

# Translanguaging Health

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This article considers the complex communicative practices of contemporary consultations in a superdiverse London hospital, as staff and patients employ the breadth of their linguistic and semiotic resources to navigate health information, in an attempt to ensure mutual comprehension. Drawing on observations of antenatal appointments, I investigate how creative and flexible interaction appears to enhance patient experience, and present data which seem to extend notions of settings that can be understood to offer a translanguaging space. Yet tensions lie in the epistemological emancipation and parity that the conditions of superdiverse consultations can be seen to imply, as such circumstances may also hold the potential for situational, or clinical, consequences. Similarly, although creative repertoires appear to transcend and transform bounded notions of language, I note that their exploitation nevertheless remains contingent on the flexibility of the personal and institutional affordances available—the instigation of which ultimately rest with those in positions of authority.

## INTRODUCTION

This article considers the complex communicative practices observed in contemporary antenatal consultations in a superdiverse London hospital. At a time when an overstretched National Health Service (NHS) is compelled to respond to evolving and rapidly changing populations, and given its own increasingly international workforce, I explore how linguistic diversity is managed in practical terms. As medical professionals, interpreters, patients, and their companions employ the breadth of their linguistic and semiotic resources in an attempt to ensure mutual comprehension, I draw attention to instances of situated translanguaging, the communicative features of which are said to be inherent in heterogeneous populations. In doing so, I also seek to extend notions of what can be considered a translanguaging space. However, I argue that tensions lie in the epistemological emancipation and parity that these conditions could be seen to imply. First, while flexible repertoires can offer a means to navigate epistemic asymmetries and enhance patient experience, the everyday spontaneity of translanguaging frequently gives rise to approximated meaning, creating circumstances that hold the potential for clinical consequences. Secondly, it is apparent that the decision to draw upon multimodal resources not only remains contingent on the personal and institutional affordances available at the time, but ultimately with those

in positions of authority. In this way, such practices may inadvertently mask the disparities that translanguaging orientations are said to be ideologically committed to dispel.

In order to explore these challenges, I begin with a discussion of superdiversity and translanguaging, two concepts that underpin my study, before reviewing existing literature on multilingual health communication. In the following sections, I provide contextual information on the site of my research and my methodological approach. I then proceed to present my data and findings. The article concludes with a discussion of the opportunities presented, and challenges faced, by the multilingual consulting room.

## BACKGROUND

### A changing world

As global migration flows have increased, demographic changes have made ‘difference’ more visible, audible, and tangible than ever before. The ensuing unpredictability of ethnic, linguistic, national, and cultural variables, and the interplay between them, has created a ‘diversification of diversity’, or what Steven Vertovec entitles superdiversity (2007). Highlighting the blurring of lines between multi-ethnic, multilingual communities, the term captures demographic dynamism and disrupts assumed imaginings of national and diasporic homogeneity. While scholars working in medical sociology (Bradby *et al.* 2017) or on the effects of population change on housing, equal access to healthcare and maternity services (e.g. Phillimore *et al.* 2019) have all drawn on Vertovec’s concept, superdiversity has arguably been most influential in the field of sociolinguistics. There is number of reasons why this may be so: by encouraging a move beyond the ethno-focal, Meissner and Vertovec (2015) note that a superdiverse lens offers a more nuanced way of exploring population change; Simpson recognizes that by then exposing ensuing practices to fine-grained analysis, attention is extended past the sociolinguistic foci of language and society to ‘the spatial and the economic’ (Simpson, 2016: 4), that is, phenomena previously unconsidered. Underpinning a superdiverse approach is an ideological alignment to difference that seeks to expose and address intersectional relationships between power and inequality. In exemplification, research from the highly influential multi-sited ethnographic ‘Translation and Translanguaging’ collaborative (see, e.g. Baynham *et al.* 2015) reveals the complex and emergent range of linguistic and semiotic resources used by interactants and the ways in which they are used to negotiate diversity. At the same time, findings also point to ideologies, structures, and processes which have the potential to shape interaction.

Although some have questioned the novelty of superdiversity and warn of the potential to over-romanticize and actually obscure difference, the shifting landscape of UK cities has arguably made diversity commonplace and the once exceptional, unremarkable. This does not presume to suggest a multicultural

nirvana free from the vagaries of racist or nationalist discourse (Gilroy 2006), but a recognition that as layers of environmental, social, and institutional determinants intersect, essentialization become irrelevant and *a priori* classifications, redundant. Jaffe (2016) suggests that individuals may come to adopt a ‘superdiverse stance’, conceived of as an ideological intention to accommodate linguistic, cultural, ethnic, or national difference. In a similar vein, Wessendorf recognizes a ‘civility towards diversity’ (2013: 7) in superdiverse communities, or a sense of conviviality that is ‘lodged not in spectacular features and interventions, but in the small stuff of everyday contact’ (Blommaert 2014: 444).

Further interrogation highlights a proliferation of ‘multiple discursive practices’ (García 2009) seemingly brought about and fuelled by transnational migration, as bi/multilinguals negotiate the world around them, free of imposed positionings (García and Li 2014: 43). In any one of these connected encounters, individuals may draw upon a range of resources in their repertoire. From fluent to ‘truncated’ versions of language(s) associated with different nation-states individual idiolects are formed, and informed, by personal biographical trajectories (Blommaert and Backus 2011: 21). As the degree to which interpretations can be made within existing frameworks become blurred, scholars are prompted to interrogate further the notion of repertoire, in order to capture the ‘richness and depth’ (Li 2018: 11) of superdiverse communicative practices.

