Translanguaging health: navigating antenatal consultations in a superdiverse setting

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I, Emma Jane Brooks, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Abstract

Against the backdrop of an established literature on doctor/patient relationships and mediated intercultural health interaction, this thesis uses a linguistic ethnographic lens to illuminate the complex communicative considerations of contemporary antenatal consultations, in a superdiverse London hospital. At a time when the NHS is compelled to respond to evolving and rapidly changing populations, and given its own increasingly international workforce, the study explores how such diversity is construed and navigated in institutional and practical terms, whilst simultaneously drawing attention to emergent communicative features which are said to be inherent to heterogeneous populations.

Over a period of six months, twelve antenatal appointments were observed, recorded and transcribed, before being analysed, using methods associated with interactional sociolinguistics. Moving away from traditional notions of fixity, findings appear to indicate that, in the (frequent) absence of a professional interpreter, or proficiency in the dominant language associated with institutional and national concerns, participants draw on the breadth of their linguistic and semiotic resources to navigate understanding. Recognition of linguistic hybridity/bricolage extends the concept of a translanguaging space to institutional settings, allowing creativity and flexibility to flourish, especially for individuals in possession of, what has been referred to as, a translanguaging instinct. Indeed, midwives appear to disrupt understandings of medical discourse as asymmetrical, as they seek to establish an atmosphere of conviviality.

Yet tensions lie in the epistemological emancipation and parity that the conditions of superdiverse consultations seem to imply. While the pursuit of clarity may be facilitated by flexible repertoires, such circumstances may obscure issues of participant comprehension, and therefore hold the potential for situational, or clinical, consequences. Similarly, although languaging practices appear to transcend bounded notions of language, they nevertheless remain contingent on the flexibility of the personal and institutional affordances

available – the instigation of which ultimately rest with those in positions of authority.

Impact statement

This thesis has emerged in response to interlinking discourses related to language, population change and health, the nexus of which can be seen to hold material relevance for communication in superdiverse clinical settings.

In recent years, globalised trends in migration have seen an increase in the number of people moving internationally, in pursuit of perceived improvement to personal, economic or environmental circumstances. Whether joining existing diasporas, extended family or establishing new roots, migrants have not only contributed to changes in the linguistic, ethnic and cultural landscape of contemporary Britain, but also to the UK workforce and the healthcare sector, in particular. Indeed, with such diversity reflected equally in patient profiles, considerable scholarly attention has been paid to patterns of intercultural interaction, 'effective' communication skills and access to services, as well as to the epistemic (a)symmetries, that medical consultations can be seen to imply.

Building on established canons, from a variety of disciplines, this study seeks to contribute to several fields of inquiry. Firstly, to that of socio- and applied linguistics, where the theoretical concept of translanguaging is invoked as a means of exploring how individuals in superdiverse settings draw on creative linguistic and semiotic resources to communicate. While much of the previous work in this area, has been conducted in educational or informal settings, this research offers substantial evidence of flexible, multimodal communication in an institutional healthcare context. As such, findings also speak to the field of health communication: they highlight tensions between the advantages of using the breadth of one's linguistic repertoire to navigate epistemics, and the potential pitfalls of 'getting by', without the services of a professional interpreter.

Secondly, on a societal level, it is hoped that findings from this research can contribute to parallel discussions regarding notions of equality. As this study demonstrates, language concordance plays an integral role in health

outcomes and experience: it is therefore arguable that the inclusion of language as a protected characteristic (Equality Act, 2010), would go some way to informing greater institutional consideration (and constructive utilisation) of (staff and patient) repertoire, establishing linguistic equity and legally enshrining the right to have access to processes which facilitate informed consent. In the short term, more practical impact could be achieved by commissioning an NHS audit of staff language(s), to both stimulate an institutionally productive recognition of skills and resources, to be used to further advantage intercultural health interaction.

On an educational level, anonymised transcripts could be used to support medical school curricula on patient/professional communication, as well as having the potential to influence the content and design of emergent technology that seeks to bridge the epistemic gap between medical professionals and their patients.

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Chapter 1 - Introduction

1.1 Background

The driving force behind this study is multi-faceted, stemming from first-hand experience of teaching ESOL/antenatal classes to expectant women who speak languages other than English, and subsequent research into migrants' experience of having a baby in the UK. In 2012, I was approached by Hayfield[1] Public Health, to run bespoke antenatal classes, in response to statistical evidence pointing to poor outcomes for local residents not born in the country and/or from black and minority ethnic groups: data identifies that these groups generally encounter a higher than average risk of maternal and infant mortality, across the UK (Centre for Maternal and Child Enquiries (CMACE), 2011; Hacker, 2011). In an attempt to ensure "easily accessible, reliable and relevant information [was available] in a form" (Crown copyright, 2015) that could be understood by women who use English as an additional language, the antenatal classes were designed to explain routine medical information and NHS processes, as well as exploring healthy eating and preventive healthcare. During teaching, it became evident that expectant mothers are often faced with complex medical literature, unfamiliar institutional practices that can prove difficult to negotiate, and, what they feel to be, unsatisfactory communication with health professionals. Concern that these issues may contribute to the very outcomes the classes aimed to prevent, led me to undertake a small, mixed-methods MA study (Brooks, 2013), comprising migrant women as focus group respondents and a discourse analysis of 'Pregnancy Notes', the medical document carried by expectant mothers at all times (see Appendix A). Interestingly, while findings appeared to confirm participant difficulties in comprehension, particularly when encountering medical language, women gave contradictory reports of interaction with medical staff. On one hand,

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[1] A pseudonym

patients reported a sense of objectification by doctors; on the other, they expressed positive sentiments towards their midwives, by whom they felt fully supported. Significantly, very few women referred to mediated encounters, or the presence of interpreters, despite the hospital's obligation to provide linguistic support when requested, or deemed necessary (NHS England/Primary Care Commissioning, 2018: 16). In sum, the study appeared to highlight the role played by language in facilitating patient experience, and, by extension, potential outcomes. Indeed, findings implied a need to further explore the day-to-day realities of multilingual health encounters, whilst also alluding to a more holistic consideration of consultations, and the wider environment in which they take place.

Building on these propositions, this introductory chapter presents the rationale behind my research, initially locating it in the contemporary demographic, linguistic and institutional context of Hayfield University Hospital (hereafter, also referred to as HUH), and subsequently in relation to existing literature in the fields of multilingualism and health. Having established the foundational concepts which inform the study, I next detail my research questions and aims, followed by the theoretical frameworks which underpin this enquiry. The chapter then concludes with a brief overview, charting the ensuing sections of the thesis.

1.2 Rationale

During the twentieth century, the UK experienced sporadic phases of immigration: from those displaced by war, socio-political or environmental concerns to economic workers from ex-colonies, many migrants were also attracted to the UK by family reunification and the possibility of joining existing, settled diasporas (Castles, de Haas & Miller, 2014). Simultaneously, as traditional industries such as mining and manufacturing began to witness a slow decline, advances in technology and access to quick and relatively cheap transport, offered alternative international employment opportunities. More recently, changes to communication networks have made it possible to

maintain daily contact with established networks on the other side of the globe, helping to facilitate 'virtual' transnational communities and mitigating the isolating aspects of the earlier diasporic experience (Blommaert & Backus, 2011; Jacquemet, 2005).

As a result, the variety and number of people migrating from different parts of the world has increased, dispelling previous ideas of diverse populations as comprising pockets of homogeneous groups with shared norms living within bounded communities, and replacing them with an understanding of contemporary urban populations as having 'meshed' realities (c/f Canagarajah, 2011), where heterogeneity of ethnicity, nationality, language, education, age and gender profiles, immigration and work status have become the new norm. A descriptor that attempts to encapsulate this unpredictability, and one which has gained most scholarly traction, can be said to be that of 'superdiversity', coined by Steven Vertovec and defined as:

> …distinguished by a dynamic interplay of variables among an
> increased number of new, small and scattered, multiple-origin,
> transnationally connected, socio-economically differentiated
> and legally stratified immigrants (Vertovec, 2007).

With the notion of superdiversity capturing the academic imagination and giving rise to a plethora of research in contemporary urban settings (see for example, Simpson, 2016; Wessendorf, 2015; Blommaert, 2014), I propose that Hayfield can also be seen to possess some of the dynamic characteristics associated with this paradigm: a large conurbation nestled in the depths of south London, it has a demographic profile that is notable for its ethnic, cultural, national, socioeconomic and linguistic diversity. Focussing further, this study explores changes to the contemporary linguistic landscape in the town, where, although over 100 discrete languages are currently approximated to be spoken (Hayfield Public Health, 2017), the number is likely to both underestimate and obfuscate the breadth of resources employed in intercultural encounters. In the past, linguistic communities were viewed as 'bounded', linked by either

space or knowledge and shared cultural and communicative norms: as such, patterns of speech and behaviour were reproduced and established (Blackledge, Creese, Baynham, Cooke, Goodson, Zhu, Malkani, Phillimore, Robinson, Rock, Simpson, Tagg, Thompson, Trehan and Li 2018). In contrast, findings presented here will reflect repertoires said to be characteristic of diasporic multilingual communities, i.e. a complex blend of communication strategies, "not predicated on the forms of knowledge-of-language one customarily assumes, since Chomsky, with regard to language" (Blommaert, 2013a). As individuals migrate, internally as well as internationally, and encounter new social, cultural, political and historical frameworks, within which they must interact, they are obliged to draw on the mobile linguistic and semiotic resources at their disposal (Blommaert, 2013a). In this context, languages can no longer be seen as fixed conventions of communication: existing classificatory frameworks become redundant, prompting changes in the ways in which we must see the world. As Blommaert and Rampton (2016) note, superdiverse practices can be seen to

> deconstruct notions of languages as bounded entities, associated with nation states….. [as we move] from speech communities to linguistic repertoire 'a priori classifications…..are abandoned, research instead has to address the ways in which people take on different linguistic forms as they align and disaffiliate with different groups at different moments and stages. (Blommaert & Rampton, 2016: 26)

Similarly, as subsequent data will illustrate, participants in the superdiverse antenatal setting of HUH appear to draw on broad personal linguistic and semiotic repertoires, which may include features commonly associated with different 'languages'. For example, when a first-generation Indian doctor encounters a Tamil-speaking, Sri Lankan patient (see 6.4.1.) and an Italian midwife meets a woman who is a first language speaker of Portuguese (see 6.5.), they focus on talking to them as directly as possible. Although some professional mediation does take place (in 6.4.1), exchanges are

characterised by a combination of shared language(s), semiotics and gestures, with clouds of potential misunderstanding seemingly dispersed by a mutual commitment to convivial negotiation, also noted to be a feature of the everyday intercultural exchange (Wessendorf, 2015, 2014; Gilroy, 2006a, 2006b). While a wealth of neologisms continue to emerge in response to the increased visibility of these flexible repertoires (see 3.4 for an extensive discussion), for the purposes of this study, the notion of translanguaging (Li, 2018) appears to offer the most comprehensive approach. Firstly, by moving away from a static sociocultural definition of 'language' towards the more active concept of 'languaging', the term is able to capture the interactivity of making meaning, so evident in superdiverse settings, and to acknowledge the ways in which individuals strategically deploy "particular features from [their] linguistic repertoire…to negotiate particular communicative contexts" (Vogel & Garcia, 2017: 1). The use of the prefix 'trans' also represents a disruption, and transcendence, of "socially constructed language systems and structures [therefore enabling individuals] to engage diverse multiple meaning-making systems and subjectivities" (Li, 2018: 27). As linguistic creativity and hybridity flourish, a sense of liminality is said to emerge, offering a 'third' (Bhabha, 1994, 1990), or 'translanguaging', space which offers space for "innovation and creativity" (Li, 2018: 23). It is said that by paying attention to this unsettling of communicative conventions and norms, that translanguaging has the potential to illuminate the ways in which sociolinguistic practices can be linked to inequality, but also to empower those whose voice is often inaudible (Otheguy, García & Reid, 2015; Heller, 2007) - in this instance, that of the patient.

However, much of the seminal work on translanguaging has been conducted in educational environments where transformative effects on learning can be evidenced (see for example, García, Flores & Woodley, 2015; Flores & García, 2014), or in informal, urban contexts where a degree of multilingual practices could be assumed (see for example, Blackledge, Creese & Hu, 2015). Although observations of linguistic flexibility in alternative settings commonly recognised as formal have been somewhat limited to date, research undertaken in a community legal advice centre (Baynham, Callaghan,

Hanusova, Moore & Simpson, 2017) illustrates the intricate negotiations that are needed to achieve understanding when communicating technical discourse, but yet notes some inherent tensions with the approach:

> the constraints are clear, insofar as the translation provided is not particularly accurate: miscommunication ensues, and is only resolved – i.e. meaning is only made – through perseverance in face to-face, human-human interaction.
> (Baynham et al., 2017: 55)

Primarily, 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 (Simpson, 2016; Blommaert, 2007). In addition, pluralised indexical interpretations have the potential to challenge shared meaning and understanding (Blommaert and Rampton, 2011), and to give rise to the kinds of asymmetries, so vividly documented across a plethora of existing health communication research (see for example, Moyer, 2013; ten Have, 1991). Indeed, Foucauldian notions of power/knowledge 'implying each other' (Pennycook, 2010a: 42) have greatly influenced conceptions of medical professionals and their communication with patients, in the same way that language, or the perceived lack of it, and (inter)cultural difference are regularly positioned as problematic (see for example, Li, Gerwing, Krystallidou, Rowlands, Cox & Pype, 2015; Baraldi & Luppi, 2015; Jansson, 2014; 9; Vilpert & Hudelson, 2009; Aspinall, 2007; Abbe et al., 2006; Jacobs et al., 2006). In alternative research in the field of health interaction, language has been conceptualised as a resource, a 'thing in itself' which can be drawn on and where communication can be improved through the use of (formal and informal) interpreters (see for example, Davitti & Pasquandrea, 2017; Baraldi & Gavioli, 2014; Baraldi, 2009; Hsieh, 2008, 2007; Karliner, Jacobs, Chen & Mutha, 2007; Aranguri, Davidson & Ramirez, 2006; Wiener & Rivera, 2004): or not (Cox, Rosenberg, Thommeret-Carrière, Huyghens, Humble & Leanza,

2019; Moyer, 2013; Hadziabdic, Heikkilä, Albin & Hjelm, 2011; Davidson, 2000).

As will become apparent in later literature reviews (see Chapters 3 and 4), much of the prevailing research on the role of language in intercultural communication, has been measured against the premise of fixed institutional, monocultural, monolingual/proficient user norms, where "shared practices (i.e. interaction orders)…can be understood with reference to…history and tradition" (Sarangi & Roberts, 1999: 3) and which rely on, and "derive their legitimacy through, clients' recognition and willingness to abide by a set of institutional routines" (Sarangi & Roberts, 1999: 4). However, moving on from a priori assumptions about fixed conventions, and in light of a wider, superdiverse, context, this thesis takes as its starting point, the fact that the linguistic and ethnic diversity of the hospital workforce mirrors the complex textured landscape of the local population. That is, to paraphrase a team of contemporary medical sociologists, "[a]s the ongoing diversification of diversity plays out in professional as well as patient populations, common cultural knowledge" and therefore linguistic repertoire(s), "cannot be assumed at any given healthcare encounter", firstly making it "unclear who counts as the stranger" (Bradby, Green, Davison & Krause, 2017: 6), and subsequently throwing in to question the ways in which 'difference' can be navigated.

1.3 Research questions

Therefore, in light of my rationale, this study hopes to contribute to several, interrelated areas of research: in the first instance, to the field of socio- and applied linguistics, where I hope that the following considerations of languaging practices in a superdiverse, institutional setting will inform conversations on contemporary intercultural communication across epistemological divides. Secondly, by looking anew at the creative communication strategies that are used to navigate (some of the challenges posed by) changing populations, this thesis seeks to disrupt established understandings of (a)symmetry in medical professional/patient interaction, but

also to simultaneously problematise an implication that translanguaging necessarily facilitates mutual comprehensibility. Locating these topics within a wider societal context, I attempt to highlight additional tensions between institutional methods of categorisation, communicative practices and related areas of social justice.

Therefore, this thesis documents an analysis of communicative practices within the context of antenatal medical consultations at Hayfield University Hospital, an institution situated in a superdiverse suburb of London, and seeks to answer the following research questions (RQ):

1.   What are the ways in which linguistic difference is identified, experienced and navigated, during everyday antenatal consultations at Hayfield University Hospital (HUH)?

        a.   In a contemporary health setting, what are the range of linguistic and semiotic resources drawn upon by participants in everyday antenatal consultations?
        b.   (How) do the characteristics which are said to exemplify superdiverse environments, affect the interactional space of the consulting room?

2.   (In what way) do communicative practices appear to have an impact upon mutual comprehension and experience?

At this stage it must be noted, that while findings from this study may raise questions pertinent to the area of health inequalities, it does not have the scope to explicitly draw on the associated professional specialisms of medical or public health (see for example, Urquia et al., 2015; Viruell-Fuentes, Miranda & Abdulrahim, 2012; Hankivsky et al., 2010; Mastrocola & Nwachukwu, 2009). Rather, implications from this study are informed by applied and socio-linguistic scholarship.

1.4 Methodological and analytical frameworks

In line with previous sociolinguistic research in both superdiverse, and healthcare, settings (e.g., Blackledge, Creese & Hu, 2017; Sarangi & Roberts, 2005), I employ a linguistic ethnographic lens with which to conduct my research, as by placing the researcher at the heart of the study, the ensuing observational methods can generate a uniquely 'thick description' (Geertz, 1973) and breadth of data (Cicourel, 2007). On one hand, a "sustained ethnographic focus on everyday diversity allows us insight into the processes – both formal and informal – that shape urban encounters [as well as] everyday negotiations with difference and practices of accommodation" (Wise & Noble, 2016: 427); while on the other, an orientation to language, puts under the microscope the (tensions within the) wider sociocultural context that the interaction order may index (Creese, 2008; Gumperz, 1982). Reflecting these micro/macro tensions, I use a combination of methods to shed light on my data: while transcription conventions associated with conversational analysis (Jefferson, 2004; ten Have, 1990) are used to detail the minutiae of communicative practices, an interactional sociolinguistic approach (e.g. Goffman, 1972; 1971; Gumperz, 1999, 1982) sheds light on the relationship between interaction and wider social contexts.

1.5 Overview of Chapters

Following this broad summary of the rationale, research questions and methodology guiding my research, I now give a brief overview of the subsequent seven chapters.

I begin by acknowledging an intrinsic tension within this research. Due to the sensitive nature of health consultations, this study has been heavily influenced by the ethical considerations which clearly compel full pseudonymisation of the setting and participants. Ostensibly, this lies in stark contrast to the methodology, which is underpinned by an epistemological commitment to 'thick description' (Geertz, 1973). Indeed, building on Hymes's (1972)

assertion that language cannot be separated from its social context, a central premise of this thesis is that antenatal consultations do not take place in a sociolinguistic vacuum, but are part of a 'local practice' (Pennycook, 2010a). As such, Chapter 2 treads the delicate epistemological tightrope of attempting to give a sufficiently detailed contextualisation of Hayfield's diverse demographics and socioeconomic conditions, while simultaneously trying to preserve the anonymity of participants and the institution in which the events take place.

