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Cultivating capabilities and coping: accepting and analysing moments of communicative opacity in multilingual encounters

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Abstract: Researching in heterogeneous communities can present challenges for the most experienced of researchers, especially in the context of ethnographic work, where the dynamism and unpredictability of a research setting can make it difficult to anticipate the languages spoken. Drawing on data from multilingual health consultations, I reflect on incidents where language(s) extend beyond the scope of my repertoire and inhibit the immediacy of inference. Ensuing collaborative processes of translation, transcription and analysis offer opportunities to illuminate (mis)understanding(s), but also demonstrate how additional contributions can complexify and shape what can be understood as 'interpretation'. In documenting some of the practical and ethical considerations that emerge during the research journey, I explore the experience of developing capabilities to cope with communicative opacity and (un)expected tensions. I conclude with some tentative recommendations for institutions seeking to support doctoral students embarking on fieldwork in diverse settings.

Keywords: linguistic non-understanding; capabilities; multilingualism

Résumé: La recherche dans des communautés hétérogènes peut présenter des défis pour les chercheurs les plus expérimentés, surtout dans le cadre d'un travail ethnographique, où le dynamisme et l'imprévisibilité d'un contexte de recherche peuvent rendre difficile l'anticipation des langues parlées. En m'appuyant sur les données des consultations de santé multilingues, je me penche sur les incidents où la(es) langues s'étendait(ent) au-delà de la portée de mon répertoire et empêchent une déduction immédiate. Ensuivant les processus collaboratifs de traduction, de transcription et d'analyse, offre des opportunités d'éclairer les (mé)comprehension(s), mais aussi démontre comment des contributions supplémentaires peuvent

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compliquer et façonner ce qui peut être compris comme ‘interprétation’. En documentant certaines des considérations pratiques et éthiques qui émergent durant le processus de recherche, j’explore l’expérience du développement de capacités pour faire face à l’opacité communicative et des tensions (in)attendues. Je conclus par quelques recommandations provisoires pour les institutions cherchant à accompagner les doctorants entreprenant des travaux de terrain dans divers contextes.

1 Introduction

While current preoccupations with (super)diverse populations rest on the presupposition that such demographics are something new (Pavlenko 2016; Vertovec 2007), there is no doubt that researching in linguistically, culturally, and ethnically heterogeneous communities may present challenges for the most experienced of researchers, even when highly prepared with a linguistically representative team, attuned to situational sensitivities (Andrews et al. 2019). This is especially true in the context of ethnographic work, where the very nature of the methodology can make it difficult to anticipate the languages spoken by participants encountered in dynamic and unpredictable settings.

Building on experience gathered during linguistic ethnographic research exploring multilingual practices in antenatal health consultations, and undertaken for my doctorate, this paper reflects upon how a naïve understanding of ‘multiple cultural competence’ (Vertovec 2009) gave way to a gradual, uncomfortable recognition of my own ‘linguistic incompetence’ (Phipps 2013), when interaction extended beyond the scope of my distinctly limited repertoire. Unfamiliar lects, varieties and languages not only served to highlight my linguistic shortcomings but often restricted the immediacy of inference. In turn, discomfort with my ‘incompetence’ was frequently exacerbated by ongoing processes of analysis, when the circularity of transcription, translation, clarification and (re)transcription, complexified what could be understood as ‘interpretation’ and contributed additional layers to possible (mis)representation. On the other hand, as my ethnographic journey continued, I began to explore some affordances of linguistic non-understanding (van Hest and Jacobs 2022). With a growing appreciation of the consulting room as a liminal, ‘third’ space (Bhabha 1990) of potential unknowability, a capabilities approach (Nussbaum 2011; Phipps 2013) offered a chance to focus more keenly on what I *was* able to do. My attention was drawn to the linguistically strategic, corporeal, and non-verbal aspects of relationality embodied by healthcare professionals, which appeared core to enhancing women’s experience. Simultaneously, and perhaps for the first time, I began to really understand the notion of transcription as an integral dimension of

data interpretation, a joint endeavour shaped with collaborators, and fraught with personal subjectivities (Bucholtz 2000, 2007).

This paper discusses some of the emergent vulnerabilities which came to light during ethnographic fieldwork and data analysis and seeks to illustrate how moments of communicative opacity can be navigated. I begin first with an overview of the literature on researching multilingually, drawing on work which explores some of the challenges posed by linguistically unpredictable contexts, the limits of personal repertoire and the unanticipated affordances prompted by liminal spaces.

Methodological reflection on translation and transcription follows, before an introduction to the research context and participants. In sharing data extracts from the field, I will exemplify some of the complexities presented by language incongruence and multiple transcriptions, exploring the impact of unsolicited commentary and potential strategies for coping with (un)expected tensions. In documenting practical and ethical considerations, I explore my own personal limitations in the hope that these will contribute to open and ongoing conversations within the research community. I end this paper with recommendations for institutions supporting sole doctoral researchers working with multilingual participants.