## Translanguaging

While the increased visibility of such multiple discursive practices has led to extensive theorization, the transdisciplinary framework of translanguaging (García and Li 2014; Li 2018) is one that has become synonymous with superdiversity. Tracing its origins from a term to describe the flexible translation practices of students moving between Welsh and English (Williams 1994; Baker 2001), through to more expansive definitions in the context of minority language speakers in US schools (García 2009) and ethnographic investigations in linguistically, socially, and culturally diverse contexts (e.g. Zhu *et al.* 2020), a translanguaging perspective is characterized by its attention to idiolect. It is said to capture the ways in which individuals strategically deploy ‘particular features from [their] linguistic repertoire. . .to negotiate particular communicative contexts’ (Vogel and García 2017: 1), ‘without regard for watchful adherence to the socially and politically defined boundaries of named (and usually national and state) languages’ (Otheguy *et al.* 2015: 281). In documenting how hybrid practices disrupt and transcend ‘socially constructed language systems and structures’ (Li 2018: 27) and drawing attention to the complex relationship between language and mechanisms of inequality, researchers in the field are often explicitly positioned to address matters of social justice. This is particularly so in education, where much of the focus on translanguaging has rested. Here there is an understanding that being able to utilize ones’ continua of linguistic resources resists imposed boundaries,

advances equitable access to the curriculum, and transforms experience and outcomes. This stance is not without challenge, however: noting that discourses of hybridity emerge from essentialized understandings of language, [Jaspers \(2018\)](#) contests the implication that any 'language' is 'fixed' or without variation. It is also argued that an over-celebratory attitude to hybridity may have unintended effects in either disregarding the authenticating experience of cultural identity or intensifying inequalities ([Kubota 2014](#); [Jaspers 2019](#)).

While educational contexts undoubtedly provide fertile ground and content for observation and explicit metacommentary, translanguaging research continues beyond pedagogy, to explore environments where interactants may be less attentive to linguistic foci. Ethnographic work in superdiverse settings such as a karate club in East London ([Zhu et al. 2020](#)) or a multicultural shopping district in Belgium ([Blommaert 2014](#)) reveal the everyday and often mundane ways in which 'translanguaging practices are locally occasioned' ([Baynham and Lee 2019](#): 26). In a more formal context, research was undertaken in a community legal advice centre ([Baynham et al. 2017](#)) illustrates the intricate negotiations that are needed to achieve understanding when communicating across a technical and epistemic discourse. Tracing these, it becomes apparent that the opportunity to utilize one's full repertoire is contingent on the communicative stance of participants and whether they are willing to adopt the mantle of conviviality, so intrinsic to the superdiverse context. It also seems to depend on the metaphorical openness of the space, that is, whether individuals have the personal or institutional freedom to employ a breadth of resources. In order to ensure participant voice or audibility, successful interaction is reliant on the existence of a facilitative environment, and the freedom to flex language from below. Li suggests that environments where individuals communicate between and across conventional linguistic boundaries are places of 'innovation and creativity' (2018: 23), where 'exclusionary language practices' (Baynham and Lee 2019:17) can be resisted. As linguistic creativity and hybridity flourish, a sense of liminality is said to emerge, creating a 'third' ([Bhabha 1990, 1994](#); [Soja 1996](#)) or 'translanguaging' space ([Li 2018](#)), that allows 'Others [to] come to the forefront' ([Li 2018](#): 24).

Building on this premise, this article aims to illustrate how staff and patients working and living in the diverse setting of Hayfield<sup>1</sup> appear accustomed to accommodating and engaging with heterogeneity, frequently drawing on their full communicative repertoire to find common ground and enhance understanding. Yet, while the specific affordances of the antenatal consulting room seem to present a liminal space, the degree to which individuals are able to disrupt the power asymmetries, so often held to be well-established in formal medical settings, remains to be seen. Before exploring (the effects, and consequences, of) translanguaging in this context, I first synthesize and summarize key literature in the field of (multilingual) health communication.

## Health communication

As people negotiate and align themselves with shifting norms, moving across registers and discourses, the linguistic repertoire and discursive resources at an individual's disposal will vary, not only indexing differences in language, culture, or education, but also epistemic authority and power. In turn, pluralized indexical interpretations have the potential to challenge shared meaning and understanding and to give rise to the kinds of asymmetries, so vividly documented across a plethora of existing health communication research (see, for example, [Sarangi and Roberts 1999](#); [Moyer 2013](#)): indeed, [Foucault \(1973\)](#) reflections on the symbiosis between power/knowledge have greatly influenced conceptions of medical professionals and their communication with patients. In the same way, language, or the perceived lack of it, and (inter)cultural difference are regularly positioned as presenting a barrier to care (e.g. [Bridle et al. 2021](#)) or characterized as rife with misunderstanding (e.g. [Roberts et al. 2005](#)). In alternative intercultural health communication studies, language has been conceptualized as a resource, a 'thing in itself' which can be drawn on, and where communication can be mediated effectively through the use of (formal and informal) interpreters (see for example [Baraldi and Luppi 2015](#)); or not ([Moyer 2013](#); [Cox and Maryns 2019](#)). A lack of linguistic concordance is not always presented as problematic. Foundational work by [Roberts et al \(2005\)](#) examines doctor/patient interaction in a medical practice serving a diverse community in London and finds that despite instances of misunderstanding, medical professionals appear to be able to accommodate differences in communication styles, by engaging active listening skills: rather than focussing on 'processing English' ([Moss and Roberts 2005](#): 417) patients are given the time to form narratives which, in turn, allow doctors time to gather meaning. The doctors' use of formulations and reformulations to summarize, confirm, and clarify also demonstrate a sensitive approach to patients' linguistic input, echoing findings from [Baraldi and Luppi's \(2015\)](#) work with similarly multilingual encounters in Italy, as well as [Baynham et al.'s \(2017\)](#) observations of legal advisors using equally technical language. Looking at the strategies used by midwives to overcome language 'barriers', [Baraldi and Luppi \(2015\)](#) observe consultations with migrant patients. Although many of the appointments are mediated by family and friends, and several are conducted in the lingua franca of English, midwives also employ reformulation strategies to give meaning to the patient's agenda. The researchers note that this form of intralingual assistance demonstrates an orientation to patient-centred care, as well as having the potential to empower women and promote active participation. Alternative work focuses on strategies of alignment, as nurse practitioners and midwives attempt to reduce distance between themselves and their patients ([Defibaugh 2014](#)), and to distribute knowledge more symmetrically ([Linell and Bredmar 1996](#)).

