is that she considers a mediator to be is a 'third person who is interfering' in her interaction with the patient, only rendering his/her personal interpretation of the patient's conditions. As she said:

> *"Quiero que me traduzcan a mí y al paciente. No me hace falta la interpretación de una tercera persona, necesitaría un traductor. Para mí es muy importante el mensaje que hay entre el paciente y yo"*

> [I want someone who translates me and the patient. I do not need the interpretation of a third person. I would need an interpreter. The message between the patient and I is very important]

The fear that mediators might ''filter'' information that could potentially distort doctors' medical diagnosis was widespread among doctors in the study. In their interviews, they repeatedly expressed their concern regarding the possibility that

mediators alter the patient and/or the doctor's message by providing their own renditions and filtering the primary interlocutors' message. Therefore, when mediators provide their renditions they include more or less explicitly expressed information to the preceding original utterance. For instance, in summarised renditions, mediators provide a *new version* of what originally was contributed in more than one original, which can be seen as a form of intervention. This is what doctors refer to as 'the alteration of the message' and this seems to be the reason behind their perceived need for working with interpreters who do not interpret the originals. However, Wandensjö understands this *new version* or interpretation as a "result of dialogue between the primary party and the dialogue interpreter herself" (Wadensjo, 1993, p.113). Although it is usually the health staff that exercise control in the cultural and multilingual interactions, it seems that the fact that they do not control the interpretation causes them concerns about losing power and control of the encounter.

In addition to specialised competences generated by forms of linguistic capital, cultural mediators are also endowed with competences generated by forms of cultural capital. However, the data in my study seems to confirm that mediators' socio-cultural knowledge of patients is a resource to which the majority of doctors attribute a low value, which has consequences on the relations of power between doctors and mediators. As discussed in section 2.3, Bourdieu's (1991) theory of social reproduction understands the notion of capital and resources as goods that become associated with material and symbolic wealth and power in a given period. The possession of different forms of capital bestows status on its owners and positions agents within fields in specific ways.

Bourdieu (1990) uses the market metaphor as an alternative to the notion of the field. He claims that different resources have different values on different markets and there are resources that have value on certain markets, but not on others. Although some health staff values the possession of the mediators' cultural capital, the prevailing view is that patients' cultural issues are not relevant and, therefore, mediators' knowledge of migrant patients' culture is not generally considered a valuable resource in the market.

Nurse Mercedes and Dr. Albert illustrate examples of where cultural knowledge is seen as resource.   Mercedes, a female in her 40s with 17 years experience, highlights the important assistance that mediators provide in helping health staff to get to know and understand the patient.   As the excerpt below shows, she also acknowledges how important it is to explain new concepts to patients, such as the need to consult a psychiatrist or to take an antidepressant.

> *"Cómo le explicas que le tienes que dar un ansiolítico? O que tienen que ir a un psiquiatra o a un psicólogo? Eso en su cultura no lo pueden entender, para ellos eso es nuevo"*
>
> [How do you explain to them that you have to prescribe them an antidepressant? Or that they have to go to a psychiatrist or a psychologist? They cannot understand that in their culture, this is new for them].

In the same vein as Mercedes, Dr. Albert, a general practitioner in her 50s with 25 years seniority, also considers mediators of key relevance in overcoming cultural barriers in cultural and multicultural interactions.   He compares mediators with Sherpas, those experienced individuals hired to help and assist others on mountaineering expeditions. As can be seen in the excerpt, for him, mediators are like Sherpas, since they help health staff to climb the mountain or overcome the barrier of cultural differences that separates them from the migrant patients.   Here mediators' cultural knowledge is seen as a valued resource that helps doctors to get to know and understand their migrant clientele.

> *"¿Cómo colonizarías el Far West, con un guía que conoce los valles y las tribus o con alguien que sólo sabe cuatro palabras? Los mediadores son estos guías, estos sherpas que nos ayudan a llegar al paciente porque conocen el terreno".*
>
> [How would you colonize the Far West, with the help of a guide who knows the valleys and tribes or with someone who only knows a few words? Mediators are these guides, these Sherpas to help us reaching the patient because they know the ground].

Dr. Albert believes that by only paying attention to physical symptoms and ignoring patients' social, cultural and job related issues, doctors can only "deal with the tip of the iceberg".   However, he states how some of his colleagues prefer to ignore aspects

other than physical condition as a strategy to distance themselves from the patients and do not get emotionally involved.

However, the examples above with Dr. Albert and nurse Mercedes are exceptions since the prevailing view among doctors in the study is that mediators' socio-cultural knowledge of patients is a low value resource. This is clearly expressed by Dr. Fidel, a male family practitioner in his mid-30s with nine years working experience. He has a strong commitment to working as a family doctor with migrants and he dedicates time outside of his work schedule to volunteer activities serving the patient community. However, the point made in the state below expresses quite clearly his view that there is no need for mediators highlighting the universal nature of illnesses. Dr. Fidel believes that the main barrier with migrant patients is not cultural, but linguistic. He claims he only needs an interpreter to translate words. There is no point, he argues, in going into areas of patients' culture since physical symptoms are similar regardless of the patients' country of origin and cultural background. According to Moyer (2011), the implicit ideology has to do with language.

> *"No necesitamos mediadores. Nosotros necesitamos traductores. Las enfermedades son mundiales, o sea, a mí una persona que me venga con un problema intestinal me da igual que venga de donde sea porque tendrá los mismos síntomas"*. *"Un dolor de cabeza es lo mismo aquí que en la China, o un embarazo es igual aquí que en Pakistán"* *"Necesito un traductor que me diga lo que le duele al paciente"*
>
> [We do not need mediators. We need translators. The diseases are global, that is, to me a person who comes to me with an intestinal problem that I do not care where he comes from because he will have the same symptoms].[A headache is the same here as in China, a pregnancy is the same here as in Pakistan]. [I need an interpreter who tells me what is wrong with the patient].

Dr. Fidel considers that all patients are similar in medical terms regardless of their background and culture. This is why he believes that he does not need a mediator to interpret cultural issues relating to the patient. According to Moyer "the reason doctors claim that they only need an interpreter to translate words hinges on the view that understanding is accomplished if the words alone are translated, hence, the view that meaning is about the denotation of each word" (Moyer, 2011, p.1220). It seems

that, for Dr. Fidel, the main goal is to reach an accurate diagnosis and cultural differences can be ignored since they are not relevant from a purely biomedical point of view.

The absence of the economic value of mediators' language competence together with the low value in the health market attributed to mediators' socio-cultural knowledge of patients may also have an impact on power relations. In negotiating these relationships, mediators may find themselves in the middle of potentially conflicting agendas.

4.2 Sharing Patients' Background as Source of Tension

A further theme identified by some of the mediators during their interviews is the issue of having a shared cultural background with patients. Although they are aware of the importance of sharing the patients' background in order to gain a deeper understanding of these patients, some mediators also state this may be a source of tension. Karim and Seema, for example, comment on the fact that there have been occasions where patients did not seem to trust them just because they share the same culture.

As Karim explains, one illustrative example of where tension generally emerges between mediators and patients occurs when doctors seek information from Muslim patients regarding alcohol intake. He comments that Islam's holistic approach to health and well- being means that anything that is harmful is forbidden. Therefore, Islam takes an uncompromising stand towards alcohol and forbids its consumption in either small or large quantities. Karim explains that a practicing Muslim will not touch alcohol "out of fear of God" and those who do usually feel much guilt on breaking a Qur'anic rule.

Interestingly, Karim also explains that patients who take alcohol feel ashamed to admit their practices in front of a mediator; however, they don't feel embarrassed to tell the doctor. They are also scared in case the mediator uses this information later on and let other members of the community know. It can therefore be argued that, on some occasions, patients fear being exposed and are ashamed to explain certain habits

or behaviours to mediators which are not considered as appropriate in their shared culture.

To illustrate this point, Karim explains in the excerpt below how some Muslims do not admit that they have taken alcohol because they are afraid of portraying themselves in a bad light in the eyes of Muslim mediators. Interestingly, they are not afraid of admitting these behaviours in front of Western doctors, since patients are aware that these habits, which are considered embarrassing in their culture and in that of mediators', are tolerated by individuals coming from a different background. It might be the case that this situation makes it difficult for mediators to actually empower patients, even if they are willing to do so.

> *"Hay musulmanes que viven aquí que sí toman alcohol, y muchas veces tienen miedo a decir la verdad porque quedan mal delante de mí si lo confiesan. A mí me dicen que no han bebido y cuando se hace un análisis ya se ve enseguida que están tomando alcohol. Después les tengo que decir: si bebes tienes que decirlo porque el médico necesita saber la verdad, yo no se lo voy a decir a nadie y entonces lo reconocen, dicen "sí, sí, hemos tomado". Al médico no les importa decirles que han bebido pero a mí sí, porque les da vergüenza. Hay algunos que a veces dicen mentiras para que yo no me entere. Así que intento hacerle este tipo de preguntas de manera indirecta para que no se sientan avergonzados"*

> *[*There are Muslims who live here who do take alcohol, and they are often afraid of telling the truth because they are going to be in a difficult position if they admit it to me. They tell me they have not drunk and when an analysis is done it can be seen that they have been drinking. Then I have to tell them: if you drink you have to say so because the doctor needs to know the truth, I 'm not going to tell anyone and then they admit "yes, yes, we've been drinking". They don't mind telling the doctor that they have been drinking, but they are embarrassed of telling me. Sometimes there are some of them who tell lies so I'm not aware. So I try to ask these questions indirectly to avoid embarrassing them].

In this excerpt, the mediator talks about adopting the strategy of asking what can be seen as "uncomfortable" questions in an indirect way to avoid embarrassing patients. He also highlights that he reassures them by letting them know that the information

provided is strictly confidential. In the same vein as Karim, Seema also comments that patients are sometimes reluctant to explain their problems in front of her for fear of being exposed. Seema believes that this distrust arises simply because patients do not fully understand what a mediator is and what his/her role is. It might be the case that patients are not fully aware of the mediators' roles and that the information they provide to them in the consultation is confidential. Additionally, it is not a common practice for doctors to explain what the mediator's role is to patients, probably assuming that they already know it.

This situation has a potentially disempowering effect on patients; since they probably do not know to what extent they can trust mediators and explain their problems to them. As shown in the quote below, Seema tries to reassure patients by letting them know that she is there to help them. She explains to patients that her work is to interpret the doctor's and the patient's words, always treating information in a strictly confidential way.

> *"Estoy para ti, para ayudarte, todo lo que digas tú se lo tengo que decir al médico y todo lo que diga él lo tengo que traducir. Mi papel es éste. Lo que me diga usted se queda aquí, no tiene que preocuparse, la información que me cuente no va a salir de estas cuatro paredes"*
>
> [I'm here for you, to help you, everything you say I have to say it to the doctor and everything he says I have to translate it. This is my role. Everything you tell me stays here, no need to worry, the information you provide me is not going to come me out this room].

Manifestations of patients' distrust for mediators, with whom they share a cultural background, illustrate the complexities of the mediation task and evidence of potential sources of tension. However, despite patients' fear of being exposed, mediators' strategy of asking uncomfortable questions indirectly to avoid embarrassment and/or the provision of information regarding their role can be seen to help alleviate tensions and facilitate patients' empowerment.

4.3 Cultural Mediators' Role as Providers of Empowerment to Patients

As discussed in section 2.2.1 of the Critical Literature Review Chapter, mediators play an active interactional role by bringing their language and cultural knowledge to the interaction. According to Baraldi "interpreters are the only participants in triadic interactions who can effectively understand all the contents and intentions uttered in communication; consequently, they always assume the role of promoting and co-ordinating the interaction in which they participate"(Baraldi, 2009, p. 121). Interpreters can occupy multiple social roles, including that of a translator, educator, advocate and link worker. This section explores how mediators perceive their role as providers of empowerment to patients and whether their perceptions coincide with those of healthcare staff.

4.3.1 Cultural mediators' perception of their own role in patients' empowerment

Four out of the five mediators in this study acknowledged that their role requires more than linguistic conversions, especially when the cultural framework of meaning for patient and provider are very disparate. They highlighted the provision of the appropriate linguistic conversion from one language into another as a crucial part of their work, performed by actively assisting patients and doctors to overcome barriers to communication embedded in cultural, religious and other social differences. Karim understands his role is to facilitate communication between doctors and patients and to solve any communication difficulty that might arise during the medical encounter. In the same vein, Seema and Barahim believe that their role is to assist communication and help bridge the language and cultural gap.

Fatima feels her primary role is to facilitate the understanding and communication between patients and doctors, intervening, when necessary, to assist in exploring information that will diminish cultural barriers to understanding. She believes that mediators are also responsible for leading and directing medical encounters, establishing triangular interactions where doctors address patients and patients address doctors. Of particular interest is that all mediators in this study claim that they are likely to perform actions beyond the act of linguistic and cultural mediation while in the consultation, such as facilitating access to the Spanish medical service and providing medical information to patients following a medical consultation. As an

illustrative example, Karim explains that it is a common practice for him to explain to patients that they need to apply for a medical card and to further help them to fill out the application form.

Only one of the mediators who participated in this study, Shazia, a trained female mediator from Pakistan with four-year experience, perceives her function in terms of a linguistic conduit. She understands her main role is to transmit information between doctors and patients and believes that her job consists of providing a linguistic conversion from one language system into another. However, there are some contradictions in her discourse and she does in fact admit that her role extends to explaining to patients how the local healthcare system works. While in the consultation, she says she only interprets the doctor's and patient's utterances, but that, it is outside the consultation where she spends time with patients to explain procedures and answer their questions.

Shazia's claim shows that what goes on in the consultation room and in the medical encounters does not provide the full picture of her job. She seems to suggest that she acts differently in the consultation room, where she performs the role that is expected of her as an interpreter or mediator and only interprets utterances. However, once the medical interaction is over, she goes into lots more detail and her role gets extended. Therefore, although Shazia initially sees her role as a conduit, she is not following the conduit model. Her perception is therefore strikingly similar to that of the other mediators in this study, who claim that they perform actions beyond the act of linguistic and cultural mediation. Section 4.3.2. below analyses those extended roles perceived and advocated as legitimate by mediators.

4.3.2   Cultural mediators' perception of their role extension

The extended roles claimed by mediators in their interviews include (a) facilitating patients' access to the Catalan medical service by helping them with the administrative practices, (b) assisting patients following a doctors' consultation by answering clinical questions, and (c) mediators as co-interviewers prior to the medical encounter. Below I critically examine these three extended roles with the aim of identifying whether they might have any impact on patients' empowerment.

Facilitating patients access to the Catalan medical service

As discussed in section 2.3.3, individuals' opportunities for social actions might be constrained by their limited access to certain forms of capital (Bourdieu, 1991). The knowledge of how the Western healthcare system works is a valued form of capital that migrant patients often do not have and, which might in turn constrain their opportunities for action. By assisting patients to navigate their way through the healthcare system, mediators can be seen to provide access to patients to a valuable resource of knowledge that potentially places migrant patients in a more powerful position.

From my discussion with Fatima, a certified female mediator from Alger with three years experience, she claims that she dedicates extra time outside of the consultation to helping newly arrived migrants to become familiar with bureaucratic procedures associated with healthcare. As we can see in the excerpt below, she stresses that many migrants are unaware that there is a health centre in each neighbourhood, they don't know who to address when they enter the building, they don't know that different specializations are on different floors, not to mention that they are normally unaware that they have to issue a medical card, make appointments and cancel them in case they cannot attend. She believes mediators play a crucial role in assisting migrant patients to become familiar with the instructions a patient must follow before a medical procedure is carried out, as application for medical card. That is how she illustrates her views:

> *"Pienso que los mediadores son imprescindibles en servicios sanitarios y servicios sociales. Muchos inmigrantes cuando vienen no saben que hay ambulatorio, ellos saben que hay hospital pero no saben que en la zona tienen un CAP, y que cada CAP corresponde sólo a la zona y cuando entran las visitas no saben con quién hablar y cada servicio tiene su planta, para tener visita con el médico no es solamente entrar y visitarse, también hay que tramitar la tarjeta y pedir hora".*

> [I think mediators are essential in healthcare centres and social services. Many migrants do not know that there are health centres, they know there is a hospital, but they do not know that there is a health centre in their neighbourhood, and that each health centre corresponds to a particular area.

When they enter, they do not know whom they have to address to, they do not know that each specialization is located in a different floor. In order to be visited by a doctor one has to do more than just to come and be visited, you also have to process your medical card and make an appointment]

In the same vein, Karim also takes time to explain to patients not only the procedure which they should follow to obtain a medical card, but also how to make an appointment. Like Fatima and Karim, Barahim also understands one of his roles as helping migrants to become familiar with the Western healthcare system. As a normal practice, Barahim spends time with migrant patients who visit the centre to explain to them how the system works, either before or after their consultation. He usually has these informal chats either in the waiting room or in the corridor. It seems that the health centre has not established a room or a timetable where mediators are available to assist patients on these matters.

As a consequence, mediators end up providing this assistance as an "on the spot" extra service, always depending on their availability, good will and empathy towards patients.

As Barahim illustrates in the following excerpt, recently arrived migrants are often used to healthcare systems that are differently organised and administrated than the Catalan healthcare system. Patients are not aware of what procedures to follow in order to be visited by a doctor. For instance, they do not know what a medical card is for, they don't understand they have to make appointments and wait for a few days or weeks to be visited. According to Barahim, one of his roles is to help migrant patients to expedite access to healthcare services, through the provision of information and support to help them to become familiar with administrative procedures.

> *"Los pacientes no saben cómo funciona el sistema. Cuando un paciente llega al mostrador para pedir visita con el médico y sólo le dan la TS se queda perplejo y no sabe para qué sirve. Luego le dan cita con una enfermera. Este paciente quizás lleva una semana esperando y, cuando llega su día y hora, se encuentra que está allí hablando sólo con la enfermera y ésta le dice que tiene que pedir visita para el médico. Después de esperar tanto para ver al médico, sólo le dan una tarjeta y le dicen que tienen que volver otro día."*

[Patients don't know how the health system works. When a patient arrives at the counter to ask for a doctor's consultation, he gets perplexed when staff gives them a medical card. He simply does not know what it is for. Then, he is given an appointment with a nurse. The patient finds himself in a situation where he has been probably waiting for a week to be visited and, when the day of his appointment finally arrives, he finds he is visited by a nurse only (and this nurse tells him he has to make a further appointment with a doctor). After waiting for so long to see a doctor, he only receives a card and is told to come back another day.]

Interventions concerned with the provision of information on how to navigate the system seem to increase patients' agency and their capacity to act. However, the provision of this bureaucratic information does not seem to lead to patients' empowerment since it is not related to patients' health and does not influence the decision-making process.

The second extended role identified in the mediators' interviews relates to the provision of information to patients regarding methods of healthcare and treatment. This role seems to have a more direct impact on patient empowerment. It could be said that the supportive process of information that mediators provide to patients following a doctors' consultation potentially gives patients the power to make informed choices and decisions regarding their health, which ultimately lead them to empowerment. In what follows, I will examine this particular role more closely and its potential consequences on patients' empowerment.

Mediators as doctors' assistant beyond the medical encounter: Provision of information to patients regarding methods of healthcare and treatment

An additional role perceived by most of the mediators who participated in the study is the provision of information about healthcare practices and the treatment that patients may need as a result of their clinical consultations. According to some mediators, one of the main reasons for the development of this role is to save time for health staff that would otherwise have been dedicated to answering the patients' questions or doubts following a medical consultation. In some cases, this may entail explaining to patients the reason behind the need to go through the different tests previously

prescribed by doctors. In her interview, Seema claims how it is quite usual for her to leave work late in the evening after spending extra time with migrant patients. One of the functions she performs is paraphrasing information previously stated by the doctor in the consultation but that had not been understood by patients. A further function she performs is to explain new information to patients that was not conveyed by the doctor in the consultation. In the excerpt that follows, Seema claims that she explains basic Western healthcare issues addressed in the consultation to patients, such as the meaning and consequences of certain diseases or why patients have to have a blood test or an X-ray, many of which are often new concepts for migrant patients. As we can see in the excerpt, she highlights how twofold nature of this in that: not only is she able to help patients, but she can also assist doctors outside the consultation.