2 Challenges to researching in multilingual contexts

The number and variety of people migrating from different parts of the world has increased exponentially in the 21st century, dispelling previous ideas of diverse populations as living within bounded, diasporic communities, linked by either space or knowledge and sharing cultural and communicative norms. Such conceptualisations have been replaced with understanding of contemporary urban populations as having 'meshed' realities (Canagarajah 2011), where a heterogeneity of ethnicity, nationality, language, education, age and gender profiles, immigration and work status has become the new norm. In response to the demographic changes that may present challenges for traditional ethnographic fieldwork, and in the anticipation that researchers may encounter non-hegemonic and/or unfamiliar repertoires, Andrews and colleagues (2019) propose a framework for researching multilingually. One recommendation is that studies should be approached with a degree of clear intentionality, with researchers giving thorough consideration as to how they will respond to the linguistically diverse populations with whom they may engage. This preparatory stage should not be underestimated, for there may be a number of issues which need prior deliberation. In their recent paper proposing a 'methodological

multilingual turn', Costley and Reilly (2021) reflect upon the degree of planning and preparation that may be needed before embarking on fieldwork in linguistically diverse contexts and offer a prescient reminder that we cannot expect to engage with multilingualism from a monolingual perspective.

This implies a need for flexibility, resourcefulness, and heightened awareness of the local context. From the outset, one may be well advised to pay attention to the kinds of practices and language that may or may not be generated, or even tolerated, in a specific research space (Andrews et al. 2019). At the same time, the multivalence of language(s) may mean that while speaking a language loaded with historical legacies may inhibit the potential for collaborative relationships with some participants (Sepielak et al. 2023), it may nonetheless hold different associations for others. Of course, it is clearly advantageous to have a degree of proficiency in (a) shared language(s) when working with specific communities. Not only can direct communication enhance comprehension and strengthen relationships but there are likely to be additional benefits in terms of increased ethical sensitivities, authenticity, and the reduction of asymmetries (Costley and Reilly 2021; Ganassin and Holmes 2013, 2020; Holmes et al. 2013). However, conducting research in a superdiverse environment nevertheless poses challenges in terms of practicalities, and to suggest otherwise would be disingenuous (van Hest and Jacobs 2022). While some multilingual researchers may have the resources, and occasion, to draw on different parts of their repertoire (Ganassin and Holmes 2013; Polo-Perez and Holmes 2023), others may need to reflect on personal limitations. Indeed, research by Sepielak et al. (2023) finds that linguistic concordance can frequently be a scholarly aspiration rather than an everyday reality. Communicative ambitions can remain unfulfilled if a language is not spoken fluently by a researcher and if a variety is considered rare or difficult, there may be limited inclination, time, or budget to learn it.

Pre-empting such scenarios, Costley and Reilly (2021) follow calls to problematise the notion of a sole ethnographer (Creese et al. 2015). They underline the importance of creating flexible alliances with 'knowledgeable collaborators' (Lorette 2023), where researchers can work hand-in-hand with participants, guides and interpreters in an as non-hierarchical manner as possible (Ganassin and Holmes 2020). By adopting an 'ontological imperative' to prioritise language (Costley and Reilly 2021: 1041) in such settings, researchers also have the advantage of making audible a "plurality of multiple authorities" (ibid 1042) to strengthen insight, nuance reflexivity and enhance the potential for real-world impact. It is claimed that this approach can be especially powerful for projects that seek to advance representation of linguistically diverse and minoritized populations.

While extensive recommendations are likely to prove helpful in shaping future research plans for collaborative endeavours, doctoral students comprise one group of researchers for whom the journey is often uncomfortably solitary. Although some may solicit informal advice and practical support from fellow students, participants, and individuals they meet in the field, the inherent unpredictability of ethnographic fieldwork in a diverse context can make it difficult to anticipate the languages one is likely to meet and what one should do if, or when, faced with stretches of incomprehensible talk (Andrews et al. 2019; Lorette 2023). This is not to suggest that doctoral students are any more likely to be confronted by 'spaces of linguistic non-understanding' (henceforth, LNU) than more experienced researchers: communicative opacity can of course be alienating and destabilising for both those in the early stages of their career (van Hest and Jacobs 2022), and beyond. In Phipps' (2013) highly personal and moving account, reflecting on perceptions of her own 'linguistic incompetence', she lays bare the complexities of holding oneself to account on a lack of language(s), and lects lost. Highlighting the ethical obligation to acknowledge the limits of one's repertoire, Phipps encourages researchers to avoid dwelling in a state of *lanxiety*, side-stepping unpredictable situations or unfamiliar repertoires: this may be to ignore the superdiverse realities of everyday communication and research demands, as well as running the risk of observational and analytical paralysis. Instead, I suggest that we may be better placed to begin with an acceptance that stretches of LNU are likely to be both commonplace and rhizomic in nature (c.f. Deleuze and Guattari 1988), with a network of invisible, convoluted, interrelated and symbiotic constituent factors complexifying interaction, and our understanding of it.

In this vein, it is important to note that linguistically and culturally diverse environments are regularly recognised as being particularly well placed to foster a sense of liminality and hybridity (Bhabha 1990; Li 2018). Following a post-colonial logic, Bhabha argues that cultures can be seen as social constructions, "constituted in relation to that otherness internal to their own symbol-forming activity" (1990: 210). As mutually constitutive concepts, they are therefore "subject to intrinsic forms of translation" (ibid), with iterative processes of othering and reinscribing identit(ies) creating liminal, or 'third' space(s). Bhabha maintains that such spaces can enable new cultural articulations and translation of difference. Closely linked to this is the importance of relationality, that is how one uses language(s) to position oneself and build relationships with participants and colleagues (Andrews et al. 2019), while still remaining cognisant to the delicate line between forming connections and remaining sensitised to difference (Rampton 1995). Canagarajah encourages researchers to develop "cooperative dispositions and performative competence for cosmopolitan relationships" (2013: 202), whereas Andrews and Fay (2020) emphasise the need to nurture a 'translingual mindset' that can enable

individuals to be "prepared for the unexpected, dynamic, or even playful uses of language in their research contexts" (Polo-Perez and Holmes 2023: 741; see also, Rampton 1995). Leading by example, Phipps (2013) encourages us then to remain mindful of our own linguistic shortcomings, while simultaneously urging us to focus on personal *capability*, that is, not just the skills and assets that we do possess, but also those that we have freedom or the opportunity to be able to develop in a specific context, or at specific times (Nussbaum 2011). By enhancing our capacity for attentiveness and attuning to the paralinguistic and affective aspects of communication, as well as sensitivities to research context, our ability to build relationships with collaborators, may be enhanced and our analyses improved (Rolland et al. 2023).