Significantly, much of the prevailing research on the role of language in healthcare settings, has been measured against the premise of fixed

institutional, monocultural, monolingual/proficient user norms, where shared practices rely on, and ‘derive their legitimacy through, clients’ recognition and willingness to abide by a set of institutional routines’ (Sarangi and Roberts 1999: 4). While it is not unusual for interpreters to make use of their broad linguistic repertoires—for example in Baraldi’s observations (2009), interpreters employ their resources contingently, using repertoires that include features associated with Italian, Arabic, and English to communicate with patients—fewer medical professionals are recorded as making similar efforts or moving beyond a lingua franca predictable to their setting (see Angelelli 2004; Moyer 2013). There are some exceptions, as can be seen in Mori and Shima’s (2014) observations of a Japanese general practitioner and his patients, for example. The increased demand for bilingual health workers also prompts Ortega and Prada (2020) to call for (trans)linguaging ‘training’ to be integrated into medical education programmes. Most notably, Cox’s (2017) ethnographic research in a Belgian hospital emergency department yields comprehensive documentation of translanguaging between doctors who are first-language speakers of French/Dutch and migrant patients, but also between ‘non-native’ speaking medical professionals and laypeople.

This study moves on from *a priori* assumptions about fixed conventions and takes as its starting point the fact that the linguistic and ethnic diversity of the workforce at Hayfield University Hospital,<sup>2</sup> mirrors the complex textured landscape of the local population, first making it ‘unclear who counts as the stranger’ (Bradby *et al.* 2017: 6), and subsequently throwing in to question the ways in which ‘difference’ is routinely navigated and managed.

## METHODS

The extracts presented in this article are from a selection of consultations in an antenatal clinic at Hayfield University Hospital, which were observed as part of a doctoral study on translanguaging in healthcare (Brooks 2020). Ethics approval for data collection was obtained in 2014, in line with hospital and university requirements.

This research adopts a linguistic ethnographic approach: as a methodology implicitly aligned with superdiversity’s ‘ideological orientation to difference’ (Blackledge *et al.* 2018: xxvi), it situates language, literacy, and discourse as analytical starting points of investigation, and reveals how everyday practices relate to wider process of power (Blackledge *et al.* 2018: xxvi). In an attempt to give a holistic account of situated communication, ethnographic observations of everyday activities in the clinic were made over a period of six months, between September 2016 and February 2017. These were enriched by focus group and individual interviews with midwives and interpreters, in addition to detailed field notes. Thirteen antenatal consultations were also observed, 12 of which were audio-recorded: although it is important not to conflate ethnicity, nationality, language, or cultural knowledge, it is of interest that all but two of the medical professionals in these appointments is a transnational worker. All data

were pseudonymized, so that individuals could not be recognized: the name and location of the hospital have also been changed, to further prevent participant and institutional identification. A combination of inductive methods is used to shed light on data. In the first instance, conventions associated with conversational analysis and pragmatics detail and explore the minutiae of communicative practices (Brown and Levinson 1987; Jefferson 2004; see Online Appendix A): fine-grained analysis of talk can capture an expanse of detail, and has been used extensively in the documentation of doctor/patient communication to look at how interaction is managed and meaning construed (see, e.g. Moss and Roberts 2005; Baraldi and Luppi 2015). Here, following Zhu *et al.* (2020), transcription remains in a consistent font to avoid the imposition of ‘artificial boundaries’ between languages. However, in order to move beyond the immediacy of the consulting room and to link nuanced interaction ritual actions to the wider social setting (Goffman 1972), I also draw on interactional sociolinguistics. As it is underpinned by the premise that ‘extralinguistic knowledge’ (Gumperz 1982: 157) cannot always be assumed and focuses on ‘how diversity affects interpretation’ (Gumperz 1999: 459), the approach particularly lends itself to examining intercultural encounters, as well as consideration of ‘how these interactions are embedded in wider social contexts and structures’ (Blackledge *et al.* 2018: xxxvii).

In recognition that discussions surrounding migration and health regularly fail to acknowledge the transnationalism of NHS health professionals and support staff, this study draws attention to the considerable number of international workers employed by London trusts: for example, in the area of London where this research takes place, approximately 25 per cent of NHS professionals have a nationality other than British (Parliament, House of Commons 2020). Hayfield is also classified as a minority/majority town, where approximately 52 per cent of the population identify as black or minority ethnic. Such heterogeneity is given due acknowledgment by Hayfield University Hospital who recognizes the comparable transnationalism of staff and patients. However, while the Trust’s website notes that the ‘rich’ diversity of the workforce mirrors that of the local population, enabling improved understanding and respect for diverse health needs, NHS interpreting guidelines currently offer ambiguous guidance in regard to using (shared) language(s): medical professionals are advised to only draw on these to help patients make appointments and identify communication requirements (NHS England/Primary Care Commissioning 2018). Health workers are directed to draw on expertise from an external interpreting and translation service to ensure, as far as possible, that encounters are facilitated by impartial linguistic concordance. Nevertheless, during the period of fieldwork, it appeared that staff were frequently obliged to rely on informal linguistic and strategic resourcefulness when interpreters were not present.

