UDK: 314.7:614.2](450.45)
614.2:314.7](450.45)
316.73-054.7:614.2](450.45)
Izvorni znanstveni rad
Primljeno: 13. 05. 2008.
Prihvaćeno: 22. 09. 2008.

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Intercultural and Interlinguistical Mediation in the Healthcare System: The Challenge of Conflict Management

SUMMARY

Nowadays, young women and their children are the most important migrant users of healthcare services. In particular, these people may encounter different cultural constructions of health, disease, therapy, and motherhood. The observed difficulties in intercultural communication encourage healthcare systems to promote mediation. Mediation consists of the intervention of a third person, who promotes reciprocal understanding and acceptance between participants. The research presented in this article focuses on the intercultural communication that is produced in these services between healthcare personnel and migrant patients. To achieve this goal, the research aims at integrating different theoretical and methodological approaches: conversation analysis, in order to observe the interaction between healthcare personnel and patients, pointing out the cues of the participants' turn-taking sequences; analysis of the cultural presuppositions of the healthcare system as a communication system with a specific function in society, by highlighting contextualization cues, that is, cultural presuppositions that steer the interaction system, which result from the wider social context and are cues of the cultural identities that characterize it. It was observed that the patients in most cases have very few opportunities to answer the physicians' questions or to pose questions or doubts. Substituting the patients as the main participants in interactions, the mediator never refuses the physicians' indications, never expresses doubts, and never asks the patients if they have some reason to doubt or refuse. In these cases, interlinguistic and intercultural mediation de-emphasizes the importance of the larger social context, of the durability of relationships between the parties, and of their social and political recognition.

KEY WORDS: migration, Emilia-Romagna Region, interlinguistic and intercultural mediation, conflict management, political recognition, pregnancy, childhood

1. Introduction

This paper introduces a research program designed at the University of Modena-Reggio Emilia (Department of Language and Culture Sciences); this program concerns the healthcare personnel-migrant patients interactions, produced within the services in the districts areas of Modena and Reggio Emilia in Region Emilia Romagna (Northern Italy).

Migration flows have been, and still are, very much intense in the two district areas above. Recent data (2008) indicate that immigrants are 8.9 % of resident population in the Modena district and 10.2 % in the Reggio Emilia district. In both cases, the largest cultural community comes from Morocco (25.4 % of the whole migrant population in Modena and 16.3 % in Reggio Emilia), followed by the Albanian community (11 % in Modena, 11.3 % in Reggio Emilia). In the district area of Modena, Tunisian immigrants are also numerous (8.9 %), whereas in the area of Reggio Emilia the Indian (9.2 %) and the Chinese (10.3 %) communities are quite large. There are three more ethnic groups which are particularly big: the Ghanaians, especially in the Modena district, and the Pakistani and Ukrainian in the Reggio Emilia district.

Migratory flows imply considerable consequences and the need to change is a priority for many institutions. Healthcare services are among these institutions, since they are in frequent contact with migrants, and consequently, they have to deal with particular communication problems in order to treat their illnesses. In healthcare services involving migrants, doctor/patient communication may become intercultural, that is, it may point out a diversity of cultural presuppositions and cultural identities which may produce problems in reciprocal understanding and acceptance (Baraldi, 2003; Castiglioni, 2005; Gudykunst, 2005; Samovar-Porter, 1997; Ting-Toomey, 1999) due, for example, to the different meanings and values attributed to illness, to therapy and to the ways of participating in the interaction. "Different meaning and values" are not conceived as components of ontological cultural identities: they emerge only if they are observed in communication, and they are cultural differences only in the measure they are attributed to cultural specificities.

Cultural differences do not depend on the participants' cultural origin or belonging, but they are decided through a communication process, as has been recently demonstrated in conflicts between East Asian host-nationals and Western expatriates in workplaces (Brew and Cairns, 2004). Cultural differences are produced in communication (Baraldi, 2005; Pearce, 1994; Koole and Thije, 2001). The problematic nature of a communication process which is *observed* as an intercultural communication process is not inferable *a priori*; it must be observed as it emerges in communication, only by moving "from the perspective of communicative actions as being *shaped* by culture to seeing them as *shaping culture*" (Koole and Thije, 2001: 585), that is, making actual communication processes an object for a sociological analysis.

Young women and their children are the most important migrant users of healthcare services in the Modena (67.4 % of migrant users) and Reggio Emilia (70.1 %) districts. In particular, these people may encounter different cultural constructions of health, disease, therapy, motherhood. There are serious difficulties in accepting new forms of body treatment, as body is traditionally "ordered" by specific normative structures that guide female patients' actions. As a result, healthcare services, in which intercultural communication is predominant, are those belonging to the nursery-infantile and women areas, whose activities address the needs of migrant families, particularly young migrant women and their children. Young women and their children are very much exposed to cultural changes, because of the significant cultural differences concerning the

conditions of children and women all over the world, with reference both to family roles and relationships between individuals and the external world. Therefore, it is very probable that these young women, children and adolescents will experience a radical change within the social positioning and cultural identity proposed to them, as a consequence of the evolution in the relationship between them and a new society; this encourages healthcare system to promote mediation.

As many Western healthcare services are increasingly attended by foreigners, interlingual and intercultural mediation plays an ever more important role in them. Emilia Romagna Regional Law 5/2004, affirms that "The Region promotes, also through the Local Health Units and Hospitals, the development of informational interventions aimed at immigrant foreign citizens, *along with activities of intercultural mediation within the social-health field*, finalized at ensuring appropriate cognitive elements, in order to facilitate access to health and social-health services".