3 Methodology

Underpinning the tenets of qualitative research is an understanding that every aspect of data collection is saturated with subjectivities, from the moment of project inception. The questions as to where research is conducted and who is recruited to take part, are ostensibly guided by a (pre)determined orientation to phenomena of (presumed) relevance to a (research) community. In the context of the doctoral project introduced today, my overriding concern was in exploring the role of multilingualism in intercultural health encounters. My interest in the topic had been piqued by migrant accounts of antenatal care in the UK and guided by the potential role of language (in its broadest form) as a social determinant of health (Federici 2022). This paper shares extracts from fieldwork, a corpus which comprises 12 clinical observations, focus group and individual interviews, and extensive fieldnotes: these were collated over a period of 6 months in an antenatal department, in an NHS London hospital. In line with previous sociolinguistic research in diverse, as well as healthcare, settings, I approached my research site from a linguistic ethnographic perspective (e.g. Blommaert 2013; Cox 2017; Roberts et al. 2004; Simpson 2016). An understanding that "language and social life are mutually shaping" (Rampton et al. 2004), enabled me to explore "the processes … that shape urban encounters [and] everyday negotiations with difference, and practices of accommodation" (Wise and Noble 2016: 427). Similarly, a close focus on language allowed further examination of (tensions within the) wider sociocultural context that interactions may index (Gumperz 1982).

During the research journey, in the linguistically and culturally diverse setting where my study was situated, it became increasingly apparent that languages spoken in addition to English were difficult to anticipate. This inevitably raised anxieties

about being able to gain informed consent from patient participants. Given that I also knew that I would have very little time to adequately approximate patients' understanding of spoken or written English prior to their appointment, I designed a series of differentiated consent forms. To try and make the forms both syntactically and epistemologically comprehensible, and as ethically robust as possible, I followed principles underpinning the creation of differentiated resources for language learners, and those proposed by NHS Health Education, to address readers with low literacy skills (Learning and Work Institute n.d.; NHS Scotland n.d.). Consequently, forms were designed for readers with English competency equivalence to CEFR levels of B2/A2/A1. Moving away from presumptions of literacy skills in English, a pre-literacy form was designed with a series of picture prompts to enable me to talk through my research with potential participants: ideally these were to be used with support from interpreters.

Although key members of staff helped me to understand the relevance of specific appointments and the institutional processes of engaging interpreters, spaces of LNU emerged during observations, and frequently extended to the introduction of unfamiliar medical terminology and specialist acronyms. In the material conditions of a consulting room, I had no recourse to linguistic or insider support and was precluded from spontaneous participation in dialogue, because of the normative constraints of medical appointments. In this context, it was not just my limited linguistic repertoire which prevented inference and interaction but also my lack of epistemic and institutional authority. Lacking the immediate affordances of language congruence and professional knowledge, I was often only able to focus on what was possible in the moment and impelled to embrace a capabilities approach (Phipps 2013). I therefore sought to capture interactants' intentionality through 'thick description' (Geertz 1973) and by enriching fieldnotes with detailing on context cues such as expression, gesture, prosody, touch, mime and/or drawings.

On returning to my desk, I adopted a reflexive stance, thinking back on the implications of observations and shaping an intentionality of gaze for future forays into the field. Central to these reflections were ethical questions prompted by the consultations I had attended. Although my proposed research had been approved by the hospital and university ethics boards, preparatory work had not fully equipped me for the highly personal and sensitive information that I was to encounter on an everyday basis. Ensuing discussions with supervisory and experienced colleagues gave me space to think about whether specific data were relevant to research questions or principled to share. They also allowed me the time to reflect on Holliday and MacDonald's argument that "interpretation begins to some degree even at the data generation stage" (2020: 634). With this in mind, I recognise that my presence as an observer, and the notes that I made, create a complicity in interaction as well as in

interpretation and documentation of what I *perceived* was going on (Bucholtz 2000). Accordingly, it was my input, what I later decided to foreground and transcribe, and who I chose to undertake translation, that set in motion an assemblage of co-constructed realities that can only claim to be a partial representation of an authentic health encounter (Holliday and MacDonald 2020; Károly 2022; Ochs 1979; Vigouroux 2009).