The following data extract comprise interaction from four antenatal appointments. They were selected to illustrate situated instances of translanguaging in different types of consultation: the first two extracts document an

initial, or ‘booking-in’, appointment; the following two examples feature a consultant who specializes in gestational diabetes as she meets two patients; the final encounter takes place in a specialist, ‘anti-D’ clinic.

## DATA AND FINDINGS

### ‘Talking it through’

Booking-in interviews are typically the longest consultations a woman will experience during a healthy pregnancy. Lasting approximately one hour, the midwife gathers medical history, informs a woman about her appointment schedule, and offers advice on keeping healthy during this time: patients are also encouraged to ask questions and share any concerns. As professionals and patients work together to create an accurate representation of health, the co-construction of a patient record is generally acknowledged to be collaborative. In a superdiverse setting however, the process of ‘talking things through’ (Li 2018) may also involve formal or *ad hoc* interpreters, resulting in the possibility of several languages working contemporaneously.

In Extract 1, the midwife (MW1) has begun to take initial details from her patient, Melina: the latter is accompanied by a male companion (PC) and a professional Portuguese-speaking interpreter (I1), who has been engaged through the hospital’s preferred provider. Systematically following a standardized set of routine questions designed to elicit a yes/no response in relation to Melina’s medical history, the participants have reached ‘b’ on the alphabetical list and the noun phrase ‘blood/clotting disorder’. In the first of several examples of apparent uncertainty, the interpreter is prompted to seek clarification. It is unclear whether she is unacquainted with the equivalent Portuguese word or the condition itself, but when the patient’s friend is unable to assist, the interpreter makes an explicit request for the midwife’s help (L4). It proves a difficult complaint to explain:

#### *Extract 1.*

M= Melina; PC=Patient Companion; I1= Interpreter; MW1= Midwife 1

- |   |   |   |
|---|---|---|
| 1 | I1: Esse é o quê↑ Se pensa↑ em relação<br>(.) o clotting                  | That is what↑//you think in relation<br>(.) the clotting... |
| 2 | PC:   | //()  |
| 3 | ((I1 turns to midwife))   |   |
| 4 | I1: <u>clotting</u> (.) how//can explain it↑                              |   |
| 5 | MW1:  | //yeah blood blood (.) £ I don’t speaka da Spanish £ (.)    |
| 6 | Like if you have the normal flow of blood and it just clots ((shows lumps |   |
| 7 | by creating circle with hands)) little clumps of clots=                   |   |
| 8 | PC: = is like bubbles//or something                                       |   |

(Continued)

*Extract 1. (continued)*

M= Melina; PC=Patient Companion; I1= Interpreter; MW1= Midwife 1

- 9 MW1: //yes (.) little bubbles clots (.) where it can cause  
 10 problems to the heart to the organs (.) she would know if she ever had it  
 11 cos they would have to give you medication to stop it or to (.) to decrease  
 12 it (.) so she would know it if she had it it affects the blood flow in your body  
 13 I1: ye( )=  
 14 MW1: =>I want you to ask her< has she had any problem <with her blood  
 flow> in her body  
 15 PC: á tiveste algum problema Não ↑ have you ever had a blood problem No↑  
 16 I1: fluide (.) sangue↑ fluid (.) blood↑  
 17 M : não No

MW1's interruption (L5) demonstrates recognition of lexical confusion, but her impatient repetition of 'blood blood', followed by the stylized utterance, 'I don't speak da Spanish', does not initially offer the other participants much help. Equally, they also appear oblivious to MW1's clumsy conflation of Spanish and Portuguese. As she 'slip[s] into... [her]... speech an other-ethnic form as if it were... [her]... own' (Rampton and Charalambous, 2012: 490), the purpose of her stylization is ambiguous. On the one hand, her 'smiling' voice (Jefferson 2004) seems to demonstrate a sympathetic appreciation of the breakdown in communication; on the other hand, it could equally reflect the midwife's frustration at the time that is being taken to clarify what she understands as routine health information. Nevertheless, after a pause, MW1 begins to modify the technical term, engaging in intralingual, epistemic flattening to give an extended explanation of the condition, creating circles with her hands in an attempt to demonstrate the shape of blood clots (L6). This is followed by an elaborate co-construction (L8–17), as participants draw on their linguistic and epistemic repertoires to elucidate the relatively abstract term 'blood clotting': in Lines 8 and 9, MW1 and Melina's companion's utterances elide, as he responds quickly with helpful synonym 'is like bubbles or something' (L8) and the midwife agrees. However, in recognition that comprehension clearly relies on ones' ability to navigate a contextual continuum (Cox and Li 2019), MW1 continues, changing reformulations to not only explain the medical condition but to shift the agenda and confer the patient with epistemic authority (Baraldi and Luppi 2015), 'she would know if she ever had it', 'she would know' (L10/12). While the repetition of the word 'blood' (L12, 14) is also used to aid comprehension, idiomatic reformulations of the condition ('blood flow' L14, 'fluid blood' L16) also appear to aid understanding.

As the consultation progresses, mediation continues to be employed simultaneously across languages and epistemologies, frequently giving rise to

approximated meanings, which often prompt extended negotiation and may hold the potential for unanticipated consequences. In the next example, initial confusion is caused by the term chicken pox—a very common, mild childhood illness but one which can cause complications if contracted during pregnancy.