The literature reviews presented in Chapters 3 and 4, can be seen to broadly correspond to the two overarching research questions. The wide-ranging literature review in Chapter 3 includes a detailed account of the changing sociolinguistic, ethnic and cultural landscape in the UK, as well as the communicative practices which can be said to characterise diverse populations. This is followed by Chapter 4 which begins by documenting the changing face of the NHS and how it is positioned to respond to superdiversity. This is set against the background of foundational literature on health communication, which explore the intrinsic asymmetries of doctor/patient relationships, as well as the role that language plays in consultations. This chapter also documents established literature on mediation and emerging evidence of linguistic flexibility in institutional practices.

Chapter 5 presents the aims and questions underpinning this research, giving an explication of the methodological approach and analytical framework used to inform findings. It also offers an exploration of some of contextual and ethical considerations which can be anticipated, when undertaking research in a healthcare setting.

Similar to the literature reviews, data presentation and analysis are also mapped respectively onto the two main research questions. Chapter 6 explores the range of resources utilised in superdiverse antenatal consultations, noting the space afforded for emergent creative and flexible languaging practices. Complementing this, Chapter 7 considers the methods

through which meaning is negotiated in interaction (Roberts & Sarangi, 2005: 2), and the contextual implications such practices may hold.

In the final chapter, I return to my research questions in order to bring together the findings of the study, and to reflect on the role and influence of language in a superdiverse health environment. While acknowledging the limitations of my research, I conclude with recommendations for future explorations in this increasingly complex field.

Chapter 2 - Context

2.1 Introduction

Tracing details from the macro through to the micro, the purpose of this chapter is to give a rich description, and contextualisation, of the setting in which my research takes place. While I acknowledge that the extensive details that follow may initially appear extraneous, an appreciation of the features which can be said to characterise a superdiverse setting, and the ways in which they may intersect to affect and shape communicative encounters, is central to this study. Indeed, when considered in conjunction with the different contextual factors affecting individual participants, they hold specific significance.

As such, I begin by establishing the integral role of context in ethnographic research (see also 5.3.1), before describing Hayfield, the town in which the hospital is located (2.2.1). Here, I give a breakdown of the changing demographics which mark it as one of the most linguistically and ethnically diverse boroughs in London. Next I outline how the NHS, as the principal provider of healthcare in the UK, recognises such diversity, or superdiversity (Vertovec, 2007) at an institutional level, examining to what extent it can, and does, respond to evolving recommendations on provision for rapidly changing populations (NHS England/Primary Care Commissioning, 2018; Phillimore et al., 2018; Bradby et al., 2017; Li et al, 2017; Phillimore, 2015, 2010; Tranekjaer, 2015; Moyer, 2013; Heller, 2001; see also 4.2 for further discussion). Exploring antenatal provision at a local level, section 2.3.1 documents the processes of accessing care, as well as giving an overview of the hospital, staff and patient demographics and interpreting provision. I then illustrate the environment in which women find themselves as they wait for antenatal appointments, surrounded by posters and information and assailed by an iterative infomercials (see 2.3.3.). The chapter ends with an illustration of the consulting rooms themselves.

2.2. Context

An ethnographic account places context at its core, although there are multiple definitions of what counts as context. From an institutional perspective a context can refer to the

> institutional framing of activities, where people adhere to a series of group-derived prescriptive norms that pressure and/or channel people with designated titles, presumed competencies, duties or responsibilities into certain physical spaces at certain times in order to engage in a finite number of specifiable activities (Cicourel, 2014: 376)

Expanding further, Duranti and Goodwin define context as a 'socially constituted, interactively sustained, time-bound phenomenon' (1992: 6), not only shaped by setting, and behaviour therein, but also constituted by it. The ways in which people interact, 'how participants use their bodies and behaviour as a resource for framing and organising their talk… is intricately and reflexively linked to it within larger patterns of social activity" (Duranti and Goodwin, 1992: 7). In an antenatal setting therefore, context can be seen to include how women's bodies are both presented and framed as objects of interest, as they become substantiated as 'antenatal patients' (see 2.3.2), the care and treatment of whom is institutionally contextualised. Yet, while talk can be positioned as locally organised and negotiated interaction, it both 'invokes context and provides context for other talk' (Goodwin and Duranti 1992: 8): participants also draw on extrasituational contexts, which go beyond the immediacy of the setting but are dialogic with them, thus rendering potentially static interpretations of context as reductive (Blommaert, 2009). As such, the following sections seek to give an overview of observable contextual considerations which may affect the ways in which women, but migrant women in particular, experience antenatal care in a superdiverse setting.

2.2.1 Hayfield

2.2.1.1 Housing

Although intermittent pockets of wealth spring up in London's urban peripheries, the creep of gentrification in Hayfield has been slow. Yet, after decades of stop/start negotiations with a range of town planners and developers, it is now undergoing huge structural transformation, driven by local government which has an ingrained, neoliberal, understanding of change as progress. The regeneration scheme involves the demolition of much of the faded town centre, with plans to replace it with a huge, and prestigious, retail development. Championed as an opportunity for employment, and in anticipation of an uplift in the local economy, new housing is also springing up in the town centre. Paradoxically, it may prove unlikely to meet the needs of existing residents. As new and expensive housing arrives, the resulting squeeze in an already competitive market can be predicted to boost rents and property prices, driving the poorest inhabitants elsewhere – often into the precarity of cramped bed and breakfast accommodation (B and B) and emergency housing. In fact, Hayfield has a higher than average number of households accepted as homeless, at 6.63 per 1000 households, with the most up-to-date figures noting that 2,005 households are currently living in temporary accommodation (Morris, 2018; Hayfield Public Health, 2017). However, it must be noted that this statistic may not give a true reflection of numbers (see 2.2.1.2).

2.2.1.2 Initial Accommodation Centres

A large Home Office department, responsible for processing visa and immigration enquiries, is based in close proximity to Hayfield, giving rise to a significantly transient population of asylum seekers and refugees. Therefore, many applicants live in local, temporary accommodation, as they await decisions on their asylum claims.

When a migrant first presents to the authorities as someone seeking asylum, and their claim of destitution is thought to be credible, they are placed in an initial accommodation centre (IA): if there are no spaces, then they will be placed in full-board accommodation in an interim hostel in Hayfield, or a local hotel/B and B. It is at this point that migrants register their formal application for asylum: once received, procedures dictate that they are 'dispersed' to other parts of the country, theoretically having spent no longer than 19 days in the Hayfield hostel. They are housed in the new location by one of the three private companies contracted by the Home Office to provide accommodation (Asylum in Europe, n.d), and remain there until their claims have been processed. However, when there are dispersal backlogs or medical conditions to be considered, it is not uncommon for people to remain at the Hayfield IA for weeks or even months. This is not ideal. A recent report by the (independent) Chief Inspector of Borders and Immigration (2018), gave a litany of reasons as to why this accommodation, and other similar types across the UK, could be considered poor. It highlighted the inadequacy of provision for expectant mothers and children and women-only spaces, as well as the lack of nutritious food. Indeed, to walk around the hostel, is to step into a different era; the air lies pungent with the smell of over-cooked food, as it creeps up the caged, concrete and unwelcoming stairwell; rooms are cramped and overcrowded, with families squashed into rooms designed for two; children run around the communal dining room, bored, under-stimulated and under-exercised, often going without access to formal education for months at a time, and desperate for some kind of normality; and as young men loiter expectantly around the reception desk, waiting for positive news on their journey towards stability, their impatience is palpable. Nevertheless, despite the poor quality of the hostel accommodation, residents do have access to award-winning healthcare. The local GP surgery provides a discrete Homeless Health team, who offer a consulting room on site in order to quickly support vulnerable residents with what are very often complex healthcare needs (see 2.3.2.1).

At the end of 2018 there were 2,129 residents living in IA centres around the UK (Asylum in Europe, n.d.): more specifically, there are approximately 100-200 people housed in the Hayfield hostel at any one time (personal correspondence, 2019).

2.2.1.3 Employment

From an employment perspective, with a plethora of skyscrapers punctuating the skyline, Hayfield's growing urban sprawl appears to indicate a thriving economy. It has a similar employment rate to London and other parts of the UK, with many of its residents working in retail, business services or public sector jobs (Hayfield Observatory, n.d.). Interestingly, the number of employees who work less than 10 hours a week is almost double that of those living in London and other parts of the UK. This figure may potentially reflect the higher than average number of Hayfield residents working in the care sector (ibid), as well as food, retail and construction industries, i.e. areas of employment that typically involve shift-work, feminised labour and often rely on semi/unskilled or migrant workers.

2.2.1.4 Deprivation and health

Like London, Hayfield is a town of parallel experience, where rich and poor can live but several miles from each other and yet have very different life experiences. Using a set of measures to compare relative poverty, the Department of Communities and Local Government, regularly publishes information on deprivation. In 2017, Hayfield was within the top twenty most deprived boroughs for housing, out of 326 local authorities nationwide. The pockets of high deprivation are specifically within the more densely populated areas located in the north of the borough, close to HUH. In line with the argument that communities othered by poverty are commonly distinguished by ethnicity, linguistic diversity and class, a close examination of new applications for National Insurance numbers, reveals that those who were made by people

who previously lived abroad, originate from residents in the north of the borough (Hayfield Public Health, 2017).

The significance of these seemingly unrelated statistics on employment, housing and poverty, lies in the fact that each one of these features is considered to be a social determinant of health (Marmot, 2015). Indeed, a woman living next to the local hospital, an area marked by poverty and inadequate housing, is likely to die 7 years earlier than a woman living 5 miles away in a relatively wealthy suburb (Hayfield Public Health, 2017). Similarly, data also demonstrates that there is an increased risk to maternal and infant health, posed by the sociocultural, ethnic and linguistic diversity of mothers (Phillimore, 2015, 2010; CMACE, 2011). While this thesis does not have the scope, and nor do I have the necessary expertise in population health, to provide an analysis of health inequalities, in a borough characterised by its superdiversity, this information is considered of contextual relevance (see also 4.2).

2.2.1.5 Population data

Hayfield's population has risen by 9% since 2011. Currently estimated to have approximately 384, 837 residents (Office for National Statistics, 2017), Hayfield is the second most populous borough in the Greater London area.

	Country of birth (UK and non-UK) for Hayfield, 2018	
	Population by country of birth - UK - % of total 2018	Population by country of birth – Non-UK- % of total 2018
Hayfield	67.7	32
London	63.5	36.2
England	90	9.9
		ONS, 2018 (Table 2.1)

Data from the 2011 census reports that 28% of the Hayfield population were born outside the UK: 5.1% originating from the EU and 23.4% from the rest of the world (ONS, 2011). More recent data indicates a sharp increase in international migrants and a continued breadth of diversity. Table 2.2 (below) gives a further breakdown of the Hayfield population, by country of birth, and illustrates that 32% of the current Hayfield population were born abroad (ONS, 2018).

Country of birth (non-UK) by Region, 2018						
	Hayfield		London		England	
	Count	%	Count	%	Count	%
European Union	32,000	8.3	1,023,000	11.5	3,246,000	5.9
Non-EU European	2,000	0.5	182,000	2	176,000	0.3
Middle and East Central Asia	2,000	0.5	153,000	1.7	178,000	0.3
East Asia	2,000	0.5	115,000	1.3	175,000	0.3
South Asia	30,000	7.8	662,000	7.4	680,000	1.2
South East Asia	1,000	0.3	87,000	1	139,000	0.3
Sub Saharan Africa	33,000	8.5	520,000	5.8	410,000	0.7
North Africa	N/A	N/A	53,000	0.6	47,000	0.1
North America	2,000	0.5	97,000	1.1	165,000	0.3
Central and South America	16,000	4.1	264,000	3	162,000	0.3
Oceania	3,000	0.8	79,000	0.9	111,000	0.2
Rest of the World	55,000	14.2	1,013,000	11.4	896,000	1.6

ONS, 2018 (Table 2.2)

While many residents were born in mainland Europe, often migrating from Albania, Poland, Spain, Portugal and Romania, the borough is also home to large Sri Lankan, Somali, Ghanaian, Nigerian and Congolese diasporas. Much of the substantial Spanish speaking community, have migrated from central and South America, via Europe. However, these statistics may still not give a true reflection of the total number of international migrants living in Hayfield, due to the fact that the residence of asylum seekers living in the temporary accommodation is not included in the figures (see 2.2.1.2).

2.2.1.6 Ethnicity

Hayfield Ethnic Group Profile						
Ethnic Group / Year	2011	2017	2018	2019	2020	2021
White	55%	49%	48%	48%	47%	46%
Mixed	7%	8%	8%	8%	8%	8%
Asian	16%	19%	19%	19%	20%	20%
Black	20%	23%	23%	23%	24%	24%
Other	2%	2%	2%	2%	2%	2%
TOTAL	100%	100%	100%	100%	100%	100%

Source: GLA 2015 Projections, long-term migration scenario (Table 2.3)

Ethnicity is often used as the key marker of diversity, with the number of people from black and minority ethnic communities often summarised by the acronym, BAME - the higher the BAME statistic, the greater amount of 'diversity' is assumed. Hayfield's population has long been considered 'diverse'. In 2011, census data recorded the percentage of non-white residents at 45%, compared with the slightly lower London average of 40% and the noticeably lower 14% national figure. More up-to-date demographic predictions by the Greater London Authority (Greater London Authority, 2015) predict a population mix of 46%/54% white/BAME by the time of the next census in 2021, making Hayfield a so-called minority-majority town. Recent figures on the ethnicity of children starting school in 2016, substantiate the GLA predictions: a community profile records ethnic percentages of reception-age population in 2016 (see Table 2.4.)

(Ethnicity of children in reception, 2017 (by %)
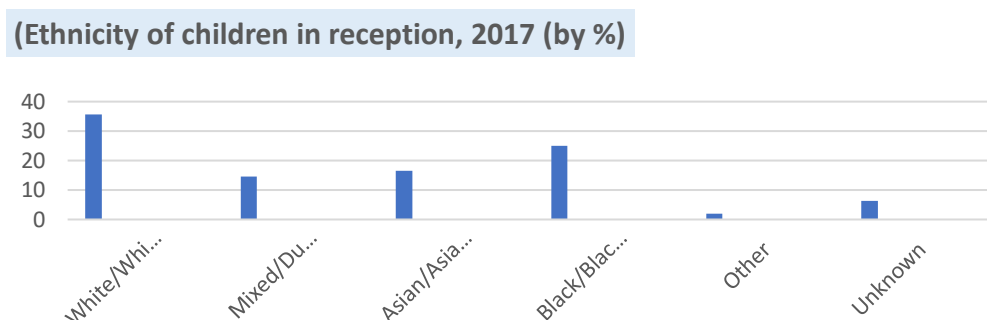
Early Intervention Support Service - Best Start Community Profile: School Census, 2016 (Table 2.4)

Table 2.4 illustrates that Hayfield is home to specific diasporas, and echoes data from the 2011 census, which found that there are twice as many people of 'Black Caribbean' ethnicity living in the town than in London and eight times as many people who identify as having 'Black African' heritage than in the rest of the UK. Nevertheless, in a superdiverse setting, using ethnicity as a yardstick of difference appears somewhat simplistic, when categories such as 'Black/Black British: African' (Office for National Statistics, 2011) mask the fact that many of these residents are 2nd, 3rd or 4th generation British, and an implied conflation between 'Whiteness' and indigeneity (see also 3.2 for further discussion).

2.2.1.7 Language

The 2011 census revealed that 85.5% of the population speak English as their main language, although more recent data suggests that this is likely to have decreased to 80% in the intervening years (Greater London Authority, 2018). While recent statistics released by the Office for National Statistics (2018) currently estimate that 32% of children in Hayfield schools speak English as an additional language (EAL), Best Start, a local, early intervention support service aimed at transforming care for the under 5s in the area, collated more expansive data from children starting school. It found that in Spring 2016, 36% of children starting reception in the borough spoke English as an additional language, although it became apparent that numbers were disproportionally represented in different institutions: for example, in a relatively affluent area, only 12.6% of reception intake were identified as 'EAL', which contrasts starkly with 61% of the year group in a deprived ward in the north of the borough (Early Intervention Support Service, 2016). Indeed, one local nursery reported that 100% of its intake in 2018, spoke English as an additional language (personal correspondence, 2018). A breakdown of discrete languages, per se, is difficult to gauge, although anecdotally, it has changed considerably since 2011 (see Table 2.5). Indeed, a recent examination of translated patient literature, available via the HUH website, offers a brief glimpse of Hayfield's current linguistic profile: material is currently available in Albanian, Arabic, Farsi, French, Kurdish, Portuguese, Spanish, Tamil and Turkish, although this by no means captures the true linguistic diversity of the borough (Hayfield Health Services, n.d.).

Languages spoken in Hayfield	
Language	%
English	85
Tamil	1.5
Polish	1.4
Gujarati	1.2
Urdu	1.10
French	.70
Portuguese	.60
Turkish	.40
Malayalam	.40
Spanish	.40
Other	6.8

Census Data, 2011 (Table 2.5)

Due to the proximity of the Home Office, Hayfield is also home to the largest population of unaccompanied asylum-seeking children (UASC) in the UK, other than the *county* of Kent, with over half of the looked-after children in the borough having been born overseas (Hayfield Public Health, 2017). In addition, it must also be noted that much of the data captured by schools may not account for the number of transient children who are not in formal

education or are schooled for a short period of time, a fate which often befalls those housed in initial accommodation and temporary housing (see 2.2.1.2).

Having examined context in terms of demographic and local environmental details, I now move on to look at the institution(s) that lie at the heart of the study.

2.3 The National Health Service (NHS)

Established in 1948, and underpinned by the ideal of universal healthcare, the National Health Service (NHS) is the largest provider of care in the UK, with approximately 1 million patients being seen nationally every 36 hours (NHS England, n.d.). Not only is care free at the point of delivery, based on clinical need, but NHS constitutional principles establish aspiration for excellence and professionalism, assurances for patient-centred care, a commitment to work across institutional boundaries and a pledge to provide UK tax-payers with value for money. Should a non-UK citizen require medical assistance, hospitals are obliged to be non-discriminatory: depending on the nationality of the patient costs are recoverable through a variety of means, which vary from reciprocal arrangements with the patient's country of origin, to health insurance schemes or surcharges paid at the time of immigration.