> *" Hay días que salgo muy tarde de trabajar porque me quedo con los pacientes explicándoles cosas que les haya dicho el médico y no entiendan, por ejemplo explicándole qué es la diabetes, por qué se tienen que hacer análisis de sangre, cómo pueden mirar la fiebre a un niño y otras cosas básicas para nosotros que ellos no saben. Así puedo ayudar a los médicos incluso fuera de la consulta y también puedo ayudar a los pacientes que necesitan atención."*

> [Some days I leave work late because I stay with patients explaining things that doctor has told them in the consultation and they have not understood, for example explaining what diabetes is, why they have to do a blood test, how they can look at a child's fever and other basic stuff that they do not know. I can help doctors even outside the consultation and I can also help patients that need attention].

Therefore, she believes that by providing this information to patients outside of the consultation she is in a way also acting as a doctors' assistant as she is providing patients with clarifications on medical information that has to be provided by doctors. She also claims she is comfortable performing this role because she believes that patients deserve attention, which implies that she also aligns herself with patients. It may perhaps be the case that she aligns herself both with the patients and the institution, as she addresses the patients' needs for information and in doing so, at the same time, also alleviates some of the institutional pressures of the hospital. She even claims how dealing with patients' requests after consultation, even if this is performed

outside her working hours and represents unpaid extra work, gives her a sense of value and also empowers her. As we can see in the excerpt, she points to the fact that she feels very fortunate to be doing these tasks and gives a value to her multilingual abilities which in turn justify her role.

> *"Me siento muy afortunada haciendo estas tareas, porque estoy aquí solamente porque sé idiomas"*
>
> *[*I feel very fortunate doing these tasks since I am working here just because I am fluent in languages*]*

It seems that the sense of value she claims to gain from performing this unpaid work might be a consequence of the low status that mediators are given. As discussed in section 4.1, the fact that mediators are not recognized as professional groups and they have a low status places them in a less potentially powerful position. Their role may, as a result, be questioned by healthcare staff. As a consequence, it seems that mediators consider performing off-schedule unpaid work as a way to gain recognition and respect from the institution and doctors. They feel the need to safeguard their reputation, especially as migrants themselves. It seems that they want to be accepted, integrated and recognized by doctors and to do so they often try to align themselves with the institution within which they are working. The belief and hope that their extra dedication will place them in a more powerful position may represent a source of empowerment to them. It may be that they need to feel empowered themselves before being able to empower patients.

In the same vein as Seema and other mediators in the study, Shazia also acknowledges how difficult it is for migrants to understand why they have to go through many clinical tests that are unknown to them. Shazia explains that many migrants are used to going to the doctor in their home country and being prescribed with medication without undergoing previous testing. According to her, migrant patients feel bombarded with new information and it is usually one of the mediator's role to explain to them why tests are required before prescribing drugs. As we can see in the excerpt below, Shazia shows an awareness of the lack of power that patients may have. Therefore, it may be the case that mediators are reacting to this situation by trying to empower them. It might be claimed that mediators' provision of information to

patients outside the consultation following a doctor's consultation may ultimately lead to patients' empowerment.

> *"Allí en su país lo que pasa es que no le hacen ninguna prueba y te dan directamente antibióticos y todo, y para ellos es más fácil. Hay que explicar por qué hacemos las pruebas y por qué nosotros no les podemos dar los medicamentos sin hacer pruebas antes como en vuestro país".*

> [While in their home country, they do not have to go through any test, even if they have been prescribed with antibiotics. It is easier for them. We have to explain why we do the tests and why we can not prescribe them medication without doing any test beforehand as they do in their home country.]

From the interview accounts from mediators in the study it is possible to claim that they perform this particular role on their own initiative and always outside the medical consultation. It could be argued that this supportive process of information that mediators provide to patients following a doctors' consultation potentially give patients the power to make informed choices regarding their health, which might ultimately lead them to a greater degree of empowerment.

Mediators as co-interviewers prior to the medical encounter

As identified in four out of the five interviews conducted, one of the extended roles mediators are performing is that of acting as co-interviewers prior to the consultation. A common scenario at the health centre was that the mediator would arrive while the doctor was busy in another consultation or elsewhere and he or she would begin an interaction with the patient before the doctor arrived. From my discussion with Karim, he understands one of his roles is to save doctors' time. This is the main reason why he claims to interact with patients to elicit information that allows him to present the patient's problem to the doctor at the beginning of the encounter. As the excerpt shows, the mediator explains that, while waiting for the doctor, he uses his time to find out the reason behind the patient's consultation. As we can see in the following excerpt, the mediator claims that this is a common practice used to save the doctor's time since as it allows the mediator to present the reason for the patient's visit to the doctor. However, this strategy could also be seen as form of patient disempowerment as the mediator is in fact preventing the presentation of the problem phase and aligning himself with the institution for which he works.

"A veces llega el paciente y el médico está todavía ocupado con otra persona en la consulta, así que tengo tiempo para estar con el paciente y puedo preguntarle lo que le pasa. Una vez que entramos en la consulta ya le digo directamente al médico para qué viene esta persona y así ahorramos tiempo. Es decir, si puedo consigo la información antes de entrar a consulta y así ahorro tiempo".

[Sometimes the patient arrives and the doctor is still busy with another person in the consulting room, so I have time to spend with the patient and I ask what's wrong with him. Once we enter the consulting room I tell the doctor what's wrong with this person and thus we save time. I mean, if I can, I get information before entering the doctor's room and thus I can save time].

In the same vein as Karim, Shazia also claims that she tries to save the doctors' time by eliciting information from the patient before the encounter actually takes place. As the excerpt shows, she claims mediators are familiar with the routines and already know what type of questions doctors are going to ask the patient when it is a first consultation.

Therefore, they initiate a series of questions to elicit the information they assume the doctor will need.

"Cuando es la primera visita ya sabemos lo que va a hacer el médico. Le va a preguntar si tiene alergia a algún medicamento, si tiene o ha tenido alguna enfermedad, antecedentes familiares. Todo eso ya lo tenemos preguntado al paciente y se ahorra tiempo, ya le informamos al médico porque ya le hemos preguntado antes al paciente".

[When it is the first consultation we know what the doctor will do. He is going to ask if he is allergic to any medication, if he has or has had a disease, his family history. We have already asked all this to the patient and this way we save time. We are in a position to inform the doctor because we have already asked the patient beforehand]

In taking charge of initiating the medical interview, the mediator is preventing the presentation of the problem phase, where the patient presents the reason for the consultation to the doctor and "is also sacrificing the notion that the doctor and the patient are participating in a conversation with each other" (Davidson, 2000, p. 388).

As Davidson (2000) claims, it might be the case that mediators adopt the role of co-interviewers not only because of time pressures, but because they are institutional insiders and align themselves with the institution for which they work. The mediator can be seen to align himself with the institution and prevents the presentation problem phase where the patient presents to the doctor the reason for the consultation. As Hsieh's (2006) also points out, mediators often see themselves as part of the healthcare team and try to align with them, causing them to over-emphasize the information gathering aspect.

Unlike the other mediators interviewed, Barahim was the only participant who displayed a different perspective. As he claims below, he does not try to obtain information from the patient before entering the consultation. He believes this practice represents a waste of time since patients would have to explain their problems twice:

> *"No hablo antes con el paciente, esto representaría una pérdida de tiempo porque el*
>
> *paciente debería explicarlo todo dos veces"*
>
> [I do not speak with the patient before entering the consultation. This would be a waste of time because the patient should have to explain everything twice].

It is possible to conclude that mediators perceive their role as facilitators of communication between doctors and patients, intervening, when necessary, to assist in exploring information that will diminish linguistic and cultural barriers to understanding. The additional roles they claim they perform beyond the act of linguistic or cultural mediation while in the consultation include facilitating patients' access to the Catalan medical service, assisting patients following a doctors' consultation, and acting as co- interviewers prior to the medical encounter to elicit information from patients prior to the medical encounter.

By facilitating access to the Catalan medical service, mediators provide a type of assistance to patients that seem to increase their agency. However, since this bureaucratic information it is not related to patients' health and does not influence the health-related decision-making process, it might be the case that it does not have any impact on patients' empowerment.

In their role as providers of information following a medical encounter, they perceive themselves both as agents who empower patients' to make informed choices regarding their health and, at the same time, as doctors' assistants who alleviate institutional pressures. Regarding their role as co-interviewers prior to the medical encounter, although they claim they develop this role as a result of institutional time constraints, this role might be a consequence of their alignment with the healthcare institution where they work. It is therefore of particular relevance to analyse whether mediators' perceptions of their role coincide in any way with those of healthcare staff. The following section is devoted to exploring the degree to which both groups' perceptions of each other either coincide or diverge.

4.3.3 Cultural mediators' role perceived by healthcare staff

Doctors in this study expressed mixed views and contradictions in their discourses regarding the role of mediators. Although they acknowledge that mediators are useful when it to comes to resolving communication difficulties, most doctors in the study share the perception of mediators as linguistic conduits, whose only responsibility is to provide 'accurate' and 'complete' transmissions of messages from one language into another. They see the mediator simply as an instrument, someone whose main role is to transmit a specific message. This seems to indicate that healthcare staff fear to lose control over the process and content of communication, assigning a restricted (conduit) role to mediators.

However, as Dysart-Gale (2005) argue, the conduit model does not provide a complete description of the mediator and interpreter work in clinical setting. At first glance, it is unclear why healthcare staff perceive mediators' role as conduit while, at the same time, they expect them to perform actions beyond the act of linguistic and cultural mediation (i.e. assisting patients in the completion of application forms, etc.). This is one of the contradictions that arises with respect to the perception of the role of the mediator. As Hsieh (2006) claims, it would be therefore necessary for institutions to present mediators and interpreters with realistic expectations and appropriate means to accomplish them.

From my interviews with healthcare staff, I have however also found doctors and nurses who had a more favourable perception of the mediators' role. This is the case of Mercedes, a female nurse in her 40s with 17 years of experience, who stresses that mediators have an important role because they might help the healthcare system to save money. Since doctors are able to understand the patient, the number of tests that patients have to go through can be dramatically reduced and doctors do not have to make unnecessary medical tests in order to 'guess' the right diagnosis. The rationale behind this idea is that mediators are useful to the institution in practical and monetary terms, not as a way of empowering patients.

In the same way as Mercedes, Dr. Alicia, a female paediatrician who has been working for ten years at the clinic under study, also displays a favourable perception of the mediators' role. She believes that mediators not only bridge the linguistic gap between doctors and patients, but they also bridge the cultural gap. As she claims, there are cases where patients accomplish a linguistic understanding of doctors' words, but they lack the cultural understanding of the utterances:

> *"El problema también es que a veces sí nos entienden verbalmente pero no pueden entenderlo desde el punto de vista cultural. Por eso una mediadora es importante, para que pueda explicar esta cosas"*
>
> [The problem is that many times they understand us verbally, but they cannot understand from a cultural point of view. That is why a mediator is important, to be able to explain all these issues].

From the data collected in the interviews it might be claimed that there are mixed views and some contradictions in doctors' perceptions of mediators' roles. Although all doctors acknowledge mediators usefulness to overcome communication difficulties, the widespread view is that their only responsibility is to provide accurate and complete transmissions of messages conveyed in one language into another during the medical encounter. Although some doctors openly acknowledge the help that mediators provide in bridging the cultural gap, the majority of professionals believe that the main barrier to overcome with migrants is not cultural, but linguistic and they would prefer to have the service of an interpreter to avoid interferences.

It seems that mediators' perceptions of their own role do not totally correspond with how they are perceived by some doctors. Although mediators are often likely to perform a variety of extended tasks outside the mediated medical encounter, doctors seem unaware of these extended roles. Mediators claim that they elicit information from patients prior to the encounter to save doctors' time that they provide clarification to patients outside the consultation once the medical consultation is over and they also assist patients to become familiar with the Western healthcare system. Therefore, doctors in this particular study at least seem to be insufficiently aware of all roles undertaken by cultural mediators.

4.4 Concluding Remarks

The data from the interviews presented in this chapter highlights several issues that are rarely examined in bilingual health communication. A key insight identified in the chapter is that mediators' agency is limited because of their lack of specialized medical knowledge, which might ultimately place them in a potentially less powerful position and their role might be questioned by healthcare staff. A further factor identified which might influence power relations between cultural mediators and doctors is the fact that mediators' position is not officially recognised by the institution and they enjoy a low status. As a result of these unequal power relations with doctors, cultural mediators seem to be occasionally disempowered in their role, which might in turn constrain them from empowering patients.

This chapter also examines the potential tensions and conflicts that arise between mediators and patients as a consequence of sharing a common cultural and language background. Some illustrative examples of patients' distrust for mediators have been presented in section 4.2 and strategies developed by mediators to mitigate tensions, such as asking questions indirectly to avoid embarrassment, have been discussed and analysed here.

Cultural mediators' insights into their complex role as providers of empowerment to patients suggest that mediators perceive their role as facilitators of communication between doctors and patients, far beyond a mere linguistic conversion from one language into another. The interviews provided a starting point for cultural

mediators to highlight potentially demanding aspects of their role. In fact, they believe that their role is extended since they facilitate patients' access to the medical institution. By assisting patients to navigate through the healthcare system, mediators provide access to patients to a valuable resource of knowledge and place migrants in a more powerful position. Additionally, a further extended role claimed by mediators is that of assisting patients following doctors' consultations, where they provide patients with clarification on medical information that was previously stated by doctors in consultation but had not been understood by patients. Mediators also claim that their extended role includes to act as co-interviewers prior to the medical encounters, where they elicit information from patients prior to the medical encounter.

A further finding of this study is that, despite there are mixed views in healthcare staff perception of mediators' roles, there is a widespread perception of mediators as linguistic conduits whose responsibility is the accurate transmission of messages. This might also have consequences on power relations and evidences a mismatch between mediators and doctors perceptions.

The following chapter will examine the results from the transcribed excerpts of the mediated medical interactions recorded. The implications from the findings chapter will be then discussed in Chapter Six, relating both chapters to the reviewed literature.

Chapter Five

Analysis of Medical Encounters

The discussion thus far has sought to analyse how mediators perceive their role in empowering patients and how they are positioned in interpreting contexts. The interview data presented in Chapter Four examined mediators' attitudes and some of the ways they claim that they intervene in mediated activities. The role of mediators as perceived by healthcare staff was also considered in the previous chapter, showing that doctors presented mixed views and contradictions in their discourse relating to the role of mediators.

The present chapter looks at the institutional encounters in which mediators, patients and doctors come into contact. The discussion that follows will explore whether the practices undertaken by mediators in medical consultations make it possible for migrant patients to be empowered. Additionally, I will analyse the extent to which the claims made by mediators and doctors when questioned through interviews match with their actual practices in medical encounters.

As discussed in chapter three, the recorded observational data consists of ten face-to-face medical encounters, involving nine health staff and two mediators. For the purposes of discussion here I will focus on seven of these ten encounters. These seven encounters contain the whole range of issues relevant to my analysis, including alignment and face-work. The remaining encounters were not discussed as they repeated instances of the same issues.

As stated in section 3.3.2 of Chapter Three, the two mediators involved in the encounters were Karim and Seema. Karim participated in five out of the ten-recorded encounters, while Seema took part in the further five. Four out of the five encounters with Karim and three out of the five encounters with Seema were used in this study. These two mediators also took part in the interviews analysed in Chapter Four. The fact that they were working at the reception desk of the clinic and assisting doctors' consultations when required made it easier for me to interview them in the first place and to shadow them in medical encounters. This was the main reason in deciding to record the encounters where they were present.

Health staff participating in the encounters consists of seven doctors, six females and one male, and two female nurses. Four of them were family practitioners, and the remaining three included a dentist, a paediatrician and an otolaryngologist. All staff were from Spain and had Catalan and Spanish as their first languages. Although my initial intention was to record encounters with those doctors who participated in the interviews, I could only record those encounters to which I had access. Therefore, Dr. Albert was the only doctor who participated both in the interviews and the encounters.

In his interview, Dr. Albert had revealed a positive attitude towards mediators. He considers them of key relevance in overcoming cultural barriers and highlights how mediators' cultural knowledge of the patient helps doctors to get to know and understand their migrant clientele. In their interviews, both Karim and Seema understand their main role is one of facilitating communication between doctors and patients and to solve any communication difficulty that might arise during the medical encounter. In addition to assisting doctors in the consultation, they claim that they perform extended roles such as facilitating patients' access to the Catalan medical service, assisting patients following a doctors' consultation by answering clinical questions, and acting as doctors' co- interviewers prior to the medical encounter. The discussion that follows analyses whether what they claim in their interviews matches what happens in practice during an encounter.

In chapter two, three categories of empowerment were identified. These include Provision of Information, Expression of Emotions and Decision Making. These will be discussed separately in three sections. The first section is devoted to the role of mediators in situations where patients seek information. The second section focuses on the examination of the mediators' actions when patients try to express emotions and concerns. Likewise, it examines how mediators manage patients' refusals, complaints and doubts regarding medical treatments and institutional procedures. The last section focuses on the empowering role of mediators when patients have to make decisions.

The first category looks at the provision of information when patients seek it, and includes instances where mediators help patients to obtain health-related information. The second category focuses on expressions of emotions through active listening, and

includes those cases where mediators elicit and acknowledge patient's beliefs, priorities and fears, always listening carefully to patients' perceptions of their problems. The third category looks at decision-making, and includes instances where patients are actively involved in negotiating the goals of their care plan and have freedom to make choices and accept responsibility.

In all categories, motivation on the part of the patients is necessary, since they may wish to be involved in decisions regarding their health. Good communication and dialogue among the doctor, the mediator and the patient is a further common link shared by these categories, since the achievement of patient empowerment in mediated encounters appears to depend on how well the doctor, patient and the mediator can communicate with each other. The sharing of responsibility and a partnership between the doctor, patient and the mediator based on mutual trust and respect is an additional characteristic present in the three categories.

The discussion that follows will explore the role of mediators as providers of empowerment to patients in situations where patients seek information, express emotions and make decisions related to their healthcare. It will also consider whether this opens up the possibility for mediators to challenge or alter the status quo of social systems or if they mainly support doctor-centred communication, preventing the empowerment of linguistic and cultural minorities. In order to explore these issues, I will discuss some examples from the data set.

5.1 Patients Receive Information or Clarification when they Seek It

Following Sarangi and Slembrouck (1996), in most bureaucratic encounters the client is cast in a supplier role, while the bureaucrat is in a demander role. According to them, "healthcare practitioners function mainly in a *seeking* frame and patients in a *giving* frame" (Sarangi and Slembrouck, 1996, p. 38) and only in a marginal way the roles of supplier and receiver are reversed. As Sarangi and Slembrouck argue "this is linked up with the ways in which institutions maintain social control, as information exchange is instrumental in drawing certain divisions between clients and institutions" (Sarangi and Slembrouck, 1996, p. 38). However, some patients decide to ask for information. They may seek information about the cause and origin of a disease, its

prognosis, treatment options, medication instructions, and such like. As Erikson (2001) states, practitioners default mode of conduct tends towards the reproduction of existing power relations in society, while migrant patients try to balance out asymmetries of power that underlie information exchange in bureaucratic or medical encounters.

In interlinguistic interactions involving cultural mediators as the third party in a communicative process, mediators assume the role of promoting the interaction in which they participate. In this particular category, my analysis focuses on mediators' practices during episodes in which patients seek information, with the aim to elucidate whether or not mediator's practices promote patients' empowerment when a patient decides to ask for information. After all, as Piper (2010) claims, although information giving is not empowering per se, it is an important starting point and patients cannot be empowered without information.

The discussion will explore some of the actions and strategies used by mediators in situations when patients seek information. It will also consider whether these strategies open up the possibility for mediators to promote and enhance patients' empowerment.

5.1.1 Mediators facilitating patients' understanding of the medical dialogue

Based on the patient empowerment indicators identified for this particular category in the Literature Review, the data set analysed presents numerous instances where mediators' actions seem to promote patients' empowerment. Actions such as inviting patients to speak, helping them to seek information and adjusting the scientific doctors' language to make it more available to patients are some of the strategies identified. The following excerpt represents an illustrative example, which includes these particular practices.