*Extract 2.*

M= Melina; PC= Patient companion; MW1= Midwife 1; I1= Interpreter 1

- 22 I1: (2) chicken box↑ Eh (.5) Eh (.5) chicken pox is ↑  
 23 MW1: in childhood  
 24 I1: Quando tu era pequeno. . . When you was small (2) ((turns to PC))  
 ((Turns to PC)) o que era a palavra what was the word chicken pox erm (.) in  
 chickenpox erm é em  
 25 Português↑Vocês é. . . Portuguese ↑You all. . .  
 26 PC: chicken box↑  
 27 I1: yeah é chickenpox, aquele do (.)↑ yeah chicken pox that one of the (.) ↑  
 28 MW1: (.) yes (little?)//skin (.) spots  
 29 PC: //aah varicella  
 30 I1: rabies= rabies=  
 31 M:= (okay) (okay)=  
 32 I1: rabies (.5) rabies de pequeninho () =rabies (.5) little rabies () when you  
 quando tu era pequeno were little  
 33 M:( okay ↑ (.) // okay ↑ )  
 34 I1: //( )  
 35 PC: ( )  
 36 I1: yes  
 37 MW1: she said yes↑(.) put in yes (.) yeah↑(.) okay ↑

Initially mispronouncing the word ‘pox’ as ‘box’ (L22), the interpreter raises her eyes from the form in query as she repeats ‘chicken pox’, with upward intonation. In response, MW1 collaborates to confirm that that the disease is often contracted in childhood, although her minimal input (Line 23) suggests that she expects the interpreter to be familiar with the condition and therefore able to translate. However, I1 appears to remain unsure. In a move of dyadic separation (Baraldi 2009), the interpreter turns away from the midwife and Melina to discuss the term with the patient’s companion, who is sitting on the hospital bed behind them and, at this point, paying little attention to the conversation. Glossing MW1’s earlier clarification, the interpreter explicitly asks for a translation of the condition to Portuguese, ‘When you was small. what was the word chicken pox erm (.) in Portuguese ↑You all’ (L24/25). Although by deferring to a lay participant, I1 appears to expose a lack of epistemic authority, her reformulation of the companion’s response, ‘chicken box’, is

nevertheless collaborative in nature, and it becomes clear that she recognizes the patient's friend as a helpful ally: from Lines 24 to 32, the participants work jointly to negotiate meaning. While she does not speak Portuguese, MW1 realizes that the medical term is causing confusion so, squinting and pressing her fingers together to indicate 'small', she elaborates with further description, 'yes (little?)//skin (.) spots'. Interestingly, Melina's companion understands the explanation almost immediately and identifies the disease by its medical term, 'varicella', whereas I1 translates 'chicken pox' as the more improbable 'rabies', a term she reiterates in L32. The ensuing exchange between interpreters proves too difficult to hear (L34/35), making it unclear to which condition Melina indicates having had in the past. As she utters 'okay' (L31, 33) the patient demonstrates an understanding of *something* but, with her contributions overshadowed by others, she then falls quiet. Simultaneously, MW1 appears to sense some disagreement between the formal and ad hoc interpreter and urges clarification, seen through her use of rising intonation and repeated checking, 'she said yes ↑ (.) put in yes (.) yeah ↑ (.) okay↑' (L37). Despite the protracted negotiation, the participants reach an understanding and, unaware of the potential confusion, the midwife does not further probe epistemics as she has received the answer she is seeking.

In many ways, Melina's consultation can be seen to epitomize key aspects of translanguaging in healthcare that would benefit from further consideration. While interaction points to the productive and generative advantages of the linguistic and epistemic negotiation, it also highlights the implications that multi-authored discussions may have for limiting patient agency and the ways in which approximated meaning may complicate what can be understood as informed consent. Setting aside these concerns temporarily, the following section seeks to introduce the consultation room as a translanguaging space (Li 2018), which indexes not only biographies, but 'the polycentricity of the-environments in which the speaker(s) dwell(s)' (Blommaert and Backus 2011: 15).

### A translanguaging space

Linell and Bredmar (1996) note that are two types of sensitive topics in health care; 'lifestyle-implicating' topics, for which the patient must take responsibility, and 'those that relate to serious disease and disabilities' (1996: 348). Gestational diabetes bridges both categories as a condition that can be somewhat self-managed, yet simultaneously holds the potential for complications for mother and child. In the first of several consultations where she is seen to draw on her broad linguistic repertoire, we now meet a diabetes consultant, DC, as she is advising a Sri Lankan patient (Maalini) on how to manage her diet. A professional interpreter and the patient's husband are present.

*Extract 3.*

Ma= Maalini; Hus= Husband; I2= Interpreter; DC= Diabetes Consultant

- |    |   |                               |
|----|---|-------------------------------|
| 1  | DC: ... what do you eat for dinner ↑  |                               |
| 2  | I2: இரவு என்ன சாப்ட்டிங்க↑  | What did you eat for dinner ↑ |
| 3  | Ma: ந்தாளை முன்னாள் இரவு↑   | Yesterday's dinner↑           |
| 4  | Hus: இடியாப்பம் தான் சாப்ட்டிங்க  | Idiyappam is what we had      |
| 5  | DC: roughly like every day<br>(very quiet discussion between interpreter, husband, and patient) |                               |
| 6  | I2: வழமையா என்ன சாப்பிடுவீங்க↑  | Usually what do you eat↑      |
| 7  | DC: puttu=  | puttu=                        |
| 8  | Ma: =>no no no no< ( )//(<)   |                               |
| 9  | DC: //hhhh  |                               |
| 10 | Ma:=two weeks or three weeks, no puttu  |                               |
| 11 | DC: no puttu no idly no dosa hh   |                               |
| 12 | Ma: na (.) na (.) na (.)=   |                               |