With regard to women and their children, the Law 5/2004 makes another reference to mediation by affirming that "Immigrant women are guaranteed treatment equal to that offered to Italian women, as well as social welfare, in compliance with the legislation relevant to family consultories, *promoting and sustaining social-health services that are attentive to cultural differences*. The guardianship of minors, under the age of 18, is also guaranteed, in compliance with the principles established by the Convention on the rights of the Child, held in New York on November 20th, 1989 and ratified with Law n. 176, dated May 27th, 1991". In order to serve as a mediator in Emilia Romagna's hospitals and consultories, it is necessary to follow a 400 hours course. A high-school certificate is required for enrolment. The Emilia Romagna Region finances two courses for mediators each year in any of its districts.

The research presenting herein focuses on the intercultural communication which is produced in these services between healthcare personnel and migrant patients, with the mediator's intervention. Mediation consists of the intervention of a third neutral person, who promotes reciprocal understanding and acceptance between participants (Bush and Folger, 1994; Ceccatelli Gurrieri, 2003; Luatti, 2006; Winslade and Monk, 2000). Mediation is widely used and studied in medical systems (Baraldi, 2006b; Bolden, 2000; Cambridge, 1999; Davidson, 2000, 2001; Meyer, 2002; Meyer and Buhrig, 2004; Pöchhacker and Kadric, 1999; Tebble, 1999), which require systematic communication between healthcare providers and patients (Ulrey and Amason, 2001).

The cultural features of Western medical communication, which represent the framework of mediation in the healthcare system, can be summarized as follows: information is coded through a distinction between health and illness, which guides relevant communication between care providers, particularly physicians, and patients (Luhmann, 1983). Participants assume particular roles, which are relevant for care providing: in particular, the physician's role is to provide technical information based on long-term training; physicians are experts who deserve trust for their technical competence. The main expectations are cognitive, concerning adaptation to physicians' recommendations. In particular, the physician's role provides technical information based on long-term training; physicians are experts who deserve trust for their epistemic authority

(Heritage and Raymond, 2006). Within the healthcare settings we analyzed, mediation materializes in triadic interaction involving an interpreter/mediator as a third party in the communication process between individuals speaking a different language and following different cultural orientations, where interpreters/mediators assume the role of promoting linguistic interpretation and cultural relations. Hence, we refer to interlingual and intercultural mediation.

The empirical observation of mediation is particularly interesting for studying the forms of intercultural interactions. The integration between translation and the promotion of co-ordination between the parties in interaction is a complex one and while, on the one hand, sole translation does not seem sufficient to assure reciprocal acceptance of cultural expressions, what interpreters actually do, as intercultural co-ordinators in the interaction is still a matter of inquiry (Gavioli and Baraldi, 2008). While interpreters' co-ordination activity has been, at least partly, examined in its cognitive function of asking or providing clarification about linguistic or cultural interactional problems, there are other aspects of co-ordination which are less explored, among them the issue of conflict management.

This article takes an empirical approach and investigates processes of interlingual and intercultural mediation when an emerging conflict between the expectations of the medical system on the one side, and the behavior or attitudes of the patient on the other, is observed. Interlingual and intercultural mediation is particularly interesting for studying conflict management. In their co-ordination of contrasting communicative actions, interpreters/mediators inevitably select their actions, and by so doing, they also select their interlocutors. Consequently, mediation has strong effects on healthcare communication, as it conditions the meanings of information and actions.

The present article focuses on the issue of conflict management in interpreted medical interactions. Before discussing effects of mediation on communication and conflict management in the medical interactions that we analyzed, it is necessary to offer a theoretical definition of the objects of our analysis, that is, conflict, conflict management and mediation.

2. Theoretical background of the research: conflict, conflict management and mediation

According to Luhmann (1984) a *conflict* can be observed as a *communicated* contradiction, that is, a communicated refusal which elicits a reaction of refusal. In this perspective, conflicts are communication systems in which refusals elicit other refusals in response.

Refusals create uncertainty and doubt, lack of trust in continuing communication and in obtaining some social order or common ground. Hence, conflicts can be destructive for their long-term persistence and their relevance for the communication systems in which they arise: conflicts are communication systems which tend to substitute previously ongoing communication systems (e.g. healthcare), destroying their structures.

Paradoxically, conflicts do not only destroy communication opportunities, but, in the meanwhile, they also assure the reproduction of communication through refusal: a

refusal is a blockage of the existing communication, but it is also a starting-point for a new communicative process. Conflicts can create conditions of change in existing social systems (Moscovici, 1976), questioning stable social structures and opening up new possibilities for communication; thus, conflicts can be observed as productive, and social systems can protect themselves *thanks* to the changes that they produce, which avoid their structural rigidity (Luhmann, 1984).

Conflict management means conditioning conflicts (Luhmann, 1984), that is, structuring them as immune systems, which transform the uncertainty produced by refusals into opportunities for change; that is, transforming destructive refusals in productive interactions. A conflict can be conditioned and managed through the intervention of a third party, which introduces a new form of uncertainty, one concerning the conflicting positions. The ways in which a third party can prevent conflicts from becoming destructive or help to gear them towards productive conflict management appear to be particularly relevant for research (Deutsch, 2002). Two ways of involving a third party in a conflict may be observed, assigning to it two different functions: 1) distinguishing and classifying the conflicting parties as a right party and a wrong party (*judgement*); 2) helping the conflicting parties to appreciate each other and to work together (*mediation*).

These are two different forms of introducing uncertainty within a conflict through external intervention: judgement introduces uncertain conditions by siding with a party, while mediation introduces uncertain conditions facilitating co-ordination between the parties (Pearce, 1994). Judgement and mediation are communicative structures that increase opportunities for refusals and change: they treat refusals as less risky, showing that their management is possible (Luhmann, 1984). Judgement and mediation can be considered as ways of promoting conflicts, creating an opportunity for their resolution, and in this way making them productive.