Excerpt 1 below presents an example where the mediator invites the patient to speak and helps him to seek information. It is also the case that the mediator elicits information from the doctor and adjusts the doctor's language to make it more available to the patient. Thus, not only does the mediator allow the patient to carry on asking for additional information, but he also facilitates the patient's understanding of the

medical dialogue. In this particular encounter, the mediator (Karim) is requested to assist Tahir, a Punjabi- speaking patient from Pakistan who comes to the clinic for a consultation with Dr. Albert, a Catalan-speaking family practitioner with a favourable attitude towards mediators. Karim, and I enter the doctor's consulting room and the patient is sitting opposite the doctor. Both Dr. Albert and Tahir agree with my being present there and they accept to be recorded. The mediator immediately sits down close to the patient, opposite the doctor. I place the audio-recorder equipment on top of the doctor's desk and take a seat a few meters away behind the mediator and Tahir.

For a couple of minutes, the doctor is busy with his computer. The mediator then engages in a conversation with the patient, eliciting some information about his condition. As discussed in section 4.3.2., acting as co-interviewer prior to the medical encounter is one of the roles Karim claims in his interview that he performs to save doctors' time. By doing so, the mediator can be seen to be aligning himself with the institution and prevents the presentation problem phase where the patient presents to the doctor the reason for the consultation. Once Karim has elicited information from the patient, he presents Tahir's problem of bleeding gums to Dr. Albert. The doctor explains to the patient that the medication he is taking for his heart condition might be the reason behind his bleeding and he checks if the patient has had any recent blood test done. Immediately afterwards, the doctor asks the mediator to explain to the patient the procedure to follow to make an appointment with the dentist. By providing the mediator with the responsibility of explaining a procedure to the patient, the doctor seems to expect Karim to be more than a transmitter of messages and allows him to be an active participant.

The doctor is about to conclude the consultation and uses the formulaic "*Anything else?*"(turn 62) to bring the consultation to a closure. This is in effect a signal to the patient that the consultation has come to an end and the expectation is likely to be a "no" response from the patient with little by the way of invitation to request anything further on the part of the patient. The rhetorical question posed by the doctor is however turned into an invitation to speak when the message is conveyed through the mediator who asks, "*Do you want to ask about anything else?*" (turn 63). The patient in turn takes up this invitation and extends the consultation by revealing the additional medical condition of a nosebleed. At this point the mediator becomes more involved in the fact finding process and rather than simply conveying this piece of

information to the doctor, probes to see if the reported nose-bleeds are a result of the patient's existing medication.

While we may accuse the mediator of disempowering the patient for not allowing him to ask these questions himself, intentionally or not the mediator can be seen to facilitate the communicative process and actually empower the patient through his probing for the additional information than perhaps the doctor intended to provide. Arguably, the mediator may be seeking to de-routinize the process of information exchange and thus breaking with institutional conventions relating to patient-doctor exchange. His knowledge of the situation (perhaps as a migrant himself) may provide him with access to specific cultural knowledge about the degree of forthrightness or not on the part of the patient and may see his interventions as a mediator as a deliberate attempt to impact on this process. Essentially, therefore, by asking more questions than he should, he may be (consciously or not) advocating the patient's right for information.

Excerpt 1

62 Dr. ALBERT: Alguna coseta més? *Anything else?*

63 KARIM: Hor koi chis te ni puchna chande*? Do you want to ask about anything* else?

64 TAHIR: Sirf ae khoon da masla, kisi vele nakkch vi aanda hai khoon. *The only problem is this bleeding; at times my nose also starts bleeding.*

→ 65 KARIM: Diu que de vegades li sagna el nas també. Diu que si pot ser també per la medicació**.** He says that his nose bleeds sometimes as well. *He's asking if it could also be the medication.*

66 Dr. ALBERT: //Passa que, aviam, jo la medicació no m´atreveixo a treure-li perquè com que té una malaltia coronària de tres vasos, vull dir que no:, no:, les coronàries les té obstruides. Llavors, bueno, que, home, si és un sagnant molt, molt, molt, molt, que vingui de seguida, però si són petits sagnants, no cal. *The thing is, let's see, myself I don't dare take him off the medication because since he has a three-vessel coronary condition, I mean that I won't, won't: his coronary arteries are obstructed. So, well, that I mean, if it's heavy heavy bleeding, he can come straightaway [to the clinic], but if it's light bleeding then it's not necessary.*

67 KARIM: Ke rahen ke gar thoda ja khoon aanda hai te fer ni masla , bohat zyaada ikdam khoon aana lag jaaye te fer te tusi aana hai, emergency hai, par ae chhota-mota khoon je aanda hai kyunke tvadda khoon patla kar ri hai duvaai dil vaaste kyunke dil vich tvannu problem hai, te is wajah ton thoda-bahot khoon jera hai o kisi na kisi raste baar nikalda hai..samajh gaye? *He's saying that if there is minor bleeding then it's not a*

problem, but if the bleeding is severe then you have to come, it might be an emergency, but minor bleeding shouldn't be a problem because it might be because of the medication that you are taking to thin your blood.

68 TAHIR: Sahi hai. *Ok.*

Following the doctor's explanation, the mediator condenses the information in the form of a reduced rendition (turn 67). In what seems like an attempt to facilitate the patient's understanding, Karim replaces the doctor's technical terms '*three-vessel coronary condition*' and '*coronary arteries obstructed*' with an explanation of the general condition, cause of bleeding and what to do in case of emergency. The mediator asserts his control over the information exchanged by changing the content of the doctor's narrative to facilitate the patient's understanding of the medical dialogue. An examination of what the mediator summary translations provided to the patient contain can give an important insight into what the mediator considers to be relevant to be adapted. I have observed that the mediators involvement in medical encounters seem to be shaped by their orientation to providing information formulated in the "language of the patient". Given this fact, we may expect that issues considered by mediators to be relevant for patients will be adapted in the summary translations offered to the latter. This is in line with earlier studies such as the one undertaken by Hiesh (2010), where she found how interpreters replaced providers' terms to facilitate patients' understanding of the medical dialogue.

However, Hsieh (2010) also states that this type of mediator strategy might lead to doctor-mediator conflict over expertise and authority. According to her, since mediators do not tend to communicate the change of content to doctors, it may be a signal to doctors that they may be losing control over the medical encounter, thus creating tensions between doctors and mediators. However, this does not seem to be the case in the encounter presented here.

In addition to the adjustment of the doctor's scientific language, the analysis of medical encounters revealed additional strategies used by mediators that also seem to lead to patients' empowerment when they seek information. The discussion that follows will explore further strategies such as the double-checking of information when mediators answer questions addressed to doctors and the alternation of dyadic sequences.

5.1.2 Mediators answering questions addressed to doctors: provision of distorted information

In the ten consultations recorded, there are a total of five sequences (included in Appendix A) where patients pose a question to the doctor and the mediator initiates the answer to the patient's request for information. As Baraldi (2009) points out, mediators' habit of answering questions might be viewed as a move to prevent conflicting positions between doctors and patients. In the same vein, Davidson (2000) claims that the mediators' habit of answering questions might be viewed as a way to insulate doctors from patients' challenges to their authority and it may also be a way for mediators to try to save doctors time. Based on previous research (see Erzinger, 1991; Baker; Hayes; and Fortier, 1998), the significance of this pattern is that it increases the likehood that patients are seen as passive, since doctors are not aware that their mediated patients are asking questions at all.

Theoretically, such mediators' practice might increase the likelihood of disempowering patients by providing them with advice that does not totally correspond to the doctor's recommendations. As Metzger (1999) claims (see section 2.1), mediators can misrepresent the source message footings by using their own renditions. However, it could be argued that, the fact that patients receive clarification from mediators wouldn't represent a major difficulty if the information provided is totally reliable and could help in any way to empower the patient. The crucial point here is to elucidate what the consequences for patients are in terms of empowerment when the information provided on the mediators' initiative is distorted.

The recorded interactions show that, once mediators answer questions on their own initiative, they tend to use subsequent turns throughout the encounter to double-check the accuracy of the information they provide with the doctor. By doing so, this potentially puts them in a position to amend or correct any distorted information previously provided to the patient. There are instances in the data where mediators end up even supplementing the information provided by the doctor. In other words, what seems to be an undesirable practice, in which mediators answer questions directed at doctors, does not seem to have a disempowering effect on patients. In fact, on some occasions it might be conducive to patient empowerment if mediators undertake corrective actions and if they end up providing further information.

Excerpt 2 presents an example of the above-mentioned sequences in which a mediator answers questions addressed to the doctor and provides distorted information to the patient. The sequence is drawn from an encounter that involves Adil, a Punjabi-speaking patient from Pakistan, Elena, a Spanish-speaking nurse, and Karim, the cultural mediator on duty. In this particular encounter, I go with Karim to a consulting room where he has been requested to assist Adil. The patient is standing in the corridor outside the door of the consulting room. When we meet him, the mediator greets the patient and I was introduced to him. The mediator explains that I am a researcher currently carrying out a study in multilingualism for the University. He explains that I want to observe the services provided to the patients at the clinic and that I need to make an audio recording and that the information would be kept confidential and the anonymity of participants protected. The patient accepts to be recorded. He explains how he was scheduled to be examined by a Family Practitioner, but he was also told that a nurse would ask him a few questions beforehand. I thanked him for his co-operation and for answering my questions.

Nurse Elena comes and joins us at the corridor. Since the doctor has not arrived yet, she stays with us for a few minutes waiting for the doctor at the door of the consulting room. When Dr. Albert, a Catalan-speaking family practitioner, finally arrives, the nurse explains to him that we have been waiting there for a while and she remarks how busy the mediator is. In saying this, the nurse is giving importance to the role of the mediator. Perhaps in an effort apologise for his lateness and to avoid the mediator wasting further time, Dr. Albert decides to start the consultation right there on the corridor. The background noise was considerably high, with staff and patients walking up and down. There were people talking in the waiting room opposite us and there was frequent noise of banging doors. It is at this point that the recording started.

Once Dr. Albert had asked what was wrong with him, the patient explained that he had been having knee pain for three or four months and it hurts a lot. The mediator interprets the patients' words to the doctor and Dr. Albert tells the mediator to enter the consulting room with the patient to examine him. Afterwards, the doctor addresses the nurse and asks her to start preparing the patient. Nurse Elena, Karim and the patient enter the consulting room and the nurse starts the history-taking process with the assistance of the mediator. After finding out that the patient had his last tetanus

vaccine more than ten years ago, she tells him that he will have a tetanus' injection today. The excerpt starts at the point where the patient requests information regarding any possible side effects of the vaccine, which the nurse intends to administer.

As we can see in Excerpt 2 below, the mediator answers the question addressed to the nurse. His rendition contains distorted information, since he tells the patient that the vaccine does not have any side effects (turn 90), but in fact, it has some reddening and inflammation effects. The mediator uses the proceeding turn (91) to double-check the information with the nurse. When he finds out that the vaccination does have side effects, Karim (turn 95) ends up amending the information previously provided to the patient and even supplementing it with an illustrative example (turn 97).

Following the patient request for information, the mediator (turn 90) assumes the role of the nurse and answers the patient saying 'It *has no side effects'*. Here, Karim acts on his own initiative, that is, not interpreting what the patient's originally said and answering the question addressed to the nurse. In the last part of turn 90, the mediator lets the patient know that he is going to double-check this information with the nurse ('*I'll ask her and tell you').* This is a significant point in the encounter, since the mediator lets the patient know that he is going to confirm this piece of information, and therefore, he might come back to him with new and different recommendations. In turns 91-94, the mediator and the nurse engage in a dyadic sequence where the nurse explains the possible side-effects. Here, the nurse confirms that the vaccination, contrary to what the mediator has previously communicated to the patient, does have some side-effects, such as reddening and inflammation. The mediator, therefore, has provided distorted information to the patient.

Excerpt 2

89 ADIL: E vaala tika hai…e koi side effect te??? *Does this vaccination have any side effects?*

→ 90 KARIM: Side effect nahin hain isde..main us kol pataa karr denda haan o. *It has no side effects; I'll ask her and tell you.*

91 KARIM: Me pregunta si tiene efectos secundarios la vacuna. He is asking me if the vaccination has any side effects

92 NURSE ELENA: Lo único, explícale xxx, pero es. ¿Lo sabes? Ahora te examino yo a ti. **((lf))** ¿cuáles son? Son efectos locales que son enrojecimiento y…. *The only thing, explain to him xxx, but it is. Do you know? Now I will examine you. What are they? There*

are local effects such as reddening and...

93 KARIM: Inflamación. *Inflammation*

94 NURSE ELENA: Inflamación de la zona y como mucho le pueden dar unas décimas de fiebre, pero le podemos dar un Paracetamol si tiene y ya está. *Inflammation of the area and, at the most, he may have a slight temperature, but we can give him a Paracetamol if he has these symptoms and that's all*

95 KARIM: ke rahi hai ke e hai ke tvaddi jis jaga te injection lagge ga na us jagah te thodi- bahot sojen ho sakdi hai par o bohat kaat kesis vich hunda hai…*She's saying that you might get swelling and inflammation at the place where they give you the injection, but it only happens in very few cases....*

96 ADIL: Achha Ok

97 KARIM: … Ya laal ho sakdi hai jaga par lekin oh vi bahot kaate lokan nun hunda hai, par hai ke vetar hai tussi lavaa lao kionki tussi te kaam jaddon karoge, khudaa na khaasta tvannu koi satt lagg jaandi hai, koi..koi..koi chis katt jaandi hai ungli de naal, ya kamm karde vaqt bande tau galti de naal.. koi karr vich bhi katt janda hai hathh, te jera scene jere honde ne etthe zadaa hain, te hafazati taur te tika assi landen harr bande nun … *it might turn a bit reddish. But it is better if the injection is given since it will protect you. For instance, in case you cut yourself in your hand when you are working or you have an accident, so we give you this injection as a precautionary measure to protect you from any infection.*

98 ADIL: Achha ji. *Ok*

Following the nurse-mediator dyadic sequence (91-94) where the Karim double-checks the information, he uses the following turn (95) to amend the previously provided distorted information. He informs the patient that he might get swelling and inflammation. In turn 97, Karim ends up even supplementing the nurse's information, when he explains to the patient the different uses and benefits of vaccinations, such as to protect from infections in case of accidents.

Data presented in Excerpt 2 seem to indicate that, once the mediator provides information based on his own initiative, he tends to use the subsequent turns to control and monitor the accuracy of their statements, making the necessary '*corrections*' further down the interaction. Therefore, it might be possible to claim that, since the original distorted information is adjusted, the mediator's habit of answering questions, even if it is not a recommended practice, does not necessarily have a disempowering effect on patients. In fact, it seems that it might lead to patients' empowerment when

they seek clarification when the information they receive "allow them to know enough about health and disease to make decisions about the variety of options available to them" (Feste and Anderson, 1995:140)

5.1.3 Alternation of dyadic sequences Mediator/Doctor Mediator/Patient

As discussed in section 2.4, Wadensjö (1998) and Pasquandrea (2011) have highlighted that mediated interactions do not always follow a triadic pattern, where interpreters translate each of the doctor and the patient's turns immediately after they have been uttered, but often assume dyadic configurations where the interaction involves just two of the three participants. The data examined in this study show that, on many occasions, segments of triadic interactions alternate with dyadic conversations between the mediator and the patient, or between the mediator and the doctor. There are numerous occurrences that exhibit patterns where mediators avoid after-turn translation and engage in after- sequence interactional structures. According to Baraldi and Gavioli (2010, p.146), after- sequence translation structure of talk which may help to achieve empathic doctor-patient communication:

> Includes two phases: (1) sequences of turns where the mediator talks to one of the interlocutors, either the patient or the doctor; (2) a translation of that sequence in the form of a formulation summarising or developing the core of the preceding sequence.

After-sequence interactional structures are explored in detail in Excerpt 3 below. The sequence is drawn from an encounter that involves Rajinder, a Punjabi-speaking patient, Dr. Albert, a general practitioner and Karim, the mediator. The patient comes to the consultation since he is experiencing back pain as a consequence of a fall at work. The doctor prescribes the patient with some anti-inflammatory tablets and he also offers him the possibility of having an injection for his pain. Dr. Albert decides to prescribe him three different types of tablets, Paracetamol, Ibuprofen and Omeoprazol.

The first phase of after-sequence translation in Excerpt 3 is a dyadic interaction involving the doctor and the mediator. As Baraldi and Gavioli (2010) claim, even if it

separates the interlocutors temporarily, the dyadic phase in the excerpt bellow allows the doctor to explain the instructions for treatment in a clear way in order to have the collaboration of the patient. In turn 77, the doctor asks the mediator to write down on a piece of paper the prescribed treatment with Omeoprazol and Ibuprofen for the patient. This is immediately responded to by the mediator (turn78) who double-checks with the doctor if he has to include the third type of tablets, namely Paracetamol, which the doctor has also prescribed. Karim's intervention in turn 78 might represent an attempt to make sure that the patient understands the doctor's explanations properly and as a means of collecting the maximum amount of information possible

It seems that the mediator uses this sequence to double-check information with the doctor (see turns 78-84). By doing so, it is likely that the mediator can be in a position later on to provide comprehensive and reliable information to the patient in a second phase (turns 85-92, continuation of Excerpt 3). The following turns follow a pattern with the doctor providing explanations (turns 80-82) and the mediator echoing the doctor's words to confirm (turn 83) he understands the information. During the doctor-mediator interaction, the patient remained seated on his chair without interfering, not even looking at the diagram and just waiting for the doctor and the patient to finish their conversation. Despite the patient not being involved, the result of this doctor-mediator dyadic sequence is likely to have consequences on the patient as well. This sequence ultimately allows the mediator not only to collect information, but also to confirm he understands the doctor's instructions he has to deliver later on to the patient.

Excerpt 3

> → 77 Dr.ALBERT: Que vagi alternant cada 4 hores. Aviam si li saps explicar. Li apuntes aquí: Ibuprofeno, 4hores. Omeprazol, 4hores. Ibuprofeno, 4hores. Omeprazol, 4hores. *He has to alternate every four hours. Let's see if you can explain it to him. Just write it down here: Ibuprofen, four hours. Omeoprazol, four hours. Ibuprofen, four hours. Omeoprazol, four hours.*

> → 78 KARIM: Amb Paracetamol, ¿no? *With Parecetamol, isn't it?*

> 79 Dr. ALBERT: O sigui, és cada 8 hores l'un i cada 8 hores l'altre, alternant-ho, ¿eh? Fas una fletxeta. "4 hores", poses aquí dalt. *I mean, one pill is every eight hours and the other pill is also every eight hours, alternating them, right?*

> 80 Dr. ALBERT: Poses, 4 hores, 4 hores, llavors alternes i llavors ell ho veurà de seguida.

Write down, four hours, four hours, then alternate and then he will see it [he will be able to understand it] straightaway.

81 Dr. ALBERT: Fletxeta, quatre hores, i ara poses, "Paracetamol". Posa aquí dalt: "quatre hores". *Put an arrow here, four hours, and now write down Paracetamol. Write here above "four hours".*

82 Dr. ALBERT: Fletxeta, Paracetamol. *Arrow, Paracetamol.*

83 KARIM: Paracetamol.

84 Dr. ALBERT: Fletxeta, four hores. Ibuprofeno. *Arrow, four hours, Ibuprofen.*

As seen in the example above, the engagement of the mediator and the doctor in dyadic talk gives the mediator the opportunity to solicit the doctor's opinion on how he wants to present the information to the patient. Continuation of excerpt 3 below shows the start of the second phase of the after-sequence structure of talk. Here, the doctor allows a mediator-patient dyadic interaction, where the mediator translates the previous section to the patient developing the core of the preceding sequence. As we can see, the mediator opens a dyadic interaction with the patient to provide him with the doctor's instructions about how to take the medication, and he ends up providing much more detailed information than the doctor's original.

In turn 85, the mediator formulates what is his understanding of the dyadic sequence above (excerpt 3). The patient asks for clarification (turn 86) and this is followed by a mediator's turn (87),where Karim echoes the patient's utterances '*No they are not to be taken at the same time*' and again explains the instructions to the patient in a detailed way. Of note also is that the mediator uses the formula '*Do you understand*' at the end of his utterance, thus inviting the patient to request further clarification. Therefore, not only does the mediator provide information and clarification at the patient's request, but he also expands the doctors' explanations. He also makes sure that the patient understands the instructions and invites him to ask additional questions, which might represent a case of patient empowerment.