Listening to the conversation between interpreter and patient, DC's receptive skills prove to be finely tuned and enable her to specify the aspects of Maalini's diet in which she is most interested (L5). As the consultant begins to flex her linguistic repertoire, DC straddles the realms of medical professional and co-participant, combining medical knowledge and language skills to both tease the patient, and tease-out the couple's eating habits. To clarify the information that she needs, DC playfully interrupts mediations and answers the interpreter's question with an interjection of 'puttu' (L7). Although the speedy, emphatic denial from her patient '>nononno<' (L8) draws overlapping laughter from the doctor, DC nevertheless continues to tease her patient by listing other food which is traditionally high in fat or sugar, 'no puttu no idly no dosa hh' (L11). This is an interesting move, especially as [Goffman \(1972\)](#) notes that individuals generally work hard to maintain interactional harmony by paying close attention to preserving a positive self-image, or 'face', as well as considering the face needs of fellow interactants. In this instance, although teasing a patient about their diet clearly holds the potential to offend, the doctor not only skilfully personalizes the exchange by utilizing her ability to codeswitch, but her convivial stance and laughter also mask the face-threatening, or interactionally destabilizing, nature of advising dietary compliance ([Fatigante and Orletti 2016](#)). By prefacing the list with 'no', DC's prosocial move is confirming Maalini is not eating unhealthily, as well as emphasizing the threat the foods pose to her health ([Hudak and Maynard 2011](#)). It is not clear from the patient's comparatively measured response, however (L12), whether Maalini is already adhering to a healthy diet or that she intends to do so.

We next meet the diabetes consultant in a more sombre encounter with Sadia, a patient in the last trimester of pregnancy. As she is pregnant with her fourth child, Sadia is presented with the additional complication of a potentially short labour, which could give her very little time to get to the hospital. Much of the consultation is conducted in Urdu,<sup>3</sup> with few interventions forthcoming from the interpreter or Sadia's husband. I enter the room at the end of a physical examination, when DC is urging Sadia to monitor her blood sugar levels strictly, prior to admission for a planned caesarean section.

*Extract 4.*

S=Sadia; DC=Diabetes Consultant

- |  |  |
|--|--|
| <p>5 DC: aur tera (13) taarikh ko apka induction hain, saare saath (7:30) baje haspatal mein phone karke. . .kabhie haspatal mein bahut busy ho jaata hain toh bed ki kami ho sakta hain toh us chakkar mein phone karke poochna parega 'mein aa rahi hoon', 'ya mein aa sakti hoon' toh woh bolenge ki 'aap aao' toh jab aap aayengi toh mid-wife aapko examine karke dekhengi (.)</p> <p>6 S: mm</p> <p>7 DC: ki andar bachedani ka much khula hain kya hain, phir ek dawai lagayengi aur phir aapko labour mein. . .ho sakta hain ussi din bacha aa jaye</p> <p>8 S: Ye (.)</p> <p>9 DC: theek hain ↑who tera taareekh ko hain. Lekin use pehele aapka bacha ghoom nahin raha hain ya paani aa raha hain ya dard shuru hua, aisa kuch bhi hain toh please yeh notes leke aa jana haspatal</p> | <p>= On the 13th you have your induction you need to call the hospital at 7:30 and confirm once again (.) sometimes it is very crowded at the hospital and there may be a scarcity of beds (.) so you need to call and ask 'can I come today?' or 'should I come today?' and if they say, 'yes come' then you come in and the midwife will examine you (.)</p> <p>carefully and measure you..your opening then she will apply/put a medicine and you will go into labour (.5) chances are high that you will get the baby that day itself</p> <p>Okay</p> <p>Okay↑ (.) this is going to happen on 13th but before that if your baby is not moving, or there is water or you start feeling pain of any sort then (.) please (.5) refer to the notes and immediately please come to the hospital</p> |
|--|--|

Calling to mind an oft problematized model of power in doctor/patient relationships, here the consultant can be seen to shape the agenda, dominating the conversation, as she leads the patient through a series of instructions and explanations. In line with [Brown and Levinson's \(1987\)](#) suggestion that 'rational actors' only forego the mitigation of face-threatening acts when necessity takes precedence over the hearer's face needs, the patient receives vital information directly, rather than accompanied by normative features of mitigation or via the interpreter. DC's iterative use of the imperative verb 'you need to' (L5), and use of 'okay' as a device for checking comprehension (L9), emphasizes the degree of urgency which may accompany the onset of labour. In addition to a series of ventriloquized reflections (L5), they place upon the

patient a series of obligations, 'establishing how [s]he is morally constrained to conduct [her]self' (Goffman 1972: 49). The instructions also imply the consultant's expectations, and although Sadia indicates understanding and compliance through the use of back-channelling agreements (L6, 8), this sequence appears to position the participants asymmetrically.

While it is possible to construe the extract solely as a display of institutional power, with DC addressing Sadia in an apparently simplistic and patronizing tone, her communicative approach may be more generously understood as displaying a sensitivity towards her patient. DC's use of Urdu may be designed to reduce her symbolic authority, aligning the consultant with her patient, and allaying Sadia's fears about having a baby in an unfamiliar environment. Similarly, by reducing information into short, comprehensible chunks (L5, 7, and 9) and flattening epistemics when describing the medical procedure of induction, (she replaces 'cervix' with the word 'opening', L7) DC appears to anticipate, and avoid, any possible threat to face which may be posed by the use of technical, unfamiliar, or explicitly gynaecological vocabulary. Indeed, the consultant's interactions with her patients seem to acknowledge and reflect the fact that while medical appointments are positioned as locally organized and negotiated events, they also index extrasituational contexts. As can be seen in the final extracts, DC is not alone in her ability to draw intuitively on the breadth of her linguistic and cultural resources to facilitate antenatal care effectively.