Although the NHS is politically neutral, it is financed through national taxation, and thus remains accountable to government, communities and patients (Crown copyright, 2015). The constitution states that "The NHS belongs to the people" and has legally enshrined patients' rights,

not to be unlawfully discriminated against in the provision of
NHS services including on grounds of gender, race, disability,
age, sexual orientation, religion, belief, gender reassignment,
pregnancy and maternity or marital or civil partnership status
(Crown copyright, 2015)

While is noticeable that language is not explicitly recognised as a 'protected characteristic', updated NHS commissioning guidelines on interpreting and translation (2018), recognise the potential for linguistic diversity to affect access to health. In specific reference to 'patients who do not speak English', they draw attention to earlier legislation under the NHS Act (2006), which emphasises "the need to reduce inequalities between patients with respect to: (t)heir ability to access health services; and the outcomes achieved for them by the provision of health services" (NHS England/Primary Care Commissioning, 2018: 16). In addition, the guidelines also note, that in order to prevent "disadvantaging specific patient groups" (2018: 12), hospital trusts may need to reconsider commissioning priorities in light of the potential challenges posed by demographic changes, i.e. supplementing the current package of 'values' it purports to hold, with that of linguistic equality. Proposed changes highlight the fact that existing frameworks which, although they attempt to accommodate heterogeneity, no longer reflect the needs of an ever-changing linguistically, ethnically, socio-culturally diverse population (Bradby et al., 2017; Li et al, 2017). Saliently, as the UK potentially emerges from an extended period of austerity into an uncertain post-Brexit referendum climate, government funding for the NHS has reduced in real terms (NHS England, n.d.). In combination with a growing and ageing population, the health service has faced increasing pressures over number of years, which, it has been argued, have affected its ability to provide the level of excellence for which it strives. As financial constraints have very real effects in terms of staffing, equipment and waiting times, the consequences of which can affect patient safety and positive outcomes, it is perhaps unsurprising that interpreting and translation services sit under a cloud of uncertainty and are often perceived as under threat (Phillimore, 2010). Framed by an emotive rhetoric that is often

inspired by a conceptualisation of the NHS as an intrinsic part of British cultural identity, interpreting services are repeatedly portrayed either as a luxury that the NHS can ill-afford (e.g. Borland and Hayward, 2019) or politicised by right-wing politicians intent on problematising the nexus between migration and health (Phillimore, 2015). In recent times, an explicitly hostile discourse on immigration in general, and perceptions of health 'tourism' in particular, has sporadically fuelled the flames of intolerance, putting some migrant patients under particular institutional scrutiny when seeking healthcare (Home Office, 2014). In spite of the unease cited by many frontline medical professionals intent only on preserving health, there is also contrasting evidence that other healthcare workers are not immune to the wider discourses surrounding the 'deservingness' of migrant patients (Piacentini, O'Donnell, Phipps, Jackson & Stack, 2019; Haith-Cooper & Bradshaw, 2013; Wallace & Bhatia, 2007). In the current 'hostile' climate, pregnant migrants who do not qualify for exemption are pursued by NHS administration for costs associated with care (which can be up to £6000 for birth, without complications) (Maternity Action, 2019).

Paradoxically, discussions surrounding migration and health regularly fail to acknowledge the transnationalism of NHS health professionals and support staff (Bezemer, Cope, Kress & Kneebone, 2011), which has grown steadily over the past decade, especially from EU accession countries (see Table 2.6, below). In highly populated, superdiverse regions, the number of international staff is considerable: for example, in South London, where this research takes place, 25% of NHS professionals have a nationality other than British (Parliament, Houses of Commons, 2019). As such, and while it is important not to conflate nationality with variables such as linguistic skills or cultural knowledge, it worth reflecting on the ways in which those migrants on whom a functioning health service relies, may also hold the potential to mitigate mediation costs (see for example, 2.2.1.6, 2.3.1, 4.5; Chapter 6, extracts 21, 29).

Nationality of NHS staff by country grouping

March 2019 and September 2009 in England, with comparison to wider economy in Q1 2017. Headcount.

Nationality Group	NHS 2019		Whole economy	NHS 2009	
	Number	% of known	Estimated %	Number	% of known
UK	1,021,257	86..9&%	88.3%	850,091	88.9%
EU (Pre-2004 members)	44, 124	3.8%	3.4%	21.262	2.2%
South Asia	28, 992	2.5%	1.2%	26, 668	2.8%
Sub-Saharan Africa	22,133	1.9%	0.9%	21, 414	2.2%
South East Asia	21, 517	1.8%	0.2%	15, 413	1.6%
EU (Post-2004 members)	20, 949	1.8%	4.2%	6, 945	0.7%
Latin America & Caribbean	3, 111	0.3%	0.1%	3, 487	0.4%
Oceania	2, 892	0.2%	0.3%	2, 572	0.3%
North Africa	2, 216	0.2%	0.1%	1, 373	0.1%
North America	2, 210	0.2%	0.4%	1, 773	0,2%
Middle East & Central Asia	1, 692	0,1%	0.2%	1, 798	0.2%
East Asia	1, 374	0.1%	0.3%	1, 432	0.1%
Europe (Non-EU)	1, 198	0.1%	0.2%	916	0.1%
South America	936	0.1%	0.2%	807	0.1%

Parliament. House of Commons (2019) (Table 2.6)

2.3.1 Hayfield University Hospital

HUH stands on a 19-acre site in the north of Hayfield. Established in 1923 as the infirmary for the town's workhouse, it has grown considerably during the past century. When approached from the rear of the building, the imposing Victorian mansion looks in need of repair: as paint peels from the window ledges, the remnants of a rolling lawn now hemmed in by well-kept flower beds hark back to the grandeur which may once have impressed visitors. The other side of the facade, however, lies facing a London arterial road, a steel and brick edifice sprouting incongruously from its red brick neighbour, as if resisting the trials and tribulations of populace and pollution. In a modern twist on rolling lawns, a glass frontage now welcomes the sick and the needy to a trust which provides integrated care across the borough. The sprawling hospital currently accommodates more than 100 specialist services, an Accident and Emergency department and a 24/7 maternity service (Hayfield Health Services NHS Trust, n.d.).

In a metaphorical reflection of structural changes and architectural diversity, recent statistics demonstrate that of the 3,655 staff employed by the trust, 44% are from black and minority ethnic communities, while 41% are of white ethnicity (Hayfield Health Services NHS Trust, 2016) although no information is collated on linguistic skills. Nevertheless, the ethnicity data leads the hospital to claim that,

> (t)he rich diversity of the Trust's workforce reflects the diversity of the local population of Hayfield and enables a greater understanding and respect for individuals, cultures and diverse health needs (Hayfield Health Services NHS Trust, n.d.)

As I discuss further in subsequent chapters (see for example, Chapters 3, 6 and 7), the culturally, ethnically and linguistically diverse nature of the hospital staff appears to echo that of the wider community, potentially providing opportunities for hitherto undocumented ways of communicating in institutional

settings (see 3.3, 3.5). Yet, in contrast, but of specific interest to this study, are the formal ways in which HUH is also reported to inadequately support patients who speak English as an additional language. Not only is the hospital seen to fail to provide information in the languages relevant to the local populations (Care Quality Commission, 2018), but the CQC's report finds 'a lack of use of interpreters and an over-reliance on family members to interpret which is not in line with best practice' (Care Quality Commission, 2018: 4; see 2.3.2.5). The tensions between apparently effective day-to-day interlingual communication and institutional constraints are explored further in Chapter 7, as well as highlighting the need to include language as a protected characteristic to ensure appropriate support, where necessary (see 3.5.4; 4.2.1; Chapter 8).

2.3.2 Maternity Care

Pregnant women are advised to access antenatal care before the 10th week of pregnancy, in order to receive appropriate and timely support (NHS, 2017). Once pregnancy is confirmed, their doctor will complete an NHS online, or manual, referral form: alternatively, women are able to self-refer through the HUH website and complete a similar document. Apart from contact information, additional details are requested, i.e. previous pregnancies, whether the patient is considered high-risk and whether they need additional support due to a disability. On the GP referral form, doctors are asked to indicate the patient's proficiency in English so that an interpreter may be requested, if necessary: this is done by ticking boxes entitled 'Interpreter required? Yes/No' and 'languages spoken'. Once completed, this form is sent to antenatal administration and the patient is allocated to a midwifery team, based on her address. On a self-referral form, the patient also indicates whether she needs an interpreter and completes (or not) a box which asks for 'further details'. Again, based on her address, the patient is allotted a specific midwifery team. The responsibility for booking interpreters, once a need is identified, lies with administrative support (see 2.3.2.4).

The first antenatal appointment, known as 'booking-in', usually takes place on the antenatal ward at HUH and lasts for approximately one hour. Like many initial appointments with a specialist, the booking-in session features a somewhat predictable series of checks and conventions (see for example, Chapter 7, extract 30), but where the emphasis is on establishing the health of the patient, rather than diagnosing illness. As well as an electronic record, medical history is also recorded in 'Pregnancy Notes', a document designed to "encourage… two-way communication so the expectant mother and her family are fully informed and able to contribute to the decision making process" (Perinatal Institute, 2019; see Appendix A). Once initial information has been captured, these notes are continuously updated and remain with the patient throughout her pregnancy so that, should she become unwell or need to access care elsewhere, the information is readily available for alternative medical staff. The notes adhere to the genre of medical records, which are typified by a highly structured layout, standardised use of medical terms and require the authors to conform to specific conventions (Harvey and Koteyko, 2013). They are intended to be a 'multi-authored, inter-group document' (Harvey and Koteyko, 2013: 96) as well as being a legal record. The first page is designed to be answered by the patient herself: depending on how easy the patient finds it to complete, the subsequent page offers room for the midwife to recommend interpreter support should it be identified at this point. Ensuing pages are characterised by dense text on both sides of the paper, implying a less than patient-centred approach, but that of an academic one (Harvey and Koteyko, 2013). On the right-hand side, there are spaces for medical information to be recorded, whilst on the left, there are 'helpful notes' which are designed to assist patients in understanding acronyms and opaque language. However, the undifferentiated semantic field of medical lexis makes the document exceptionally challenging for those who do not have a full understanding of the technical register.

It is also at this stage where women begin to be categorised (see 4.2.1 and 4.2.2 for an extensive discussion). Whether they need additional interpreter support, or require referrals to obstetric specialists, expectant mothers are

offered particular maternity 'pathways', ostensibly in order to meet their medical and emotional needs. First time mothers with no complications can expect to see their midwives nine times during their pregnancy, whereas those who have given birth before will have seven appointments. In comparison with a GP appointment, in which a patient is typically allocated a 10-minute time slot, a routine antenatal check-up lasts 15-20 minutes.

When it comes to delivery, those who are identified as having no complications may choose to give birth in the state-of-the-art Birth Centre, which provides midwife-led care in individual rooms, and are designed to replicate a home environment. Alternatively, women may elect to have a home-birth, which is overseen by a specialist midwifery team. The Labour Ward provides care for women who are at risk of complications or have complex care needs. HUH and the wider Hayfield trust provides support for approximately 4,000 women a year (2018).

2.3.2.1 Homeless health team

In contrast to the rest of the trust, which was judged to be 'requiring improvement' (Care Quality Commission, 2018), recent reports by the Care Quality Commission (CQC), the body which monitors hospital standards, rated the antenatal department at HUH as 'good' (2015), with the specialist 'Homeless Health' maternity team graded as 'outstanding' (CQC, 2018).

> The trust's homeless health team...provided an in-reach and outreach programs to both support and provide purposeful interventions to asylum seekers and homeless people. This service took a holistic approach which included coordinating accommodation for service users (CQC, 2018: 7)

Indeed, such is the high standard of care for this particular group of women that the team under whose care they fall have been the recipients of numerous local and national awards. Central to the provision, is the understanding that refugees and those seeking asylum must be offered equitable care:

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the right to the enjoyment of the highest attainable standard of physical and mental health; equality and non-discrimination; equitable access to health services; and (access to) people-centred, refugee- and migrant- and gender-sensitive health systems (WHO, 2018)

Care is also informed by the knowledge that poor maternal and infant outcomes are higher for BAME and migrant women (CMACE, 2011; Mastrocola and Nwachukwu, 2009), for numerous, intersectional reasons. Often presenting late in to the pregnancy, the latter cohort have often had no prior antenatal care and may have more complex physical, and mental, health needs due to adverse pre-migration experience. Thus, refugees and those seeking asylum are seen as requiring extensive monitoring and support, are prioritised in terms of appointments and consistent interpreter provision, and have an allocated midwife for the duration of their pregnancy (unlike those in the general population) (see also 2.3.1.4). In addition, under the auspices of protected status, pregnant women cannot be moved for the last 6 weeks of pregnancy and first 6 weeks after birth. In practical terms, this means that they cannot be detained, dispersed or returned to country of origin at this time, whatever changes may occur in their legal status (U.N. Committee on the Elimination of Discrimination against Women, n.d.). A significant number of women, therefore, remain in hostel accommodation in Hayfield for up to 3 months.

2.3.2.2 Medical staff

According to recent figures (Hayfield Health Services, 2019), there are 14 consultant gynaecologists and obstetricians currently attached to the maternity department, although this number may not reflect full-time positions at this institution and may differ from the period when I was conducting my research (2016/17). At this time, HUH employed approximately 180 midwives, on a variety of full-time and part-time contracts. Nevertheless, from informal conversations it became clear that staffing maternity services 24 hours a day, 7 days a week, was a challenge. As such, it was also common practice to

employ temporary staff, referred to as 'Bank', in order to adequately cover employee sickness, holidays and maternity leave. Health Care Assistants (HCA), who support midwives and doctors by conducting routine tests, are also key to the smooth running of the department (see 2.3.3). Although there are no figures publicly available to substantiate the claim, it is superficially apparent, through ethnographic observations of communicative encounters, that employees working in antenatal care, appear to reflect the ethnic and linguistic diversity of the town where they work (see also, 2.3.1 and 5.4.5.1).

2.3.2.3 Patients

Reflecting the superdiverse nature of Hayfield's population, records show that in 2015, 3503 out of 5,833 births in Hayfield, were born to mothers who were not themselves born in the UK: in 2016/17, 45% of births were to mothers from Black, Asian and minority backgrounds (Hayfield Public Health, 2018). Such diversity presents additional risks, as women who can be classified as BAME not only have a prevalence of certain conditions (e.g. diabetes, sickle-cell anaemia, see 3.3; 4.2.1), but women born outside the UK are less likely to access early maternity care (CMACE, 2011). These factors are often seen as a key indicator of perinatal health.

In Hayfield 2014/2015, one third of initial antenatal assessments were later than recommended (Osbourne, Colledge, & McDonald, 2014) – current guidelines are for women to see a medical practitioner before 10 weeks gestation. Within the cohort of women who present late for care, are often included a number of pregnant women, seeking asylum and placed in temporary accommodation (see 2.2.1.2). Of these, many have been victims of human trafficking (see 7.2.1). Indeed, in the first quarter of 2019, over half of the reported victims of modern slavery and human-trafficking were identified by the UK Visas and Immigration as migrants (UKVI): 773 of this number (1,215) were female with 48% recorded as victims of sexual exploitation. While many of the referrals included women with UK nationality (but not necessarily women born in the UK), 39% were non-UK nationals: of these, 35% were

Albanian, 22% were Vietnamese, 17 % Chinese, 16% Eritrean and 13% Sudanese (National Crime Agency, 2019). The majority of pregnant women from this group (who are often rejected by the traffickers when pregnancy is discovered) are treated by a bespoke medical team (see 2.3.2.1), and clearly present a unique challenge to antenatal care, in terms of pre-existing conditions and social complexity, as well as linguistic and sociocultural concerns.

Additional population statistics reveal that over 60% of women giving birth in Hayfield in 2018 were overweight, obese or morbidly obese, and from the most deprived quintile of the population, factors which also have considerable impact on the care pathway given to an expectant mother (Osbourne et al, 2014; Hayfield Observatory, n.d).

2.3.2.4 Formal interpreting services

At the time that this research was undertaken, HUH was contractually bound to employ interpreters via Living Language[2] one of the leading providers of interpreting and translation services in the UK. Although it was not possible to substantiate the amount of employee training provided by the company or the qualifications of the interpreters observed, information available via the Living Language website seems to suggest robust recruitment and training processes. In contrast, anecdotal comments by some of the interpreters paint a less streamlined and professional approach, as they bemoan the zero hours contracts and reduced wages (as an apparent result of service centralisation - personal correspondence). Some interpreters also express frustration at not being paid for the travel time between jobs.

On a practical level, once an interpreter has been requested by the administrative team at the hospital or doctor's surgery, an 'advert' appears on

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[2] a pseudonym

Living Languages' employee portal: interpreters checking the job site, can then 'bid' for the work that they are available to do and are notified when it is 'won'. Perhaps unsurprisingly, one of the participants (I2) noted that much of the interpreting workforce is feminised, as interpreters appear to fit work in around caring responsibilities, close to home. As such, I2 often worked at HUH as it was convenient and she felt that it offered a more convivial atmosphere than another large hospital nearby.

Living Language also provide a telephone interpreting service, for when circumstances dictate that face-to-face mediation is not possible. In this instance, the hospital contacts the service, preferably in advance of the appointment, to make a request for a speaker of a specific language. An interpreter is then available at the appropriate time, to take part in a triadic consultation and to mediate on behalf of the patient and the medical professional. In a focus group interview with the heads of the various local (see 5.4.5.1; Appendix B) midwives report conflicting emotions regarding the use of a remote interpreting service: on one hand, they appreciate that any form of mediation contributed towards patient understanding and assisted informed consent; on the other hand, they find the dearth of extra-linguistic clues, such as gesture, expression and gaze, somewhat restrictive, in terms of ensuring understanding. As one midwife illustrates, this is especially pertinent when the medical information may have consequences for a patient's decision on whether to continue with a pregnancy:

> When I'm trying to deliver.. like tell them bad news …these
> are the results that I need to discuss and that I need them to
> come in or see me or go through what they need to do….I'm
> on one phone the interpreters on another phone, we're not in
> the same room….and we've got the couple at home …and it's
> going around …….it's backwards and forwards and I actually
> like to see people's responses to things because it actually
> helps seeing what they've understood as well for me. (Moira,
> Appendix B, L302-310)

2.3.2.5 Informal interpreting

It is interesting to note that, while this study is located in a superdiverse suburb of London, with a hugely diverse hospital workforce, the NHS currently offers ambiguous guidelines for multilingual health professionals, leaving the decision to interpret to the discretion of the individual.