Despite recommendations that advocate the use of (a) research assistant(s) who may be able to support the fieldwork linguistically, this is rarely possible in doctoral research (Sepielak et al. 2023). Instead, I was reliant on help after data had been collected, and this took the form of various kinds of formal and informal translation: while I was able to employ a professional translator on several occasions, at other times it was less easy to both find and/or finance additional professional services. On these occasions, a pragmatic decision was to recruit fellow doctoral students, and/or colleagues, who were proficient speakers of the sought-after varieties. I did so with the understanding that they were likely to have experienced (doctoral) training on the ethical, sensitive, and confidential dimensions of research, and to consider the responsibility carefully. It is well recognised that translators inevitably bring their own perspectives to a script, consciously or subconsciously, and add a layer of subjectivity to the interpretation (Károly 2022; van Hest and Jacobs 2022). Once dialogic practices of back translation, checking and confirmation are introduced the process becomes complex, especially if misunderstandings and variability emerge (Hennink 2008; King 2023; Thompson and Dooley 2019). Thus, far from being neutral texts that capture an objective reality, transcripts can be seen as *'creative and politicized'* textualized documents, shaped by researcher(s) and collaborator(s) (Bucholtz 2000: 1440). We must recognise that material is selected to best support our argumentation, epistemologies, and ontologies: but even without guile, it is an opaque process, interpolated by ideologies and demanding a vigilant self-awareness and reflexivity.

In the following section, I introduce extracts from three case studies which document episodes and different aspects of LNU, as they occur in authentic medical consultations. Data is transcribed using conventions associated with applied conversational analysis in order to shed light on communicative detail (see appendix 1; Jefferson 2004; ten Have 1990) and to help explore interaction in diverse healthcare encounters. I begin with an account of a brief, unrecorded, consultation which is mediated in Hindi, a language I do not speak. It leads me, for the first time, to think explicitly about what researchers can gain from paying attention to body language, prosody, gaze, and physical contact. Following this is an extract from another appointment conducted entirely in Hindi, this time with a consultant whose repertoire mirrors that of her patient: faced once more with opaque

dialogue, I focus on corporeal and relational aspects of the exchange. The final three extracts come from different stages of a multi-authored consultation, featuring a Portuguese patient, her companion, a midwife and, for a time, a professional interpreter. These illustrate how episodes of interpretation can enable clarification but also hold the potential to compound or obfuscate (epistemic) (mis) understanding. As this appointment continues, the apparent arbitrariness of content prompted me to engage another translator (translator B), to double-check that the first (translator R) was not mishearing utterances. I seek to demonstrate that as iterative processes of translation, transcription, questioning and clarification bring multiple opinions to the fore, they blur what can be understood as interpretation in its broadest sense.

4 Data

4.1 Cultivating capabilities

A few months into fieldwork, Suhana, a healthcare assistant, invites me to sit in on a consultation with a senior midwife and a young woman in her second trimester of pregnancy. Being multilingual herself, Suhana had previously expressed a lot of interest in my research and had been very helpful in identifying potential participants. On this occasion, the unaccompanied woman is attending in response to a phone call she had received from the department earlier in the day: she is a first language speaker of Hindi, with limited English proficiency. No interpreter has been booked for the appointment and it is planned that the midwife will explain the need for this unscheduled meeting, with Suhana reformulating in Hindi. Prior to my arrival, both had gained consent for my attendance: this was on the strict understanding that no recording would take place and that I was only there to observe a bilingual consultation.

Set against the regimented, time-bound appointment system that I had witnessed in the antenatal department, the ad-hoc nature of this mediated encounter struck me as unusual from the outset. Not only was a back-office being repurposed as a consulting room, but a junior member of the team also appeared to be formally positioned as an (informal) interpreter and/or cultural mediator. The physical set-up of the room was far from the norm: in a hastily emptied, communal office space, the midwife sits with her back to her workstation, creating a circle with Suhana, the patient and me. We all sit on office chairs, our knees almost touching. In a hushed voice, the midwife begins with a short explanation: as the patient had presented late in her pregnancy, some important blood tests are now very urgent, to ensure that the foetus is healthy and to prepare for difficult decisions should the tests reveal

otherwise. Looking anxiously between the health professionals seated before her, it is clear that the patient does not understand the midwife's explanation but gauges the gravity of the situation.

It is at this point that Suhana intervenes in Hindi. Following Baraldi's observation that interpreters are the only active participants who can understand everything uttered in triadic communication, the healthcare assistant appears to "assume the role of promoting and co-ordinating the interaction" (Baraldi 2009: 120). The midwife seems equally content to assign Suhana the role of 'co-diagnostician' (Hsieh 2008) as she turns away from the patient to work on her computer. As she talks at length and answers questions, Suhana's confident mediation appears to be alleviating the anxiety which had been earlier etched on the patient's face. Situated in an unanticipated space of LNU and presented with my own linguistic incompetence, I attempt to follow Phipps's (2013) advice to focus on what I have the capacity to interpret. I try to disattend from efforts to comprehend the verbal exchange and to concentrate instead on gaze, touch, tone, and register. Facial expressions indicating concern establish this as a serious, high-stakes consultation. Suhana's soft and unmodulated voice is accompanied by a focussed gaze, and handholding, apparently to offer reassurance. Simultaneously, her free hand is raised to chest height, and she moves it rhythmically away from her body in fractions, as if to imply a series of impending stages and/or decisions that are likely to unfold. At this moment, I am totally extraneous to the conversation, humbled by the intimacy of the interaction and embarrassed at my inability to leave the room without disturbing the consultation. I was later to reflect on this episode as one of analytical paralysis, but also as pivotal to my nascent understanding of what it might be to centralise humility and attend to what I was capable of doing within the confines of an institutional space (Nussbaum 2011; Phipps 2013).