Once the patient recapitulates the information in turn 88, the mediator delivers (turn 89) a detailed and comprehensive explanation to the patient to clarify what the doctor has said. Additional information (not provided by the doctor at any time during the encounter) is being added here by the mediator when he explains to the patient that one of the pills is to relax the muscles before going to sleep. It might be the case that

the mediator is familiar with this medication and he wanted to inform the patient of the effects. He also takes this opportunity to provide additional information to the patient regarding the reason behind the prescribed medicines *'these are strong pills, so he's giving the other medication for the stomach'* (turn 89). As we can see, the mediator (turn 91) reassures the patient and he essentially claims that the doctor's prescription will cure him *'If you take this medication you'll become perfectly alright'*. The patient-mediator dyadic sequence comes to an end in turn 92 when the patient indicates that he has understood all the information. Once the mediator (turn 93) indicates to the doctor that he has provided all the information to the patient, this gives way to the doctor to move on, change the topic and proceed with the consultation.

Continuation of Excerpt 3

85 KARIM: M□P tussi tin time jeri khaani hai davaai, theek hai, par je agar chaande ho te char-char ghante da v kar sakde ho matlab for example je agar tussi athh vaje khaande ho e vaali davaai, brufen di te paracetamol jeri hai na tussi char ghante baad kha sakde ho, char ghante baad matlab barah vaje tussi kha sakde ho, thik hai, is tarah tussi char-char ghante de farak de naal e goli kha sakde ho, athh vaje e khande ho na te barah vaje e kha lao....*You have to take the medication twice, but if you want you can take it every four hours also, so if you take Ibuprofen and Paracetamol at 8 o'clock, the next one can be taken after a gap of four hours, at 12 o'clock, so if you take this one at 8 o'clock, take the next one at 12 o'clock.*

86 RAJINDER: Matlab e kathiyaan ni khani?. *So they are not to be taken at the same time?*

→ 87 KARIM: Kathiyaan ni khanian, char-char ghante de farak te....kathiyaan kha sakde ho par behetar hai ke char-char ghante de farak de naal, aggar barah vaje e te kade char vaje e kha lao fer athh vaje e kha lao fer barah vaje e kha lao, samjhe meri chis? *No they are not to be taken at the same time, they have to be taken at a gap of four hours, if you are taking one at 12 o' clock, take the next one at four, the next at eight and the next one at 12...do you understand?*

88 RAJINDER: Haan ji, ikk goli hun kha laan, ikk goli fer char ghante baad kha laan. *Yes, I take one pill now and the next one after a gap of four hours.*

89 KARIM: Ratti goli jeri hai na tussi kyasapaan, kyasapaan di goli hai ratti jera na son ton pehlan muscle nun jera na patthe nun relax karna hai. Ke rahen ke e goliyaan do han, ratti di ikk goli hogayi, te aggar chaande ho na savere khaali pet, XXX (name of medication) ikk hor goli dega kyunke goliyaan zyaada khan ton mede di problem ho sakdi hai, garam goliyaan hain, te mede vaaste e goli di hai. *You have to take this pill XXX(name of the pill) to relax the muscles before going to sleep. The doctor is saying*

there are two pills, one has to be taken at night and if you want you can take the other one on empty stomach (fasting) in the morning, he'll give you another medication XXX (name of medication), because these medication can cause problems for your stomach, these are strong pills, so he's giving the other medication for the stomach

90 RAJINDER: thik hai. *Ok.*

91 KARIM: E tussi char goliyaan khaoge te ede naal bilkul thik ho jaoge. *If you take this medication you'll become perfectly alright.*

92 RAJINDER: Samaj gian waahn ji saari gaal mian tu hadi. *OK, I have understood everything.*

93 KARIM: Ja està, ja està. *That's it, that's it.*

In the example analysed, the alternation of dyadic sequences requires the mediator to firstly align with the doctor and later on to align with the patient. In Excerpt 3, the mediator first favours the production of the doctor's discourse and then formulates what is his understanding of it to the patient. In this second phase, in addition to translating the previous sequence to the patient, the mediator also responds to the patient's need for information, which might be an indication of patient empowerment.

The discussion thus far has sought to analyse the different strategies used by mediators in situations when patients seek information and the examples presented above have been concerned with the impact these strategies might have on patients' empowerment. The discussion that follows will explore some of the ways in which mediators handle patients' expression of emotions and whether their implemented strategies may contribute to patients' empowerment.

5.2   Patients are Allowed to Express Emotions/Concerns and are Actively Listened to

The importance of patients' expression of emotional concerns has been outlined in section 2.4.2 of Chapter Two, where Aujoulat (2007) discusses how the acknowledgement of patient's priorities and fears can be vital to ensuring patients' empowerment. In this section, I examine how mediators handle patients' expression of emotions and if they contribute in any way to their empowerment in these circumstances. It also analyses how mediators manage or not to represent patient positioning when patients' contradictions emerge and where they express disagreement with the medical treatment being prescribed.

5.2.1   Mediators' empowering strategies when patients express emotions

One of the crucial challenges of mediators and physicians is to be able to grasp and respond to the patients' expression of emotions, worries and needs. As Zimmermann et al. (2011) claim, such utterances from patients may relate to uncertainties about their medical conditions but also may regard life events. The acknowledgement of patients' emotional problems may therefore strengthen the therapeutic alliance (Shields et al., 2005), promote better coping with illness (Zachariae et al., 2003), reduce anxiety (Butow et al., 2002), and foster empowerment (Piper, 2010). Doctors' responses to patients' concerns is a particularly sensitive area because patients are often reluctant to reveal their real problems directly, providing subtle concerns, instead. According Mazzi et al. (2013), healthcare providers often ignore patients' concerns, leaving important issues unspoken.

The categories of empowerment presented in section 2.4.2 show that mediators' actions such as allowing patients to express their emotions and paying attention to their concerns through active listening might lead to patients' empowerment. The following excerpt is an illustrative example of these empowering actions. It is drawn from an encounter with Ahmed, a male Punjabi-speaking patient. He has come for a follow-up consultation and Dr. Alexandra who wants to know if he has got better or worse since the previous day. The patient expresses his concerns about his pain and he is particularly worried since he had a friend with similar symptoms who died recently. This fact is causing him additional stress and the excerpt begins at the point where he starts verbalising his fears. As we can see, the mediator (Seema) not only gives voice to the patient's emotions, but her intervention is vital to make the doctor aware of the patient's concerns.

Once the patient expresses his concerns about having a dangerous disease and even the possibility of dying as had happened to a friend who experienced similar symptoms, the mediator develops the patient's emotional statements through translation (turn 10) and includes additional information. This represents a case of expanded rendition, where the mediator includes more explicitly expressed information than the preceding patient's original utterance. It seems that the mediator is adding information to prompt the doctor not only to concentrate on the patient's

pain, but also to pay attention to the patient's fears. It is quite significant that, in turn 11 ("*OK, but this is because the pain runs down your entire leg...*"), the doctor addresses the patient directly and uses 'you' compared to other encounters where doctors use 'he' when they address the patient or the mediator. The choice of grammatical person in addressing participants in a mediated encounter is not an insignificant one. In my data, most of the references to patients made by doctors are in the third person and they usually address mediators, resorting to formulas such as "*Tell him/her*" or "*Ask him/her*". Therefore, the choice of perspective adopted by the doctor in turn 11 when he refers to the patient using the second person shows that her communicative axis is oriented towards the patient. This might be interpreted as an attempt to include the patient in the exchange as well as to pay attention to him.

In excerpt 4, the patient expressed need for explanations (turn 9) and the psychological opportunity that the patient presented here was not ignored or missed by the doctor. In turn 11, the doctor acknowledged the emotions expressed by the patient and also provided some information advice ("This is because the pain runs down….").

Excerpt 4

09 AHMED: Zyaada pata ki hai mainu, o chhe mine ho gaye, mere kol hi mera ikk dost si, o problem si yaar mere dost wi isi dard tu mar giya si menú wi dar lagda hai we ke eh dard khtre nak na huwe. *I'm very worried about this pain; six months ago a friend of mine died of a similar pain and now I'm scared that it might be a dangerous disease.*

10 SEEMA: Dice que tenía un amigo que se murió de este dolor, y lo que le pasaba [a su amigo], era lo que tiene él, que se le calienta la zona, que nota como…nota esa zona como caliente, que arde, no sé *He says that he had a friend who died from this pain, and [that] what happened to him is what he has, that he gets a burning feeling in this area, that he feels a kind of...he feels this area as hot, it's burning; I don't know.*

11 ALEXANDRA: Ya, pero eso es porque el dolor te baja por toda la pierna hasta el pie, hasta aquí. *OK, but this is because the pain runs down your entire leg as far as your foot, as far as here.*

12 SEEMA: Lo que me comenta es que su amigo murió porque: después de eso le entró una herida y después falleció. *What's he's explaining is that his friend died because after this there was a wound and he died afterwards.*

13 ALEXANDRA: Pero ¿está MEJOR que antes o igual?. *But, does he feel BETTER than before or the same?*

14 SEEMA: Poch rahi hai ke beter ho kal ton tussi ajj? *She is asking if you are better today than yesterday.*

15 AHMED: Dard te beter hai, o hunda hai na ikk sek jeya o ni nikalda. *The pain is better but there is this swelling which doesn't go away.*

16 SEEMA: Tiene menos dolor pero esta inflamación no se le va. *It's less painful, but this swelling doesn't go away.*

17 ALEXANDRA: A ver, déjame que le vea a ver si tiene algo ahí en la espalda. xxx. A ver, ¿dónde es el dolor? ¿Aquí? ¿Pero no baja? ¿No baja por la pierna? *Let's see; let me take a look at him to see if he has anything here on his back. Let's see, where is the pain? Here? But it doesn't run down? It doesn't run down your leg?*

18 SEEMA: is jaga dard hai we? *Does it hurt here?*

19 AHMED: Haan isi jaga the hai we. *Yes it's here.*

20 SEEMA: Está ahí. *It's there.*

21 SEEMA: idhar thalle te ni aa reya dard?. *Can you feel the pain running down?*

22 AHMED: Thalle ni aa rahi. *No, I can't feel it running down*

23 ALEXANDRA: Se queda ahí. Vale. *It stops here. OK.*

24 ALEXANDRA: Ya está, ya está. Mira, levántate que voy a mirar a ver si tienes alguna lesión en la pie:l o algo, levántate tú como puedas. ... Ponte abajo, en el suelo, un momento. *That's it, that's it. Look, stand up, I'm going to take a look to see if you have any skin injury or something. Stand up as well as you can....Get down, on the floor, a moment.*

(the doctor examines the patient)

→ 33 ALEXANDRA: Bueno, que te vistas. Que te pido el TAC para que te quedes tranquilo. *OK, get dressed. I'm going to ask for a CAT scan to put your mind at rest.*
34 SEEMA: Ke rahi hai ke main tuhada urgent CT scan karwandi haan roko saara. *She's saying she'll have an urgent CAT scan done for you*

As we can see, immediately after turn 12, '*What he's explaining is*', the mediator does not translate the doctor's originals, which represents a case of 'zero rendition' since there is a lack of corresponding translation. Instead, the mediator addresses the doctor in what seems like an attempt to make the doctor aware of the patient's fears. Technically, the mediator is substituting the patient, but his action gives voice to the patient's concerns. The doctor seems to ignore the patient's concerns and she just utters "*But, does he feel better…?*" (turn 13), which might indicate that she wants to move on from the patient's fears and that she is only interested in finding out whether the patient is feeling better or not. The doctor decides to examine Ahmed and it seems

that the mediator's intervention (in particular in turns 10 and 12) eventually prompts the doctor to pay attention to the patient's fears. Once Dr. Alexandra completes the patient's examination, she provides reassurance to the patient by requesting a scan to calm the patient down (turn 33), which seems to indicate that the doctor is aware of the patient's anxieties.

Seema informs the patient that the doctor will request an urgent scan for him (turn 34). The mediator's addition of the term 'urgent' is quite significant since it seems like an effort on the part of the mediator to calm the patient down. On the one hand, it could alarm the patient, who might believe that he has a serious illness and. On the other hand, however, this additional word might give false hope to the patient, who might think the scan needs to be done urgently. Based on the analysis of this particular stretch of text, it is therefore possible to claim that the mediator's formulation of the patient's feelings suggests that the mediator is actively listening to the patient, paying attention to his fears and concerns and therefore empowering him.

The next interaction, Excerpt 5, illustrates how the mediator echoes the patient's utterances and encourages her to express her worries and concerns. A Pakistani patient comes to visit the paediatrician (Dr. Carmen) with her baby boy and the patient's sister. Although Seema, a Pakistani mediator, is assisting the encounter, the mother remains silent with the baby on her lap and it is Rupinder, the mother's sister, who interacts with the mediator. A nurse, Montse, is also present. The paediatrician has already explained to the mother during previous consultations of the need to feed her baby with all types of food; however, she carries on feeding the baby with milk only. The mediator echoes the patient's utterances and this seems like a strategy used to encourage the patient to go on. Echoing the patient, Seema supports the patient emotional expressions (turns 4, 12), helping the patient to continue talking, which might have a potential empowering effect on the patient as she is allowed to express her problems.

Rupinder confirms that her sister only gives milk to the baby (turn 3). This is immediately responded to by the mediator who echoes the patient's last utterance ("*He only has milk,* turn 4) and encourages the patient to go on explaining the baby's diet and any further concerns regarding his feeding. Once the patient replies, the Seema initiates a further question *"Nothing else?"* (turn 6), in what seemed an attempt

to elicit the patient's concerns. This is followed by the patient's expression of her concerns to feed the baby with any type of food other than milk (turn 7). The mediator formulates the patient's utterances for the doctor (turn 8) and the doctor insists on knowing the reason behind feeding the baby with milk only. The patient says that the baby only likes spicy things (turn 11) and the mediator again echoes the patient's statement and encourages her to go on (turn 12). Echoing the patient is an indicator not only that the patient is being actively listened to, but that the mediator is also trying to elicit and give voice to her concerns. This leads to the nurse providing reassurance in the following turns by delivering an exhaustive explanation to the patient regarding the baby's feeding (turns 20 and 47).

Excerpt 5

2 SEEMA: E bachche noo ki dende ho khaan waaste? *What do you give the baby to eat?*

3 RUPINDER: Khaan waaste hor maa-baap ki dende hain? Mama sirf dudh hi dendi hai. *What do parents give to eat?. Mama only gives milk.*

→ 4 SEEMA: Dudh hi dendi hai. *He only has milk*

5 *RUPINDER: Ji. Yes*

→ 6 SEEMA: Bas hor kuch nahin? *Nothing else?*

7 RUPINDER: Na, Agge zukaam hon lag jaanda hai, hor koi chinta nahin. *No. It gives him a cold, that's the only worry.*

8 SEEMA: Solamente leche. *Milk only*

9 Dr. CARMEN: ¿Por qué sólo leche? *Why milk only?*

10 SEEMA: Ae kion Sirf dud hi kion dere ho tussi? Koi na koi naal Choti moti chis cereal wagera kion nahin? *Why do you only give milk? Why don't you also give him small things like cereals?*

11 *RUPINDER: Siraf namak mircha wali chis khandi wey hor onu pasans nahin khuch. Because he only likes spicy things. He doesn't like anything else*

→ 12 SEEMA: Namak mircha waali chis khaandi hai. *He only likes spicy food*

13 RUPINDER: Jee. *Yes.*

14 SEEMA: Dice que sólo le gusta comer cosas que tengan especies como picantes y sal, lo dulce no le gusta a su niño. *She says he only likes spicy and savoury; her baby does not like sweet food.*

15 Dr. CARMEN: **D□M** Pero no es que le guste, es lo que tiene que comer, ¿sabes? y la madre sabe lo que: la leche actualmente ya es es un: tiene que tomar leche pero no como único alimento. Si ahora le hacemos un XX, necesita verdura, necesita fruta, necesita carne. Y si el niño no lo quiere, que le haga pasar hambre. Ella se lo pone en el plato, no lo quiere, bueno pues que no coma, pero que no le de leche. La siguiente

comida da lo mismo, ¿sabes? Le tiene que hacer pasar hambre, y entonces al final se comerá lo que haya. Pero le tienes que hacer entender, o sea que, que la que sabe lo que necesita el niño es ella, no el niño. *But it isn't [a matter of] what he might like, it's what he has to eat, you know? And the mother knows what...milk now is, is already a...he has to have milk but not as the only kind of food. If we give him a XX now, he needs greens, he needs fruit, he needs meat. And if the child doesn't want it then let him go hungry. She puts it on his plate; he doesn't want it, then well let him go without. But no milk for him. The next meal she gives him the same, know what I mean? She has to let him go hungry and then in the end he'll eat what's there. But you have to make her understand, that is, she is the one who knows what the boy needs, not the boy.*

16 SEEMA: Ke rahi hai ke tussi matlab jera dud dende ho o theek hai par lekin isnu tussi mitthi chisan deniyan shuru karni han matlab agar tussi o nahin daoge te isde jere khoon vich na kamin rahegi hamesha, jeri iron di lod hai, taqat di lod hai, o chisan nahin millan giyan, zaroorat diyan hor chisan bhi naal honi chaidiyaan….ae kende ne agar dud pinda hai, agar dud tussi ek din nahin daoge, khaali plate rakhoge cerelac wagahra banake te dud nahin daoge te automatically do-tin dafaa agar jera tussi plate rakhoge te appu khaega jadon pukh lagegi, ke tussi zaraa koshish karni hain o chisan. *She's saying that it's OK to give milk, but you also have start giving him sweet things because if you don't, there will always be some deficiency in his blood, like his need for iron and energy will not be met and all the other necessary nutrients should also be there. She is saying that if the baby drinks milk, and if you don't give him milk for one day, and let him go hungry and give him the plate of cereals 2-3 times the baby will eat cereal when he is hungry; that you have to try these things.*

17 RUPINDER: (0.5) Ji, kedi chisan de sakdi haan? *(0.5) Ok, what can I give him?*

18 SEEMA: Dice que sí, que ahora lo va a intentar, pero pregunta que qué alimentación tiene que darle. *She says that she is going to try it now, but she is asking what type of food she has to give to her baby.*

19 Dr. CARMEN: Bueno, ahora te lo explica la enfermera. *Well, the nurse will explain it to you now.*

20 MONTSE: //Sí. A veure, la última vegada que va venir això mateix ja havia passat, ja ens va dir que només prenía llet i li vam explicar lo de les papilles, vale? Vull dir que a veure, que ho tornarem a explicar una *altra vegada, però que ens faci cas, perquè no cada vegada que vingui aquí ens té que* dir que només pren llet i tornem a explicar una altra vegada lo mateix. *Yes. Let's see; the last time she came the same thing had happened. She already told us that he only took milk and we told her about purees, right? What I mean is, let's see. We'll explain it to her again, but she needs to take note, so that we don't have to tell her the same thing again every time she comes here she has to tell us that he's only taking milk.*

The doctor interrupts the nurse and starts asking about a tuberculin test. Later on (turns 45 and 47), the nurse carries on providing reassurance to the patient.