The intervention of a third party introduces a treatment of the conflicting positions in communication. A third party can enhance two possible forms of conflict management: 1) *judgement* that is siding with a "right" party against a "wrong" party; 2) *mediation*, that is, co-ordinating the conflicting parties, helping them to appreciate each other and to work together.

Mediation is an alternative to judgement in promoting conflicts: "The mediator's role is to 'facilitate' discussion that will lead to the parties settling their dispute rather than imposing a judgement" (Mulcahy, 2001: 508).

Mediation can modify the relationship between the conflicting parties, "changing the angle of approach" (Zeldin, 1998: 162). Mediation's function is "facilitating communication" (Shah-Kazemi, 2000: 305), which means creating the particular structural conditions for it. According to Ayoko, Härtel and Callan (2002), facilitation consists of discourse management strategies, actions of interpretation and positive interpersonal control. Discourse management includes the facilitation of participants' contributions, "promoting conversation, offering speaking turns, using conversational repairs, or event choosing familiar and non-threatening topics" (2002: 169). Interpretation includes actions such as the use of explanations and the checking of reciprocal understanding. Po-

sitive interpersonal control consists in avoiding self-expressions which can interrupt communication, such as status assertions and other forms of dominance behaviours or ignorance of particular topics, and promoting encouragement. Very similar ways of managing conflicts have been indicated as *dialogue process* (LeBaron and Castarphern, 1997) and *interactive problem solving* (Kelman, 2004).

Hence, the general function observed for mediation with regard to conflict management is that of facilitating a positive dialogic form of communication (Bowling and Hoffman, 2000); it is supposed that mediation tends to create trust and to explore common ground and continuity of views between the conflicting parties, thus favoring reconciliation. Even though the idea that mediation may serve to promote dialogue has firm theoretical foundations, it entails two major problems.

The first problem concerns the mediator's engagement in the decisional processes, particularly in promoting symmetrical relations in power. In most perspectives, mediating is observed as taking a neutral stance (Mulcahy, 2001; Shah-Kazemi, 2000) and "the notion of neutrality becomes synonymous with invisibility and passivity", as the mediator is considered "absent from decision- making", assisting a bi-lateral negotiation, in which, "emphasis is placed on what mediators do not and what the parties do" (Mulcahy, 2001: 509). This representation includes the linguistic aspects of mediation. For example, a traditional representation considers interpreters as *voice-boxes*, *overhearers* or "non-persons" (Davidson, 2000; Mason, 1999; Wadensjö, 1998). In recent years, however, mediation has been increasingly seen as a form of active participation in conflict management. According to Mulcahy (2001), mediators actively intervene in disputes as distributors of opportunities to talk, inducing the parties to introduce and deal with particular issues, reinforcing certain roles and identities, making some outcomes more likely than others. Therefore, mediation is considered active co-ordination of the conflicting parties since "the integration of third parties in the process of framing and fuelling the dispute is inevitable" (Mulcahy, 2001: 512). Consequently, dialogic mediation cannot be neutral; rather, it is a pre-normative paradigm (Isajiw, 2000) of conflict management which is not negotiated in interaction.

In this perspective, however, dialogic techniques might be considered insufficient for managing conflicts (Isajiw, 2000). Many researches have demonstrated that mediation does not necessarily promote a durable empowerment of all parties involved in the conflict. When mediation is used as a technique to manage conflicts, it can effectively improve only short-term success in resolving conflicts, measured in temporary progress in social relationships, expressions of satisfaction, and agreements about specific issues or goals (Gwartney, Fessenden and Landt, 2002), while it de-emphasises the importance of the larger social context, of the durability of relationships between the parties, and of their political recognition. In the framework of mediation as an instrument to solve conflicts, a mediator uses "his or her intervention skills to assist parties to resolve particular issues under dispute", but the single connections between these disputes and their social context are "coincidental and outside the parameter of the mediator's responsibility" (Schoeny and Warfield, 2000: 254). In this way, mediators "become de facto agents of the status quo invested in maintaining the stability of

the current social system and stopping the conflict before it moves beyond the affected institutions' control" (Welsh and Coleman, 2002: 345–46). In actual fact, mediators align with one party and work as "gatekeepers", to use Brad Davidson's expression with reference to interpreters in Californian hospitals (Davidson, 2000, 2001): they collaborate in maintaining order inside a social system. Effective conflict management requires recognition and treatment of more complex cultural forms such as racism, sexism, and forms of oppression. While mediation promotes contingent harmonisation, "systemic re-evaluation and re-construction (...) can, and perhaps should, characterise conflict resolution" (Welsh and Coleman, 2002: 350). An effective third party can be observed as a "social instrumentalist" who integrates issues of justice and participation with issues of system maintenance, rather than as a mediator" (Schoeny and Warfield, 2000: 266).

The second problem concerns the definition of what is included in mediation. Conflict management is primarily observed as conflict resolution associated with a final agreement (Deutsch, 2002). The primacy of conflict resolution assumes that open conflicts are positive, since they allow for debate and integrative solutions incorporating the best of opposite ideas (Tjosvold and Sun, 2002). However, conflict management is not confined to conflict resolution (Lynch, 2001): the primacy of conflict resolution is associated with the idea of conflict as an immune system, and it assumes that open conflicts are positive, since they allow for debate and integrative solutions incorporating the best of opposite ideas (Tjosvold and Sun, 2002). As a matter of fact, conflict resolution may be considered *a particular form* of conflict management: "Conflict resolution is participatory in nature, seeking to involve the parties involved directly in the generation of solutions. It seeks changes in the established social order and consists of mechanisms designed to bring closure to a conflict cycle" (Schoeny and Warfield, 2000: 257).