## LINGUISTIC CREATIVITY

In this section, I continue to explore how speakers in possession of a 'translanguaging instinct' (Li 2018) intuitively navigate and negotiate the unpredictability of the consulting room: that is, they use strategies that cannot be immediately anticipated, and which may 'transcend defined language boundaries to achieve effective communication' (Li 2018: 22).

MW3 has reported initial difficulties in communicating with their patient, Alicia, using English: no interpreter is present. The midwife is originally from Italy, the patient is Portuguese and although neither speaks the other's language, MW3 has established that Alicia speaks some Spanish. I join the consultation at this point, where MW3 is beginning to explain the complexities of an anti-D injection. As Alicia is due to have the injection for the first time, the midwife is obliged to advise the patient of the reason for the injection: it soon becomes clear that the patient does not realize that she is being addressed. Following Li's observation that '[a]s people become more involved in complex communicative tasks and demanding environments, the natural tendency to combine multiple resources drives them to look for more cues and exploit different resources' (Li 2018: 23), MW3 decides to draw on a wider repertoire.

*Extract 5.*

AL= Alicia; MW3= Midwife

- 1 MW3: do you know why you're having this injection ↑
- 2 MW3: (2) no ↑okay so (2) ((papers rustle as they turn pages to check details))
- 3 your blood is rhesus negative okay↑ so that means (3) let's take it very easy okay↑  
((bending slightly, to show Alicia a drawing of a red blood cell, drawn on a paper towel))
- 4 this is a red blood cell okay ↑this is the negative
- 5 and this is the positive the positive around it has got kind of let's call it protein
- 6 okay↑ so (1) this means that if your baby is rhesus positive (.) > baby you're
- 7 carrying <if the baby is rhesus positive and during your pregnancy you have a  
bleeding
- 8 in between you and your baby okay↑ do you understand what I'm saying↑(1)
- 9 Okay, if you don't (.) just stop me okay ↑so let's say again everything in Spanish (.)  
umm↑ what d'you think ↑Okay ↑

The midwife pauses sensitively (L2). As 'involvement is an interlocking obligation' (Goffman 1986: 346) MW3 changes footing in an attempt to further engage Alicia and to explain why an anti-D intervention is recommended. The premise underpinning the anti-D injection is complex, yet there are potential consequences for future pregnancies if it is not administered: as such, and in keeping with a commitment to patient consent, it is important that Alicia understand why she is being offered the injection. Rather than reverting to a traditional, hierarchical model which privileges the epistemic authority of medical professionals, MW3 employs a wide range of semiotic strategies to encourage 'the participants' rights of and responsibilities for access to and production of knowledge' (Baraldi and Luppi 2015). The repetition of 'okay↑' as a discourse marker, throughout the explanation (L2, 3, 6, 8, and 9), is used to check understanding, reassure, and nurture co-construction: when accompanied by pauses, it also acts as punctuation to slow down the delivery and make the content more accessible. Drawing on their semiotic repertoire, MW3's head inclines to make eye contact with Alicia and to draw attention to an illustration of a red blood cell (L3) they have drawn on a paper towel from the dispenser (see Figure 1).

As they explain the notion of negative and positive blood, the midwife gestures to the inside and outside of the cell. However, despite MW3's attempts to avoid any possible threats to face through interlingual description, the patient sits passively throughout: although she is smiling, it is unclear whether Alicia understands the midwife. After a series of requests to clarify comprehension (L8, 9), and to verbally engage the patient, MW3 begins to reformulate in Spanish.

*Extract 6.*

AL= Alicia; MW3= Midwife

- |    |   |  |
|----|---|--|
| 10 | MW3: okay so esta es tu celula de sangre (.) okay ↑ (.) Es negative. Esta es (1) positive | okay this is your blood cell okay↑<br>It's negative. This is (1) positive. |
| 11 | MW3: Si hija o hijo es positivo, okay ↑Si tu tienes un sangramiento ↑                     | If your daughter or son is positive, okay↑ If you have a bleeding↑         |
| 12 | what do you say in Spanish ↑u: m (1) exchange of blood                                    |  |
| 13 | AL: yes=  |  |
| 14 | MW3: = cambio de sangre   | blood change   |
| 15 | MW3: between you and your baby which can happen in pregnancy (.) u: m (.5) the baby       |  |
| 16 | MW3: will be sick (1) okay↑ okay ↑because your blood your body will not recognize         |  |
| 17 | MW3: tu cuerpo no conoce el positivo porque tu estas negative(.)                          | your body does not recognize the positive because you are negative         |
| 18 | MW3: por eso tiene que destruir (.) la sangre de tu hijo, okay ↑                          | and because of this it will destroy your child's blood, okay↑              |
| 19 | MW3: (.) Puede ser muy malo, okay↑  | This can be very bad, okay↑  |
| 20 | MW3: So that's why you're gonna have this injection okay↑ (.2) you're gonna               |  |
| 21 | have one now at 28 weeks  |  |