> Professionals and primary care staff may use their language
> and communication skills to assist patients in making
> appointments or identifying communication requirements,
> (language brokering) but should not, other than where
> immediate and necessary treatment is required, take on the
> role of an interpreter unless this is part of their defined job role
> and they are qualified to do so. Staff trained and used as
> interpreters must be covered by indemnity insurance (where
> clinical staff are bilingual they should use their professional
> judgement to decide whether they are able to competently
> communicate with the patient) (NHS: 2018: 8)

However, as data analysis will reveal (see Chapters 6 & 7), medical staff often make use of their linguistic repertoire for more than administrative duties if they believe it will enhance communication (see 7.1.3). They may also request the help of colleagues: for example, having recognised that her patient was unfamiliar with the condition of Down's Syndrome, and that it would be difficult to find an interpreter at late notice, an experienced midwife recalls drawing on her colleague's language skills:

I had a lady yesterday who spoke Fula .. luckily I found out
that ….. ████████ speaks Fula ….she was going to a
conference but I told her what I needed and I asked can you
please translate it on a message to me then I can play it for
this lady when she comes in (Stephanie, Appendix C, L40-44)

Alternatively, in the absence of a professional interpreter, or (institutional permission to use) shared linguistic resources, it is unsurprising that a considerable proportion of interpreting work is conducted informally, with family and friends offering ad hoc support. Although this is widely considered to be poor practice for numerous reasons (see 4.2.2.5), there is currently no method of recording the presence of informal interpreters at HUH, which makes it difficult to estimate the number of consultations that are conducted in this way. However, if one were to extrapolate from studies conducted in similarly diverse multilingual settings (see for example, Cox, 2017; Moyer, 2013), one could presume that the practice of using patient companions as interpreters is widespread (see 4.4.2.5, for further discussion).

Cox and Maryns (2019) also reported the ad hoc use of translation software (see 4.4.2.1). However, while midwives in this study expressed an enthusiasm for 'Google Translate', i.e. "If the language is really bad I call up the information on Google and then translate the page and then they can read it because they have to give their consent" (Student midwife, Appendix D), there were no observable instances of the use of apps or translation software during my fieldwork.

2.3.3 Antenatal waiting room

Mirroring the rambling features of the hospital's eclectic architecture, the sprawling antenatal waiting room emerges from the Victorian original, into a large, modern extension, with glass windows on one side, looking out on to a small courtyard. Yet, zigzagging through to the Victorian original to the rear of the room is a smaller, cramped desk and waiting area, with consultation rooms sprouting from the centre. Official signs signify the area

'antenatal/gynaecological reception' although, faced with a sea of chairs and two reception desks, women regularly wander vaguely between the two, before being redirected to the appropriate zone. On more than one occasion during fieldwork, patients present at the hospital rather than their local, community clinic, having been unable to read a letter from their midwife. Whatever their stage of pregnancy, they are observed to be turned away, and advised to seek help at the community health clinic highlighted on their letters: it is clear that not all the women so advised are able to understand the receptionists' instructions. At the largest desk, which faces the main seating area, are a number of uniformed receptionists sitting at computer terminals, checking-in patients for antenatal scans and non-pregnancy related, gynaecological appointments. The smaller desk doubles up as a both a workstation for midwives and HCAs, and a reception for booking-in patients, or those who are attending specialist antenatal appointments. In contrast to the clinically tidy main reception workspace, this desk is piled high with papers and patient notes. It is here, in the smaller waiting room, sitting as if I too were a patient, that I base myself during fieldwork, observing the ebb and flow of staff, patients, families and friends.

With women arriving from 8.30am, the space is typically overflowing by 10am, dwindles to a trickle of patients by 12.30pm, before a resurgence arriving for afternoon appointments. Similar to a GP's surgery, waiting times can differ, depending on whether an appointment is routine, or complex: consultations which require the mediating skills of an interpreter take longer (see 4.4). A specialist, diabetic clinic is held on Friday mornings, when women who are thought to be at risk of developing gestational diabetes, are invited to take a glucose tolerance test (GTT). As the process involves a 2 hour wait between an initial and subsequent blood test, some patients sit in the waiting room for a considerable amount of time: some women study their phones intently, while others use them to entertain their children. Unlike many waiting rooms, there are no magazines to read. Instead, patient leaflets offer advice on nutrition and exercise in pregnancy, immunisation and breastfeeding, while also giving additional information on potential conditions that women may develop during

pregnancy, such as pre-eclampsia. Reflecting the diversity of the patient population, there are also leaflets on hereditary conditions which tend to affect specific ethnic groups, e.g. sickle cell anaemia, which is most common amongst those of Caribbean and African heritage. Posters adorn the walls of the waiting room, so that wherever the eyes may travel, they are met with health advice or warnings, much of it repeating the information which is available in leaflet form. At the time this fieldwork was undertaken, the only information visible was in English.

On the waiting room wall, placed centrally between the seating, and surrounded by posters, is a television, playing 'BABY TV' on an iterative loop. The 'channel' covers a huge range of topics, from the dangers of scalds from tea and formula milk, to the fact that prescriptions are free for women during pregnancy and for the year following a baby's birth. As part of an NHS drive to 'sell' breastfeeding to expectant mothers, there are several interviews featuring women talking about how good the experience has been for them and their baby, promoting improved infant health and sleeping, as well as emphasising weight loss (maternal) and the fact that breast milk is free. Cameos from teenage mums giving tips on how to cope with morning sickness, can be seen to reflect local maternal population patterns and, in a limited recognition of women who may be newly arrived in the UK, there are onscreen reminders for the NHS advice service (111) and the national emergency number (999). Nonetheless, core representations of 'pregnancy' appear to reflect a (predominantly white) heteronormative, nuclear family, with a disposable income. There is advice for expectant fathers on how to plan a quick, alternative route home from work, when their partner goes into labour, and how to fit a car seat safely for the return journey. In a similar theme, the following advert can also be seen to target men, as the viewer is invited to '#pimpmybump, while glamorous and sporty 'mums' are depicted adjusting, pushing and running with shiny, new pushchairs. While car seats are vital (if you have a car) and pushchairs undoubtedly helpful, the ways in which helpful advice on infant care blends into the promotion of accessories proves an uncomfortable experience, incongruous to its setting.

A persistent murmur of activity, and a faint smell of disinfectant, permeate the waiting room. The four lines of seating are arranged in pairs, so that two rows face each other: making eye contact and small talk, women also strike up sporadic conversations about test results and due dates. Having just received a copy, prior to their booking-in appointment, patients in the early stages of pregnancy can be seen filling-in their 'Pregnancy Notes', often with the help of a partner or Google Translate. In contrast, a few heavily pregnant women in hospital gowns drift through the waiting room, en route to the smoking area outside, as the occasional cries of new-born babies alert them to the lifelong journey ahead. The staff at reception field queries, as patients request directions or sample bottles, while simultaneously, midwives, health care assistants and doctors, crisscross between the desk and consultation rooms, stopping occasionally to call out patient names or numbers for blood tests. All the while, the waiting room echoes with different languages, in a reflection of the dynamic local soundscape.

2.3.4 The consulting room

Although the consulting rooms at HUH vary slightly in size, they all comprise a desk, with a computer terminal and occasional medical equipment, such as a blood pressure monitor. The midwife's chair is typically on one side of desk, with provision for two or more chairs on the opposite side. The clinical appearance of each room is completed by the presence of an examination table, surrounded by curtains, and a trolley containing medical supplies. Where consulting rooms differ, is that their position in the building affects access to windows and natural light. Regardless, all rooms are lit with overhead, fluorescent lighting. The generic photograph below seeks to illustrate the clinical environment, which was typical of those observed during this research.

A typical consulting room (Figure 2.1)

2.4. Conclusion

Hayfield is a borough with a linguistically, culturally, ethnically and socioeconomically diverse, and growing, population. However, while it shares many of London's cosmopolitan features (see 3.3), it also has very distinct, contextual considerations which affect the ways in which interaction may be experienced on a local, and institutional, level. Following Wessendorf, I adopt a stance which is

> (r)elated to theoretical approaches of intersectionality (Collins 2000), albeit not specifically focusing on power relations…. [but which] …. draws specific attention to the interplay of factors … [and] highlights the importance of going beyond the analysis of conditions of multi-ethnicity when analysing diverse urban areas (Wessendorf, 2010: 7)

When viewed through this lens, the nuanced complexities shaping some contemporary consultations are thrown into relief against established research on intercultural health communication, much of which does not consider interaction in relation to extrasituational influences. Before presenting data which explores this concern (see Chapters 6 & 7), the following chapter

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features the first of my two literature reviews, and documents established literature related to the nexus between superdiversity and language. In doing so, I also examine the emergence of a space which allows inventive and flexible languaging practices to flourish, as people from diverse backgrounds work to negotiate difference and communicate across cultures.

Chapter 3: Language and communication in a superdiverse setting

3.1 Introduction

Having summarised the rationale for my thesis (see Chapter 1) this first literature review will begin by giving a brief overview of 20th century migration flows to the UK, before exploring the characteristics of London's contemporary population, which can be said to exemplify the concept of superdiversity (Vertovec, 2007, 2006). While acknowledging concerns about the novelty of the paradigm (Pavlenko, 2016), and taking into account, what some would call its commonplace presence (Wessendorf, 2014), I nevertheless demonstrate that the adoption of a superdiverse lens can shed light on communicative practices in linguistically, ethnically, culturally and socioeconomically diverse communities. As features which have been identified as inherent to heterogeneous populations, I will first reflect on conviviality (Wessendorf, 2014) and cosmopolitanism (Vertovec, 2009). Next I discuss the plethora of terms which have emerged in an attempt to capture the complex languaging practices it has been suggested typify linguistic superdiversity (Blackledge et al., 2013; Blommaert and Rampton, 2011; Jörgensen, et al., 2011): I first consider the descriptive adequacy and applicability of some of these terms, before moving to a more detailed exploration of translanguaging (Li, 2018), the concept I find most pertinent to explicate the communicative practices between health professionals and their patients. Finally, I then further explore how the inherently unpredictable linguistic, ethnic and cultural permutations of superdiverse settings encourage a liminal space, which leads to, and is facilitated by, the process of translanguaging. Thus, the consulting room is transformed into a 'third' (Bhabha, 1994) or 'translanguaging' space (Li, 2011), which offers interactants the opportunity to utilise the breadth of their linguistic and semiotic resources in order to achieve shared understanding and communicative goals.

3.2 20th Century migration to the UK

Migration is not a new phenomenon. Human beings have always moved from one place to another, whether motivated by intrinsic needs such as food, shelter and safety, or more contemporary economic drivers such as work and educational opportunity. The search for an improved environment appears fundamental to the human condition, and often survival. It stands to reason, therefore, that in a world increasingly threatened by environmental and humanitarian disasters, economic uncertainty and violent conflict, migration is a key concern for nation states and smaller communities alike.

Early to mid-twentieth century migration flows to the UK predominately originated from Europe and ex-colonies, such as India, Jamaica, Trinidad and Guyana: movement was facilitated by rights gained under post-colonial rule (Vertovec, 2007), buoyant labour markets in need of additional workers, or settlement visas to join family members (Castles, de Haas & Miller, 2014). Although immigrants were met with varying degrees of antipathy (Grillo, 2010), successive governments passed laws which attempted to combat racial discrimination, embrace cultural diversity and promote mutual tolerance (e.g. the Equality Act[3], 2010; Commission on Integration and Cohesion, 2007a; the Macpherson Report, 1999; the Public Order Act, 1986; the Race Relations Acts, 2000). As the century ended, the Parek Report into multi-ethnicity concluded that Britain was "a community of citizens and a community of communities, both a liberal and multicultural society" (Parekh, 2000:IV). However, in the past decade, there has been a further, more substantial, increase in migration to the UK, due, in part, to the expansion of the EU community and amendments to original free movement restrictions. The influx of economic migrants from Europe has been matched by people from outside the Union who have been motivated to migrate for environmental or political

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[3] For ease of reference, legislation passed by parliament is referred to by the names of the act e.g. the Equality Act (2010), Public Order Act (1986),Race Relations Acts (see Parliament, House of Commons for complete citation in references).

reasons: wars, famine, drought and the impact of the global financial crisis have impacted unevenly upon the most poverty-stricken nations. Simultaneously, triggered by a decline in traditional industries, in addition to advances in technology, an increasingly mobile workforce has been able to take advantage of cheap transport, international recruitment and instant communication (Blommaert & Backus, 2011). Not only can workers move to another part of the planet relatively cheaply, but they can also make use of mobile and new technologies to maintain virtual communities and transnational ties. Under dominant, neoliberal regimes the world has also witnessed the rise of globalised trading practices across a swathe of industries, even affecting previously non-commercial sectors such as education (Allan & McElhinny, 2017): in these, and as an integral part of Britain's (post)colonial endeavours, English is held to play a significant role (Crystal, 2012; Pennycook, 2010a) (see for example 4.5). Indeed, although the multitude of 'push' and 'pull' factors associated with migration, and the influence and exercising of soft power, make generalisations impossible (Castles et al 2014), there is a general consensus (see for example, Graddol, 2010, Pennycook, 2010a; Jenkins 2009; Phillipson, 1992) that the English language plays a central part in globalisation. As its tentacled hegemony stretches far beyond the Anglophone world, Appadurai's notion of mediascapes transmitting 'complex repertoires of image and, narratives and ethnoscapes' (Appadurai, 1990: 299), creating 'imagined worlds', may also help to explain why some are drawn to the UK, with expectations of increased health, wealth and happiness. However, while the intrinsic relationship between globalisation and the linguistic dominance of English is significant, this thesis seeks to demonstrate that, given the complexities of a contemporary superdiverse environment, and the rising visibility of practices which draw on multiple 'languages' previously regarded as discrete, that communication may be more fruitfully analysed as historical and socio-politically contingent features of individual repertoire (Allan & McElhinny, 2017; Creese & Blackledge, 2010; Heller, 2007) (for a participant discussion of this issue, please see Chapter 6, Extract 19).

3.3 Superdiversity

Migration in the 21st century is both quantitively and qualitatively different from earlier patterns (Geldof, 2016), creating complex populations which defy traditional notions of multicultural societies, historically imagined as comprising pockets of homogeneous groups, living within bounded communities and sharing assumed norms. Instead the "increasingly stratified and multiple processes and effects of migration" (Blackledge et al, 2018: xxii), have "altered the face of social, cultural and linguistic diversity in societies all over the world" (Blommaert & Rampton, 2011:1), leading to a 'diversification of diversity', or what Vertovec calls 'superdiversity' (2007). Originally coined as a descriptive term to highlight the breadth of demographic change,

> (s)uper-diversity underscores the fact that the new conjunctions and interactions of variables that have arisen over the past decade surpass the ways – in public discourse, policy debates and academic literature – that we usually understand diversity in Britain" (Vertovec, 2007: 1024)

As lines between multi-ethnic, multilingual communities living within a host population become blurred, the 'other' becomes a category in constant flux' (Blommaert, 2013a:5), thus making conventional notions of 'integration' into the rose-tinted imaginary of cultural homogeneity (cf. Berry, 1997) both implausible and irrelevant. Vertovec (2019) seeks to describe and analyse the new complexities of migration, noting that "the new migration patterns not only entail[ed] variable combinations of … traits, but that their combinations produce[d] new hierarchical social positions, statuses or stratifications" (2019: 126). The fluid and mobile realities (Blommaert, 2013a) of contemporary urban populations are recognisable only by their unpredictability, and shifting heterogeneity – not only of ethnicity, language or gender but of innumerable factors, including education, migration trajectories, age and religion. Countering potential perceptions of the term as a metonym for 'more ethnicities', Meissner and Vertovec suggest that while superdiversity can be

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used as a 'summary term' to "encapsulate a range of such changing variables surrounding migration patterns – and, significantly, their interlinkages" (2015: 542), it is also more than a descriptive tool to delineate majority/minority changes in demography.

Since its initial proposition, Vertovec's reconceptulisation of urban populations has wielded influence across a variety of disciplines (Vertovec, 2019), from housing (Phillimore, 2013) to medical sociology (Bradby, Green, Davison & Krause, 2017). It also holds specific significance for equal access to healthcare (Phillimore et al, 2018; Phillimore, 2015, 2010) and maternity services (Phillimore, 2015), topics which are discussed further in Chapter 4. However, as Vertovec highlights (2019), the concept has been most influential in the field of sociolinguistics (see for example, Karrebaek & Charalambous, 2017; Arnaut et al., 2016; Wessendorf, 2015; Silverstein, 2015; Padilla, Azevedo & Olmos-Alcaraz, 2014; Blommaert, 2013b, 2013a). Following Blommaert and Rampton (2011), Simpson (2016) sheds light on why the concept may have been so universally embraced, and the ways in which it advances sociolinguistic thinking: he notes that much of the attraction lies within the dynamic, unpredictability of contemporary migration, and the ensuing effects that this has on populations. Simpson also recognises that by exposing subsequent 'processes and practices' (2016: 5) to fine-grained analysis, attention is extended beyond the sociolinguistic foci of language and society, and instead drawn to "phenomena …..we had not noticed before" (ibid). Sociolinguistic scholars have also recognised the methodological potential of superdiversity, to "shift the gaze to the linguistic, focusing on the ways in which the new diversity becomes the site of negotiations over linguistic resource" (Creese & Blackledge, 2010: 550; see also 5.3.1). By encouraging a move beyond the 'ethno-focal' (Meissner & Vertovec, 2015), superdiversity can examine "changing practices and norms in established migrant (and non-migrant) groups" (ibid), allowing a "more nuanced understanding of social interactions, cosmopolitanism and creolization" (Meissner & Vertovec, 2015: 543).

Nevertheless, the concept of superdiversity has not gone unchallenged, with some questioning its 'newness', by looking to trends of mobility in the global South (Blackledge et al, 2018: xxii) or reflecting on distant history, such as the spread of the Roman Empire (Pavlenko, 2016). In this sense, Pavlenko (2016), alerts us to dangers of admiring the academic equivalent of the 'Emperor's New Clothes', which she sees as designed and motivated by the competitive commercialisation of education, encouraging the coining of neologisms and 'empty slogans', to advance personal and institutional recognition. Although appreciating the benefits of its descriptive terms, Pavlenko also suggests that the apparent Eurocentric bias of superdiversity, comes solely as a reaction to unprecedented migration flows to the EU, and the accompanying upsurge in linguistic diversity. In contrast, the relative lack of attention given to the huge breadth of linguistic repertoires spoken in Asia and Africa (Pavlenko, 2016; Makoni & Pennycook, 2006) appears to reflect Makoni's concern that decisions made on "whether we are diverse or not depends on the power of the social microscope being used" (Makoni, 2012: 193). With the majority of research on superdiverse populations originating from a Western canon (Pavlenko, 2016), Makoni's claim that it is often the "powerful who celebrate the notion of diversity" (2012: 193), is clearly substantiated, emphasising that an over-romanticisation of difference could have an unintentional impact on (post)colonial asymmetries. As such, it is also arguable that by focussing too closely on diversity, the potential to recognise, and therefore legitimise, difference and individual experience is reduced, which in turn may affect personal outcomes and subjectivities (Urciuoli, 2016).