Within this perspective, avoiding conflict (that is, ignoring a refusal), is considered counterproductive, and it is associated with a low level of concern for relationships and problem solving (Shell, 2001); it means refusing to participate in an active way and is deemed as unproductive passivity. However, it may be argued that *conflict avoidance* is positive for co-operative and relational-oriented reasons: it can avoid destructive escalations and defend positive relationships from stressful and unnecessary disputes (Tjosvold and Sun, 2002). Conflict avoidance can be highly productive when relationships are highly valued, and when a relationship is effective. Further, conflict management may be seen to block possible refusals, as a form of *conflict prevention*: conflict prevention means that a social structure avoids the production of refusals in communication.

To sum up, mediation can be considered as a way of resolving, avoiding or preventing conflicts. On the basis of these theoretical premises, by means of the methodology we are about to outline in paragraph 3 below, it is possible to explore how conflict management materializes in medical interactions involving an interpreter/mediator, in the context of healthcare institutions in the Modena and Reggio Emilia districts. It is possible to observe both the most common form of conflict management promoted by interpreters/mediators and the way in which this promotion materializes in interaction.

3. Methodology of the research

The data analysed in this study are recordings of naturally-occurring encounters in Italian healthcare settings. They are talks between healthcare providers (doctors and nurses) and patients speaking different languages and communicating with the help of an interpreter. The study is based on the analysis of 60 encounters involving the English and the Italian language. The institutional representatives are Italian in all cases, the patients being from Central Africa. The interpreters are two Nigerian English-Italian speakers. According to the Laws of the Emilia Romagna Region, the interpreters followed a 400 hour course on mediation before starting to serve in the hospitals in the first semester of 2005.

The settings involve surgeries in or connected to four main hospitals, in three cities in the Modena and Reggio-Emilia districts (Northern Italy). Most surgeries deal with the care or prevention of gynaecological diseases and pre- or post-maternity follow-ups and the patients are women. The interpreters are all women; the doctors and the nurses are both men and women. Transcription conventions are those commonly used in Conversation Analysis (Jefferson, 2004). All personal details that are mentioned in talk have been altered in the transcription to protect the participants' anonymity. Due to the sensitiveness of the situation, we were authorised to collect audio, not video, recordings, which did not allow observation of non-verbal action produced through gaze, gesture, facial expression, body posture, etc.

The object of our analysis, that is, institutional talk involving speakers of different languages and an interpreter providing translation services represents a type of interaction that is acquiring increasing interest in studies on translation and the intercultural. Such type of talk is referred to as "interpreter-mediated interaction" (Wadensjö, 1998) or "dialogue interpreting" (Mason, 1999). The increasing interest in the work of interpreters is connected to the increasing acknowledgment of the complexity of the interpreter's cultural task as a translator and also as a mediator in the literature on dialogue interpreting. Analyses of recorded and transcribed data show that interpreters are active participants in the interaction: they select information to translate, ask and provide clarification, give support to the interlocutors (Baker, 2006; Mason, 1999, 2006; Wadensjö, 1998). In order to explain the type and amount of work that interpreters do in the interaction, Wadensjö (1998: 145-150) suggests that interpreters play a twofold role in the conversation, they *translate* and they also *coordinate* the talk activity.

Such co-ordinating activity is aimed at making possible and successful the interaction between the participants of different languages and it is concerned with the promotion of their participation and understanding. It allows a linguistic-cultural bridging which makes effective the voice of the interpreter's co-participants and makes possible their cultural expression. It also aims at participants' reciprocal understanding and sharing of information. Specifically, interpreters can mediate "a form of cross-cultural encounter between immigrants and agents of institutions of the First World" (Davidson, 2000: 381), and Wadensjö observes in this sense that they "cannot avoid functioning as intercultural mediators" (1998: 75).

Observing interlingually and interculturally means understanding how linguistic and cultural interventions go hand in hand and are intertwined, as interlingual and intercultural mediation has the function of promoting cross-cultural adaptation, while resolving language problems through translation. It means considering the conjunction of functional systems cultural forms and specific structures of interaction, which interlingual and intercultural mediation presents. These structures concern the participants' turn-taking (Goodwin and Heritage, 1990; Hutchby and Woofitt, 1998; Sacks, Schegloff and Jefferson, 1974), specifically: 1) the recurrent action sequences in interlingual and intercultural mediation interactions; 2) the deviations from these action sequences and the corresponding repairs; 3) the techniques used to manage speakers' transfers. These structures have wide-ranging implications for the relationships between participants and for information selection.

Observation of interlingual and intercultural mediation requires adequate methodology. Gwartney, Fessenden and Landt (2002) suggest that the basic unit of analysis concerning conflict management is given by interaction, and that audio or video recordings of conversations may be considered the best technique for collecting data. It has been widely demonstrated that interpreting activities can be productively analysed in the same way (Davidson, 2000; Mason, 1999; Wadensjö, 1998).

In order to analyze collected data we used Conversation Analysis (CA). The distinctiveness of CA as a social scientific approach emerges from its topic. CA investigates turns at talk and interactional moves in their sequences. It inspects the ways in which a turn at talk treats a previous one, and what implications this poses for the succeeding turns.

CA approaches talk and actions in interaction as sequentially organized and ordered. The relationships between turns and actions in interaction are considered the key resource both for participants and analysts. The sense of ongoing action is created and deciphered by the positioning of turns and moves in interaction. Contributions in interaction are sequentially implicative, delimiting the possible next contributions by making some types of action conditionally relevant. The turns and actions in interaction form their own context in an endogenous, orderly manner.