45 MONTSE: I:: lo del menjar. *And regarding the feeding.*

46 SEEMA: //XXX?

47 MONTSE: Sí, senta't. A veure, fins els sis mesos, només havia de pendre llet i prou, però ara ja només falta una setmana perquè compleixi un any. Llavors perquè el nen pugui moure's tal i com li ha de tocar, o sigui, a caminar, aprendre coses, ha de tenir una alimentació correcta, ¿vale? Llavors, només llet sola no és una alimentació complerta, li falten coses. Ja hauriem d´haver introduit tot: cereals, fruita, verdura, proteines animals, tant sigui carn com sigui peix, ou. L'altre dia li vam explicar i no ens ha fet ni cas. Vull dir, a veure, tornem-hi. Però que és pel bé del seu fill perquè ha de menjar ja de tot. ¿Coses que no pugui menjar? Coses que es pugui atragantar, e:, fruits secs, olives, coses grosses, no. ¿Vale? Ha de triturar-ho perquè el nen s´ho mengi més bé. Però sí que és important que a les papilles no hi posi picant, el seu estómac no està preparat per menjar coses picants, però si que ha de menjar verdura, ha de menjar patata, ha de menjar pollastre, que li pot triturar tot, ha de menjar fruita, que li pot triturar la fruita, ¿vale? Ha de menjar cereals. Vull dir ara ja té que menjar de tot, perquè si no no el deixem créixer bé, ¿vale? *Yes, sit down. Let's see, for the first six months he only had to have milk and nothing else. But now we're just a week off him being one. So, so that the boy can move about the way he should for his age, that is, walk, learn things, he needs the right diet, OK? So, only milk alone is not a complete diet, he needs other things. We should be introducing everything: fruit, vegetables, animal proteins, whether meat, fish or eggs. The other day we explained to her and she didn't take any notice. I mean, let's see, back to what I was saying. But it's for the good of her son because he has to eat everything. Things he can't eat? Things that he can swallow, and...dried fruit and nuts, olives, not big things. OK? She has to mash it up so it's easier for him to eat. But it's important the purees aren't spicy; his stomach isn't ready for eating spicy food, but he does need to eat vegetables, he has to eat potatoes, he has to eat chicken; she can puree it all. He has to eat fruit, she can puree the fruit OK? He has to eat cereals. What I mean is that now he has to eat everything because if not we're not letting him grow properly, OK?*

Echoing the patient's utterances seems to be a strategy used by the mediator to encourage the patient to go on talking and to express her concerns regarding her baby's feeding. This strategy might therefore be seen to lead to patient's empowerment since the mediator gives voice to the patient's doubts and fears. As illustrated in the above examples it is possible to claim that, echoing patients and/or giving voice to their concerns, mediators' active participation seem to encourage patients to express themselves and it could be said that this strategy may ultimately lead to patient's empowerment.

5.2.2 Mediators management of patients' contradictions

The introduction of patients' contradictions is an ever present and complex phenomenon both in monolingual and inter-linguistic medical encounters. These contradictions generally concern refusals or complaints regarding medical treatments and doubts regarding institutional procedures. However, in inter-linguistic interactions involving a mediator as the third party in a communication process between individuals (doctor and patient) speaking different languages, the management of patients' contradictions is arguably even more complex. The examples presented below try to illustrate the different strategies used by mediators when patients' contradictions emerge and whether these strategies empower migrant patients in any way.

Excerpts 6, 7 and 8 are taken from an interaction with Jaswinder, a patient from India, Dr. Esther, a Spanish-speaking family doctor, and Karim, a cultural mediator assisting the medical encounter. The patient has her consultation on floor three; however, when she arrives at the clinic she immediately goes to floor seventh to request the service of the mediator (she is familiar with the clinic and knows that Karim spends most of his time there). She wants to make sure before entering the consultation that the mediator is available to assist her.

However, Karim is busy attending another medical encounter and the administrator at reception tells the patient that the mediator will go to help her as soon as he is free. The patient expresses disappointment. She says that she really needs the mediator to be able to communicate with her doctor and she complains about the situation. The mediator has always been available for her and she does not understand how the clinic can leave her without this service. In a matter of seconds, Karim appears and the patient feels relieved. The administrator explains to the mediator that the patient has been waiting for him and she was slightly stressed. The mediator then greets the patient and starts talking to her to reassure her and they both go to floor three to attend the medical consultation.

Since her assigned doctor is away, today the patient has a consultation with Dr.Esther, a substitute doctor. The mediator and the patient enter the doctor's consultation and they sit close to each other, both opposite the doctor. The mediator initiates the

medical encounter and he engages in a dyadic exchange with the patient while the doctor allows the interaction to take place and remains at her desk watching them. Karim asks the patient why she has come to see the doctor and, after the patient's reply, he carries on questioning to find out for how long the patient has been experiencing her pain. It seems that the mediator-initiated questions are designed and sequenced in such a way as to expedite the task of collecting relevant information from the patient and to obtain diagnostically relevant data that might be useful to the doctor.

In taking charge of initiating the medical interview and acting as co-interviewer, the mediator is preventing the opening phase of a prototypical medical consultation, when a relationship between the doctor and the patient is established (Davidson, 2000). The patient has come to the consultation because she has some pimples on her head that are causing her pain. The doctor examines the patient's head and confirms that she has two lumps, but says that it's nothing serious. In the preceding turns, the doctor gives indications to the patient on how to take her anaemia and thyroid's medication.

Excerpt 6 begins at the point where the mediator establishes a dyadic sequence with the doctor to let her know of the patient's complaints prior to the encounter. This sequence begins with the mediator making a somewhat ironic comment "*She's a bit calmer. She went upstairs (before the consultation) and she was complaining because I wasn't there*". The irony can be noticed in the mediator's laugh at the end of his first statement and also on the emphasis he makes in his second statement.

The patient interrupts to express her pain in Spanish 'Mucho dolor ésto. *This is a lot of pain'* (turn 139) which represents a case of code-switching. As Moyer (2011) claims, code-switching is a feature of multilingual communication where migrants have a greater agency. By uttering a few words in the language of the doctor (Spanish), it seems that "the patient is making an effort to find the meaning making mechanisms available to her to achieve her goals" (Moyer, 2011: 1216) and the patient is making a plea to the doctor and the mediator to take notice of her. However, despite the patient's efforts to be listened to, the mediator ignores the patient contribution and he carries on his interaction with the doctor. He emphasizes to the doctor that the reason why the patient couldn't find him earlier was because he was

assisting some other doctors. As we can see, it is the mediator who introduces the issue of the patient's complaint, since the doctor was not aware of the previous incident on floor seven.

It seems from this excerpt that the mediator establishes an exclusive relationship with the doctor as a strategy to deal with patient's complaints and demanding attitude.   It is significant that this banter takes place in the presence of the patient who would seem to understand Spanish evidenced in her code-switching in turn 139. The patient probably understands what is being said, although the doctor and the mediator act as if the patient were not there and they do not include her in their conversation. This provides a very clear example of what can be considered patient's disempowerment, since neither the doctor nor the mediator pay attention to the patient's concerns and the patient's contributions are ignored.   The excerpt ends up with the doctor supporting the mediator and dismissing the patient.

Excerpt 6

> 138 KARIM: Ahora está un poco más tranquila ((LF)). Antes ha subido arriba Y se estaba quejando de que no estaba yo. *She's a bit calmer ((LF)).* *She went upstairs (before the consultation) and she was complaining because I wasn't there.*
>
> 139 JASWINDER: //mucho dolor ésto] *this is a lot of pain.*
>
> *140 KARIM: Que dónde estoy yo, y digo NO, ¡ES QUE YO TAMBIEN ESTOY YENDO A CONSULTA!* Where I am, yes I was there, *I WAS ALSO GOING TO THE DOCTOR'S SURGERY [HELPING OTHER DOCTORS].*
>
> 141 Dr. ESTHER: ¡Tomando café ESTÁS venga! Es que VAYA TELA. *Off having coffee were you! Unbelievable! That takes some beating!*

The mediator's exclusive relationship with the doctor reduces the patient to a passive role of further complaints. It might be the case that the mediator was also trying to save face in case of future patients' complaints regarding the unavailability of mediators.   As discussed in section 2.1, the notion of 'face' put forth by Goffman (1967, p. 12) is helpful to understand how the mediator is claiming a positive social value for himself, a public self-image of efficiency, which was threatened by the patient's complaints. It looks as if Karim was trying to get the doctor's complicity and understanding, letting the doctor know how busy he is assisting doctors in consultations and therefore not always available when patients require his services.

This stretch of talk is quite relevant, since both the mediator and the doctor criticise the patient's attitude and behaviour. According to them, the patient is in a position where she cannot complain about the institution and its functioning. The patient is led to believe that he has to understand that sometimes they (official representatives) are not available due to their workload. By explaining the previous incident to the doctor, he distances himself from the patient and aligns with the institution. It seems that the mediator is claiming more power and is trying to obtain the doctor's recognition to counteract the patient's complaints.

Further down in the same encounter (Excerpt 7), the patient expresses her disagreement with the medical treatment received up to the point of her visit to the clinic. The patient also mentions her financial problems and her difficulty in buying the prescribed medication. Her assigned doctor prescribed her some pills a few months previously and now, a substitute doctor (Dr. Esther) is prescribing her additional medication. She explains that her husband only makes €800 a month and they have to spend €600 to pay the rent. The patient positions herself in disagreement with the medications prescribed by the doctor and she wants her to provide a solution to her problems. She refuses to buy new medication and follow the doctor's recommended treatment. The mediator selectively translates some parts of the patient's claims to the doctor. Later on, Dr. Esther disengages with the patient's economic problems, claiming that she is a doctor and if the patient has any problems she should go to the social worker. As Moyer (2013) discusses, the doctor's claim reinforces her position of a medical authority who is not responsible for patients' other life concerns (turn 144). The doctor and the mediator meet the patient's refusals with sarcasm and laughs. Since the mediator does not interpret the doctor's words to the patient (turns 147, 149), Jaswinder is not aware of what is being said and cannot participate in the interaction, therefore being disempowered by the mediator.

It seems that Dr. Esther uses a discourse of power to justify her disagreement of prescribing cheaper medication. This discourse of power (turn 144) can be interpreted through the use of the language the doctor uses. In Spanish, the use of the pronoun "I" is not necessary to conjugate a verb tense and is only used when emphasis has to be made. Therefore, the use of *"I"* in her statement *"I'm a doctor"* can be interpreted as if she is the one with the knowledge and the power to make

decisions. The mediator's rendition in a joking tone (turn 146) does not seem to alleviate the tension emerging in the doctor- patient conversation and he chooses to align himself with the institution.

Excerpt 7

142 JASWINDER: Pehele ide kol aye haan, do goliyaan khaiyaan fer uttle doctor kol gai haan fer do khaiyaan , te o etni te pakki tankha hai na mere marido di 700 o 800 te 40 rupaiyaah hai, te assi che so vich dene haan karaya, te o khayie ki ros golian main kithon lavaan, e hun saatan dina wich main do vari khar ri haan che che euro di davaai. *I've seen another doctor and he's prescribed me other medication. My husband doesn't make much money, he only makes €700 or €800 and €600 is to pay the rent. I can't buy medication every day. This week I've bought medication twice and it's cost me €6.*

143 KARIM: Ahora se me está hablando del tema económico, que su marido no cobra mucho y tiene problemas. *She is telling me she has economic problems. Her husband does not make much money and she has problems.*

144 Dr. ESTHER: Esto::, DILE QUE YO SOY MÉDICO Y QUE SI TIENE ALGÚN PROBLEMA **((LF))** QUE VAYA A LA ASISTENTE SOCIAL .... Y QUE ENTONCES YA xxx**.** *Tell her I'm a doctor and that, if she's got any problems, she should see a social worker .....and then, we'll see.*

*: disagree on prescribing cheaper medicines.

145 JASWINDER: // Mainoo koi roz paise den da shaunk te ni hai. I don't like having to pay money every day (for medication). *I want you to prescribe medication that works well. I've bought lots of other medication that didn't work at all.*

146 KARIM: dice que: **((LF))** ha comprado mucha medicación cada día compra diferentes medicaciones pero resulta que:: no se cura, dice que tiene que hacerle una receta de una medicación que vaya muy bien. *She says that ((LF)) she's bought a lot of medication; every day she buys different medication but it turns out she doesn't get better. She says you have to give her a prescription for a medication that works.*

147 Dr. ESTHER: Claro, dile que. Of course, tell her that…
148 JASWINDER: //Otro dia e::: médico.] *other day e::: doctor*

149 Dr. ESTHER: DILE QUE MEJOR LE VOY A IMPONER LAS MANOS Y LA VOY A CURAR. *Tell her that I'm going to heal her by laying my hands on her.*
*: Irony
150 KARIM: Ha, ha, ha ((LF))

Karim (line 143), when addressing Dr. Esther, leaves out Jaswinder's account at the beginning of line 142 ("*I've seen another doctor and he's prescribed me other medication")* of her previous experience at the clinic and the prescriptions she was given of various medications. The mediator selectively translates just the part where the patient is

talking about her husband not earning enough money. The disagreement and criticism of previous medical attention received expressed by Jaswinder in line 142 is not translated by the mediator to the doctor, which might have consequences for the limited empathy between doctor and patient. The mediator choice of not translating all the patient's complaints has also consequences for Jaswinder's chances of negotiating alignment with her doctor.

Also of significance in this excerpt is the way in which the doctor uses the third person to refer to the patient (turns 144, 147 and 149). It seems like a clear example of patient's disempowerment since the doctor brushes off patient concerns as insignificant and refers the patient to the social worker. The doctor does not show any kind of empathy towards the patient's economic problems and seems to be using her institutional power to impose her criteria regardless of the patient's refusals.

It seems that the doctor feels under attack and she wants so make it clear to the patient who is boss. As can be seen in this particular turn (144), one of the strategies used by the doctor to cope with patient's refusals is the definition of her professional role (*"I'm a doctor"*). As Hall et al. (1990) argue, it is not possible to define social roles, such as professional occupation, unproblematically. Hall et al.'s concept of role-identity is useful here for understanding the process of re-definition of professional identity in which doctors engage. Roles are viewed as a resource that speakers draw upon to create a particular identity for themselves in local face-to-face interactions (Hall et al., 1990). Because of her situated role as "health provider", the doctor is expected to have the scientific knowledge to treat her patients adequately, although Dr. Esther is not expected to deal with seemingly trivial issues such as the patient economic problems. The doctor therefore marks her position in the medical hierarchy and refers the patient to the Social Worker, since probably the doctor considers this as a "lower" position dealing with less important issues such as the patient's money problems.

Before the mediator can actually deliver the doctor's words to the patient, the patient interrupts and she carries on complaining about having to buy so much different medication (turn 145). This patient's refusal to take the medication represents a challenge to the doctor. The mediator interprets the patient's utterances and it seems that he aligns with the doctor, as he uses an ironical tone of voice and laughs when

transmitting the patient's words (turn 146). Neither the doctor nor the mediator are paying attention to psychological and social aspects of the patient's health, and they do not provide practical support for problems of daily living such as economic problems. It is possible to claim that the mediator's intervention in this particular encounter helps to reduce the tension between the patient and the doctor. However, since he does not interpret the entire patient's and the doctor's utterances, the patient's chances to negotiate with the doctor are reduced, leading potentially to the patient's disempowerment.

As we can see in turn 148, the patient interrupts the doctor and tries to provide additional information in Spanish, which represents a code-switching instance. By changing into Spanish, it seems that she is trying to be heard and included in the conversation. However, her contribution ("*other day e::: doctor",* 148*)* is ignored and it is not even interpreted by the mediator, who instead allows the doctor to carry on talking. It might be the case that the patient does not hold the legitimate competence to use the legitimate language (Spanish), which is the language of authority (of the doctor). This might be linked to the idea of the "legitimate speaker" that draws on the work of Bourdieu (1991), which claims that the legitimate competence (independent of the knowledge of the language) is the statutorily recognized capacity of an authorized person to use the legitimate language. Therefore, regardless of her language skills, the patient is excluded from interaction and condemned to silence.

The doctor's ironic utterance (*Tell her that I'm going to heal her by laying my hands on her'*, turn 149) is not interpreted by the mediator to the patient. Instead, the mediator laughs with the doctor (turn 150), which clearly indicates he is aligning with the doctor. This utterance (149) represents a derogatory interference with obvious condescending undertones. Further down in turn 150, Excerpt 8 integrates the proceeding utterances of the same medical encounter detailed in Excerpt 7. It displays a further example of how the mediator is a collaborator in the process of patient's disempowerment initiated by the doctor. Here, the doctor and the mediator engage in a dyadic conversation from turn 151-155. It seems that the mediator engages in an exclusive relationship with the doctor as a strategy to deal with the emergence of patient's refusals. He can be seen to align with the doctor and potentially limiting the patient's chances of expressing resistance and disagreement with the medical treatment, therefore leading to possible patient disempowerment.

Excerpt 8

151 Dr. ESTHER: No, **((LF))** dil que si va al médico cada tres días, que es lo que hace ella, **((LF))**. *No. Tell her that if she goes to the doctor every three days, which is what she's doing...*

*: the doctor is laughing

152 KARIM: ((LF))

153 Dr. ESTHER: Pues claro, le vamos dando medicación. Que yo le cambio las pastillas porque el Paracetamol no le ha ido bien, le doy el hierro QUE YA SE TOMABA porque se lo tiene que tomar si no no se va a curar, le doy el protector de estómago porque si no le hace daño el estómago y si no se toma el hierro, y se lo tiene que tomar, le doy la pastilla para el dolor porque ella ha venido por dolor. O sea que. Que los médicos curamos con pastillas y que sin pastillas no sabemos curar y que ésto lo tiene que entender. *Of course we're giving her medication. I'm changing her pills because the Paracetamol hasn't worked well for her; I'm giving her the iron that she was already taking because she has to take it otherwise she won't get better. I'm giving her the stomach shield because otherwise she's going to have stomach ache and if she doesn't take the iron, and she has to take it... I'm giving her a pain killer because she came here because of the pain. In other words, doctors, cure with pills and without pills we don't know how to cure and she needs to understand this.*

→ 154 KARIM: Y tampoco hay una pastilla que sea milagrosa. *And there are no magic pills.*

155 Dr. ESTHER: Y que si hubiera una pastilla milagrosa el primer día ya se la hubieran dado, pero que a veces, ¿vale?. *And, if there had been a magic pill we would have already given it to her the first day. But sometimes....OK?*

156 JASWINDER: XXX.

157 KARIM: Ke rai hai ke mere kol aisa koi maussa nahin hai ke main aisi davaai devaan ke tussi bilkul theek ho jao. *The doctor says there's no magic pill which will make you feel perfectly OK.*

Therefore in this interaction, the patient's refusals and complaints regarding the medical treatment are met with laughs by the mediator and the doctor. In turn 153, the doctor provides an expanded explanation containing further arguments to support the treatment. The first part of this rendition may be interpreted as a doctor's attempt to define the problem and justify the treatment. However, the last part of the doctor's rendition ("*Doctors cure with pills and without pills we don't know how to cure and she needs to understand this)* might indicate that the doctor is treating the

patient as incompetent, which in turn might represent a further case of patient's disempowerment.

Turn 154 represents an important moment in the encounter. It is noteworthy that the mediator does not render the doctor's utterances (153) to the patient, where the doctor explains the reason behind prescribing this new medication. This omission of information is quite significant, since the clarification provided by the doctor might be of particular relevance to manage the patient's refusal to take the medicine. Instead, the mediator continues his dyadic interaction with the doctor and introduces an utterance with a tone of irony '*And there are no magic pills*' where he seems to portray the patient as incompetent (or naive), excluding the patient from conversation. By omitting information to the patient of what is being in the doctor-mediator exchange and by adding a sarcastic comment (154) it seems that the mediator is disempowering the patient and trying to reinforce the doctor's position as well. The doctor carries on (turn 155) his conversation with the mediator, in what seems an attempt to justify her prescription to the patient. In the following turn, the patient reacts and mumbles, although, due to the sound quality it was not possible to transcribe her words.

In this particular interaction, there is total lack of alignment between the patient and the doctor. It is possible to claim, with some degree of certainty, that each speaker (doctor and patient) is pursuing his own agenda, but at no point do these different agendas converge. This is because participants have conflicting goals and interests: the doctor is expected to "act institutionally" by justifying the treatment prescribed, while the patient attempts to assert her rights to have cheaper and better medicines. There is no evidence either of the mediator putting forth the patient's agenda, which might be a result of his position within the clinic hierarchy of the clinic. In this particular case, the patient didn't have the opportunity to express her concerns. However, this is not surprising given that (a) doctors sometimes use their situational powers to constrain patients' chances of participation (Codó, 2003) and (b) mediators do not seem to level out the power between doctor-patient when the latter introduces contradictions (refusals and complaints) in interactions (Baraldi, 2009).

The data presented in this study don't represent all mediated interactions that happens each day in medical settings, since different mediators might have different stances

toward contradiction management. My intention was neither to present all the strategies used my mediators when patients' contradictions emerge (it would be impossible) nor to generalise findings. With this limitation in mind, I decided to focus on those strategies which might have any impact on patients' empowerment. On the basis of the analysis in this section, it is possible to conclude that in some situations, mediators intervene as providers of opportunities to talk, using and treating patients' emotions, which might lead to patients' empowerment. However, it would also seem that mediation is not always effective in promoting symmetrical power relations when patients introduce contradictions that may challenge the doctor. In these circumstances, it seems that mediators analysed in the data here tend to align with doctors and doctors exploit the existing situational asymmetries to exert their power and safeguard institutional interests.