However, despite the fact that these critiques highlight problematic aspects of superdiversity (see Chapters 4, 6 & 7, for further scrutiny), it must be accepted that, during the past century, global migration flows have impacted upon Europe in unprecedented ways. 'Difference' is significantly more visible, audible and tangible than before, and superdiversity offers a framework through which to examine change. Thus, academic discourse on the concept can be seen to have moved beyond the confines of mere description of hybridity, to reiterate an alignment with "contingent, ideological orientation to

difference" (Blackledge et al, 2018: xxvi) and a commitment which seeks to address "relations of inequality and power" (Blackledge & Creese, 2010: 556). By offering a lens through which to examine "new patterns of inequality and prejudice including emergent forms of racism, new patterns of segregation, new experiences of space and "contact", new forms of cosmopolitanism and creolization" (Vertovec, 2019: 126), many superdiverse scholars also strive to expose and critique "forces of discrimination" (Blackledge et al, 2018: xxiii). In a highly influential piece of work, comprising multi-sited research, which sought to examine languaging practices in superdiverse communities, findings from the Translation and Translanguaging project (hereafter referred to as TLANG) not only reveal the complex, and emergent, range of linguistic and semiotic resources used by participants (e.g., Blackledge, Creese & Hu, 2015) and the ways in which they are used to negotiate difference, but also point to ideologies, structures and processes which shape interaction, having the potential to benefit or disadvantage individuals (e.g., Baynham, Bradley, Callaghan, Hanusova & Simpson, 2015; Simpson & Cooke, 2017). Similarly, research data from this thesis, reveals how pregnant women and health professionals navigate an unpredictable communicative landscape, drawing on personal repertoire to steer their way through what, on one hand, is an everyday activity for the midwives, but on the other, is a profoundly emotional, physically demanding, and unique, one for patients. In order to "understand how everyday encounters are unbalanced or stabilised" (Blackledge et al, 2018: xxxv), in the superdiverse institutional realm, I employ, amongst others, Goffman's framework of 'interaction ritual'(1972), which focuses on the adherence, and departure, from rules and norms which guide communication, to examine the experience in-depth (see Chapters 4, 6 and 7).

However, such is the ubiquity of diversity in contemporary urban populations, that some scholars have attempted to capture everyday characteristics of "superdiversity 'on the ground' (Jaffe, 2016: 6). In the following section, I explore these features, from 'commonplace diversity' (Wessendorf, 2014), to cosmopolitanism (Vertovec, 2009), civility (Lofland, 1973), and conviviality (Wessendorf, 2015, 2014; Gilroy, 2006a, 2006b), where the reimagining of

diversity in neighbourhoods challenges previous understandings of community relations.

3.3.1 Commonplace diversity and civility

It is argued that as "(d)iversity has become habitual and part of the everyday human landscape" (Wessendorf, 2015: 7), the mixture of languages, nationalities, cultures and ethnicities have made difference, commonplace (Wessendorf, 2014), and the exceptional, unremarkable (Blommaert, 2015). While difference does not go unnoticed, and in reality, is often commented on in 'parochial spaces' (Wessendorf, 2014), such as the shop or consulting room, it is no longer seen as unusual (Creese, Blackledge & Hu, 2016: 6). As we see in Chapter 6, the extent to which health professionals explore their patient's cultural and linguistic backgrounds in everyday encounters, demonstrates how civility can be used as a strategy that can be used to either "engage with difference" (Wessendorf, 2014: 393) and build relationships (see 6.3.2, extract 19), or ignore difference in order to avoid conflict (see 6.2.2.2, extract 9). However, Wessendorf (2010, 2014) also notes that although the acknowledgement of variance, i.e. 'civility towards diversity', may be a way of dealing with diversity, its everydayness should not presuppose a multicultural nirvana. Indeed, while the tendency to display 'civility towards diversity', could imply an appreciation of difference, it may also indicate nothing more than an ambivalent acceptance, or close attention to 'facework' i.e., features of social interaction which are held to indicate and maintain mutual respect and self-presentation (Goffman, 1972; see 6.2).

Building on the notion of civility, Buonfino and Mulgan (2009) suggest that individuals living in superdiverse communities in fact learn 'grammars of sociability', in the same way that one learns and cultivates a language through regular, daily contact with others. Unfortunately, this idea implies a degree of self-consciousness which is unsubstantiated by existing research in superdiverse communities (see for example, Baynham et al., 2017; Wessendorf, 2015). The use of a grammatical analogy also renders the

hypothesis somewhat problematic, not least because it suggests that there are specific guidelines, or rules, to be followed, which subsequently carry implicit notions of both fixity and the finite, concepts at odds with the fluidity and creativity associated with the superdiverse. In contrast, and reflecting inherent complexities, Vertovec recognises that individuals living in diverse areas, need to have a "multiple cultural competence" (2009: 7), which moves beyond features associated with civility. Whereas the latter implies relating across age, gender, sexuality and class, superdiverse populations need to employ strategies more often associated with cosmopolitanism, i.e. skills comprising 'a combination of attitudes, practices and abilities gathered from experiences of travel or displacement, transnational contact and diasporic identification" (Vertovec, 2009: 5). However, rather than reflecting the lives of elite transnationals, as those imbued with 'moral virtue' (Noble, 2009: 53), Wessendorf (2014) reimagines a 'corner-shop cosmopolitanism' built around local everyday activities of individuals from diverse socioeconomic, cultural, religious and ethnic backgrounds. At the core of these local interactions, she argues, are a versatile range of linguistic and semiotic resources, used flexibly and strategically, in order to accomplish any given task. Wessendorf also observes that multicultural communication in contemporary diverse settings, relies less on civility, than on the ways in which interactants search for common ground and shared understandings. As such, she draws on the seminal work of Paul Gilroy, a prominent critical race theorist, widely acknowledged for rethinking the paradigm of race relations in contemporary Britain.

3.3.2 Conviviality

Gilroy (2006a) calls for a shift in thinking about difference, to one which no longer misunderstands and oversimplifies 'culture' as "ethnic property to be owned and held under copyright" (Gilroy, 2006a: 43). Arguing that we have too long focused on 'difference' at the exclusion of 'sameness', he suggests that interaction between the two, should be considered, a process he summarises as "conviviality – just living together" (Gilroy, 2006b: 7). He notes that,

racial, linguistic and religious particularities do not – as the logic of ethnic absolutism suggests they must – add up to discontinuities of experience or insuperable problems of communication. There are institutional, demographic, generational, educational, legal and political commonalities as well as elective variations that intercut the dimensions of difference and complicate the desire to possess or manage the cultural habits of others as a function of one's own relationship with identity. Conviviality acknowledges this complexity and, though it cannot banish conflict, can be shown to have equipped people with means of managing it in their own interests and in the interests of others with whom they can be induced heteropathically to identify. (2006b: 40)

Although Gilroy recognises the difficulties that can arise when diverse groups share an environment, he emphasises that proximity does not automatically presuppose conflict. Individuals are more than the sum of inherent, or imposed, characteristics: as the layers of environmental, social and institutional determinants intersect, essentialised imaginings become irrelevant. Instead, people search for an overlap of experience, navigating the "insecurities of de-categorization" (Wessendorf, 2015: 10): Jaffe suggests that they embody a "superdiverse stance" (2016: 12), which reflects the emergence of 'an intentional, positive, ideological orientation" (ibid) that can respond to tensions in linguistic, cultural, ethnic or national difference (Jaffe, 2016). Arguably, it is valid to turn a critical eye on what may first appear to be over-romanticised subjectivity (Gilroy, 2006b). While this thesis takes conviviality as central to the superdiverse mosaic, it is crucial to appreciate that "recognising conviviality should not signify the absence of racism" (Gilroy, 2006a: 40). In subsequent chapters (see Chapters 4 & 7), I touch on the parallel "paradoxes of convivial coexistence (which are) always enmeshed in, mediated by and shadowed by colonial histories, enduring racisms, variegated and uneven belongings and entitlements" (Wise & Noble, 2016: 430), but with an understanding that "everyday racism and everyday cosmopolitanism (are)

coexisting… not mutually exclusive. This is so because convivencia[4] emphasises togetherness as lived negotiation, belonging as practice" (Wise & Noble, 2016: 425). Nevertheless, as these claims may imply, there is a sense that conviviality, as an observable practice, could be elusive or difficult to identify. As such, I now briefly refer to earlier research which pinpoints the tangible features of small talk and humour, as key characteristics which help to illuminate the concept, while reflecting more specifically on their relevance to this thesis.

3.3.2.1. Small talk

Blommaert's influential, ethnographic research in a superdiverse suburb of Antwerp (2014), pays close attention to the linguistic landscape and the ways in which the predominately migrant population communicate: where linguistic resources are valued, not for their economic worth (Heller & Duchêne, 2016), but for their facilitative qualities. Making 'small talk' in the local, informal dialect of oecumenical Dutch (what Blommaert defines as Dutch on a continuum of 'accented' varieties), the community "display(s) surprising levels of elasticity in production and interpretation" (Blommaert, 2014: 248), in their efforts to make themselves understood.

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[4] Differing from the English term 'conviviality', the Spanish term that originally referred to the co-existence of Moors, Jews and Christians 'co-existing' in medieval Spain

> Thus, while most of us have learned to disregard small and routine talk as relatively unimportant – it is often seen as the prelude or coda to 'serious' talk – we see that it is in actual fact a critical feature of social structure. Small talk in non-standard varieties of language is, in fact, the very 'stuff' of conviviality, and thus a key infrastructure of superdiversity. (Blommaert, 2014: 248)

Echoing this, Holmes also sees 'small talk' as "oil[ing] the social wheels" (2014) of encounters, on occasion preparing interactants for further transactions (Zhu, 2014), while on others, sometimes simply acting as way of mitigating difference (Wessendorf, 2015). Similarly, in the superdiverse parochial realm of HUH, patients and health professionals appear to use superfluous 'small talk' to avoid or distract from embarrassment (Maynard & Hudak, 2008), or blur 'transactional goals' (Zhu, 2014: 31) (see 6.2.1). Although the strategic use of 'small talk' is also widely recognised in literature on health communication (see for example, Defibaugh, 2017: Hudak & Maynard, 2011; Aranguri, Davidson & Ramirez, 2006), we can nevertheless see that, in a superdiverse environment, the mundane process of 'rubbing along', is underpinned by the need to look beyond the local (Jaffe, 2016), in order to achieve the specific transactional goals surrounding medical care. The salience of a superdiverse stance as central to patient-centred care becomes further apparent in Chapters 7 (see for example, 7.1.3, extract 34).

3.3.2.2. Humour

Research undertaken in the public realm of markets (Creese, Blackledge & Hu, 2016), as well as the parochial realms of children's centres (Wessendorf, 2016), legal advice centres (Baynham et al, 2017) and workplaces (Wise, 2016) also touches on humour as a characteristic of conviviality within superdiverse settings. Wessendorf's ethnography of an East London borough (2008-2012) observes that conversations amongst people of different ethnicities, languages and nationalities are punctuated by laughter and smiles,

which may function as superficial glosses to fleeting moments, or as an introduction to further friendship. In contrast, Wise (2016) remarks on the more active 'convivial labour' present in a multicultural workplace, where she demonstrates how humour helps to create bonds, "mediating potentially awkward differences, and establishing a sense of groupness" (Wise & Noble, 2016:430). These conclusions resonate with the research findings of this thesis, where humour and laughter are used to both mediate tensions between difference and understanding, as well as to demonstrate the sameness of shared health concerns, (see for example, 6.2.2.2 and 6.2.2.3), even when the subject matter is very serious (6.2.2.3, extract 15).

Small talk and humour do not in themselves foster a convivial environment, but they are part of the "specific practices of recognition, enquiry, negotiation, incorporation, care and accommodation …which create relationship and meaning" (Wise & Noble, 2016: 426). It is the complex interweaving of these features, and the flexible approach to articulating and accommodating heterogeneity, which confirms the 'superdiverse stance' (Jaffe, 2016: 15) of interactants as "an emergent property of communicative practice in sites of engagement and interaction" (Blackledge et al, 2018: xxix), at HUH. Staff and patients in this setting, are focussed on facilitating communication across difference. Intercultural competence is characterised by the pursuit of commonality and shared understanding, whether it be communicative (i.e. linguistic, semiotic), epistemic, ethnic or sociocultural. Indeed, the interaction ritual (Goffman, 1972) of the consulting room (where ritual is taken as a form of action which may be deployed to re-establish the flow of everyday life) offers a defence against the vulnerabilities of the ordinary world, and is oriented to the maintenance and recovery of stability. It draws participants into the unfolding moment, into the situated, contingent, cultural, and corporeal experience. (Blackledge et al, 2018: xxix).

However, in acknowledging the intricacies of communication, it must be recognised that the multitude of, what are commonly seen as individual, languages has indeed affected the practicalities of day-to-day living, not least

healthcare consultations, in superdiverse settings, thus directing the gaze of linguists onto the ways in which people draw upon their full linguistic repertoire. In the following section, I shall briefly compare key approaches to language practices in superdiverse settings, which I see as falling under the broad umbrella of linguistic repertoire (Busch, 2012), before continuing with a detailed exposition of the translanguaging, the framework I have chosen to adopt for the purposes of my study.

3.4 Linguistic diversity

The distinctly dynamic language use within diverse populations has captured the imagination of contemporary sociolinguistics, giving rise to a plethora of neologisms, each seeking to reflect a shift in thinking. While many academics have drawn inspiration from the urban environment (Otsuji & Pennycook, 2010) where sociocultural and linguistic diversity is clearly visible, especially among the young (Jörgensen et al, 2011; Maher, 2005; Rampton, 1995), others forge links between the fluidity of transnationalism and linguistic change (Blommaert, 2012a; Jacquemet, 2005). Moving from a focus on oral communication, additional approaches address the writing strategies utilised in multilingual environments (Luna & Canagarajah, 2007), as well as meaning-making practices "which emerge from the contextual affordances in the complex interactions of multilinguals" (Garcia & Li, 2014: 40). In the following section, I begin by briefly exploring the concept of linguistic repertoire, the foundations of which underpin a range of competing, but by no means exhaustive paradigms, before conducting an in-depth consideration of translanguaging (Blackledge & Creese, 2017; Garcia, 2009). This framework, with its orientation to social justice (Garcia & Li, 2014), allows a nuanced conceptualisation of communicative practices in my superdiverse research setting.

3.4.1 Repertoire

The concept of linguistic repertoire draws inspiration from Gumperz's seminal work (1964) on 'verbal repertoire', where interactants call upon a broad "arsenal in accordance with … meanings" (1964: 138). Rather than conforming to historically essentialised understandings of monolingual practices, Gumperz observes the ways in which interactants talk in different ways to different people in different settings. As such, he concludes that an individual's choice of language(s), dialect or patois, 'form[s] a behavioural whole, regardless of grammatical distinctness, and must be considered constituent varieties of the same verbal repertoire" (Gumperz, 1964: 140). Nevertheless, the academic notes that repertoires appear to be "subject both to grammatical and social restraints" and limited by "commonly agreed on conventions which serve to categorize speech forms as informal, technical, vulgar, literary, humorous, etc." (1964: 138). As the breadth of language practices exemplified by his empirical research originates in two distinctly different communities (agricultural villages in India and Norway), and all interactants appear to alter speech and language choice in the different settings they encounter, this then leads Gumperz to further associate verbal repertoire as something shared within 'speech communities', i.e. groups which can be "characterized by regular and frequent interaction over a significant span of time and set off from other such aggregates by differences in the frequency of interaction" (Gumperz, 1964: 137). Incorporating Hymesian notions of 'communicative competence' (1972), broadly interpreted as the rules of speaking, Gumperz's concept also presupposes "knowledge – 'competence' – because 'having' a particular repertoire is predicated on knowing how to use the resources that it combines" (Blommaert & Backus, 2013: 3), and, more importantly, the context in which to use them (Gumperz, 1977). While acknowledging that all speakers have individual verbal repertoires, Gumperz asserts that it is membership of the speech community that enables mutual intelligibility between speakers.

However, almost fifty years after Gumperz's initial conceptualisations, the term speech community, has become more nebulous and difficult to define, as

personal networks extend beyond the traditional ones of families, neighbours and local employment. Replaced, often synonymously, by 'communities of practice' to include the multiple sets with which an individual shares a mutual endeavour, groups not only encompass workplace colleagues, football teams or classmates, but in a globalised era, they can be long-distance, transnational and virtual. Under the contemporary conditions of superdiversity (see 3.3), "speakers participate in varying and deterritorialized communities of practice" (Busch, 2012: 3), where they may lack "commonly agreed on conventions" (Gumperz, 1964: 138). In any one of these connected encounters, individuals may draw upon a range of resources, from speech to emoticons, each reflecting individual idiolects formed, and informed, by personal biographical trajectories, in order to reach mutual understanding. Thus, Gumperz's vision of shared norms is blurred, effectively restricting the degree to which interpretations can be made within existing frameworks and prompting scholars to interrogate further the notion of repertoire, to capture the "richness and depth" (Li, 2018: 11) of superdiverse communicative practices.

Whilst Africa and India, for example, have an established history of multilingualism, the acceleration of transnationalism has instigated an avid interest in language use that breaks from accepted understandings of 'one-nation, one-language' discourse. In order to accommodate the dynamic and, ever changing, individual "records of mobility, which construct and constitute contemporary Late-Modern subjects" (Blommaert & Backus, 2011: 22), Blommaert and Backus (2011) propose a move from Gumperz's focus on communities to looking at personal repertoire. As we all experience change throughout our lives, they assert that individual repertoires in themselves should be viewed as "the real 'language' we have and can deploy in social life: biographically assembled patchworks of functionally distributed communicative resources, constantly exhibiting variation and change" (2011: 23). A disregard for the nationalistic and ethnic discourses constructed around notions of 'language', is advised by Busch, who reiterates the idea of repertoire as individual, "linked with personal experience and life trajectories" (Busch, 2012: 18). She also points to the indexical, contextual, and dialogic nature of

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communication, as occurring in a space which will also have its "own language regime—its own set of rules, orders of discourse, and language ideologies—in which linguistic resources are assessed differently" (ibid). Contemporary notions of repertoire contrast with historical understandings of languages as countable nouns, "belonging to separate linguistic systems" (Heller, 2007: 13). Instead, when "understood in relation to histories, power and social organisation" (Creese & Blackledge, 2010), 'languages' also become visible as ideological, social constructs (see for example, Makoni & Pennycook, 2008), or, as Heller notes, a "set of resources called into play by social actors, under social and historical conditions which both constrain and make possible the social reproduction of existing conventions and relations, as well as the production of new ones" (2007: 13)(see Chapter 7.1.3, extract 34).

Following these reconceptualizations, in an era of globalised movement, where participants may need to draw on repertoires, which consist of multiple, 'fluent', 'partial' or 'truncated' 'languages' (Blommaert & Backus, 2011: 21) in order to communicate outside a particular 'community of practice', it makes little sense to adhere to fixed notions of single language systems: rather, it holds more relevance to look at an individual's entire communicative capacity. While categories such as 'bilingual' or 'multilingual' enumerating the number of named languages and individual can speak, certainly help to reveal the ways in which certain languages are valued or dismissed, as well as the ways in which linguistic resources are distributed (Creese & Blackledge, 2010), they carry inherent restrictions in terms of analysis. As such, the following section, examines a selection of 'competing' approaches (Pavlenko, 2016), which, build on Gumperz's foundational work, and foreground the complexities of repertoire.