The central findings of CA concern the organization of ordinary conversation and the accomplishment of task-oriented, institutional interactions. The validity of CA research consists in showing how participants orient to this sequential order and how they realize the normative orderliness of social actions through their orientation.

Research into social actions shows that talk is not "just talk" for parties in action. Talk is both consequential for the further development of the ongoing action, and is also preconditioned by the nature of ongoing activity. The analysis of social action should not artificially concentrate on "talk itself" but should grasp the totality of talk-and-action-in interaction.

The studies on institutional interaction focus on questions of what talk and interaction do in goal-oriented settings, that is, institutional environments. The analytical aim is to specify how the parties' orientation to a context becomes consequential for their conduct (Schegloff, 1991). In other words, CA does not presuppose that a context

such as a medical or therapeutic one is an external constraint that restricts the participants automatically. For instance, a doctor or a therapist may have institutional power, but it must be exercised and made consequential in interaction with clients. The studies on institutional interaction may discern how institutional realities are sustained and managed and institutional power exercised. From a sociological point of view, it is essential to relate the role of talk-in-interaction to the emergence of social and cultural structures other than the talk itself (Have, 1999).

4. Discussion of data

This case analysis aims to describe the different forms of conflict management which emerge from these interactions. We cannot use our data to demonstrate general assumptions concerning interlingual and intercultural mediation; however, our data can provide interesting elements for reflection on interlingual and intercultural mediation as a form of conflict management, concerning the theoretical problems considered in § 2. It is possible to say that in the analyzed interactions, conflict prevention is the main form of conflict management. Conflict prevention is achieved through four structures of interaction:

1. The *physicians avoid direct interaction with the patients, selecting the mediators as primary interlocutors* and the *mediator doesn't support the patient's active participation in the interaction*. The patient is forced to maintain a passive stance during the interaction. The physicians explained medical and organizational requirements directly to the mediators, who made short summaries of these explanations in subsequent translations. With very few exceptions, this happened even when the patients spoke Italian sufficiently well to be understood.

Excerpt 1

1. Ph(ysician) – Allora, eh: ... la lettera gliela vuoi spiegare? Tanto sai già le cose! *[So, do you want to explain the letter to her? Anyway, you already know how things are!]*
2. M(ediator) – Sì! *[Yes!]* This is the letter for your baby, the discharge letter. The visiting, the date you gave birth, the time, the mode which is "full-mode". They, … this is (0.4) this is the normal quote they use to give for ( ), 9/10, is normal, is OK. And this is the weight that she was when, when you give birth to her. Now she is weighing this. It's normal that if you give birth to a baby, he normally reduces weight, but he starts ( ), now she is already growing again. Sì *[Yes]*, if you continue with your breastfeeding, you go fine, eh? This is the leg of the baby and this is the head.
3. P(atient) – Ok!
4. M – And they have done a cell for you; to know if the baby is having any infection, but not now, everything is OK! This part of sheet eh? Don't look at here, because here is for artificial milk. Don't suppose that ( ) but with this substitution now, you don't need artificial milk, you are plenty of milk. If I could, why need more milk ( ), do you understand? Because the way she is sucking, need to be hungry. So it's better you eat when … before you breastfeed and when you are breastfeeding, may should stay at least for five minutes and five minutes, so that she will eat fine and eat well.
5. P – Ok!
6. M – Do you understand? So you don't have to look this, the doctor just wrote this milk here, but put it aside. Don't buy it.
7. P – Ok!

8. M – If you have money to buy milk, you can buy, because nobody will give you milk here. Even if they give it, they give it for two/ three months! Basta! *[No more!]* So the rest, who will buy for you? So, as far you have breastfeeding, it's better you feed! What if … four/five months now and continue eating all this, fruit, fruit … eh: … banane, mele *[bananas, apples]* and all the rest. Do you understand? So, it's better you just continue like this, eh? ( ) When you'll choose doctor for the baby, (0.2) this test here, the doctor will now give you a paper. They will give you a test in two or three months' time. When discover ( ) cannot give it anymore, with the test on the weight, ( ) on the weight of the baby, to see all the choices here, the good choice, if there is any problem.

In line 1, the physician delegates the explanation of medical advice to the mediator and it clearly emerges that this is a standard procedure. During the interaction between M and P, we may notice that the mediator alternates technical or medical advice with normative suggestions, particularly in lines 4, 6 and 8. In line 6, the mediator refuses the physician's instructions but without involving the physician himself and in this way avoiding a conflict. In line 8, she explains the reasons for this conflict to the patient, reinforcing her normative advice.

2. The *mediators substitute the patients in answering the physicians' questions*, even though this is not strictly necessary as the patients are able to answer themselves.

Excerpt 2

1. Ph – Malattie del sangue? *[Blood illnesses?]*
2. M – No … in your family?
3. P – My family?
4. M – Eh? No eh?
5. Ph – Qualcuno che fa delle trasfusioni? *[Is there anyone who has blood transfusions?]*
6. M – Anybody that.
7. Ph – Qualche forma di anemia? *[Any form of anaemia?]*
8. M – Nothing. No c'è solo: suo cognato, suo suocero eh che c'ha: diabete. *[There is only her brother-in-law, her father-in-law who has diabetes.]*

The mediator almost completely ignores the patient as an interlocutor. In line 2, the mediator begins answering the physician directly. Then she asks the patient a question of sort, but she ignores the following doubtful answer, substituting it with a clearer assertion. In line 6, the mediator begins a new answer but she interrupts it, substituting the patient's answer in line 8. The patient cannot answer any of the questions and the physician must trust the mediator's information entirely.

3. The *mediators take many initiatives in instructing the patients about normative styles of behavior*. Sometimes the mediators select the physicians as interlocutors to confirm their normative perspective, and in this way mediation is reversed: the mediator was the primary participant and the physician is the conflict manager.