4.2 Navigating communicative opacity

Suhana proves to be a helpful ally in my research, and throughout the duration of my fieldwork, she often invites me to join consultations she believes I will find of interest. In this next appointment, I join the consultation after the physical examination. Here we meet a heavily pregnant patient with gestational diabetes: she is accompanied by her partner and a professional interpreter. As diabetes in pregnancy can cause serious complications, the consultant is advising her to monitor her blood sugar levels closely, prior to admission for a planned caesarean section. Research consent has been gained with support from the consultant and

communication is taking place in Hindi: this is later transcribed and translated by a doctoral colleague.

		Participants: DR = doctor; P = patient; UNK = unknown contributor	
9	DR	***theek hai ↑(.) 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 (.5) yeh*** notes ***leke aa jana haspatal***	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*
10	UNK	( )	
11	P	Mm	
12	DR	phone ***karne ki zaroorat nahin***	*no need to call*
13	P	***ha theek hai***	*yes*
14	DR	***theek hai↑ (.) turant aa jana (.)***	*okay ↑ (.) come quickly (.)*
15	P	Uh	
16	DR	***chautha bachcha hain na toh jaldi aa sakta hai↑***	*because this is your fourth baby, might come very quickly okay↑*
17	P	***hhh theek hai***	*yes okay hhh*
18	DR	(4) ((doctor averts gaze to write in Pregnancy notes/clinical notes))	
19	DR	***kuch aur poochna hain***	*do you have any questions*
20	P	***Nahin***	*No*

Although I am able to understand very little of this exchange, contextual information helps to inform initial inferences. Having witnessed the consultant's flexible languaging in previous encounters, I am unsurprised to hear her drawing on her wide linguistic repertoire. Equally, I know that she is a consultant specialising in complex pregnancies: in combination with the heavily pregnant woman standing before me, it is not difficult to conclude that crucial information is being exchanged. Nevertheless, facing a stretch of talk outside of my repertoire, I recall Cicourel's observation on the importance of inference:

> [t]he perception and comprehension of speech events or actual communication [foster] essential conditions for bringing a frame of reference into existence and making decisions about what is happening and taking action in a given setting (1999: 186).

I strive to focus on my capacity for what I can perceive (Phipps 2013). In the first instance, facial expressions indicating concern and communicating reassurance establish this as another critical consultation. My fieldnotes include reflection on the most striking aspect of this interaction, which is the degree to which the doctor holds the patient's gaze as they utter a series of what seem to be instructions. I note the tone with which the doctor speaks – serious, steady, urging – and the reiteration of a

phrase, “theek hai” (L9, 14), which seems to function as a means of checking. In response, and illustrating her attentiveness, the patient holds the consultant’s gaze, nodding and appearing to demonstrate understanding through the use of several back-channelling utterances (L11, 13, 15). However, by line 17, the patient’s agreement is accompanied by an uneasy laugh, potentially used as a subtle indication of her rising concern. Noting this shift in tone, and perhaps to indicate the end of the appointment, the consultant averts her eyes and begins to write in the patient’s medical notes.

I later consider the tangle of contextual tensions presented by finding myself bridging emic and etic positions. As this consultation took place towards the end of my fieldwork, and as an ethnographer steeped in the research environment, I had, to some extent, become an insider. Indeed, I certainly may have appeared as such to the woman and her partner: a reflection on my silent presence after the appointment provoked an uncomfortable self-realisation that my observation could have been interpreted as following a much-disparaged neo-colonial tradition (see also Phipps 2019; Tankwanchi et al. 2023). Simultaneously, I was an outsider, privileged to be allowed to observe this personal encounter, with a woman on possibly the most precarious part of her pregnancy journey, yet separated by a linguistic gulf. The fact that I was institutionally, epistemically, and linguistically incapable of contributing to the conversation, led me to (re)conceptualise the consulting room as a ‘third’ space of potential unknowability, where meanings and signs could “be appropriated, translated, rehistoricized, and read anew” (Bhabha 1994:55).

4.3 Layers of linguistic non-understanding

The second extract is from a ‘booking-in’ session, the initial appointment designed to capture a woman’s personal and medical history, and to determine their pregnancy pathway. The consultation features a Portuguese patient, with limited proficiency in English, her male companion, who appears to have good conversational English, and an experienced midwife: they are joined for the first hour by a professional interpreter, organised by the hospital’s preferred provider. Consent for my presence was gained via the patient’s companion and interpreter at the beginning of the appointment.

This example has been chosen to illustrate the layers of LNU which can unfurl during mediation but the multiplicity of which may only become fully transparent later in the research process, after translation, transcription, and additional contributions from the translator (R). In the excerpt below the midwife is asking the

interpreter to work through a set of standardised questions with the patient: the form is a tick-box exercise, requiring yes/no answers.

		Participants: MW = Midwife; I = interpreter; P = patient	
111	MW	=right right let's go through this now (.) erm just go through this with her(.) and theres a tick (.) answer the questions as they are (.) anything you don't understand ( ) I'll wait	
112	I	all these questions↑=	
113	MW	=all these questions and then you can go=	
114	I	=okay (.) ***é historia médica dele que te está perguntanto=***	*= okay (.) this is his history medical that s/he is asking you=*
115	MW	=>ask her the main term just tick them off yes or no< (0.1) she has the pen	
116	I	ask her to (.) if she understands↑	
117	MW	( ) has she ever been (.) seriously ill in erm (.) where she has to be admitted in a high dependency unit (0.1) yeah↑	
118	I	ITU //okay	
119	MW	//yes or intensive care	
120	I	okay (.) ***tu já foi admitido no (.) erm acho que (.) é sala de emergência*** ↑	*okay (.) you was admitted in (.) erm I think it is (.) emergency room* ↑
121	P	no	
122	I	no	

Initially, it is clear that the interpreter is bemused at the quantity of questions she needs to translate: her voice can be seen to rise and increase in volume, as if to express surprise and creating the impression that she is daunted by the task, "all these questions↑" (L112). Once confirmed, the pause following the ensuing response "okay(.)" implies a degree of uncertainty, prompting the midwife to interrupt her to reformulate and gloss instructions on how to complete the form (L113/115). Indeed, the midwife seems impatient to start the questioning (L117-118): it is possible that the interpreter has not had enough time to familiarise herself with the text and expectations surrounding its completion. The interpreter's attempt to clarify, with an emphasis on whether "she understands↑" (L119), obliquely implies that she herself is unsure of meaning. Yet, the midwife fails to pick up the cue and interpretation begins.