3.4.2 A multitude of frameworks

While the paradigm of superdiversity has been met with varying degrees of contention (see 3.3), the apparent proliferation of 'non-standard' speech practices (i.e. communication not identifiable as 'a' 'language' per se),

seemingly brought about and fuelled by transnational migration (see 3.2), has seen a number of persuasive conceptualisations gain considerable attention. Ben Rampton's (1995) concept of crossing, arose from his seminal study of teenage language practices in multi-ethnic schools in a south Midlands town, and vividly illustrates the ways in which different language varieties are integrated into everyday speech. Key to the phenomenon is the way in which teenagers move between, and blend, discrete languages and patois as an apparent means of resisting authority, expressing identity and reconciling ethnic difference. Similarly, Maher's (2005) research on urban Japanese youth, recognises a movement towards cultural hybridisation and ethnic tolerance, a concept he terms metroethnicity. However, Pennycook reflects that whilst the communicative orientations observed in urban youth can appear highly emergent processes, in time the iterative patterns of initially idiosyncratic speech can also become established and "recognised as a way of speaking [so that] both fixed and fluid descriptions of language and identity are constantly in play" (Pennycook, 2016: 205). Alternatively, he and Otsuji (2010) propose the notion of metrolingualism, which not only seeks to capture the rejection of cultural and ethnic essentialism, but to recognise the flexible use of 'languages' in which young, urban, speakers 'undo, queer and reconstitute their linguistic practices between the orthodox and heterodox' (2010: 424). In contrast to crossing and metroethnicity, metrolingualism avoids the connotations of moving from one distinct language, or ethnic group, to another, and instead offers linguistic analysis of the synergy between emergent and flexible "everyday language practices" in "urban space" (Pennycook, 2016: 205). Yet, in a criticism, which can clearly be extrapolated to other approaches, Garcia and Li suggest that whilst "metrolingualism focuses on social practices that are in a state of construction and disarray within urban contexts" (García & Li, 2014), it is restricted by the fact that it does not detail how 'local' practices "differ in form and function" (Jaspers & Madsen, 2019: 13). In addition, while the prefix 'metro' also implies an urban connotation that Otsuji and Pennycook insist "is not confined to the city" (2010: 245), it ultimately constrains its use.

Nevertheless, the urban environment is a plentiful source of sociolinguistic inspiration: continuing with further research of young adults in diverse urban environments, Creese and Blackledge (2011) recognise inherent tensions in the flexible bilingualism, they witness in four inner-city schools, where "students and teachers simultaneously lived both 'separate' and 'flexible' positions, and navigated between them interactively and discursively" (2011: 1196), depending on their strategic aims. Indeed, borrowing from Heller (2007), this view of "language as a social resource", emphasises the role of individual agency in "the performance of different social subjectivities" (2011: 1197), and in many ways can be seen as a precursor to translanguaging (see 3.5). Later research by Jörgensen, Karrebaek, Madsen & Møller (2016) finds that the range of communicative strategies used by Danish teenagers in metropolitan Copenhagen is difficult to analyse at a 'language' level, such is the idiosyncrasy of their speech. Reporting on their data, they claim that "It makes no sense to try to count the number of 'languages" involved or note examples of code-switching, as participants shift from standard Danish, to 'young Copenhagen Danish', interspersing these features with borrowed Armenian words (Jörgensen et al., 2016). In recognition of this idiomatic language use, these poststructuralist scholars propose a movement away from the use of the simplified sociocultural, and political, definition of 'language', and its inherent connotations of 'boundedness', towards a more fluid concept of 'languaging'. In doing so, focus shifts from abstract notions of structure and function associated with a countable nominalisation, to languaging as an activity (Pennycook, 2010a). Arnaut, Blommaert, Rampton and Spotti (2016), also make a persuasive case for 'languaging', arguing, that language, and established classifications such as lects and patois, for example, reflect nebulous social constructs, which mask the power relations involved in the hierarchisation of languages, i.e. who defines a 'standard' or 'patois', to which other varieties are compared? However, although this argument has been taken further by some academics, for example Makoni and Pennycook who reject the 'sociocultural abstractions' of discrete 'languages' (2006), as "the inventions of social, cultural and political movements" (2006: 2), this disregard could be said to ignore the sense of personal identity that some individuals

derive from being speakers of a particular 'language' (Jaspers and Madsen, 2019) (see 3.2.3.2). Returning to the notion of repertoire, Jörgensen and Møller (2013; also Jörgensen, 2008) use the term polylingualism, to describe how a variety of features, often identified as belonging to different recognised 'languages', integrate and blend in the communicative process. They also propose that whilst the process of polylanguaging is not reliant on speakers having full competency in several languages, "normativity influences linguistic practices in more than one dimension", and therefore has the potential to disadvantage those who do not adhere to convention. The salience of this observation is integral to analysis of the ensuing effects of diverse repertoire, and is a theme to which I return in Chapters 6 and 7.

In a digital age, for many people, communication is unrestricted: it is as easy to talk to our friends on the other side of the world, as it is to chat to a neighbour, whether it be by text, email or Skype. International travel is no longer the privilege of the few and, for the same price, a journey to mainland Europe takes the same amount of time as catching a train from London to Manchester. In a linguistic reflection of this new connectivity, Jacquemet (2005) uses the term transidiomatic practice, to characterise the ways in which transnational groups communicate in different languages and codes (García & Li, 2014), across continents. Acknowledging that 'co-presence' of languages, used simultaneously, is novel, it is the "de/re-territorialised technologies" (Jacquemet, 2005: 265), such as "electronic media, in contexts heavily structured by social indexicalities and semiotic codes" (ibid), that Jacquemet sees as unique to contemporary diasporas. In a similar vein, and building on his extensive work on superdiversity, Blommaert (2012a) coins the term supervernacularisation to illustrate the role of new media in the globalised practices of transnational communication. Nevertheless, while contemporary practices may be innovative, Garcia and Li assert that neither transidiomatic practices nor supervernacularisation address "the concept of language itself, nor the power dynamics involved in these constructions" (2014: 38). In an elaboration and updating of codeswitching, an established term in the sociolinguistic canon, commonly used to identify movement between discrete

'languages', Canagarajah and Luna introduce codemeshing as an integrated linguistic system, that they see as a manifestation of "resistance, reappropriation and/or transformation of the academic discourse" (Luna & Canagarajah, 2007: 56). Although the academics use the phrase more specifically in regard to written genres, the concept of codemeshing, as signalling an integrated system, shares some similarities with translanguaging (Garcia and Li, 2014). Yet there is an implication that the former is regarded as a specific act of resistance, rather than the "discursive norm" (Garcia and Li, 2014: 40) associated with the alternative framework. In further reconceptualizations of contemporary language practices, and adding to the numerous neologisms linked to superdiversity, Canagarajah also proposes translingual practices as an 'umbrella term' (Canagarajah, 2013). In doing so, he suggests that it encompasses communication that "transcends individual languages" and acknowledges the "diverse semiotic resources" (2013: 6) that are an integral part of languaging. Arguing that as "we are all translinguals" (2013: 8) drawing from broad and flexible repertoires, Canagarajah's proposal then calls in to question traditional terms such as mono/ bi/multilingualism, which focus on enumerating distinct codes. It also challenges some of the more contentious terms coined to explain idiosyncratic linguistic practises, such as semi-lingualism (Skutnabb-Kangas, 1981) and zerolingualism (Jaspers, 2011), as well as to support Makoni and Pennycook's (2006) cry for the (dis)invention of languages as social constructs. Despite sharing many conceptual similarities with the framework, Canagarajah (2013) dismisses translanguaging, believing it be restricted to cognitive multicompetence, and lacking recognition of the multimodality of communication, a claim that Garcia and Li refute:

> What makes translanguaging an important theoretical advance is that it is transdisciplinary; that is, it refers to a meaning-making social and cognitive activity that works in-between conventional meaning-making practices and disciplines and interactions of multilinguals (García & Wei, 2014: 40).

While it is clear that many of the aforementioned approaches overlap in their considerations of new, or perhaps just recently recognised (Vogel & Garcia, 2017), sociocultural and linguistic realities, and it is arguable that any number could be employed to capture the broad repertoires that characterise communicative practices in a superdiverse environment, new descriptive frameworks have not gone uncontested. Edwards refers to the rise of "uncouth neologisms and dysfluent phrasing" (2012: 37) as representing nothing more than a linguistic version of 'the Emperor's new clothes', while others such as Pavlenko (2016) have depicted them as evidence of a marketization and commercialisation of an ambitious academia. From a more political perspective, Kubota (2014) posits that iterative neologisation stimulates, and sustains, competition between academics and institutions, creating a complicity between education and a broader neoliberal agenda, in a way which ignores the complex relationship between linguistic difference, class, discrimination and inequality (see Chapters 4, 6 and 7).

Nevertheless, the huge range of ever-changing descriptors is a response to the dynamism of repertoires in a superdiverse population and reflects the impetus for "for new images, metaphors and notions to cover adequately what we observe" (Blommaert, 2013a). As such, further analysis calls for the adoption of a transdisciplinary framework without borders, that can accommodate linguistic difference in diverse settings, from urban to rural, informal to institutional, and which allows speakers to transcend the "historical and cultural positionings" (García & Li, 2014: 43) of labels such as mono/bi/multilingualism, while also recognising the multimodality of resources. In the following section I propose that while a range of competing frameworks give nuanced insight into contemporary communicative practices, it is the

specific underlying orientation towards social justice (Li, 2018; García & Li, 2014) implied by a translanguaging approach that offers the potential to explore the complex relationship between linguistic diversity and inequality (Flores & García, 2014).

3.5 Translanguaging

The term translanguaging has drawn influence from numerous sources: derived from the Welsh word 'Trawsieithu' (Williams, 1994) the expression was originally coined to describe the practice of alternating between Welsh and English in an educational setting, with the aim of encouraging and promoting balanced bilingualism. As students read something in English and then respond in written Welsh, the prefix 'trans' is intended to capture the seamless movement across and between languages, with the verb implying a focus on "function rather than form, cognitive activity, as well as language production" (Lewis, Jones & Baker, 2012a: 1).

In his seminal paper, 'A Theory of Practice' (2018), Li traces his historical, epistemological and transdisciplinary understanding of translanguaging, back to the work of two biologists and neuroscientists, Maturana and Varela, who describe languaging as "an activity of human beings in the world" (1980: 34). He also draws on the field of psycholinguistics, reflecting on the cognitive dimension of languaging in second language acquisition, where Swain sees it "as a vehicle through which thinking is articulated and transformed into an artifactual form" (2006: 97 in Li, 2018: 16). However, while this may imply that "language or any other symbolic object (could) be treated like an end in itself" (Bourdieu, 1991: 34), languaging is an activity (Li, 2018) not a product or "abstract entity" (Pennycook, 2010a: 2): it represents "the simultaneous process of continuous becoming of ourselves and of our language practices as we interact and make meaning in the world" (Garcia and Li, 2014:8). Unlike traditional understandings of language systems where speakers are imagined to access, select and deploy resources from discrete areas of the brain, a concept which is often illustrated by the use of the term codeswitching,

languaging can be seen as a cognitive act that goes beyond the additive concepts of bi/multilingualism:

> The theory posits that rather than possessing two or more autonomous language systems, as has been traditionally thought, bilinguals, multilinguals, and indeed, all users of language, select and deploy particular features from a unitary linguistic repertoire to make meaning and to negotiate particular communicative contexts. (Vogel & Garcia, 2017: 1)

Therefore individual repertoires work as an integrated social process (Pennycook, 2010a), often combining multiple resources that "may, or may not, agree with canonically recognized languages, codes or styles" (Jaspers, 2018: 4). By utilising resources strategically and contextually, agency and meaning-making remain with the speaker(s), arguably offering the potential to transform communicative processes and social structures (Li, 2018). Indeed Li asserts that the prefix 'trans', highlights the way in which fluid practices "transcend socially constructed language systems and structures to engage diverse multiple meaning-making systems and subjectivities" (2018: 27), and indicates a process which works across disciplinary divides.

3.5.1. The emergence of a concept

Translanguaging has become currently one of the most influential concepts in the field of applied and socio-linguistics, with a growing number of academics adopting the term as a pedagogy, theory, practice or descriptive lens (see for example, Blackledge & Creese, 2017; Simpson, 2016; Flores & Garcia, 2014; Li, 2014). However, the multitude of ways in which the term is employed has prompted extensive, and heated debate, often in response to the "continuous redefinition and extension by translanguaging specialists themselves" (Jaspers, 2018: 3). In recognition of this criticism, I will initially outline how the term has become so influential in the field of education, where it informs a practical pedagogical approach in many multilingual settings, as it is from this position that it has developed into a theoretical lens through which to view

communication in superdiverse environments. I also detail some of the critiques that translanguaging pedagogy has faced, not because this thesis pertains to education, but because it is within this field that much of the argumentation surrounding the concept has been played out.

Inspired by Williams' (1994) original definition of a pedagogical practice which entails "the process of meaning making, shaping experiences, gaining understanding and knowledge through the use of two languages" (in translation) (Baker, 2001: 288), translanguaging has captured the academic imagination, specifically in regard to debates around bi/multilingualism in schools. Defining translanguaging pedagogy as unique, are the ways in which the approach contrasts with established practice in the Anglophone tradition, where, from discrete 'foreign' language lessons to bilingual schools or immersion programmes, traditional educational settings echo a societal view of languages as distinct entities. Translanguaging advocates regard these methods as hindering learning potential, arguing that a child's full repertoire is restricted or goes unrecognised (García, 2009; García & Li, 2014). In contrast, the pedagogy takes the language practices of bilingual, rather than monolingual, people as the starting point. Ofelia Garcia, a leading proponent of translanguaging, sees the opportunity for children to "make meaning by engaging their entire linguistic repertoire and expanding it" (Garcia and Li, 2014: 71). Thus the "transformative pedagogy (is) capable of calling forth bilingual subjectivities" (ibid), where the possibly of change is "seen to be a desired effect, a matter of social justice" (Jaspers, 2018: 6). Garcia argues that where the monolingual classroom has historically disadvantaged students with minority repertoires, restricting them from reaching their academic potential, "translanguaging can "expos[e] alternative histories, representations and knowledge… [having] the potential to crack the 'standard language bubble' in education that continues to ostracise many bilingual students" (Garcia and Li, 2014:115). In addition, in bilingual education, the pedagogy allows learners to develop "both of the named languages… precisely because it considers them in a horizontal continua as part of the learners' linguistic repertoire, rather than

as separate compartments in a hierarchical relationship" (Vogel & Garcia, 2017: 2).

However, translanguaging pedagogy is not without criticism, with some problematizing the binarizing tendency of privileging fluid communicative practices over the fixity of a named language (Jaspers, 2019). This point is particularly relevant when highlighting the central role played a 'language' associated with a specific nation-state, or which is seen to intrinsically authenticate the lived experience and identity of minoritized speakers in that area (Blackledge & Creese, 2010). Countering this interpretation, Otheguy, Garcia and Reid insist that, in spite of good intentions, language maintenance programmes often run the risk of turning minoritized languages into 'museum pieces' (2015: 2). Instead, they assert that translanguaging gives students the opportunity to use language fluidly, using their "full linguistic repertoire without regard for watchful adherence to the socially and politically defined boundaries of named (and usually national and state) languages" (Otheguy, Garcia & Reid: 2015: 281), and to "disrupt the socially constructed language hierarchies that are responsible for the suppression of the languages of many minoritized peoples" (Otheguy et al, 2015; 283). In these circumstances, the integration, and therefore recognition, of a minoritized language into a fluid repertoire, thus revitalises it, albeit not in an essentialised way.

As much of the existing literature on translanguaging concerns practices among bi-and multilingual communities, the linguistic repertoire of the, so-called, monolingual is problematised: for example, from a translanguaging perspective, does a monolingual have a repertoire? Of what does it consist, is it fixed and (how) can it be fluid? In a very effective illustration of translanguaging, Otheguy and Garcia (Otheguy et al, 2015), respond with the culinary metaphor of catering for a Japanese guest, feeding her Cuban food one day, American another and the third day comprising cuisine from a mixture of countries. From an outsider's perspective, the guest couldn't know that the food served was not from a traditional 'American' or 'Cuban' repertoire, only that she had eaten well. Similarly, from a translanguaging perspective,

Otheguy, Garcia and Reid assert that each person's repertoire is as individual as the meals described, being contingent on context and interpretation. In an additional illustration, we could compare the variety of English as spoken by a young, unemployed, female teenager playing online video games, with an elderly, male farmer living on a croft in Scotland. Grammarians studying their speech may be able to describe linguistic features, both of which could be said to comprise non-standard components of a standardised 'English', but may conclude that, rather than either speaking the same, or different, languages, they were deploying individual repertoires, or idiolects.

> a person's own unique, personal language, the person's mental grammar that emerges in interaction with other speakers and enables the person's use of language ……viewed from the internal perspective of the individual, language seen separately from the external perspective of the society that categorizes and classifies named national languages. (Otheguy, Garcia & Reid, 2015: 289)

Acquired through social interaction, idiolects comprise features which have a large degree of overlap to those with whom we regularly communicate, as well as characteristics associated with specific geographical regions. However, assuming that "a named language is a collection of the only partially overlapping idiolects of people who share a common cultural identity …and given that the idiolects that comprise a named language are all ultimately different " (2015: 294), Otheguy et al argue that "no one really speaks a named language" (ibid). As mono-and multilinguals all draw on unique idiolects, "comprised of large numbers of organized lexical and structural features… [which]… have no inherent membership in any named language", it is this cornerstone which '"sustains the concept of translanguaging" (Otheguy et al, 2015: 294/5). Therefore, both mono- and multilingual speakers can be seen to deploy a full linguistic repertoire, differing only quantitively in the number of personal resources available. Nevertheless, while the latter may have more complex features from which to select, it must be recognised that particular

settings can privilege the monolingual, who may have further access to technical, or socio-culturally contingent registers.

In a translanguaging approach, which recognises that the "dynamic linguistic and semiotic practices" (Vogel & Garcia, 2017: 2) are decided "by the social information that (speakers have) regarding the particular communicative context in which the social interaction takes place" (Vogel & Garcia, 2017: 7), the idiolect is privileged. Translanguaging scholars adopt an emic perspective, to recognise the "fluid use of language…… as going beyond the socially constructed boundaries of named languages" (Vogel & Garcia, 2017: 5), helping to disrupt language hierarchies (Otheguy et al, 2015), rather than adhering to the imposition of restrictive, external categories "that emanate from, and in turn reaffirm, sociocultural or national (and often also political) structures" (Otheguy et al, 2015: 297). Significantly, a translanguaging lens can scrutinise how "sociolinguistic practices [are] connected to the construction of social difference and of social inequality" (Heller, 2007: 3), and, in doing so, offer scholars a pedagogic approach which has the potential to transform language education and classroom practice (Otheguy et al, 2015). While this approach may be persuasive, Jaspers and Madsen encourage sociolinguists to look past the contemporary neologism, and to "concern [themselves] with explaining the transformative potential of all language use, regardless of its fixed or fluid nature" (2019: npn). Indeed I also note, that by imbuing the notion of translanguaging practices with an almost mystical power to transform, it is possible to miss the ways in which fluidity has the potential to mask misunderstanding and reinforce asymmetries, albeit unintentionally (see 7.3.5).