Excerpt 3

1. M – So I promised her that I'll () that yesterday I saw you when you were breastfeeding the baby, and the baby was sucking it very well. So it's just a matter of kind, just wait for contact, the more you give the breast, the more breast will be stimulated and it will come out.
2. P – Okay, okay.
3. M – This is not your first baby, normally the first one, before two days (), the milk doesn't come…

4. P – Yes.
5. M – After three days (0.3), it will be coming. The better you give every to two hours, even at home. Sit down comfortably, don't bend your leg too much because the neck will be paining you. Just sit comfortably at home (). Then put the baby () stomach … to your own as she's talking to you that you will feeling your body. Uhm?
6. P – Okay!
7. M – Do you have any questions to ask about breastfeeding?
8. P – I think no: (h). *(P smiles)*
9. M – No eh? (0.2) Don't worry, it will come, milk will come, will come.
10. P – Yes.
11. M – Because, with this situation that you are now, eh? If you want to add artificial milk, who is going to assist you? So with the money that your husband is earning, is not enough! So it's better as you have breasts, don't go and it's not … you don't pay for it, you have it so you can give it to her any time. (), so that milk will come. Ok?
12. P – Ok!
13. M – A posto. *[All right.]*

The mediator gives instructions on breastfeeding in lines 1, 5 and 11. She both explains techniques cognitively and suggests behaviour normatively. In line 11 the normative form of communication prevails and concludes communication. For five turns out of six, the patient expresses only unconditioned acceptance. In line 8, she shows an indirect and weak doubt, but the mediator refuses to consider it in line 9 and in line 11 she exerts her cultural authority to propose a normative expectation, which closes the conversation with a definite cultural acceptance.

Excerpt 4

1. Ph – Bene, bene, bene, benissimo! Tutto bene, tutto bene. Avevamo già visto poi bene eh? *[Well, very well! Everything is all right, all OK. We saw before that it was all OK, didn't we?]*
2. M – How many girls do you have? You have two, maybe the third one? Is OK eh?
3. Ph – Due ne ha? *[Has she got two?]*
4. M – Eh!
5. Ph – Altre due? *[Two more?]*
6. M – Sì … no, ma è numero cinque questa! *[Yes… No, this is number five!]*
7. Ph – Numero cinque? *[Number five?]*
8. M – Sì! *[Yes!]* Is OK eh? You know this problem that you are talking to ( ) . If your husband is going to make love, go and buy condom or…*(P smiles)* go and, in this … it's true!
9. P – Yes!
10. M – You cannot face the baby. You have at this point, this problem eh? Or you want to pack the children and go to Ghana? Eh?
11. P – Ah! *(P sighs)*
12. M – Ok! So if you don't want to go and live in Ghana with these children, don't stop ( ). Go, come to via Padova *[Padova Street]* and we'll give you what you will be take in, so that you don't get pregnant. If your husband, I know uses condom… I know Africans maybe don't like condom. If he cannot use, there's a pill that you can be taking or you come at this point. Do you understand? Don't stay too long eh?
13. P – I will give you.
14. M – Eh, eh!

15. *(The physician laughs, followed by P and M.)*
16. M – No, perché, cioè, con tutto questo casino che ha adesso… *[Because with all this mess with her...]*
17. Ph – Eh, esatto! *[?. Exactly!]*
18. M – … ne fa un altro e allora tutti vanno in Ghana, a stare in Ghana. Io ho chiesto: se vuole andare in Ghana con tutti i bambini, va bene, fai ancora. Però, se vuoi rimanere qua, basta. *[She will have another and then they'll all go to Ghana, to live in Ghana. I asked if she wants to go to Ghana with all her children, OK, you can still do that. But if you want to stay here, stop it.]*
19. Ph – Anche in Ghana se si fermano è meglio! *[If they stop, it is better in Ghana too!]*

In line 1, the physician acts as having concluded his technical task. In line 2 the mediator, ignoring the physician as interlocutor, autonomously introduces the issue of birth control, which she develops in lines 8, 10, and 12 with the patient and in lines 16 and 18 with the physician. She autonomously selects issue and interlocutors, ignoring the patient's sighing in line 11, manifesting a doubt and a potential refusal, and forcing the physician to take her side in line 17, while he maintains neutrality in lines 5 and 7. In this way, the mediator's contribution prevents a conflict and in the meanwhile creates the conditions for the patient's cultural adaptation, forcing the physician's co-operation.

4. The *mediators adopt a hierarchical stance when they select the patients as interlocutors*, treating them as incompetent participants in giving information, in assuming roles and in making personal decisions. They do so both autonomously and in co-operation with the physicians.

Excerpt 5

1. Ph – Quanto pesava prima della gravidanza? *[How much did she weigh before getting pregnant?]*
2. M – Before this pregnancy, how many of we - what was your weight?
3. P – Eighty.
4. M – Eighty?
5. Ph – Quanto? *[How much?]*
6. M – No! Before the pregnancy! Before the pregnancy.
7. Ph – Prima, prima di diventare grassa. *[Before becoming fat.]*
8. M – When you were not pregnant.
9. Ph – No.
10. M – Eighty? Are you sure?
11. Ph – No:: ottanta?! No:: troppo. *[No, eighty?! No, too much.]*
12. M – It can't be. It can't be eighty! No, no. (5)
13. Ph – Beh? Quanto pesavi? *[So, how much did you weigh?]*
14. M – You can't remember.

In line 1, the physician selects the mediator as interlocutor, who translates her question. In line 4 the mediator shows a doubt about the patient's answer and in line 6, without waiting for the physician intervention, she refuses the patient's assertion. In the following lines (9, 10, 11, 12, 13, 14) the patient is treated as an incompetent informant by both the mediator and the physician. Interestingly, in the subsequent conversation, after consulting past clinical data, the physician would discover that the patient's information was reliable and that during her pregnancy she "surprisingly" lost weight.