While neither the midwife nor I are able to understand the exchanges taking place in Portuguese, it is reasonable to assume that, at the time, we are confident that the interpreter was translating the questions effectively for her client. Although my fieldnotes reflect a little unease – "the interpreter does not appear to be very confident as she keeps checking (her own?) understanding with [name]" – utterances seem to adhere to a pattern of adjacency pairs commensurate with the patient's yes/no responses. The answers are conveyed to the midwife as the form is being completed. Later, when transcribing the dialogue from the appointment, I duly leave

spaces for the Portuguese utterances to be added and on the presumption that they will correspond to the conditions, listed alphabetically on the hospital medical form. However, it is only when the transcript is returned from the professional translator (translator R) that gaps in the interpreter's understanding become visible. For those of us who do not have Portuguese within their repertoire, the most obvious breakdown can be witnessed in the exchange between L117-121, where the interpreter embarks on a confused translation between HDU/ITU and the emergency department, couching her uncertainty with "I think it is" (Line 120). Here we can see that the error appears to be epistemic rather than lexical. It is worth noting that the linguistic, literacy and epistemic demands of mediated medical encounters are widely recognised, and it is not uncommon for breakdowns in communication to transpire (see for example, Arafat 2022; Collins and Slembrouck 2006; Flores et al. 2012; Roberts et al. 2005). On the other hand, the misunderstanding may highlight the unregulated nature of interpreting provision in the UK, where it cannot be taken for granted that individuals working for a language service provider have been assessed by a regulatory body (National Register of Public Service Interpreters 2019).

It is on receipt of the updated transcript that the Portuguese translation renders visible additional dimensions to spaces of LNU, such as the potential impact that collaborators may have upon interpretation (see also, Reynolds and Holmes, this issue). Translator R notes grammatical inaccuracies and non-standard language use and expresses her incredulity at the hospital interpreter's abilities in red, bold, and capitalised annotations: later, in personal communication, she offers an informal assessment of the interpreter, categorising her "a very low B1 level – I'd even say a A2 level" (as identified by the CEFR). While these disparaging remarks could certainly contribute to alternative discussions as to what constitutes proficiency in professional interpreting, in the context of analysis they posed a question as to how to pursue my interpretation of the event. Once exposed to R's evaluations, the comments about the interpreter were difficult to dismiss and prompted reflection on the co-constructed nature of analysis.

The next extracts are taken from towards the end of the same consultation. The patient has just been offered optional vaccinations against influenza and whooping cough: in the UK these are given routinely during pregnancy, to protect the mother and child against disease and potential complications. As the professional interpreter has had to leave for another appointment, the patient's companion adopts responsibility for translation and asks the midwife for clarification. While the relevance of including a conversation which takes place entirely in English may not be immediately apparent, extract 3 illustrates how epistemic asymmetries and ambiguous explanations may provide the conditions for the kind of misunderstanding so often said to characterise intercultural health encounters (see for example, Roberts et al. 2005), and which subsequently emerges. As the patient companion reformulates

the midwife's explanation in extract 4, it seems that he may be coping with a stretch of LNU: an unfamiliar and technical register leads him to correctly infer the precautionary nature of vaccination, but to miss important details.

Participants: MW = midwife; PC = patient companion		
876	MW	= …. the flu vaccine can be given at any time=
877	PC	=what is that↑=
878	MW	=the flu vaccine can be given at any time but the whooping cough
879		vaccine it's a disease that sometimes if a woman contracts it it can e:rm
880		it's a bad cough it's like it's a bacterial infection and if you contract it can
881		cause pneumonia and pneumonia can lead to brain damage pneumonia
882		is like (2) you're quite ill you get a high temperature you have high fevers
883		sometimes it affects the brain really bad when you feel unwell
884	PC	yeah yeah yeah

Taking an understanding of the flu vaccine as given, the midwife embarks on an extended explanation of whooping cough symptoms, using a combination of technical words – "bacterial infection", "pneumonia" (L880) – and complex syntax. While reformulations indicate an attempt at patient-centred communication, it is not clear that the midwife recognises the complexity of her utterances or their potential for (in)comprehensibility (Baraldi and Luppi 2015). The hypothetical nature of whooping cough is emphasised through the use of conditionality and modality (L879-882) but the language of illness rather than that of prevention is used to advise. Towards the end of the midwife's explanation, the patient's companion nods and smiles gently, before repeatedly verbalising understanding through the repetition of 'yeah, yeah, yeah' (L884). Mirroring the patient companion's utterance, as a method of indicating conversational alignment, the midwife continues with her explanation (L885). In his apparent enthusiasm to speed up the consultation, the companion then interrupts the midwife, and begins to translate his interpretation of the vaccinations offered.