3.5.2 Beyond pedagogy

Building on the considerable volume of work in education (see for example Vogel & Garcia, 2017; Garcia & Li, 2014; Flores & Garcia, 2014), translanguaging scholarship has moved out of the classroom, with academics re-focussing their lens on linguistically, socially and culturally diverse contexts,

for example, in markets, legal settings and karate clubs (Blackledge, Creese & Hu, 2015; Baynham et al, 2017; Blackledge & Creese, 2017, respectively). In the subsequent sections, I touch on some of the findings of the TLANG project, an extensive, research collaboration, comprising research conducted in four socio-culturally and linguistically diverse cities across the UK, over the period of four years (2014-2018). By taking research beyond pedagogy, where the educational context undoubtedly provides fertile ground, and content, for explicit metacommentary, to environments where participants may be oblivious to the linguistic foci, researchers are able to examine how individuals communicate across potential language divides. Moving away from the interpretation of languages as "distinct codes" (Blackledge & Creese, 2017), the focus lies on "empirically observable practices" (ibid, 251), which illustrate that individuals employ a range of multimodal resources in order to communicate with others. In a diverse setting, "translanguaging offers a way of capturing the expanded complex practices of speakers who could not avoid having had languages inscribed on their body, and yet live between different societal and semiotic contexts as they interact with a complex array of speakers" (Garcia and Li, 2014: 18). As I will later demonstrate in Chapters 6 and 7, extended, multimodal repertoires appear to reflect "dynamic mobile resources that can adapt to global and local sociolinguistic situations" (Garcia and Li, 2014: 18).

3.5.3. Semiosis and multimodality

Communication is never solely linguistic. In almost any context, speech will always be accompanied by variations in expression, gesture, touch, tone, and visual cues (Li, 2018). On occasion, objects, pictures, videos and emoticons, for example, may also be employed to convey meaning. While the concept of multimodality can be traced back to social semiotics (Halliday, 1978), and sociological contexts (Goffman, 1981), much of current thinking can be seen to have been shaped extensively by the ground-breaking work of Gunther Kress (see for example, Kress, 2009; Kress & van Leeuwen, 1996). Using the definition of a mode as 'a socially and culturally shaped resource for making

meaning' (Kress & Bezemer, 2008: 6), Garcia and Li note that, not only must meaning be drawn from modes in 'ensemble', but also as 'part of a wider repertoire of modal resources that sign makers have at their disposal and that carry particular sociohistorical and political associations' (2014:29). During their ethnographic observations of a market in Birmingham, a city which can be said to be characterised by its diversity (see 3.3), Blackledge, Creese and Hu (2017, 2015) remark on the ways gesture, lexical items and expressions are an 'integrated system' (Canagarajah, 2011: 401) used in combination to indicate or query how much, and what kind of, meat a customer would like to buy. While many of the observations indicate that a multimodal approach helps to facilitate a successful transaction, as participants draw on a shared understanding of signs, in others, gestures are less productive: for example, when the butcher and the customer quibble over whether it is the small or large intestine that the customer would like to buy, the exchange goes unresolved and the customer goes home empty handed. In this instance, a translanguaging lens illustrates the tensions between signs, possibly because of socio-historical associations, or the way in which they are interpreted, or resemiotized (Iedema, 2003), imbuing them with new meaning. As is later illustrated, midwives frequently use a combination of gestures, objects and verbal exchange as a means of double checking patient identity, to ensure appropriate treatment (see 7.1.1.1, extract 30). However, while mutual comprehension is sometimes achieved with the help of semiotics (see 7.3.2 extract 39), at times, such methods can be unproductive (see 6.5, extracts 28 and 29).

3.5.4 Linguistic creativity and translanguaging instinct.

As we have seen, languages are not "autonomous and closed linguistic and semiotic systems" (Garcia and Li, 2014: 42), but dynamic, mobile resources, in constant flux (Blommaert, 2010). Translanguaging allows speakers to combine features flexibly and creatively, in order to make meaning, offering them the "ability to choose between following and flouting the rules and norms of behaviour including the use of language, and to push and break the

boundaries between the old and the new, the conventional and the original, the acceptable and the challenging"(Garcia and Li, 2014: 94). In his extensive essay, theorising translanguaging, Li offers very effective illustrations of Chinglish (2018), whereby speakers not only move creatively between Chinese and English, commonly seen as separate systems, but do so by reappropriating words to give them new meanings, creating neologisms, adapting "their bodies and brains to the languaging activity that surrounds them' (Thibault, 2017: 76). However, although we may appreciate that in a globalised, superdiverse environment there is a probability of "(e)nhanced contacts between people of diverse backgrounds and traditions [which may] provide new opportunities for innovation and creativity" (Li, 2018: 23), it is arguable that the degree of flexibility and creativity are both contextually contingent, as well as dependent on personal repertoire. For example, while it may be unremarkable to engage one's full repertoire when socialising informally, institutional settings may pose more restrictive boundaries, whether implicit or explicit. Nevertheless, ethnographic research in a legal advice centre (Baynham et al, 2017), a traditionally formal environment, offers a fruitful interpretation of how translanguaging becomes manifest in 'monolingual' spaces. Following a legal advisor, Lucy, whom they describe as having an 'ostensibly monolingual' (2017: 56) repertoire, the academics note that she employs a broad range of multimodal strategies in order to discuss complex information with her clients, many of whom may speak little English or have an understanding of the legal system in the UK. Borrowing from (Jakobson, 1959), the scholars note that Lucy can be seen to use a range of strategies to mediate the discourse, from the perspective of those who are outside it (Baynham et al., 2017). They describe, how using intralingual translanguaging, Lucy "shifts from specialized registers into everyday English, in an endeavour to explain technical terms" (Simpson, 2016: 15); where she uses gesture, photography, drawings and online translation software, Lucy's intersemiotic translanguaging "involves shifts and switches between spoken and written, visual and verbal" (Simpson, 2016: 15); they also note that Lucy employs interdiscursive translanguaging, which involves "translanguaging across discourses which occurs when there is an unfamiliar discourse that

needs to be negotiate" (Simpson, 2016: 15). As I will later explore (see 6.4.2, extracts 25 and 26), just as Lucy's repertoire displays the flexibility, creativity and instinct to make herself, and complex legal information, understood, medical staff working at HUH also strategize in a similar way. Displaying what Li names a translanguaging instinct, i.e. a commitment to reconcile "differences, discrepancies, inconsistencies, and ambiguities, if and when they need to be resolved" (2018: 19), medics employ epistemic flattening (Baynham et al., 2017), a method of rearticulating technical language into a lay vocabulary, in attempts to reduce inherent knowledge asymmetries and to ensure understanding. At the same time, they also appear to respond intuitively when they anticipate or recognise potential communicative difficulties, subsequently drawing on a range of linguistic and semiotic resources to navigate complex discourse (see for example, 6.5, extract 29). However, occasionally clarification and comprehension still appear difficult to achieve and participants embark on a protracted process of what I have termed transelucidation, and which can be distinguished as an aspect of interdiscursive translanguaging in that it is specifically about seeking clarity. As we will see in Chapter 7 (see 7.2.3, extracts 43 and 44), the transelucidary process involves work across languages, registers and discourses: it is noticeable for its messiness and for the time that it takes. Often involving a series of false starts, guesses, explanations and misunderstandings before the exchange is concluded, transelucidation can often result in an unsatisfactory encounter, despite the deployment of a full repertoire, and whether or not the participants are aware of a breakdown in understanding.

To recapitulate, the translanguaging instinct "drives humans to go beyond narrowly defined linguistic cues" - they are able to "transcend culturally defined language boundaries to achieve effective communication" (Li, 2018: 24-25). However, the opportunity to utilise one's full repertoire is contingent both on the communicative stance of participants, i.e. whether they are willing to adopt the mantle of conviviality, so intrinsic to the superdiverse context (Jaffe, 2016; see also 6.2.1, extract 1), and the metaphorical openness of the space, i.e. whether they have the institutional freedom to employ these skills (see 7.1.3,

extract 34). In order to ensure participant voice or audibility, "regardless of the language, variety or mode of communication" (Baynham et al, 2017: 23), successful interaction is reliant on the existence of a facilitative environment. In the following section, I address the characteristics of settings which are said to offer emancipation from institutional constraints and where superdiverse repertoires can be said to flourish.

3.6 Translanguaging space

As societies have become more diverse, the spaces in which individuals have the opportunity to interact with others from different cultures, ethnicities and religions, and with whom they may not share a 'language', have grown in number. Following this, the idea of an environment which challenges historical communicative norms and hierarchies, has been variously conceptualised as a contact zone (Pratt, 1991), third space (Soja, 1996; Bhabha, 1994) or translanguaging space (Li, 2018), and is one which has become synonymous with the notion of superdiversity. However, while Pratt's imaginings of "social spaces where cultures meet, clash and grapple with each other, often in contexts of highly asymmetrical relations of power" (1991: 34) conjure combative implications, those of Bhabha and Li share more cooperative assumptions.

Bhabha problematises the notion of 'cultures' from a post-colonial perspective, seeing them as nothing more than social constructions, i.e. "constituted in relation to that otherness internal to their own symbol-forming activity" (1990: 210). As mutually constitutive concepts therefore, cultures are "always subject to intrinsic forms of translation" (1990: 210), with the iterative processes of othering and reinscribing identit(ies) creating a continual process of hybridity. Bhabha further clarifies, postulating that from cultural hybridity emerges a 'third space' (1990:211), which enables new cultural articulations and translation of difference: meanings and signs can "be appropriated, translated, rehistoricized, and read anew" (1994: 55). However the complexities of hybridity generate contention: if hybrid societies rely on essentialised positions

from which to emerge it suggests that not only are they somehow invested in the reproduction of 'purer places' (Jaspers, 2017: 11), but also implies a paradoxical fixity of hybridity (Kubota, 2014). In turn, this logic is predicated on the idea that a language can be 'fixed', without variation or hybridity (Otsuji and Pennycook, 2010) and suggests equal margins between the two cultures, ignoring potential asymmetries. Many scholars have also highlighted a problematic positioning of hybridity as celebratory and essentialism as 'bad' (Kubota, 2014; Lorente & Tupas, 2013). The stance can disregard the authenticating experience of cultural identity (Jaspers, 2019), which has been so integral in the dismantling of colonialism, but it can also ignore the potentially active role of hybridity "within the interplay of cultural and economic processes which are the essential generators of pervasive inequalities" (Lorente & Tupas, 2013: 69). As such, while acknowledging that a space for linguistic fluidity and freedom can offer enhanced communicative possibilities, I later return to address the salience of these concerns (see 7.3.5), positing that the very characteristics that are championed may also play an inadvertent role in masking disparities.

Nevertheless, the idea of liminal space between cultures, where established conventions and norms can be resisted and reimagined, is one that has gathered momentum, with scholars strategically adopting and adapting the concept. Continuing with the idea of a third space and building on Soja's conceptualisation of a place of "extraordinary openness" (1996: 5), which moves away from the boundaries of race, class and gender to "encompass a multiplicity of perspectives" (1996: 5), Li further extends the concept. Paraphrasing bell hooks, he proposes the idea of a translanguaging space which "invigorates languaging with new possibilities from 'a site of creativity and power' (hooks, 1990: 15). A translanguaging space moves beyond the notion of hybridity, with the historical burden of implied binaries, to incorporate contemporary realities, where increased contact with people from diverse backgrounds, offers space for "innovation and creativity" (Li, 2018: 23).

> Translanguaging Space has its own transformative power
> because it is forever evolving and combines and generates
> new identities, values and practices. Translanguaging
> underscores multilinguals' creativity—their abilities to push
> and break boundaries between named language and between
> language varieties, and to flout norms of behaviour including
> linguistic behaviour, and criticality—the ability to use evidence
> to question, problematize, and articulate views (Li 2018: 23)

What is key to the idea of a translanguaging space is its emancipatory potential. As the space is created both 'by and for translanguaging' (Baynham, 2017: 56), analysis shifts from looking at restrictive nation-state identities, to challenge traditional understandings of multilingual communication. Individuals are able to respond contingently, adapting the range of multimodal resources at their disposal, to ensure effective communication and, in effect, to produce trans-spaces. The process allows "Others (to) come to the forefront" (Li, 2018: 24), giving a unique perspective for addressing "criticality… social justice and the linguistic human rights agenda" (Li, 2018: 24). Through practices where "subjectivities and social structures are dynamically generated" (Garcia & Li, 2014: 43), translanguaging is an integrated framework which demonstrates the potential to dismantle linguistic hierarchies and institutional asymmetries, which are often held to be well-established in medical settings (see Chapter 4). Indeed, in the context of my research, it is specifically because of its underlying orientation towards social justice (Garcia and Li, 2014), that translanguaging offers an effective lens to examine contemporary communication in a superdiverse context.

3.7 Conclusion

In this literature review, I have explored the intensification of diversity during the latter part of the twentieth century, which was facilitated by both increased migration and the ease of mobility. Movements have prompted huge demographic, political and sociocultural change on a global scale, arguably altering the linguistic and ethnic landscape of many countries. As discussed

earlier (see 3.3), whilst some academics highlight the Eurocentricity of debates surrounding the apparent novelty of superdiversity (Pavlenko, 2016), the concept provides a valuable lens with which to examine the multilingual, multi-ethnic and multicultural South London borough in which my research is located.

Following this, I also detailed some key characteristics of superdiverse societies (see 3.3), where communicating across potential linguistic, ethnic and sociocultural divides, as well as discourses, requires a cooperative orientation, often referred to as stance (Jaffe, 2016) or instinct (Li, 2018) (see 3.5.4) and underpinned by a commitment to conviviality (Wessendorf, 2014) (see 3.3.1). While it is often suggested that theories lack real-world application and benefit only the academics who recycle and repackage them (Kubota, 2014), I have explored the relevance and applicability of translanguaging (Li, 2018) as a framework which can not only illuminate innovative communicative practices in multilingual encounters, but potentially improve understanding and, with regard to the setting with which I am concerned, patient autonomy (see 4.5; 7.4). The flexibility afforded by a translanguaging space, consolidates its emancipatory potential and is of particular significance in a formal, institutional setting where hierarchies have historically stifled the audibility of 'othered' individuals.

However, this thesis does not rest at highlighting the creativity and facilitative aspects of translanguaging in superdiverse settings, but seeks also to examine how contemporary healthcare professionals and institutions respond to changing populations. In the following chapter, I review the established literature on doctor/patient communication in monolingual and multilingual settings, as well as looking at the role of interpreters in mediated dialogue. Locating my research in contemporary superdiverse settings, I reflect on both the positive effects of flexible communication and its role in advocacy, but also allude to the ways in which societal discourses and circulating ideologies can seep through surface-level multiculturalism, problematising interaction and highlighting power relations.

Chapter 4 - Medical consultations in superdiverse setting

4.1 Introduction

Having demonstrated the ways in which a convivial and flexible approach to language can help to facilitate communication in multilingual communities, this second literature review seeks to locate current practice in context. I begin by outlining the ways in which the NHS is positioned to respond to the unpredictable needs of an ever-changing, diverse population, and the systems in place to cater for heterogeneity in practical terms (4.2). I next consider how working with multilingual patients is construed by medical professionals (4.3), by reflecting on established literature on doctor/patient relationships and previous research on intercultural health consultations (Baraldi & Luppi, 2015; Moyer, 2013; Roberts et al., 2005; Roberts & Sarangi, 2005; Moss & Roberts, 2005; Sarangi & Roberts, 1999). While much of this literature has focussed on the potential for, and consequences of, misunderstanding (Moss & Roberts, 2005; Frankel, 1984; Korsch & Negrete, 1972; see section 4.3.2) the complexities surrounding the everyday considerations of mediated communication have also led to extensive research on language as resource, primarily through the lens of interpreting provision examining the role of the formal, and informal, interpreter in the consulting room (Cox and Maryns, 2019; Li et al, 2017; Moyer, 2013; Flores, Abreu, Barone, Bachur & Lin, 2012; Angelelli, 2004; Davidson, 2000; section 4.4). More recently, research in bi/multilingual settings indicates that medical professionals may also regularly draw on their own linguistic repertoires in order to improve communication with their patients (Cox et al, 2019; Mori & Shima, 2014; Moyer, 2013; section 4.5). Given the increasing internationality and diversity of the NHS workforce (see 2.3), this chapter seeks to summarise and synthesise emergent evidence that consultations reflect the day-to-day communicative practices of superdiverse communities, as well as highlighting the new challenges that this may bring.

4.2 Health care in a superdiverse setting

In Chapter 2, I explored the challenges of using superdiversity as a term to capture to the complexities of contemporary London, noting criticisms which question both its novelty and its Eurocentricity (see for example, section 3.3). Nonetheless, it is also clear that in specific, urban environments, demographic changes continue to be unprecedented. In this instance, Hayfield's multilingual, multi-ethnic, multinational population can be seen in a similar light to other UK cities like London, Birmingham, Leeds or Glasgow, in terms of diversity and the rate of change (see 2.2 & 3.3). In the context of healthcare, a superdiverse lens can therefore challenge "traditional multicultural models of welfare provision originally based upon an understanding of migrants as large and geographically contained clusters of predominantly postcolonial migrants" (Phillimore, 2010: 5). In turn, it can alert institutions to the unpredictable heterogeneity of communities, problematise assumptions of shared cultural knowledge and raise the wider question of who constitutes the stranger, even within the healthcare workforce (Bradby et al., 2017). However, while doing so offers the opportunity to address the demographic realities of contemporary Britain and the NHS commitment to ensure health equity for all, adapting established provision is not without difficulties (Piacentini et al, 2019; Phillimore et al., 2018; Bradby et al., 2017).