In some cases the physicians have a more active role in the prevention of conflict, implicitly supporting a normative style of behavior of the mediator, by avoiding any intervention in the mediator's translations (see also excerpt 1), even though they were able to understand English.

This prevented them from correcting mistakes or inaccuracies of information and then from communicating a refusal of the mediator's actions. The physicians avoided introducing refusals and changes in communication processes, ignoring that which could have been worthy of sanction.

For example, during a long interaction concerning the diet for the patient's child suffering from a celiac disease, a physician indirectly invites the mediator to repair a translation mistake made due to a lack of understanding or attention by continuously repeating her explanation. The translation problem arises when the physician introduces the idea of "risk", talking about the necessity to check food products.

The physician is reading an information sheet about permitted food in case of celiac disease, indicating with a question mark the foods which need careful monitoring. Translating these indications, for a long time the mediator ignores the difference between "risk" and "certain damage", systematically interpreting "risk" as "prohibition", as in the following examples.

M – She says, if you want to give her – because those ones that are already prepared, don't buy purée already prepared.

M – Look at this now. I asked the ones ( ) that are not good for her and the ones that are good, like here now, that are not good for her.

M – That are good. So if you see the question mark, ( ) you know that are not good.

During a long sequence, the physician never corrects this mistake even if she is able to understand the translations. However, she continues to stress the difference between risk and prohibition, insisting on it, as in the following example.

Ph – Okay? ( ) Eh:: tutti i prodotti che vedete, tutti: i nomi con il punto interrogativo, tutti questi col punto interrogativo, andiamo a consultare il prontuario. *[All products that you can see, all the names with a question mark, for all these with a question mark we need to consult the sheet.]*

Finally, the mediator corrects her translation, but without any recognition of the previous mistake. In this way, the physician avoids any conflict with the mediator, obtaining a solution for the problem, but it should be noted that a lot of information is lost for the patient, and a lot of confusion is created about prohibition, causing potential damage for the child's future diet.

In these five ways, possible refusals in the medical system were blocked, as the patients had very few opportunities to answer the physicians' questions or to pose questions or doubts, and the mediator was the only interlocutor for the physicians. Substituting the patient as the main participant in interactions, the mediator never refused the physicians' indications, never expressed doubts, and never asked the patients if they had some reason to doubt or refuse.

5. Conclusions

With this article, we have described the most common forms of conflict management which emerged from medical mediated interactions we recorded during our research in four hospitals in the Modena and Reggio Emilia districts. Before drawing any conclusions, we should highlight that our data don't represent all the mediated interactions that happen each day in medical settings: different mediators may have different stances toward conflict management.

For instance, data collected in a very similar setting (Baraldi and Gavioli, 2008) offer evidence that interpreters/mediators may also introduce in the conversation a direct, affective support of other participants' expressions of feelings or attitudes. This research shows that, in some cases, the interpreter's support may be very important in making the emotional expression of co-participants relevant in the interaction and in promoting the participant's acceptance and understanding. Emotional expressions can enhance affective expectations. Affective expectations are expectations in which interlocutors expect to hear expressions of concern and support in response to some previous interlocutor action (Baraldi, 2006a). These expectations allow personal emotional involvement of the participants in the interaction, which integrates or substitutes the institutional role performances, which are traditionally required in institutional contexts.

However, our intention was neither to quantify the different interactive situations and structures observed in the medical communication nor to present all of the possible forms of mediation. It would be simply impossible in the space of an article to comment in depth on qualitative data for all the forms of mediation we observed. With this limitation in mind, we decided to focus on a specific issue, conflict management, showing the role of interpreters/mediators in making *conflict prevention* the most common form of conflict management in our data.

This article was aimed at commenting on some meaningful interactions, showing the variety of possible conditions and forms of conflict prevention we observed, in order to highlight the problems that these forms may bring about. On these bases, we select in analysis examples of communicative situations and we comment on them in depth.

In the data we discussed, possible conflicts are blocked, as the patients have very few opportunities to answer the physicians' questions or to pose questions or express doubts. Substituting the patients as the main participants in interactions, the mediator never refuses the physicians' indications, never expresses doubts, and never asks the patients if they have some reason to doubt or refuse.

This article describes the most recurrent structures and the main forms of managing speakers' exchanges in certain interlingual and intercultural mediation sequences, showing their implications in the relationships between participants and for selection of information. With regard to the issue of conflict management, we observed that the form implemented systematically by the mediators' contributions was conflict prevention. The mediators' contribution prevented conflict by aligning with the physicians' contributions, that is, with the system requirements, by giving voice to the patients mainly

by substituting them and speaking herself, by excluding the patients' opportunities for participation and sometimes by actively integrating and often substituting the medical role.

In the sequences we presented, interlingual and intercultural mediation did not successfully promote participant responsibility and cross-cultural adaptation, substantially limiting interaction between physicians and patients. The mediators did not create the conditions for management of conflicts as immune systems, but, to the contrary, prevented and sometimes avoided refusals, maintaining the system free from troubles and doubts. In order to do so, mediators did not assume a dialogic form as it presented an unbalanced distribution of participation, as the mediator's personal perspective was mainly associated with normative instructions, as there were occasional intimidating assertions, as there was almost complete absence of actions addressing the patients' interests and needs, checking their perceptions, actively listening to them, appreciating their actions and experience, and creating interactive feedback on their actions.