5.3 Patients Have the Authority to Set the Agenda for the Meeting and Freedom to Make Choices

Doctors' long tradition of making decisions for the patient has been based on a belief that they know what is best for the patient (Emanuel, 1992). However, the view that patients are, along with doctors, experts on their own bodies, has arisen in recent years (Anderson and Funnell, 2005; Piper, 2010). Patients bring expertise about their own symptoms, beliefs, needs and expectations into the encounter, and the ultimate right to make decisions for themselves. Methods of making decisions about healthcare range from complete delegation of decisions to the doctor to patients making the decision themselves, with many patients preferring an intermediate, collaborative role (Richards et al., 1994). Making a decision is therefore one of patients' most sensitive moments in a medical event.

This section sheds light on the communicative strategies deployed by patients to pursue their interactional agenda. It also explores how mediators, who represent a language resource for migrant patients, manage to represent patient positioning and enable them to make decisions and negotiate health-related topics. Interactional power needs to be considered in a context in which decisions are to be made by both doctor and patient with the presence of a cultural mediator who also has power in the interactional process.

5.3.1   Patients' making health-related decisions
Mediators empowering patients

The key reflections that are relevant for understanding the way the patient's freedom to make decisions gets shaped in Excerpt 9 have to do with Dr. Albert, a male practitioner who seems to involve the patient in the decision-making process, and with Karim, who translates the doctor's empowering inputs and enables the patient to make decisions. The excerpt is taken from one encounter that takes place during a consultation with Dr. Albert, Karim and Rajinder, a male patient from Pakistan. The patient arrives in the consultation and explains to the doctor that he is experiencing back pain. The doctor examines his back and lets him know he has a severe muscular contraction. The doctor offers the patient the possibility to take a sick leave and the extract starts at the point where the mediator is reporting the doctor's original utterances.

Later on (turn 17), the doctor offers the patient the possibility to decide whether he wants to have the prescribed medication (anti-inflammatory) orally or via injection. The following sequence illustrates a case where a doctor actively involves the patient in negotiating treatment and the mediator facilitates the patient's involvement initiated by the doctor.

Excerpt 9

> 14 KARIM: Ke rahen baja chande ho kamm ton? *The doctor is asking if you want a break from work.*

> ⟶ 15 RAJINDER: Sahi ehh main is condition ich kaam nahi kar sakta. *It is Ok, because I can not work now.*

> 16 KARIM: Sí, diu que sí. Diu que no pot treballar en aquestes condicions. He says he agrees on having the sick leave. *He says he can not work in these conditions*

> 17 Dr. ALBERT: És clar, està molt contracturat. Li donarem antiinflamatoris. Si està molt futut, molt futut diga-li que li podem punxar uns dies, aviam què li sembla, o s´estima més pendre'ls per boca. *Of course, he has a serious muscular contraction. We will give him antiinflammatories. If he does not feel well at all, tell him we can give him a jab, let's see what he thinks about it, or does he prefer to have them(the antiinflammatories) orally?*

> 18 KARIM: Ke rehen ke tvadde kol do option ne davaai de, ya e teeka laa den darad

vaaste ya tussi goli khana chande ho? *The doctor is saying that there are two options, either he can give you an injection for the pain or you can take pills. What do you prefer?*

⟶ 19 RAJINDER: (0.4) goli best hai. *I think it's better to take pills.*

20 KARIM: **Diu que millor les pastilles que:** *He says he prefers pills.*

21 Dr. ALBERT: **Per boca, ¿eh?.** *Orally, right?*

As we can see in turn 16, the mediator immediately reports the patient's answer, where the patient agrees to take sick leave since he can not work because of severe back ache. Instead of imposing a specific treatment, in turn 17, the doctor suggests different possibilities by offering the patient the option to choose between having injections or pills. This might indicate that the patient is actively involved in the prescription process and he can actually negotiate the type of treatment that best suits his needs. The doctor provides options instead of telling the patient what to do exactly and, in turn 18, the mediator delivers a close rendition where he transmits the doctor's empowering utterances to the patient. By stating at the end of his rendition '*What do you prefer?*', the mediator can be seen to openly facilitate the empowering process initiated by the doctor.

Further down, in turn 19, the mediator allows the patient to take the necessary time to think (four seconds) before providing an answer. Following the mediator's interpretation of the patient's words, the doctor (turn 21), double-checks the patient's answer, in what seems like an attempt to verify his decision. It is possible to claim, with some degree of certainty, that the encounter in excerpt 9 represents a doctor's attempt to actively involve the patient in negotiating treatment. With this is mind, it is noteworthy that the mediator not only seems to facilitate patient empowerment initiated by the doctor, but he also encourages the patient's empowerment by openly asking his preferences (turn 18) and allowing him to take the necessary time to make decisions (turn19).

Mediators substituting patients in decision-making

The discussion thus far has sought to analyse how mediators position themselves to promote patients' empowerment when the latter have to make decisions. Some of the ways that mediators intervene in mediated activities have been considered in excerpt 9

above and suggests that, occasionally, mediators actively empower patients by involving them in the negotiation process. However, a much more widespread pattern identified in the data was the mediators' substitution for patients in decision-making processes. As Baraldi (1999) claims, the mediators' habit of substituting patients in the decision-making process may be a way to maintain the medical system free from troubles and has a significant disempowering effect on patients, as in Extract10, where the mediator disempowers the patient by making decisions on his behalf.

The encounter takes place during the initial phase of a general practitioner consultation. Dr. Albert tells the nurse (Elena) to start taking the clinical history to Adil, a Pakistani patient in his fifties, and he leaves the room afterwards. Apart from the nurse and the patient, Karim is also in the room as the cultural mediator assisting the consultation. At a particular point, the nurse informs the patient of the need to have a tetanus vaccine. Before making a decision, the patient wants to know whether this vaccine has any side- effects and the nurse explains that there are local effects such as reddening and inflammation. In the first few lines of Excerpt 10, the mediator produces the nurse's original utterances to the patient explaining the vaccine's side-effects. The following turns, however, illustrate how the mediator substitutes the patient and accepts a vaccination on his behalf.

The mediator (turn 95) produces the nurse's originals and his subsequent action (turn 97), seems an attempt to empower the patient by providing information so that he has enough about the uses and benefits of vaccines to allow him to make a decision. As we can see, the mediator uses the word 'we', which hints at the possible aligning of that the mediator with the doctor and the institution. The nurse's originals in turn 99, where she seeks patient's agreement, are left untranslated and the mediator (turn 100) substitutes the patient and decides for him. Seen from the point of view of translation, this would count as a 'zero rendition', which may constitute a specific strategy on the part of the mediator aimed at preventing conflict with the nurse and thus allowing communication to proceed without problems.

Excerpt 10

95 KARIM: ke rahi hai ke e hai ke tvaddi jis jaga te injection lagge ga na us jagah te thodi- bahot sojen ho sakdi hai par o bohat kaat kesis vich hunda hai... *She's saying that you might get swelling and inflammation at the place where they give you the injection, but it only happens in very few cases....*

96 ADIL: Achha. Ok

→ 97 KARIM: … Ya laal ho sakdi hai jaga par lekin oh vi bahot kaate lokan nun hunda hai, par hai ke vetar hai tussi lavaa lao kionki tussi te kaam jaddon karoge, khudaa na khaasta tvannu koi satt lagg jaandi hai, koi..koi..koi chis katt jaandi hai ungli de naal, ya kamm karde vaqt bande tau galti de naal.. koi karr vich bhi katt janda hai hathh, te jera scene jere honde ne etthe zadaa hain, te hafazati taur te tika assi landen harr bande nun … *it might turn a bit reddish. But it is better if the injection is given since it will protect you. For instance, in case you cut yourself in your hand when you are working or you have an accident, so we give you this injection as a precautionary measure to protect you from any infection.*

98 ADIL: Achha ji. Ok

99 NURSE ELENA: ¿Acepta?. Does he agree to it?

→ *100 KARIM:* Sí, acepta. Yes, he agrees to it.

101 ADIL: Te..???? *And…..???*

102 KARIM: // Baanh lanaa hai. It'll be given on the arm

103 NURSE ELENA: ...¡Oye!, ¿este dolor de rodilla él lo asocia a algún golpe, a algún, te ha explicado algo?. *By the way, does he associate this pain in his knee with any blow, with any, has he explained anything about this to you?*

It might also be the case that the mediator understands the patient "*OK*" (turns 96 and 98) as an acceptance of the vaccine which then in turn prompts him to answer the nurse's question and interprets what the patient actually said. However, the patient tries to ask a further question '*And…..???*' (101), but the mediator overlaps the patient and utters '*It'll be given on the arm*' (102), leaving no room for the patient to formulate his question. This represents a key moment in the encounter. Since the decision was already made by the mediator and communicated to the nurse (turn 100), the patient's additional questions might be seen to represent a potential threat to the doctor's authority.   The mediator is exerting a certain degree of control over the interaction and is probably trying to prevent the patient from discussing the medical decisions, in this case, the need to have a vaccine.

As highlighted in the Literature Review, mediators' practices can disrupt the assertion of power and control in the interaction through the omission of utterances or any other means (Inghilleri, 2004), and that is precisely what seems to happen in the example above. In fact, once the vaccine issue is closed following the mediator's utterance ("It'll be given on the arm", turn 102), the nurse is able to move on and carries on gathering information (103). Although, in this particular study, the mediators' habit of substituting patients in the decision-making process has a significant disempowering effect on patients (Baraldi, 1999), it is not possible to claim that mediators are doing so consciously. As discussed in section 2.3.4, Giddens' (1984) notion of agency and the unintended consequences of actions over time and space might help to understand the role that mediators play in the reproduction of a particular institutional order. Data presented above show how the practices of substituting the patient carried out by the mediator (agent) might have the unintended consequences of disempowering the patient as well as the unintended outcomes of reproducing a given social order where the doctor usually assumes responsibility for healthcare decisions.

Mediators imposing a specific action on the patient

In addition to the mediators 'substitution of patients in decision-making, a further pattern identified in the data was mediators' strategy to impose specific actions on patients, which might lead to patients' disempowerment. The next transcript fragment shows how sometimes mediators present options or suggestions to the doctors as normative actions, reducing then the possibility for the patient to make choices and leading to their disempowerment. Excerpt 11 takes place during a consultation with Dr. Margarita, a female dentist in her thirties, Gobind, a Pakistani patient, and Seema as the mediator on duty. At the beginning of the interaction, Dr. Margarita explains to the mediator that the patient does not seem to understand the information she is providing to him, as the only response she repeatedly gets from the patient is "*Yes*". It seems obvious that the patient does not comprehend the doctor's questions and that is why the presence of the mediator is required in the consultation.

The doctor explains that the patient has two cavities in his teeth, but they do not have to be taken out, instead, he can have a filling done. The patient asks how much the

filling costs and the doctor informs the patient about the possibility of booking a place for him in a clinic where the filling can be done at a reasonable cost. Gobind has to decide whether he wants a filling done in his molar cavities. The extract shows a case where the mediator tries to persuade the patient to follow the doctor's recommendations.

Excerpt 11

02 SEEMA: Ke rahen hain twadde jere do hain na matlab ki kenden jere daran, os vich kira lagya hai par osnu kadana ni hai, osnu siraf filling karani hai. Free ni hoegi o, o payment karni payegi....*te tussi karaa sakde ho filling ya nahin? It's not free, you'll have to pay for it. She's saying that you have two cavities in your teeth but they don't have to be taken out; you can get the filling done....so can you get the filling done or not?*

03 GOBIND: Filling de puchh kinne paise ne mutabik. *Just ask how much the filling will cost.*

04 SEEMA: Me pregunta más o menos el empaste cuánto le costará. *He's asking me more or less how much the filling will cost him*

05 Dr. MARGARITA: Mira, nosotros le vamos a hacer un sitio en Bucalia, es un sitio que es muy económico y se lo pueden arreglar, ¿de acuerdo?. *Look, we're going to get*

06 Dr. MARGARITA: D□P¿Quieres arreglártelo?. *Do you want them repaired?*
  kardengue. *You have to go there (Bucalia); they will treat you there; it will be cheap.*

→ 07 SEEMA: M□P Etthe jaana hai tussi, etthe jaake tvadda ilaaj karangue, sastaa *him into Bucalia; it's a place which is very reasonable and they can be repaired. OK?*

08 GOBIND: Te twadde andazan vi…mainnu pata lagge na vi…*Can you tell me how much approximately it'll cost?*

09 SEEMA: 40 euro takriban lagg jaangue. *It'll cost approximately 40 euros.*

10 GOBIND: Ji. *OK*

11 SEEMA: Sí, está de acuerdo. *Yes, he agrees.*

12 Dr. MARGARITA: ¿De acuerdo? Cualquier otra cosa, si molesta, hay cosas pendientes tenemos unas raíces xxx, y hay otro en el otro lado que no le molesta que es un tratamiento un poquito más complicado pero lo que ahí le molesta son dos empastes. DOS EMPASTES, EH¡. *OK? Anything else, if it's painful, there are things that still need doing: we have some roots xxx, and there's another on the other side that doesn't hurt, which requires treatment that's a bit more complicated, but what what's hurting are the cavities which need filling. TWO FILLINGS, EH!*

In turn 2, the mediator delivers his rendition containing the doctor's explanations and he involves the patient in the decision-making process by asking him whether he wants the filling done. Following the patient's request regarding the price of the filling (turn 3), the doctor suggests the possibility of going to a clinic where the filling can be done for a less expensive price and addresses the patient (turn 6) to ask whether or not he wants to get his molars repaired. As we can see, the doctor is providing an option to the patient, but, in turn 7, the mediator is turning this option into an imposition. He presents the doctor's option as an action to be taken when he utters to the patient '*You have to go there*'. The patient (turn 8) keeps on asking repeated questions about price, which seems like a strategy to collect all the necessary information prior to making a decision.

As we can see in turn 9, the mediator initiates a reply to the patient's question regarding the price, without the doctor ever hearing the patient's question. It seems that the mediator leaves the doctor "out" of the interaction for a while to deal with the patient to obtain the patient's acceptance of the doctor's suggestions. Once the mediator has the patient's acceptance, he communicates it to the doctor. By imposing the doctor's option on the patient, it might be the case that the mediator can be seen to be aligning with the doctor and also trying to convince the patient to accept the doctor's suggestions. This situation might lead to patient's disempowerment, since it seems he has no option but to book a place at the doctor's suggested clinic.

5.3.2   Mediators' contesting moves when patients use disagreement strategies: low adherence to treatment

This sub-section examines the strategies that mediators employ when patients manifest verbal disagreement and attempt to negotiate healthcare issues. This analysis intends to shed light on whether mediators level out the power differentials between doctor-patient when patient disagreement arises in the decision-making and negotiation process. Instances where patients manifest disagreement were common in the study. In response to this, the most common theme was that patients should continue using the medicine prescribed and they were not allowed to make health-related decisions that contradict doctors' recommendations. Mediators usually showed

empathy for the patient, but at the same time acted as the doctor's advocate and did not allow patients to initiate decisions to challenge those being made by doctors.

The following extract presents a case of low-compliance or adherence to treatment. Non- compliance is a decision made by patients, when they fail to comply with medical advice and prescriptions. Patients do not always follow the doctor's order and sometimes they want to make their own decisions as consumers. Expressing disagreement is a way of expressing potential non-compliance (Cordella, 2007), therefore, non-compliance is a form of reasoned decision-making. Many factors influence compliance, including those that affect patients' beliefs about their illness and the benefits of treatment, the belief that medication can ameliorate symptoms, perceived costs of treatment, medication side effects, and barriers to treatment.

The following piece of data is taken from the same medical encounter discussed in Section 5.2.2. above, where patient's contradictions were analysed in Excerpts 6, 7 and 8. The focus here is on mediators' strategies to handle patients' non-compliance. Jaswinder, a patient from India with a complicated medical history was diagnosed with anaemia and thyroid problems some time back. She was prescribed anaemia tablets and she has chosen to stop taking them after experiencing some side-effects. The doctor (Dr. Esther) wants to know why she has stopped taking her pills. The extract starts at the point where the mediator (Karim) delivers the patient's original to the doctor, where the patient (Jaswinder) explains the reason behind her decision.

The mediator uses turns 89 and 114 to convey the patient's reasons for stopping to take the medication to the doctor. Immediately after (turn 115), the doctor addresses the mediator and refers to the patient using the third person by uttering '*Tell her that she has to take it*''. This utterance shows that the doctor's communicative axis is oriented towards the mediator and the patient is excluded from the exchange. The patient's initiative to make decisions is combined with the doctor's disagreement and it seems that the patient feels she has to follow the doctor's instructions. The patient does not seem to be allowed to make any choices and the doctor makes decisions without involving the patient. It also seems to be a case where the patient cannot negotiate medicine taking and treatment and is expected to "do as she is told".

Before actually delivering the doctor's originals to the patient, the mediator engages in a dyadic interaction with the doctor, in what seems an effort to elicit medical information that will later be conveyed to the patient. The patient carries on expressing her disagreement about medication (turn 119), which is followed by the mediator's attempt to support the doctor's instructions ("*The doctor says you need blood in your body*"). The patient again displays her discrepancies by using expressions such as '*But I have been taking these pills*' (turn 121) which might be seen to represent a challenge to the doctor's instructions. The patient's position on taking the medication is based on dissatisfaction and in exchange she is attempting to have a voice in the process. From this point, the mediator and the patient engage in a dyadic interaction where the mediator tries to reassure the patient. Karim shows empathy towards the patient by uttering "*I know, I know, I've understood the stomach problem you have*" and he provides explanations on what seems an attempt to seek an agreement. However, when the patient carries on expressing disagreement, Karim just tries to stop the argument by insisting that '*The doctor says you have to take the medication*'.

Excerpt 12

89 KARIM: Porque dice que tiene dolor de estómago por tomar esto y tiene pérdida de apetito también, nota como una inflamación en el estómago. Por eso. *Because she says she has stomach pains because of taking this medication and she has also lost her appetite. She feels acidity in her stomach. That's the reason why.*

(Several lines omitted where they talk about another medication for thyroids)

113 JASWINDER: //: O de naal meda kharaab ho jaanda hai. *I have stomach problems because of this medication*

114 KARIM: Ella dice que cuando toma eso tiene problemas en el estómago. *She says she has stomach problems because of this medication.*

115 DR. ESTHER: Dile que se lo tiene que tomar y que aparte yo le daré una pastilla para protegerle el estómago. *Tell her that she has to take it and that I'm going to give her a pill to protect her stomach.*

116 KARIM: ¿Pero lo otro del hierro y lo de la anemia lo tiene que tomar todo? *But the other [medicines], for the iron and anaemia, does she have to take all of it?*

117 DR. ESTHER: Sí, es que el hierro si no lo toma nunca se le va a pasar la anemia, y la anemia da cansancio, da dolor de cabeza. Entonces se lo tiene que tomar. *Yes. If she doesn't take the iron she's never going to get over the anaemia, and anaemia makes you tired, it gives you headaches. So she has to take it.*

118 KARIM: Keh rahi hai que. *Doctor says.*

119 JASWINDER: // main honu lagatar mina pura pita hai ede naal mede] // he tomado todo el mes estas pastillas] *I've been taking these pills all month.*

120 KARIM: Keh rahi hai que tanu jeri khoon di kami hai bohat zaida hai. *The doctor says you need blood in your body.*

121 JASWINDER: //par main honu lagatar mina pura pita hai ede naal mede vich sore hai rooti di phookh vi koi ni rahi hai, sirf hun main ikk vele bara vaje sirf roti khadi hai. , *But i have been taking these pills all month and I have an irritation in my stomach. I don't feel hungry, today I've only eaten once at 12 midday.*

→ 122 KARIM: Mede di problem samajh gaya main par masla e ve ke tussi hun duvaai ni khaaoge te jisam vich jeri dard hai na osi vajah ton hai, khoon di kami hon di vaja ton tvaddi takat ni hai te alag alag bimaariyaan nikal riyaan ne, kadi sir di kade gardan di. *I know, I know, I've understood the stomach problem you have. But the problem is that, if you don't take the medication it will get even worse. You have anaemia and that's why you feel weak and you have headaches and pains in your body.*

123 JASWINDER: Hun e shuru ho ghai hai na aithhon do vaje ton, hun char-panj vaje ithhon paye aanda ae, hun itna sakht ais passe nu ho jayega na, te main poora mina o pindi rehi, fer dard hoya hai. *I have this pain again now. A little later it'll spread to other parts and get worse. I've been taking the medication for a whole month and I have this pain again.*

124 KARIM: Khe rahi hai ke davai main darad di navi den laggi hai tvannu. *The doctor says she's going to give you another kind of medication for the pain.*

125 JASWINDER: Hun ais jagah aithhe hi paya hunda hai, bas es de pichhe fer hosh ni rehni, etna tez ho jaida darad. *The pain gets so bad that it's unbearable.*

126 KARIM: Matlab tussi jera hai na o davaai den laggi hai tvannu jera os di darad di. *The doctor says you have to take the medication.*

Although the mediator shows empathy towards the patient and expands explanations, the patient is not allowed to make medicine-related decisions and the mediator's role is to reinforce instructions around treatment. It seems that the mediator acts as the doctor's assistant, trying to convince the patient on the need to follow the doctor's instructions. The key question is the extent to which patients, as decision-makers, have the freedom to choose a behaviour that does not coincide with a clinical prescription. As Bissell claims "interactions with patients should not be viewed simply as opportunities to reinforce instructions around treatment: rather, they should be seen as a space where the expertise of patients and health professionals can be pooled to

arrive at mutually agreed goals" (Bisell, 2004, p. 851). Non-compliance represents a challenge to medicine in general and to the professional power accrued by doctors in particular. It seems that mediators do not always empower patients when they fail to follow doctors' instructions and they make their own reasoned decisions about treatments. It is likely that mediators reinforce power asymmetries when patient disagreement arises and they do not always empower patients when the latter fail to follow the doctor's instruction, leaving patients little option but to comply with the instructions they receive.