Participants: MW = midwife; PC = patient companion; P = patient			
885	**MW**	**yeah ↑ we ask all our pregnant women to (//)**	
886	PC	***//é tipo isto (.) a vacina é se tu (.)tipo (.)***	*// it's like this (.) the vaccine is if you (.) like (.)*
887	PC	***tipo estás a ver aquela cena que dá nas mulheres depois dos 40↑ aqueles calores s e nha-nha-nha***	*like do ya know what comes upon women after the age of 40↑ those feelings of warmth and blab la bla*
888	P	***menopausa***	*menopause.*
889	PC	***essa cena (.) tu podes contrair agora por causa da gravidez (.) então eles dão-te essa vacina=***	*that stuff (.) you can catch it now because of the pregnancy (.) and so they give you that vaccine=*
890	P	= mhmm=	=mhmm=

(continued)

Participants: MW = midwife; PC = patient companion; P = patient			
885	**MW**	**yeah ↑ we ask all our pregnant women to (//)**	
891	PC	***= mas não ( ) acontece porque se tu estás gravida***	*= but not ( ) it happens because you are pregnant*
892		***=eles dão para combater isso. certo=***	*=they'll give you the vaccine to fight it right=*
893	P	=mhmm=	=mhmm=
894	PC	***= eh↑ você tem que ir***	= eh↑ *you have to go*

In line 885, the medical professional ratifies a change in footing (Goffman 1981), by withdrawing her gaze and allowing the companion to take the floor. Following the midwife's earlier explanatory stance, he begins by eliciting the word for menopause from his friend, confirming her bemused answer with "that stuff" (L889), before explaining his understanding that the 'condition' can be contracted during pregnancy. The patient's active back-channelling (L890, 893) also demonstrates her attention to his explanation, as they take turns in co-constructing meaning. However, although the companion successfully reiterates the importance of antenatal vaccinations (L894), and persuades the patient to agree to the intervention, his epistemic comprehension is fundamentally flawed. He has clearly misunderstood the midwife's earlier attempt at intralingual discourse, i.e. the transformation of technical words into everyday language (Simpson 2016). Unlike previous work on misunderstandings between practitioners and patients in a multilingual environment (see for example, Baraldi and Luppi 2015; Roberts et al. 2005; West 1984), the companion's confusion in this extract cannot be rectified through midwife reformulation or talking things through, as his explanation of the vaccinations is given in Portuguese, a language that neither she, nor I, speak. More importantly, the midwife also has the illusion of (his) understanding (van Hest and Jacobs 2022) and, later receiving the patient's consent, she does not further probe epistemics.

Although my initial transcripts of the dialogue were made in a space of LNU, the turn-taking and prosody seemed to reflect the convivial and cooperative encounter that I had observed. Such was my mistaken reliance on personal perceptions of contextualisation cues and gist (Gumperz 1999; Phipps 2019), and arrogance in my own multiple cultural competence (Vertovec 2009) that, if I had been asked, at this stage, to characterise the informal interpreting, I would have concluded that the patient's companion appeared to have been a supportive friend. He offers additional information when requested and seems to ask questions if he is unsure or wants clarification. My communicative shortcomings became visible once more, when I received the complete Portuguese translation: I

had underestimated the companion's familiarity with medical language and institutional processes. His understanding of a woman's reproductive journey appeared to be even more limited, for the menopause is a natural transition in life and can no more be 'caught' than ageing itself. Indeed, the incongruity of the epistemic misunderstanding was so odd that I wondered whether translator R had misheard the dialogue. Although we had a good working relationship, I felt uncomfortable at wanting to double-check accuracy, more than once: R had over 20 years' experience working as a translator for international organisations, and to interrogate the veracity of their work seemed disrespectful. In pursuit of inter-listener reliability therefore (Thompson and Dooley 2019), and to help me make sense of the somewhat bizarre exchange, I recruited B, a Portuguese medical professional, for help with a second translation. Although in retrospect, and with more experience, I may have asked B to transcribe from scratch, on this occasion, I sent the audio with the existing translated transcript, and asked if they could verify the content. I did not tell B who had previously translated the audio. What was returned was a very similar transcript: both collaborators had had difficulty in hearing L891, but it seemed that the patient companion did indeed believe that his friend had been offered vaccination against the menopause. Perhaps indicative of the rapport we had built over the time we were exchanging emails, translator B also "added a few extra notes that [they] thought would help [me] understand some of the culture" (personal communication). Backstage comments described the audio as "super interesting" and sought to explain any misunderstandings as being due to the participants "low class background – shown by the way they speak … and their thick accent[s]" (ibid.), rather than mishearing.

The additional 'off the record' contributions of collaborators, however illuminating and well-intentioned, seemed to imply a kind of analysis that went well beyond that of multilingual or cultural mediation, when they introduced exophoric issues of class, education, and language ideologies. Translation may have helped to overcome the 'temporary obstacle' of LNU (van Hest and Jacobs 2022), but the act(s) of doing so also rendered visible aspects of the process that often go unmentioned (Hennink 2008). With translations revealing huge gaps in participants' epistemic understanding, and simultaneously augmented by layers of opinion and value-laden commentary, *what was it* that I was (being asked) to interpret?