To sum up, interlingual and intercultural mediation was conditioned by a specific coding of information (the meanings of health/illness), by technical role performances and by a cognitive form of expectations, or rather by the function of the medical system. This conditioning prevented and avoided conflicts, despite the perceived presence of linguistic and cultural differences among the interlocutors. It is important to highlight once again that our data do not cover all of the possible forms of interlingual and intercultural mediation. The scope of the in-depth analysis of actual interactions article we presented was to discuss which consequences the preservation of medical communication structures (expectancies and cultural forms as discussed in § 1) by preventing conflict may have on the ability of mediation to fulfill its institutional goals.

These data confirm that the conditions for promoting a dialogic form of intercultural conflict management are not easy to construct inside medical systems, as Davidson (2000, 2001) demonstrated in a Californian hospital. Going beyond this, they demonstrate that ethnocentrism can arise from interlingual and intercultural mediation, despite its explicit function of promoting participation and cross-cultural adaptation.

In this situation, problems of feasibility and effectiveness in dialogic mediation can be profound. We might wonder if active participation and cross-cultural adaptation are necessary requirements of productive conflict management; that is, if immigrant patients really do require it or if interlingual and intercultural mediation should be appreciated by *all* parties for its prevention of problems. Success in preventing and avoiding conflicts might be indicative of intercultural effectiveness, and interlingual and intercultural mediation could work effectively *without* cross-cultural adaptation and dialogue. However, the main problem concerns the possibility of observing these problems: the patients' cultural and personal choices cannot be observed without dialogic mediation and this means that only such a form of conflict management can allow us to eliminate doubts about the effectiveness of dialogue.

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Federico FARINI

Interkulturno i interlingvističko posredovanje u zdravstvenom sustavu: izazov u upravljanju sukobom

SAŽETAK

U današnje vrijeme mlade žene i njihova djeca najčešći su migranti korisnici zdravstvenih usluga, pa se posebice oni mogu susresti s različitim kulturnim tumačenjima zdravlja, bolesti, liječenja i majčinstva. Teškoće uočene u interkulturnoj komunikaciji nagnale su zdravstveni sustav na promicanje posredovanja putem upletanja treće osobe, koja potiče uzajamno razumijevanje sudionika i njihovo međusobno prihvaćanje. Ovdje predstavljeno istraživanje usredotočuje se na interkulturnu komunikaciju u zdravstvenim službama između zdravstvenog osoblja i pacijenata migranata. Kako bi postiglo taj cilj, istraživanje nastoji spojiti različite teorijske i metodološke pristupe: analizu razgovora s ciljem zapažanja interakcije između zdravstvenog osoblja i pacijenata, pri čemu upozorava na distribuciju replika između sudionika; analizu kulturnih pretpostavki zdravstvenog sustava kao komunikacijskog sustava sa specifičnom funkcijom u društvu, ističući kontekstualizirane replike, to jest kulturne pretpostavke koje usmjeruju interakcijski sustav kao rezultat šireg društvenoga konteksta i koje pripadaju kulturnim identitetima što ga obilježavaju. Primijetili smo da u većini slučajeva pacijenti imaju malo mogućnosti da odgovore na liječnikova pitanja, postave pitanja ili iznesu dvojbe. Zamjenjujući pacijente kao glavne sudionike u interakciji, posrednik nikada ne odbacuje liječnikova upozorenja, nikada ne izražava sumnju i nikada ne pita pacijenta ima li razloga u nešto sumnjati ili nešto odbiti. Na taj način interlingvističko i interkulturno posredovanje umanjuje važnost šireg društvenoga konteksta i trajnosti veza između stranaka te njihova društvenog i političkog prepoznavanja.

KLJUČNE RIJEČI: migracija, regija Emilia-Romagna, interlingvističko i interkulturno posredovanje, rješavanje sukoba, političko priznanje, trudnoća, djetinjstvo

Federico FARINI

La mediazione interculturale ed interlinguistica nel sistema sanitario: la sfida della gestione del conflitto

RIASSUNTO

Ai nostri giorni le giovani donne ed i loro figli sono i più importanti utenti migranti dei servizi sanitari. Queste persone, in particolare, possono incontrare differenti costruzioni culturali della salute, della malattia, della maternità. Ci sono serie difficoltà nell'accettare nuove forme di trattamento del corpo, dal momento che il corpo è tradizionalmente "ordinato" da specifiche strutture normative. L'osservazione di difficoltà nella comunicazione interculturale incoraggia i sistemi sanitari a promuovere la mediazione. La mediazione consiste nell'intervento di un terzo, che promo muove reciproca comprensione ed accettazione. La ricerca che presentiamo si focalizza sulla comunicazione interculturale che è prodotta nei servizi sanitari tra personale e pazienti migranti. Per fare questo la ricerca integra due diversi approcci: analisi della conversazione per osservare le interazioni tra personale sanitario e pazienti, sottolineando la distribuzione dei turni di parola, analisi dei presupposti culturali del sistema sanitario come sistema di comunicazione con una funzione specifica nella sanità, evidenziano i presupposti culturali che condizionano l'interazione. Ho osservato come in molti casi i pazienti hanno poche opportunità di esprimersi, di rispondere alle domande dei medici, di esprimere dubbi o porre domande. Sostituendo i pazienti come partecipanti primari all'interazione, i mediatori non esprimono mai dubbi in merito alla comunicazione del medico, prevenendo così il conflitto. In questo modo, però,

la mediazione interlinguistica ed interculturale de-enfatizza l'importanza del più ampio contesto sociale, della sostenibilità delle relazioni tra le parti ed infine del loro riconoscimento sociale e politico.

PAROLE CHIAVE: migrazione, Regione Emilia-Romagna, mediazione interlinguistica ed interculturale, gestione del conflitto, riconoscimento politico, gravidanza, infanzia