5.4 Concluding Remarks

This chapter has presented a range of excerpts from the recorded medical interactions. This data illustrated mediators' role in situations where patients seek information and clarification. Findings from the data on this theme suggest that cultural mediators' actions such as inviting patients to speak, helping them to seek information and adjusting the scientific doctors' language might lead to patients' empowerment. Section 5.1 provides evidence for the claim that cultural mediators play an important role in shaping the content of the translations given to the patients. One of the excerpts presented in this section illustrates how the doctor's scientific explanations about the patient's condition prompts the mediator to provide a translation adjusted to the patient's level, making concepts understandable so that doctor and patient can communicate. There is also evidence from the data that mediators have the habit to answer questions addressed to doctors and tend to use subsequent turns to monitor the accuracy of their statements. Based on the evidence from medical encounters recorded, it might be possible to claim that this practice does not lead to patient disempowerment since the potentially distorted information provided is adjusted and sometimes even expanded.

Section 5.2 presented data indicating that mediators tend to voice patients' concerns through echoes and feedback, which encourages patients to carry on expressing their concerns. An important finding is that some specific types of doctors' responses to patients concerns, such as *acknowledgement of emotions* and *information advice*, seem to be adequate responses to patients' expressions of emotional distress. On the contrary, actions such ignoring the words of the patients, switching to another topic and shutting the patient down can be considered of insufficient quality, failing to

acknowledge patients' expressed emotions (Mazzi, 2013). The data also showed that, in those cases where patients introduce refusals and complaints, cultural mediators tend to reinforce the doctors' position and align themselves with the institution for which they work, which might lead to the disempowerment of patients.

The analysis of mediators' management of patients' contradiction rests heavily on Encounter 3 (excerpts 6, 7 and 8). The level of conflict found in this particular encounter is atypical as the data as a whole. This discrepancy must therefore be acknowledged and the results obtained regarding management of contradictions would probably be different if additional encounters had been analysed.

Section 5.3 reported the findings on the empowering role of mediators when patients have to make health-related decisions. The findings demonstrated that, although mediators occasionally involve patients in the negotiation process, the most commonly pattern identified is that mediators tend to substitute patients in the decision-making process, which might have unintended consequences of disempowering the patient as well as the unintended outcomes of reproducing a given social order where the doctor is who usually assume responsibility for healthcare decisions. The next chapter offers a discussion of the findings from both Chapters Four and Five, relating them to the literature reviewed in Chapter Two.

Chapter Six

Discussion and Conclusion

6.1 Key Themes

The purpose of the present dissertation has been to provide insights into the role of cultural mediators in enhancing patients' empowerment during medical encounters. In order to understand the extent to which mediators are empowering patients, I have looked at whether or not they perceive themselves as having an empowering role in the first instance and then examined how their perceptions match what they actually do in medical consultations. In doing so, the aim was to answer the broader research questions set out at the beginning of the study, which sought to determine whether cultural mediation makes it possible for migrants to be empowered.

Since manifestations of patient's perceptions regarding empowerment were not gathered, my analysis was only based on the perceptions of the mediators' role in relation to empowerment as expressed by them in their interviews and how this was then played out in observed mediated interactions. Additionally, a key question which I was trying to address related to the kind of strategies (if any) mediators mobilize to empower patients. Moreover, my intention was to explore to what extent mediation is an effective tool in changing the status quo of social systems or if it mainly supports doctor-centred communication. By foregrounding issues of empowerment, I have sought to provide insight into complex connections between power relations, roles and institutional constraints among mediators who are assisting interlinguistic interactions in healthcare services.

6.2 Power Relations in Mediated Encounters

In this thesis, I have been concerned with discovering whether mediation is effective in changing the status quo of social systems or if it mainly supports doctor-centred communication. Answering that question requires an analysis of the relations of power understood in terms of the attribution of value to resources of knowledge. Bourdieu's (1991) idea that some resources of knowledge are more valued than others

helps us to understand how power is exerted at the clinic under study. As discussed in Chapter Four, access to power at the clinic is partly based on competence in the local languages (Spanish and Catalan) and specialized professional knowledge. Mediators can be seen to possess the language and socio-cultural knowledge that fit into the established institutional ways of behaving (Heller, 2007). However, their lack of specialized medical knowledge places them in potentially less powerful position and healthcare staff may as a result, question their role. In addition to their lack of medical background, the fact that mediators in Spain are not recognised as a professional group seems to be a further factor which generates doctors' mistrust of cultural mediators as was expressed in many of the interviews which formed part of the present study.

Although mediators possess the socio-cultural knowledge of patients for whom they are mediating, the data in my study confirm that this knowledge is a resource which the majority of doctors attribute a low value, which has consequences on the relations of power between doctors and mediators. Although some health staff value the possession of this resource, the prevailing view is that patients' cultural aspects are not relevant and, therefore, mediators' specialised competencies generated by forms of cultural capital are not generally considered a valuable resource among healthcare staff.

The findings in this study suggest that mediators may not level out the power differentials between doctor-patient when migrant patients introduce refusals or complaints, since they tend to reinforce doctors position when these doctors employ a discourse of power and authority. In other words, not only do mediators not help patients to deal well with doctor's dominant position in the interaction, encouraging patients to be proactive, but also they seem to strengthen the doctor's position of power. My analysis, therefore, shows that mediation may not be effective in promoting symmetrical power relations when patients introduce refusals or complaints which might represent a challenge to the healthcare provider and the institution, a situation which may lead to patients' disempowerment.

An additional issue addressed in the present study is patients' empowerment in the decision-making process, in particular, the communicative strategies deployed by mediators to enable patients to negotiate health-related topics. Although there is an on- going debate about whether people do really want to be empowered when it

comes to their healthcare (Lewin and Piper, 2007; Waterworth and Luker, 1990), my point of departure is that migrant patients need or even want to be empowered so that they can make their own informed choices. The data explored in this study shows examples where mediators' translations transmit the doctors' empowering inputs, allowing patients to take the necessary time to think and negotiate the type of treatment that better suit their needs. However, data also show instances where mediators' practices can disrupt the assertion of power and control in the interaction through the omission of utterances. There were cases where, once a decision has been made, patients' additional requests regarding this decision were omitted by mediators, without doctors even been aware that patients have further questions about the issue. It might be the case that mediators were trying to protect doctors and thus allowing communication to proceed smoothly.

A further pattern identified is that of mediators presenting doctors suggestions as normative actions that patients need to follow, reducing the possibility for patients to make choices. This is a significant practice since the empowerment that doctors deliver to patients is cancelled out by the mediators' actions. It might be the case that by presenting doctors "options and suggestions" as "impositions", mediators try to maintain the medical system trouble free, even though this might have a significant disempowering effect on patients. This particular practice may disturb the assertion of power and control, as mediators exert control over the encounter by trying to lead patients to accept doctors' suggestions.

As evidenced in Chapter Five, mediators tend to reinforce power asymmetries when patient disagreement arise in the negotiation process, leaving patients little option but to comply with the instructions they receive from doctors. This is quite evident is cases of low adherence to treatment, where patients have made a reasoned decision and fail to comply with medical prescription. Low-adherence represents a challenge to the professional power accrued by doctors and it is usually followed by doctors' disagreement strategies. The results reveal that patients' low adherence is normally combined with further disagreement strategies on the part of doctors. This is generally followed by strategies on the part of mediators that involve reassuring patients and establishing empathy with them, although their main aim seems to act as doctors' assistants and to try to convince patients to follow instructions.

The data in this Catalan healthcare services seems to confirm that the prevailing form of mediation is dialogic and transformative, therefore empowering migrant patients, in those cases when patients seek information and express concerns. Nevertheless, the research demonstrated that dyadic separation, preventing patients' participation and maintaining the status quo of the healthcare system, is the widespread form of mediation when patients make decisions and express refusals, which confirms much of Baraldi's (2009) research. It seems that a common practice adopted by mediators in the study is to limit patients' chances of expressing refusals and make decisions that contradict the doctors' perspective. In those cases, mediation seems to serve to maintain the power of the institution and the dominant discourse of the doctor is confirmed by the intervention of the mediator. It could be said that their conditions as migrant themselves and their weakness in the asymmetric relationship of power with doctors might lead them to try to preserve the trust of the institutional members often by protecting doctors from patients' inadequate actions that might question doctors' authority .

6.3 The Role of Mediators in Medical Discourse

Role dimension is another key theme running through the dissertation. Chapter Two discusses different role theories and frameworks in field to date, Chapter Four presents the mediators' perception of their own role and Chapter Five discusses the roles performed by mediators in medical interactions. As discussed in the Literature Review, researchers have observed mediators acting as institutional gatekeepers (Davidson, 2000), co-diagnosticians (Davidson, 2001; Hsieh, 2007), doctor assistants (Bolden, 2000), patient advocates (Haffner, 1992) and some variations of these roles (Hsieh, 2004), which indicates that role boundary is not always a well defined issue in cross-linguistic medical encounters.

Although the 2005-07 Healthcare Immigration Plan provided by Catalan Health Department outlines the features and competencies of cultural mediators, there is neither a formal and recognised job description nor a legal framework to regulate their activity in Spain. As highlighted in Chapter One, this situation is also applicable to interpreters, since the term interpreter and cultural mediator are used interchangeably in Spain. Additionally, the lack of recognition of mediation as a

professional activity implies that an adequate code of practice for mediators is not set out. This situation creates potential tensions between mediators and health staff since duties and role boundaries are not clearly established.

In this study, doctors' discourses showed contradictions regarding the role of mediators. Although they acknowledge that mediators are useful when it comes to overcoming communication difficulties and they do good work, sometimes they are seen by doctors as an unnecessary requirement solicited by the patient. According to some medical staff working at the clinic, the use of mediators should be avoided where possible. Many doctors believe that mediators' only responsibility in the medical encounter is to provide "accurate" and "complete" transmissions of messages, allowing the patient and provider to interact as closely as possible. The mediator is seen as someone whose main role is to pass on a message and many doctors appear to perceive him or her as nothing more than linguistic conduits. As outlined in Chapter Two, the monological conduit model, which suggests that the speakers are the only persons to have control over the process and content of communication (Hsieh, 2009), persists as the dominant one in community interpreting, and the conduit role remains the most predominant role in the code of ethics for medical interpreters (Kaufert and Putsch, 1997). In fact, many doctors in the study claim that patients' cultural characteristics are not really important and what they really need are interpreters to act as conduits, translating their questions and the patients' answers.

This seems is in line with what was observed in Davidson's (2000) study on the role of hospital-based interpreters, where interpreters were officially required to act as an "instrument", saying only what had been said by doctors and patients and acting as neutral machines of linguistic conversion. However, as demonstrated in Chapter Five, the in- depth analysis of the various practices revealed contradiction where doctors' perceptions and expectations of the mediators' role did not seem to match. Although many doctors perceive mediators as conduits whose only responsibility is to provide "accurate" transmissions of messages, they expect them to perform additional tasks, such as filtering out irrelevant non-medical information and steering patients towards relevant information. Therefore, it also seems that doctors are insufficiently aware of these extended roles performed by mediators and this lack of knowledge about the mediator's function and role results in a slippage between their perceptions and expectations of the mediator's role.

It seems that many doctors' goal continued to be to arrive at an accurate diagnosis and believed that there was no point in going into unknown areas of patients' culture especially when there was limited time during the consultation. Therefore, health information filtered through a mediator was considered unnecessary by the majority of doctors in my study as it is seen to potentially distort the doctors´ medical diagnosis. As a consequence, the knowledge base necessary for the practice of medicine renders doctors immune to social factors.

However, the daily practice of doctors shows how other kinds of knowledge come into the so-called medical practices. In fact, a number of doctors at the clinic recognise the relevance of mediators' role as cultural brokers to bridge the cultural gap between themselves and the migrant patients and helping doctors to "get to know" the patient. There was also the view that mediators have an important role because their linguistic and cultural knowledge of the patient might help the healthcare system to save money, since the number of tests that patients have to go through can be dramatically reduced. This seems to be an interesting point of view, where doctors seem to consider the mediators'' knowledge in utilitarian terms, thinking institutionally rather than in terms of the patients' wellbeing.

Mediators in this study acknowledged the provision of the appropriate linguistic conversion from one language into another as a crucial part of their work by actively assisting patients and doctors to overcome barriers to communication embedded in linguistic and cultural differences. They perceived their function as facilitating communication and believed that they were also responsible for leading and directing medical encounters, establishing triangular interactions where doctors address patients and patients address doctors. It seems that mediators' perceptions of their own role do not totally correspond with how they are perceived by some doctors, since they perceive themselves as facilitators of communication and not as a conduit. In fact, as we saw in Chapter Four, in interviews with mediators they claimed that they often perform a variety of extended tasks outside the mediated medical interaction, which means they are doing a job that is different from the job they are officially asked.

Interestingly, Davidson's (2000) study on the role of hospital-based interpreters discussed in Chapter Two revealed a similar interactional role of the

interpreters, who were officially required to act as machines of linguistic conversion, but they ended up assuming many additional tasks. The extended roles mediators in the study claimed that they perform outside of the consultation include (a) assisting patients to become familiar with the Western healthcare system, (b) assisting patients following a doctors' consultation by clarifying doubts, which represents assisting doctors beyond the medical encounter and, at the same time, establishing a therapeutic rapport with the patient, and (c) acting as co- interviewers eliciting information from the patient before the encounter. It seems therefore that there is a gap between the job that mediators are doing and their official job profile.

As discussed in Chapter Two, individuals' opportunities for social actions might be constrained by their limited access to certain forms of capital (Bourdieu, 1991). The knowledge of how the Western healthcare system works is a valued form of capital that migrant patients often do not have, which might constrain their opportunities for action. Helping patients to become familiar with the healthcare system can potentially increase patients' agency. However, it seems that mediators' knowledge of the Western healthcare system is a resource that is clearly undervalued by medical staff and by the medical institution. Mediators are underpaid for their linguistic and cultural expertise and their specialized competencies are not often recognized or valued within the clinic.

The second extended role identified by mediators, the provision of assistance following a doctor's consultation, takes place outside the medical consultation and sometimes even out of the mediators working hours. In this role, mediators function is that of paraphrasing information previously stated by the doctor as well as new information that was not conveyed by the doctor, which might give patients the power to make informed choices and decisions regarding their health. In Chapter Four, some mediators interviewed expressed that many migrants are used to going to the doctor in their home country and being prescribed with medication without undergoing previous testing. Mediators seemed aware of the fact that, once migrants are in their new host society, they feel bombarded with new information and it is usually the role of the mediator to explain to patients the reason why tests are required as well as other medical concepts with which they may be unfamiliar such specific illness like diabetes, and so on. Therefore, from the interviews data, it seems that mediators are aware of patients' lack of information and familiarity with medical

terms and tests and it seems that, on many occasions, they react to this by providing addition information to patients that might ultimately empower them.

6.4   Patient Empowerment Through the Mediator

The main question addressed in this study was whether or not mediators' performance opened a space for migrant patients to participate in the discourse event and the subsequent impact of these actions on patients' empowerment.   Earlier research in healthcare services (Bolden, 2000; Davidson, 2000) noted that interpreters aligned with medical systems and collaborated in maintaining a specific order inside the medical system, protecting doctors from patients' complaints, refusals and challenges to their authority.   In the same vein, Baraldi's (2009) research demonstrated that, although mediators' actions might occasionally give voice to migrant minorities and enhance patients' empowerment, the prevailing form of mediation in healthcare settings prevents patients' active participation. The present dissertation reinforces existing research in the field and contributes to the study of empowerment by further identifying the (dis)empowering role of mediators in three different scenarios and categories, namely patients seeking information, expressing emotions and making decisions.   The data analysed in this study has revealed how mediators' actions empowered patients when the latter seek information and expressed emotions. However, in decision-making processes and in those situations when patients expressed refusals or complaints, mediators tended to prevent patients' active participation and protected doctors from patients' actions that might challenge doctors' authority.

Regarding the first category, Patients Seeking Information, there were many occurrences in Chapter Five where mediators changed the content of the doctor's narrative as a strategy to facilitate patients' understanding of the doctors' technical terminology.   In order to facilitate patients' understanding of the medical dialogue, mediators tended to replace doctors' jargon with an explanation of its procedure, allowing patients to carry on asking for additional information. It is important to notice, however, that this mechanism makes certain assumptions about the patients' lack of ability to decipher the scientific or medical terminology used by doctors in their consultations. Following Hsieh (2010), it might be the case that the mediators in

the current study are trying to safeguard the welfare of the patient, intervening when language barriers are in place and allowing the patient to carry on asking for further information. According to Angelelli (2004), explaining technical terms is one of the behaviours often adopted by cultural mediators that evidence their visibility and impacts on the information that is exchanged. Although this strategy might lead to doctor-mediator conflict over their expertise and authority since the mediator may be seen to take control of the doctor's narratives, this strategy may ultimately lead to patients' empowerment since it facilitates better communication between doctors and patients in interlinguistic interactions.

Furthermore, in the process of information exchange, mediators in the study also adopted invitation formulas such as 'Do you understand?' and/or 'Do you want to ask about anything else?' to offer the possibility to patients to request further clarification. In addition to these invitation formulas, a further practice identified following a patient request for information was the establishment of a dyadic interaction mediator/doctor- mediator/patient. As we saw in Chapter Two, interpreted-mediated interactions do not always follow a triadic pattern (Wadensjö, 1998), but often assume dyadic configurations where the interaction involves just two of the three participants. Episodes of dyadic sequences alternation formed a frequent pattern in the medical encounters examined in the current study and there are numerous occurrences in the data where mediators avoided after-turn translation to further engage in inter-sequence interactional structures.

In this first phase of the after-sequence structure, mediators usually elicited information from doctors and tried to collect as much information as possible. It seems that they also double-checked whether they understand the doctors' utterances before actually delivering the information to patients. In the second phase of the after-sequence structure of talk, dyadic interactions between mediators and patients were usually allowed by doctors and they were established with the main aim of clarifying what the doctor said following a patient's request for information. As Baraldi and Gavioli (2010) claim, while dyadic sequences temporarily separate the interlocutors, they also provide an opportunity for mediators not only to elicit information from doctors, but also to subsequently provide comprehensive clarification to patients, which might ultimately lead to patients' empowerment if their function is to provide detailed information to the patient.