*Figure 1: Replica of MW3's illustration of blood cell.*

Referring throughout to the drawing, MW3 reiterates their explanation in Spanish. Contrasting with findings by Baraldi and Luppi, who claim that 'reformulations show midwives' ambivalent attention to patients' understanding of technical words' (2015: 594), MW3 avoids the use of medical

terminology ‘rhesus’ in their second reformulation—no longer using it as a prefix for ‘negative’ or ‘positive’ blood (L10, 11, 17). Initially unsure of how to translate ‘exchange of blood’, the midwife bolsters Alicia’s epistemic authority by asking her to confirm the translation (L12). In this instance of intersemiotic and intralingual translanguaging (see Baynham *et al.* 2015), MW3 demonstrates a translanguaging instinct which ‘draw(s) on as many different sensory, modal, cognitive and semiotic resources as [they have] available’ (Li 2018: 23), and through which they seek to make meaning in ‘ensemble’ (García and Li 2014). However, from Line 20, we see a change in footing, where, although the midwife continues to draw on Spanish and English, they move from an explanatory stance to a more didactic one. After repeated reformulations designed to promote patient understanding, MW3 shifts to an institutional agenda, ‘so that’s why you’re gonna have this injection you’re gonna have one now at 28 weeks’ (L20), removing the potential for patient participation, and more significantly, choice. Although the bald-on-record statement may function as a direct threat to Alicia’s face needs, and the perlocutionary force of the imperative is mitigated by the informal use of ‘gonna’ rather than ‘going to’ (L20), at this point in the consultation, the reality of the interaction is stark. MW3’s summarizing tone not only indicates to the patient that they need to administer the anti-D injection within a fixed, institutional time frame, but also that having completed their explanation, they intend to do so whether Alicia has signalled understanding or not. Of course, this is not to suggest that there is sinister intent: it is likely that while MW3’s efforts indicate a translanguaging stance, they also facilitate a clinical expedience that takes precedence.

## DISCUSSION

Guided by an understanding that all interaction takes place within a social context, this article illustrates how communicative practices associated with superdiverse populations permeate the institutional environment of a 21st-century hospital, creating a translanguaging space in which diversity appears to be not only acknowledged, but routinely navigated. While health workers may be professionally compelled to ensure ‘institutional order is produced and...reproduced’ (Moyer 2013: 199), findings illustrate that when professional identities indexing specific hierarchies are ‘brought along’ to meetings, there may also be local identities that can be ‘brought about’ by interaction (Sarangi and Roberts 1999: 30). This article explores the breadth of communicative resources utilized by patients, interpreters, and medical professionals: it illustrates how those in possession of a translanguaging instinct are able to traverse sociocultural and linguistic ‘difference’ by drawing on their varied, multisemiotic repertoires to co-construct, mediate, and enhance understanding. In many ways, such orientations are consistent with an NHS commitment to ‘patient-centred care’, that is, ‘coordinated and tailored to the needs of the individual [where] healthcare professionals work collaboratively with people

who use the service' (NHS n.d.). Whether translanguaging practices are an innate response to situated demographics or exemplify a more strategic linguistic resourcefulness, aimed at bridging the gap created by inconsistent interpreter provision, this article illustrates a disruption of established guidelines and a shift in institutional practices. In sum, not only are medical professionals appearing to utilize their full linguistic repertoire to better align and communicate with their patients, but they are also being given the conditions to do so.

It seems that communicative practices are contingent not only on the orientations of interactants, but on the (superdiverse) environment from which individuals cannot be separated (Gumperz 1972). Certainly, the specific context of antenatal care involves professionals who are frequently recognized for their metalinguistic and cultural sensitivities (Baraldi and Luppi 2015) and affiliative stance (Linell and Bredmar 1996; Defibaugh 2014)—features which seem to offer unique environmental affordances for a translanguaging space. On the other hand, the epistemics of consultations can be interpreted as intrinsically asymmetrical. Although the midwives and doctor in this study demonstrate an inclination towards linguistic and cultural accommodation, it is largely at *their* instigation that negotiations are taken up, which suggests that a space for transformative dialogue may remain at the discretion of those in authority rather in the hands of patients. For example, while the midwife in the final extracts demonstrates the ability to recognize, manage, and cope with difference very creatively, the decision to communicate in a lingua franca, rather than to seek additional support in the form of a Portuguese interpreter, is arguably to enact a privilege which compromises the patient's linguistic and legal right to give informed consent. In these circumstances, a belief that an emergent liminality, superdiverse stance, or orientation towards (linguistic) equity can dispel interactional mechanisms of power or inherent epistemic imbalance must surely be acknowledged as contingent.

To focus further on intercultural healthcare, where it is understood that information should be communicated clearly, in a manner and language that is comprehensible to the patient (NHS England/Primary Care Commissioning 2018), it seems that day-to-day efforts to achieve mutual intelligibility can sometimes falter, 'even when there is goodwill on both sides' (Gumperz *et al.* 1979: 1). An additional implication for the superdiverse consulting room is therefore one of (mis)understanding, the consequences of which have the potential to adversely affect patient experience and clinical outcomes. Indeed, the first two extracts succeed in drawing attention to dilemmas that may not always be self-evident, as well as disrupting assumptions that interpreters, professional or *ad hoc*, understand the information they are given, and/or are able to translate it accurately. This clearly has implications for patient outcomes and experience and adds another layer of complexity to ongoing analysis of increased mortality rates among migrant populations (see e.g. Knight *et al.* 2019).

Findings from this study have drawn attention to paradoxical tensions between institutional and personal approaches to languaging practices, noting that while translanguaging offers the potential to contribute to feelings of well-being and ethnolinguistic acceptance, there exist tensions upon which there is an ethical responsibility to reflect (Blommaert and Rampton 2016). These may prove difficult to navigate without an explicit recognition, acceptance, and harnessing of the complexities posed by the multilingual consulting room. As urban landscapes continue to shift, the increasingly complicated repertoires of local populations present new ways of redefining experience and knowledge. These hold clear implications for institutional change.

## NOTES

- 1 Hayfield is a pseudonymised town.
- 2 Hayfield University Hospital is a pseudonym
- 3 Transliterated script.

## SUPPLEMENTARY DATA

[Supplementary material](#) is available at *Applied Linguistics* online.

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## NOTES ON CONTRIBUTOR

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