4.4 The rhizomic nature of understanding

From a patient perspective, the liminality of the antenatal consulting room – inherently heavy with unknowability – appears to be enhanced by flexible languaging and mediation, offering a 'third' space for interactants to (en)counter

potential opacities (Bhabha 1990). In the illustrated extracts, social actors seem at ease with drawing on the breadth of their repertoires to inform, ask questions or check comprehension. They also appear to have the institutional freedom or 'combined capacity' to exercise linguistic autonomy (Andrews et al. 2019; Nussbaum 2011). Yet, while one may be fully aware when one faces personal stretches of LNU – such as observing a consultation taking place in an unfamiliar language – it is not always easy to recognise the challenges faced by others, no matter how empathetic our stance. As we can see in extract 4, the midwife erroneously believes effective interpreting has taken place, but they are not the sole person to fall prey to the 'illusion of understanding' (van Hest and Jacobs 2022). The patient and their companion are also implicated, when translated renditions reveal that the former has agreed to be vaccinated against the menopause. The script shines a light on the tangled roots beneath the surface of apparently untroubled communication, unearthing a nexus of interconnected linguistic and epistemic assumptions that intersect to affect participant understanding. These rhizomic characteristics also invite us to remain vigilant to the fact that stretches of LNU can extend beyond the bounds of (a) language(s), to incorporate specialised or technical registers.

Extract 4 also draws attention to an additional aspect of analysis that this paper has attempted to address. By making visible the contributions of collaborators, the nature of reflecting on a past event which at the time was not 'fully readable', through the transcriptions and commentary of individuals who were not present, I highlight the multiple layers of subjectivity, opacity, and ethical considerations, which can complexify analysis.

5 Discussion and conclusion

In this final section, I reflect on the complexities of conducting research in contexts where our comprehension and interpretation may be fragile or contingent: I conclude by making some tentative recommendations to support researchers at the beginning of their careers.

Responding to calls for open conversations about the complexities presented by researching in multilingual contexts, this paper has sought to illustrate some of the challenges that may be presented when a researcher does not share the linguistic repertoires of their participants, where stretches of talk are witnessed but not fully comprehended, and assumptions are made about (false) fluency (Costley and Reilly 2021; Sepielak et al. 2023; van Hest and Jacobs 2022). Far from being an unusual situation, as populations grow and diversify, it is increasingly likely that researchers, especially ethnographers who immerse themselves in a particular context, may encounter language incongruence. This can sometimes be predicted, prepared for

and in some way mitigated by employing co-investigators, participatory methods, interpreters, translators and/or cultural mediators. Indeed, there exists a plethora of helpful recommendations by experienced colleagues that pave the way for ethically responsible, linguistically representative and rigorous research, and which encourage engagement with multilingual methodologies (see for example, Andrews et al. 2019; Blackledge and Creese 2010; Byrd-Clark and Roy 2022; Creese 2015).

However, there is less guidance for the sole researcher working in diverse settings and who may be obliged to explore other ways of knowing and being, in order to make some sense of the interaction that they observe. Phipps reminds us that although approaching spaces of LNU may invoke frustration and a sense of personal ineptitude, to accept the unknown and the unknowable, will increase our capacity to both infer and "engender qualities of empathy" (2013: 340). Indeed, on personal reflection, I can see that the way in which I felt able to respond to the experiences of extended linguistic non-understanding (as shown in extracts 1 and 2) developed considerably over the period of fieldwork as I endeavoured to focus on modes of communication, other than spoken language(s). My gaze was drawn to the non-verbal and embodied relational work of nursing staff, a capacity for which they are frequently recognised (Bredmar and Linell 1996) and that seems to have the potential to enhance patient comprehension (see for example, Brooks 2022).

Nevertheless, there is undoubtedly a need for further methodological guidance for doctoral students working in multilingual environments and with diverse populations. It is challenging to navigate complex linguistic landscapes unaided, often with limited recourse to institutional funding and remote support from supervisors and/or colleagues. Although rapport can be built with participants and institutions, good relationships may not always create the conditions for collaboration or assistance with interpreting and translation. During my doctoral journey, for example, I had the support of wonderful hospital staff who facilitated access to consultations during data collection. Ironically, an unforeseen consequence of my ethnographic fieldwork was that the more I began to be seen as part of the team, the more I was included in technical conversations. The ebb and flow of jargon, containing references to acronyms and specialist terms, often proved epistemically challenging. Yet it was not incumbent on the professional to help me with unfamiliar medical terminology or to translate on occasions that they shared the same repertoire as a patient. Their responsibility was to help the patient, not the observer. These experiences point to the fact that, despite linguistic concordance, spaces of LNU can emerge when one enters a new community of practice, and it may be helpful to prepare early career researchers for this.

Costley and Reilly (2021) note that while some challenges are just seen as part and parcel of the research process, little attention is given to pre-fieldwork guidance, and I echo their call for a 'methodological multilingual turn' to prioritise a rigour that is

"reflected in our training, preparation, professional practices, and disciplinary expectations" (2021: 1039). While acknowledging the unpredictability of diverse populations, and the tensions that the costs and feasibility of preparatory language lessons surely provoke, there is much that could be done to prepare students for situations where they may not speak the language(s) spoken in their research setting. Doctoral training centres are often uniquely well placed to facilitate relationships between different departments, staff, and students. Working more closely with others, to offer reciprocal translation or reflect on challenges encountered in fieldwork for example, can mitigate the sense of isolation often felt by the novice researcher: indeed, the benefits of cooperation are clearly valuable in practical, financial, developmental, interdisciplinary, and ethical terms. However, it is also through encouraging researchers to *accept* that they will encounter moments of communicative opacity, that we can begin to sow the seeds necessary to approach alternative dimensions of relationality with humility, curiosity, and purpose.

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