Manifestations of patients' empowerment due to mediators' actions were also identified in scenarios where patients were expressing emotions. There were a significant number of occurrences in the data where mediators acknowledged patients' feelings and formulated them in translation. Furthermore, instances where mediators' interventions were vital to make doctors aware of the patients' concerns were frequently identified in the data. Echoing the patients' utterances and supporting patients' tentative emotional expressions with feedback was a common strategy adopted by mediators, which helped patients to go on formulating and expressing their fears and potentially lead to patients' empowerment. This echoing strategy is one which was already identified in a previous study conducted by Baraldi (2009), where he demonstrated that patients' empowerment is achievable when mediators support patients' emotional expressions by echoing the patients' utterances where they express their worries and concerns. Moreover, the use of expanded renditions, where the mediator includes more explicitly expressed information than the preceding patient's original utterance, seems to be a strategy often used by mediators to prompt doctors to pay attention to the patients' fears.

An additional strategy identified in the data was that of mediators' initiative to ask further probing questions to elicit the patients' fears. According to Angelelli (2004), through this behaviour the mediators exercise agency and evidence their visibility. As they become the owners of text, their visibility increase and they impact both on the information that is exchanged during the encounter and on the doctor/patient relationship. Technically, the mediator substitutes the doctor and asks questions that the doctor has not asked. It could be argued that mediators are doing more than they actually should be doing and this strategy might be problematic since it may be seen to overstep the doctor's role. However, there were no examples in the data that suggested that the mediators were overstepping their role. As a consequence, this strategy might be seen as a useful mechanism to empower patients as long as it allows them to provide more detailed expression of their concerns.

In those cases where the patients expressed concerns containing complaints regarding treatment, from the data analysed it seems that mediators tended to establish exclusive relationships with doctors and aligned with them as a strategy to deal with patient's complaints, which might be seen to lead to patients' disempowerment. In those

circumstances, mediators' tended to distance themselves from patients and established an exclusive relationship with the doctor to reduce the patient to a passive role of further expressions of concerns and complaints. As we can see, this might be regarded as an institutionalization of disempowerment, where mediators do not seem to actively set out to disempower patients. However, in an attempt to protect the doctor's authority from the patient's complaints and challenges, it seems they are favouring the doctor over the patient and potentially disempowering the patient by the fact that they are not willing to take any responsibility for patient's complaints.

A similar pattern of patients' disempowerment was also observed in scenarios where patients have to make decisions. Although the data shows cases where doctors actively involve patients in negotiating treatment and mediators facilitate patients' involvement initiated by the doctor, the most common pattern identified was that of mediators substituting patients in decision-making. As Baraldi (1999) claims, the mediators' habit of substituting patients in the decision-making process may be a way to protect the doctors from potential patients' challenges to their authority, which might have a significant disempowering effect on patients. However, there is no evidence in the data that mediators are doing so consciously. Giddens' (1984) notion of agency and the unintended consequences of actions over time and space helps to understand the role that mediators play in this reproduction of a particular institutional order. The practices of substituting the patient by the mediator (agent) might have unintended consequences of disempowering the patient as well as the unintended outcomes of reproducing a given social order where the doctor is the one who usually assumes responsibility for healthcare decisions. Therefore, this might be regarded as a further case of institutionalization of disempowerment. Despite mediators do not seem to set out to disempower patients, it seems they are favouring the doctor and potentially disempowering the patients by not allowing them to make decisions that might contradict the doctors' views.

A further pattern identified where patients' disempowerment was also evident is in the mediator's initiative to impose a specific action on the patient. It was usual for mediators to present doctors' options and suggestions as normative actions, thus reducing then the possibility for the patient to make choices. Additionally, it seemed that mediators do level out power relations between doctor-patient when patient disagreement arises in the decision-making and negotiation process. In those

instances where patients manifest disagreement, mediators tended to show empathy for patients, but at the same time acted as the doctor's advocate and tended not to allow patients to initiate decisions to challenge doctors. In most of cases, patients were told to continue using the medicine prescribed and they were not allowed to make health-related decisions that contradicted doctors' opinions. The key question here is the extent to which patients, as decision-makers, have the freedom to choose a behaviour that does not coincide with the doctor's view or with a clinical prescription.

On the basis of the analysis of the encounters, it is possible to conclude that mediators tend to intervene as providers of opportunities to talk, facilitating the patients-seeking information process and allowing them to express emotions, which might lead to patients' empowerment. However, as noted in previous research (Bolden, 2000; Davidson, 2000), it seems that mediators collaborate with doctors in maintaining a specific order inside the medical system, protecting it from patients' potential challenges, limiting patients chances of introducing contradictions or making decisions which may challenge doctors' authority. In those circumstances, mediators in the study tend to align with the medical system and exclude any kind of contributions that might disturb the doctor-centred communication from translation.

6.5 Institutional Constraints

The focus on empowerment also connects to issues of institutional constraints. In particular, time constraints seemed to be an overriding factor which influences how medical interactions take place, and this was evident in the mediators' comments in Chapter Four. Institutional constraints come from several sources: institutional culture, hierarchy, policies, regulations, and excess of bureaucracy, and all may present challenges to the mediator's choice of roles These institutional constraints may also give way for the institution to disempower mediators, putting them in a position where they cannot therefore empower patients. As discussed in Chapter Four, time is one of the most important constraints mediators and doctors have to deal with. The institutional culture often treats the doctor's time as a scarce resource and can be seen to pressurize mediators into protecting this resource.

Institutionally, mediators are officially required to act as an instrument, saying only what has been said. However, they are encouraged to keep the medical interview

short and they are normally engaged in furthering the doctor´s agenda. The majority of mediators in the study talked about how time constraints limit their choice of roles. They are often concerned about saving the doctor´s time and that would be the reason behind certain practices. In particular, they claim that, as a time-saving mechanism, they elicit information from patients before the medical encounter takes place in order to save doctors' time. By doing so, they act as co-interviewers and align themselves with doctors, therefore collaborating in maintaining a specific order inside the medical system. This is in line with Davidson's (2000) claims presented in Chapter Four , where he states that mediators adopt the role of co-interviewers not only because of time pressures, but because they are institutional insiders and they align themselves with the institution.

A further time-saving mechanism that mediators claimed to use was that of answering patients' questions directed at the doctor. According to Davidson (2000), the mediators' habit of answering questions might be viewed as a way of insulating the doctor from patients' challenges to its authority or it might also be a way for the mediator to try to save the doctor's time. There is no explicit evidence, however, from direct questioning to mediators in their interviews or in the observed medical encounters that mediators are using the strategy of answering questions intentionally to insulate doctors from patients' challenges or to disempower patients. Since mediators claimed the main reason behind this practice was to save doctors' time, this might represent an instance of institutionalization of disempowerment. It seems that mediators are not actively setting out to disempower patients, however, in an attempt to save doctor's time they are in fact favouring the doctor over the patient. It might also seem that the patients' time is not as valuable as that of the doctors' and this time-saving mediators' practice might potentially disempower patients by reducing the amount of time they have with the doctor and synthesizing questions and answers.

The volume of patients appears to be a further constraint which give rise to competing mandates for doctors and mediators and can make brief medical interviews appear as a necessity. This was evident in doctors' comments in Chapter Four, who claimed that they find time management and the setting of an agenda more difficult in encounters with mediators than in monolingual encounters. It was also evident in mediators' comments in their interviews, where they claimed that the volume of patients was an additional constraint interfering with their choice of role. As a consequence, it might

be the case that mediators are forced to shift between roles in order to meet the demands of doctors and patients.

6.6 Mediators and Patients Sharing the Same Background

The issue of patients' empowerment through the figure of the mediator is linked directly to questions about how patients may actually perceive mediators. In Chapter Four, some mediators claimed in their interviews that patients are sometimes reluctant to explain their problems in front of them for fear of being exposed. Patients sometimes mistrust mediators due to their affiliation to specific ethnic group (Barsky, 1995) or their language (Pöllabauer, 2005). As members of the same community who share the same cultural and/or religious background, it seems that, on some occasions, migrant patients distrust mediators on certain levels and feel disempowered by them.

Although the importance of sharing the patients' background is widely acknowledged by doctors and mediators as a crucial requirement to gain a deeper understanding of migrant patients, some mediators in this study also claimed how this may actually be a potential source of tension. Patients might fear that the information they provide to the mediators, such as admitting they have drunk alcohol or have had sexual relations with people with different religious background, might be used outside the medical consultation and spread in their community. However, as one of the mediators in the study claimed, this distrust arises simply because some patients do not fully understand what a mediator is and what their role are, which again can be disempowering to patients in itself. In the recorded interactions, there is no single case where doctors ever explain what a mediator is to patients.

Manifestations of patients' distrust in the mediators were not found, however, in any of the medical encounters recorded. Despite evidence of distrust was not present in the interactions, future efforts should address conditions under which mediators can build trust when they deal with migrants with whom they share the same background. Trust building strategies, reassurance and confidence building measures are therefore issues that mediators would need to develop in order to avoid patients' distrust.

6.7 Mediation Practice and Service Provision versus Interpreting

As outlined in Chapter One, there is considerable confusion about the difference between an interpreter and a cultural mediator. The term 'cultural mediation' is sometimes used as a blanket term to cover both translation and interpreting and the terms interpreter and cultural mediator can appear synonymous. In terms of the spectrum of service provision, Spain does not provide fully comprehensive mediation services, including full-scale training, national register of mediators, accreditation, a professional body with agreed performance standards and adequate remuneration. As a consequence, mediators' practice continues to be unmonitored and mediators hold a low prestige, with lack of recognition and low remuneration.

Despite the considerable confusion around the term, however, the clinic staff seemed to consider mediators and interpreters as different professions. In Chapter Four, the majority of doctors claimed in their interviews that working with 'mediators' is not crucial; in fact, they would need 'interpreters' only. From the point of view of medical doctors working at the clinic, what they say they need are interpreters in order to orally translate their questions and the patients' answers. A considerable number of doctors viewed mediators as language conduits, with little power over the medical encounter or the relationship between patient and provider. As a consequence, mediators were expected to pay close attention to the meaning of the message expressed by the parties to convey that same meaning into the other language without omissions or additions.

It seems, therefore, that doctors often use the term "mediation" in juxtaposition with the more prestigious role of "conference interpreting." Expressions regarding mistrust of cultural mediators were also expressed by doctors when they claimed that health information ''filtered'' through a mediator could distort doctors' medical indications. The prevailing view among doctors was that they only need interpreters to translate their words and the patients, and mediators' interferences should be avoided. As Angelelli reminds us, this perception of invisibility "supports the idea that only one meaning exists for each verbal utterance and that this meaning is not subject to co-construction." (Angelelli, 2004, p.7). Therefore, it seems that doctors believe that mediators can alter the patient's and/or doctors' message by providing their own renditions and filtering primary interlocutors'

message. Hence the wish to work with (conference) interpreters to safeguard message accuracy and make sure their participation is limited to language switching. It seems that it might be way for doctors to exert control, since they fear mediators might alter their discourse and the patients'.

An in-depth analysis of the medical interviews shows a contradiction between doctors' perceptions and expectations of mediators. Although in their interviews doctors claimed that they want language conduits only, in the encounters they often request mediators to explain different procedures to patients, such as how to make an appointment, the need to come to collect results, and so on. Therefore, although they perceive them as conduits, it seems that they expect more of them than the simple transmission of messages, giving them responsibility to explain procedures to patients and therefore making them active participants. This mismatch between doctors' perceptions claimed in interviews and expectations observed in medical encounters makes it possible to claim, with some degree of certainty, that doctors' claims do not support their behaviour in medical encounters.

6.8 Mismanagement of Multilingualism

The implementation of multilingual practices in response to the new demands posed by the arrival of migrants has been analysed in different institutional settings, including education (O'Rourke, 2011), legal (Perez and Wilson, 2007) and healthcare (Moyer, 2010). These studies claimed that, despite the multilingual realities of different institutional settings (hospitals, schools), the linguistic needs of multilingual customers have not been addressed by these settings whose linguistic *habitus* (Bourdieu, 1991) have remained monolingual (O'Rourke, 2011). Furthermore, as witnessed in the healthcare clinic under study, the construction of multilingualism potentially generate conflicting views about the way in which the implementation of multilingual practices should be managed.

Institutional multilingualism at the clinic is based on top-down management practices where decisions about how to deal with linguistic and cultural diversity are taken by healthcare administrators with the authorization of the Catalan Institute of Health (ICS).

The meetings I had during fieldwork with healthcare administrators (see Appendix E) revealed that decisions taken by the institutional officials do not correspond to the communicative realities of migrant patients and medical staff. In my meeting with Mr. Alonso, a senior officer responsible for the Immigration Programme, he claimed that the Catalan Institute of Health (ICS) has developed material to deal with migrant patients. However, this material (videos in several languages) was kept in a cupboard in his office and it was not distributed to healthcare centres. It is therefore unclear why important resources are spent on producing material for doctors when the medical staff do not have access to it. In the same vein, Dra. Fernández, a senior paediatrician, claims in her interview (Appendix B) that the ICS produced a publication for doctors with vocabulary list of body parts in Spanish and Punjabi, but healthcare staff find it awkward to use it.

One of the most striking mismatches found was between the discourses of institutional officials and their actual behaviours and decisions. Although the *2009-2012 Citizenship and Immigration Plan* designed by the local government authorities (Generalitat de Catalunya) stated that the idiosyncrasies of each healthcare centre would be considered and measures to deal with the needs of each particular clinic would be implemented, some doctors in their interviews criticised that the institutional plans announced by the Department of Health were not implemented. As Dr.Miriam stated in her interview, clinic managers have no power whatsoever to decide the staff who should be working at the centre to fit the multilingual patient's population they receive and it therefore seems that decisions taken by officials do not correspond to the everyday communicative realities of migrant patients and medical staff.

The institution is therefore using public resources to implement multilingualism, but as Moyer claims "this sort of multilingualism is not useful to migrant patients or the medical staff who attend them" (Moyer, 2011, p.1210). These forms of management in the public sector, where healthcare administrators take decisions about how to deal with multilingual diversity with limited input from migrant patients and doctors, create basis for further reflection and the need to improve current practices.

In Chapter Four, doctors discussed the lack of availability of mediators in shifts where doctors who visited a considerable amount of migrant patients were on duty.

The fact that mediators are only partially available or not available at all on certain shifts is one of the contradictions that arise with respect to intended institutional actions to improve communication and the limited usefulness of those actions for some doctors and patients. Additionally, the uneven distribution of migrant patients among health staff leads some doctors to have 80% of migrant patients with communication needs to visit on a daily basis, while other doctors only have to visit a very small percentage of migrants.

6.9   Practice and Theoretical Implications

This thesis has demonstrated the complexities of cross-cultural and cross-language medical interactions, where different cultural expectations, different knowledge of medical language and different power potential in the negotiation for consent are at play.

This section presents the implications of the discursive practices presented for understanding the ways in which mediators taking part in cross-linguistic and cross-cultural communication in medical settings are or are not able to help patients being empowered. One of the practice implications has to do with the education of healthcare staff. It is important that the education of doctors and nurses is more inclusive of other cultural points of view. In line with Angelelli (2004), a further relevant feature of healthcare staff education is that they must be aware that they may not be in complete control of what is said in the medical interaction when they are working with mediators.

A further practice implication is related to the education of mediators. Educational programmes should include medical terminology, standards of practice, implementation of ethical principles and protocols.   Additionally, professional organisations should encourage research to explore the role of the mediator in multilingual healthcare settings. Further study is needed in order to understand the impact of the mediator on patient's empowerment. The need to implement training programmes for both healthcare providers and mediators working in healthcare systems to become more aware of their role of coordinators in the interaction has already been highlighted in previous studies discussed in Chapter Two (Baraldi, 2009;

Davidson, 2001; Perez and Wilson, 2007). The present study also highlights the need for training doctors to be able to work in a professional way with mediators, enabling them to work as a professional team and in complementary partnership. Given these practice implications, medicine programmes may need to make several curricular changes to better prepare their doctors to work with mediators. In particular, how doctors act through their relationships with mediators may require shifting to a more collaborative learning model and a more balanced distribution of power.

This thesis illustrates that the issue of patients' empowerment through the figure of the mediator is linked directly to questions of how healthcare professionals actually consider the mediator's role. The practice of mediation is not highly valued at the clinic under study. Mediators' lack of specialized medical knowledge places them in a potentially less powerful position and healthcare staff as a result questions their role. As claimed in some interviews with healthcare staff, doctors do not control the interpretation and they fear that mediators, who lack health training and medical background, can misinterpret their words and provide an inadequate interpretation to patients. Although medical terminology can be particularly challenging, in an ideal situation, mediators would be informed of the nature of an assignment in advance and would have time to prepare terminology. Unfortunately, the most likely scenario is that the mediator is called urgently to an appointment and does not receive any information on the nature of the assignment.

Additionally, the fact that mediators in Spain are not recognised as a professional group seems to be a further factor that generates doctors' mistrust of mediators. This mistrust was expressed verbally in doctors' personal interviews. Some medical staff claimed that the lack of professional recognition leads to a poor remuneration, making the quality of the mediation service precarious and not reliable. This is in line with existing literature in interpreted- mediated interactions, which has also underlined among other characteristics the lack of mediators' professionalization that is manifested in various ways such as mediators' poor remuneration (Hale, 2007) and the lack of respect by healthcare providers (Salaets and Van Gucht, 2008).

Moreover, since the prevailing view among doctors is that patients' cultural characteristics are not relevant, mediators' socio-cultural knowledge of patients is a

resource which the majority of doctors attribute a low value, which has consequences on the relations of power between doctors and mediators. Under these circumstances, where healthcare staff sometimes disempower mediators, as migrants themselves, patients' empowerment through the figure of the mediator might not be easy to construct and achieve.

The data from the Catalan healthcare services confirm that mediators' actions may enhance patients' empowerment, in particular in those situations when patients seek information and express emotions. However, when patients express refusals and in decision-making processes, mediators do not put forth the patient's agenda and the reasons they act in this way seems to be a result of their disempowered position within the clinic. It would be therefore suitable that healthcare institutions provide mediators with an official status distinct from that of the doctor, acknowledged as professionals in their own right.

Regarding theoretical implications, a theory of interpreting and mediation should integrate all the complexities of this communicative act and should look at mediation in its entirety context. External factors which derive from the nature of healthcare institutional contexts with communication to a culturally and linguistically diverse clientele have sometimes been overlooked. Some factors come about by virtue of the difference in education of the interlocutors. Healthcare staff are not generally trained in how to use mediators, beyond being told how to call them to come mediate. The training given to mediators is often scant, often being the requirement for becoming a mediator a good grasp of the languages needed at the health centre. Therefore, an integrative theory of mediation should account for the differences in education of the interlocutors and the efforts they make to bridge the communication gap.

A further important factor that should not be overlooked by a theory of mediation is the impact of institutional constraints of the interaction. For example, in medical interactions, time pressures seem to be an overriding factor which influences how interactions take place, which was evidenced in my interviews with doctors and mediators. The amount of time patients spend waiting for a doctor, the amount of time patients and doctors have to spend waiting for a mediator and the brevity of the doctor-patient-mediator encounter add scarcity of time in medical institutions seem to be factors affecting mediated interactions.

An integrative theory should also consider the mediator as an active individual who displays agency in the interaction, coordinates the three-way interaction and has the ability to exert influence on the distribution of power within the exchange.

6.10 Conclusion

The concept of empowerment is ill defined in the healthcare context and its meaning remains contested in the wider literature. The practices of healthcare staff and mediators participating in this situated study suggest that this concept translates into providing migrant patients with information, allowing patients to express emotions and facilitating informed choice, but managing patients' contradictions and patients' decision making remain within the boundaries outlined by the healthcare provider. Future research should explore further the meaning of empowerment and test the above against new findings to help identify a range of patient empowerment indicators for clinical practice. Such research should not be an objective on itself but should aim to achieve change for minority patients and health professionals.

Additionally, there is a need for more data-driven studies on what happens in mediated medical interactions, in particular on the roles mediators play and with what implications on patients' empowerment. This would include studies similar to the one presented here, conducted with doctors, mediators and migrant patients with the aim of establishing whether mediation is effective in empowering patients' voices. Such analyses should also be extended to different socio-medical contexts such as psychiatry, paediatrics and general practitioner, so as to permit comparisons among diverse medical specialties.

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