4.2.1. Institutional categorisation

Population diversity poses a challenge to public service provision and to ensuring equitable access to health: as NHS guidelines are devised as national strategies, change may potentially prove difficult to reimagine at a local level. In superdiverse pockets like Hayfield, the proximity of the Home Office and initial accommodation for those seeking asylum (see 2.2.1.2) not only increases the number of international patients, from a wide variety of countries, but the transient nature of these migrant flows understandably affects ongoing planning of health services and likely puts pressure on structural processes, hospital budgets and interpreting services (see 2.3.2.4;

4.4). As Blommaert suggests, an adoption of systems to cope with such change, depends very much on political and institutional will:

> Whether the concept superdiversity becomes a useful description of the political dynamics of citizenship to inform public service provision hinges on the degree to which people—experts, legislators, opinion makers—are capable of imagining the levels of complexity that characterize the real social environments in which people integrate. (Blommaert, 2013b: 195)

Institutional barriers and commitment notwithstanding, the NHS is compelled to adhere to the United Nations Convention for Human Rights (UNCHR), where legislation enshrines healthcare rights for pregnant refugees and asylum seekers. As I outlined in Chapter 2, maternity care of this relatively small, but distinct, diverse group is designed to recognise, and be responsive to, the unique needs of these particularly disadvantaged individuals. In contrast, the institutional systems in place for acknowledging difference in the wider, changing population appear to lack nuance. This is perhaps best exemplified by the process of registering with a midwife (see 2.3.2), where patients are subject to systems of classification, in relation to protected characteristics, such as gender, ethnicity, religion, nationality and age, as mandated by the 2010 Equality Act. Therefore, categorisations are not context-free or created in isolation, but derive meaning from the extrasituational contexts that have established which symbolic resources are of value to a specific society, at a specific point in time (Heller, 2001; Duranti & Goodwin, 1992; Bourdieu, 1982; Gumperz, 1972; see Chapter 7).

rather than considering social categories to be fixed entities that determine and fix people in a particular way within a particular social landscape, they can be thought of as products of the processes of meaning in which social reality is constructed and organised and whereby knowledge, thought and action can be considered communal constructs rather than individual properties (Tranekjaer, 2015: 90).

As Heller notes, "at the heart of the problem of social categorisation lie the resources which are valuable to people, whether material or symbolic" (2001: 214). In following sections (see 4.2.1, 4.2.2 and 4.3), I discuss this further, with particular reference to the resource of language, demonstrating that by drawing on categorisations, and sustaining them through iteration, people reproduce knowledge, which comes to be understood as 'common sense' (Heller, 2001; Bourdieu, 1982). However, I will also show how the specific circumstances of superdiversity may be instigating a redefinition of social categories, offering new ways of organising experience, and creating new knowledge (Heller, 2001; see 6.3.1, extracts 17 & 18).

Returning first to the symbolic and material effects of protected characteristic categorisation: on occasion, this data can hold particular medical relevance in alerting professionals to the likelihood of specific health conditions in antenatal care. Establishing ethnicity, for example, can help medical professionals identify South Asian women, who have a statistically higher risk of gestational diabetes, in advance of meeting them face-to-face. Patients are then immediately referred for a glucose tolerance test (c/f 2.3.2; 6.3.1, extract 17) to gauge their condition and, if positive, they are subsequently allocated a specific care pathway. A patient's age can also allow an older mother, who may consequently have a higher risk associated with her pregnancy, to be referred to a dedicated midwife. On one hand, this orderliness aids the planning and allocation of specialist staff, attempts to ensure the best care is in place for a healthy pregnancy and, ultimately, goes some way to preventing complex, dangerous, and expensive, emergency deliveries. However, on the other hand, paradoxically, day-to-day classificatory processes that seek to

break down difference and dissect factors of diversity, ostensibly as a positive means of improving care and ensuring equity, can also lead to uncritical essentialisations or lack of attention to factors not captured by the categorisation process (Urciuoli, 2016). To extrapolate, while refugee or asylum seeker categorisation may give an indication of migration trajectories and adverse experiences, the general system does not explicitly recognise settled or internal migrants, who may have had similarly negative pre-migration histories but who fail to fall into the category of protected status, thus preventing them from accessing specialised care or funding (Phillimore et al., 2018; Meissner & Vertovec, 2015). An example of this is the large Tamil population in Hayfield, the majority of whom have fled civil war: treatment solely as members of a diverse, but settled, community, is not sufficient in recognising the associated mental and physical health problems from which they may suffer as previously persecuted individuals. The categories themselves also lack nuance. Often utilised as the primary indicator for diversity, the significance of 'ethnicity' as a term of reference in a minority/majority town like Hayfield, is somewhat homogenising and arguably redundant (see 2.2.1.6). It also challenges assumptions which are somehow embedded in the classification process, whereby ethnicity is conflated with other characteristics: although colour may have once indexed nationality or first language, a large number of the Black and Minority Ethnic community in Hayfield, are 2nd, 3rd or 4th generation British, while a significant proportion of 'White Other' are Europeans, who do not speak English as a first language.

Although the extensive research on medical records is beyond the scope of this thesis (see for example, Swinglehurst, Roberts & Greenhalgh, 2014; Jones, 2013; Cicourel, 2007; Berg & Bowker, 1997), it must also be noted that patient records/databases also lack the nuance needed to fully capture the intersectional experience of individuals, i.e., their linguistic, ethnic and socio-cultural background (Crenshaw, 1989). This is exemplified by the physical limitations of the patient record, where the field to indicate country of birth, cannot be extended to capture the complexities of chain, or onward, migration,

and therefore index subsequent effects that this may have on personal or community health (see 7.2.1, extract 35).

4.2.2 Linguistic categorisation

It is clear that the tensions between the limited explanatory power of classification and the homogenising effect of using superdiversity as an umbrella term to recognise the breadth of difference, have the potential to obscure the complexities which may affect care, access to health services and outcomes, and can have real "consequences for the way people think about themselves and others, without a given context" (Tranekjaer, 2015: 89)(Urciuoli, 2016; Wessendorf, 2014). A central component of the institutional categorisation process, and one that holds considerable implicatory power is 'language'. Ostensibly synonymous with forms of verbal communication "that emanate from, and in turn reaffirm, sociocultural or national (and often also political) structures" (Otheguy, García & Reid, 2015: 297), language can be seen "a form of social action which needs to be understood in its own right, albeit linked to other forms of social action (and social organisation)" (Heller, 2007: 213). Following this, for the purposes of the ensuing section, where I reflect explicitly on existing institutional categorisations, the word 'language' is here conceptualised as it is within the NHS context (c/f 2.3).

Current NHS recommendations (NHS, 2017), advise women to visit their GP as soon as they think that they may be pregnant, in order to confirm pregnancy and receive a referral for antenatal care. At this point, a patient will be asked to confirm her first or preferred language. Although I have established that it may be unhelpful to conflate ideologies of one language/one nation (see 3.3), it is also crucial to acknowledge that the communicative resources that patients have available, in addition to the ways in which 'interactions are enacted and negotiated' (Moyer, 2013: 196), have the potential to affect their capacity to understand, respond and act on clinical advice (Piacentini et al., 2019; Moyer, 2013; Phillimore, 2010). While some participants are able to draw on extensive repertoires to facilitate understanding, additional linguistic support, in terms of

interpreting services, is often reliant on the subjective, informal assessment of language skills by frontline staff (who are as likely to be receptionists as they are doctors). Without discrete criteria for discerning which patients will benefit from interpreting services, staff may ask directly whether an interpreter will be needed, or make a judgement based on their own analysis, or interpreter availability and cost (Moss & Roberts, 2005; Cicourel, 1999) thus potentially redefining "an unequal power relation between individuals on the basis of majority defined expectations for categories and behaviours" (Tranekjaer, 2015: 54). For patients lacking linguistic or cultural capital, being categorised by a named language, potentially places them in a position which they are often unable to contest (Moyer, 2013), leaving room for inadvertent misallocation, or omission, of interpreting services. An example of this was recounted by a bemused midwife, whose patient's GP referral indicated an 'African' interpreter would be required: unsurprisingly, the administration staff had not been able to arrange this and the consultation continued without mediation.

4.3 'Language' in the consulting room

Heller observes that, if we can identify "the nature and social significance of the communicative resources people bring to interactions, and with what consequences, for them and for others, immediately and over time" (2001: 213), and by extension how successful these interactions are, we can begin to understand how conceptions of reality are constructed. In recognition that Heller's observation refers to all participants in an interaction, I begin by drawing on established literature which explores the nexus between 'language' as a social action and health, and which apparently focuses exclusively on encounters between speakers of the same language. I first reflect on doctor/patient communication, which is regularly characterised as epistemically asymmetrical, both in the way a doctor is advantaged through the initiation of dialogue, diagnosis and advice, but also by their position as biomedical knowledge holder (Harvey & Koteyko, 2013; Mondada, 2011; ten Have, 1991; Mishler, 1984). Additional research on intercultural health

consultations identifies similar themes, but with interaction taking place between a medical professional fluent in the dominant language, and a linguistic minority speaker. Many of these exchanges are said to be typified by misunderstanding and breakdown in communication, often leading researchers to conclude the relationship between participants to be linguistically and/or culturally asymmetrical (Baraldi & Luppi, 2015; Moss & Roberts, 2005; ten Have, 1991). Following this, I next touch on appointments which are mediated by either ad hoc or professional interpreters, and explore the ways in which the linguistic resources offered by mediation, can influence patient experience and understanding (Cox et al, 2019; Pöchhacker & Kadric, 1999; Jacobs et al., 1995). Lastly, I turn to the apparently new reality of superdiverse consultations, where, in the absence of proficiency in the dominant language associated with institutional and national concerns, or the affordances of an interpreter, participants draw on their personal linguistic repertoires to navigate understanding (Cox et al, 2019, Mori & Shima, 2014; Moyer, 2013).

4.3.1 Asymmetries

Much of the established literature on medical consultations has been informed by a Foucauldian perspective, originating from his foundational work on the birth of Western medicine and tracing shifting epistemologies on health from the late sixteenth century, when illnesses began to be identified, named and articulated through the 'medical gaze' (Foucault, 1973). Through the creation of new knowledge, doctors came to be known as experts, a position which was further consolidated by the establishment of institutional structures. In a practical sense, while doctors' identities can be seen to be enabled by knowledge displays, the habitual actions of the medical discourse community such as examinations, tests, note-taking, form-filling and data input, are also said to facilitate the constitution of professionalism (Harvey & Koteyko, 2013; Cicourel, 1981). Drawing on Foucault (1973), Moyer further asserts, "(f)rom an institutional perspective, medical doctors are invested by the very nature of their employment in making sure that the institutional order is produced and

that it continues to get reproduced"(Moyer, 2013: 1999). Yet patient identities are also brought about through interaction with institutional processes. When people seek expert advice, participate in consultations in which they offer intimate details and submit their bodies for examination, their personal information becomes part of a medical frame which recontextualises professional knowledge into an institutional discourse, by which I mean, creating "abstract categories that facilitate and depict efficient problem-solving" (Cicourel, 1981:73). Thus, "(e)xpert knowledge [becomes] visible as professionals and clients position themselves in an asymmetrical relation" which, Sarangi and Roberts assert, "consequentially amounts to a form of symbolic control" (1999: 8).

Also said to be a key institutional factor in facilitating asymmetries between doctor and patient, is time, or the lack of it (Harvey & Koteyko, 2013; Davidson, 2000). Medical consultations are tightly organized, time-bound events, with interaction commonly following a particular set of consecutive tasks: ten Have identifies these as forming an 'Ideal Sequence' (1991), comprising a greeting, complaint, examination, diagnosis, treatment and closing. Originally derived from primary care appointments, ten Have's systematic analysis of consultation structure shares many institutional conventions with routine antenatal appointments, despite the latter focussing on establishing and confirming the 'normality' of a pregnancy (Bredmar & Linell, 1999) rather than diagnosing illness (see for example 7.1.1.1, extract 30). Nevertheless, with only ten minutes routinely allocated for a GP appointment, and fifteen/twenty minutes for an antenatal consultation, it is arguable that the imposed structure affects patient experience, as they seek to present their 'lifeworld' (Mishler, 1984) as a contextualised health complaint, related to their lived experience. The ensuing misalliance between the biomedical perspective and institutional alignment displayed by doctors, and the lifeworld of patients, can be seen to contribute to tensions between participant goals, exacerbating the time pressures of a consultation, and compromising rapport (Harvey & Koteyko, 2013; Sarangi & Roberts, 1999; Cicourel, 1981). Indeed, the midwives who comprise part of Phillimore's study of migrant maternity care in the Midlands

(2015), voice concerns that institutional goals, such as the number of women seen within a particular time frame, often take precedence over the quality of consultations. Earlier work by Wallen, Waitzkin & Stoeckle, (1979) substantiates this, in finding that less than 1% of consultation time is spent on giving explanations to patients.

Much of the work in medical communication also suggests that time constraints promote the interactional dominance of the medical professional as they try to gain as much information, as quickly as possible, in order to complete the exchange within the allocated time frame and in adherence to institutional codes of practice (Harvey & Koteyko, 2013; Davidson, 2000; Sarangi & Roberts, 1999;). Initially controlling talk by opening the consultation, the doctor is often seen to adopt the active identity of 'questioner', which has the effect of propelling a forward-looking exchange (Goffman, 1981), as well as ensuring that she/he is able to steer the topic, guide turn-taking and decide which information is relevant (Harvey & Koteyko, 2013). Yet, while on one hand, such interactional dominance can be seen to subvert patient autonomy, Harvey and Koteyko (2013) problematise the need to establish parity between participants, suggesting that patients expect medical authority, and its subsequent exertion, precisely because they seek the help of an expert, rather than a peer. On occasions where patients do initiate conversation, in a move towards active participation, direct questions appear to be dispreferred, especially if they take part during the initial data collection phase (ten Have, 1991; West, 1984). Alternatively, if they take part later in the consultation, indirectly or in the form of confirmation requests, doctors seem to respond more favourably to the challenges implied by questioning (ten Have, 1991). Of particular relevance to considerations of asymmetry, are studies by Defibaugh (2014) and Linell and Bredmar (1996), which suggest a contrast in the approach taken by doctors and nurses, potentially in reflection of professional hierarchies, and assumptions of formality. As such, their claim that nurse practitioners and midwives frequently use strategies of alignment in an attempt to reduce distance between themselves and their patients (Defibaugh, 2014),

and to distribute knowledge more symmetrically (Linell & Bredmar, 1996), is addressed in subsequent chapters (see Chapters 6 and 7).

However, the notion of asymmetry in medical consultations is not without further criticism, notwithstanding the implication that ordinary, peer-peer conversations occur without disparity. ten Have (1991) highlights that everyday communication involves negotiation, understanding and compromise, and that interactional dominance can vary from moment to moment, both inside, and outside, the consulting room, depending on context (Gumperz, 1999). In this, ten Have also problematises the concept of patient subordinance, arguing that, not only do patients 'own' knowledge about their health complaint but, in seeking help, they are in a position to share, or withhold, information, depending on how they wish to present themselves. Indeed, as data demonstrates in Chapter 7 (extract 46), while medical professionals play primary roles in leading patients through a sequence of stages through to the conclusion of a consultation, they do not necessarily have individual control (Frankel, 1984). Nor can they be seen to retain power in community settings, where the familiarity of home can put patients at ease (Piacentini et al., 2019). It is rather, following Bourdieu, that that "asymmetries are produced in and through the details of physicians' and patients' situated interactions" (ten Have, 1991: 138), in a context which is both "brought along and brought about in a situated encounter" (Sarangi & Roberts, 1999: 30).

> In healthcare communication, the distribution of epistemic authority depends on both patients' initiatives and providers' support of these initiatives, that is, respectively on how patients show their rights of and responsibilities for knowledge, and how providers show acceptance of these rights and responsibilities (Baraldi & Luppi, 2015: 583)

As such, doctor/patient consultations cannot be "essentialised as extra-linguistically defined givens" (Gumperz, 1999: 455), but instead seen as individual, "defined as culturally framed, and [understood as] interactively constituted speech events" (Gumperz, 1999: 47; see Chapter 5). This is not to

contest earlier assertions of inherent epistemic asymmetries, nor to discredit the influence of institutional structures on such, but instead to identify the ways in which communication, and context, have the potential to shape participant experience, understanding and position in the consulting room.

4.3.2 Constructing understanding

Although framing is arguably culturally informed, from the moment a patient walks into a consulting room, there is a tacit understanding of what to expect and the kind of professional discourse that will be followed (Jones, 2013; Baraldi, 2009). Yet, as Cicourel (1999) emphasises, understanding may very well be contingent on the medical socialisation of the patient as well as their ability to construct a comprehensible narrative (Moss & Roberts, 2005). In turn, if consultations are to be seen as co-constructed, the audibility of narrative is not only dependent on the patient, but on the questions asked by a medical professional (Cicourel, 1999), and, by implication, the language used to elicit, and give, information.

Mutual intelligibility is a common theme in health communication research, and is often attributed to the patient's difficulty in accessing the technical registers used by health practitioners (Baraldi & Luppi, 2015; West, 1984). Early research on doctor/patient communication, for example, finds that time is "consumed largely by failures in communication: the doctor and patient were spending the time trying to get on the same wavelength" (Korsch & Negrete, 1972: 71). Korsch and Negrete's study, which comprises 800 participants, illustrates that over half of all mothers attending a paediatric appointment, fail to understand the cause of their child's illness, as explanations are given in 'jargon'. Not only does this impact on patient experience, as mothers reported feeling very unsatisfied with the consultations, but it also has the effect of increasing non-compliance, leading to longer recovery rates and potentially poor outcomes. In contrast, an alternative study, undertaken a few years later, reveals that physicians can equally underestimate a patient's understanding of technical language, and therefore appear to withhold information; in this

instance, the use of jargon can be seen as a method for exerting, and/or maintaining, power (Wallen, Waitzkin & Stoeckle, 1979). Further exemplification on how jargon affects patient participation can be seen in Chapters 6 and 7 (see for example, 7.3.2, extract 39).

However, it is not just patients who experience comprehension difficulties. Frankel's (1984) microanalysis of a conversation illustrates how the mis-hearings and misunderstandings experienced by a doctor, contribute to the need for additional clarification. The subsequent reiteration of the patient's full medical history complexifies the process further, as it motivates the doctor to interrupt for amplification, thus creating instances of simultaneous talk. Frankel notes,

> they were in the process of constructing the encounter
> together, through mutual participation in an unfolding event,
> both parties produced behaviours that rendered both small
> and large portions of the encounter problematic. (1984: 150)

Frankel (1984) concludes that the doctor is responsible for the joint construction of the patient's health condition, through his mis-hearings and (inaccurate) reformulation of her utterances. More importantly, the resulting confusion leads the patient to be presented as 'confused' and a 'poor historian' on her medical record, thus jeopardising the ways in which she is seen (and possibly treated) by other practitioners. However, while coherence principles in a speech exchange system depend on mutual participation, Frankel's example of misunderstanding, in common with those of Korsch & Negrete (1972) and Wallen et al (1979), involve speakers of the same first language, thus demonstrating that is not linguistic competency, or cultural similarity, per se that are responsible for breakdowns in communication but interactants' "shared interpretation" (Gumperz, 1999: 464) of the event.

In extrapolation, it is not inconceivable that intercultural encounters in a superdiverse society, where people "more often than not speak the shared language with different degrees of proficiency' (Zhu, 2014: 1), may pose the

potential for misalignment. Indeed extensive studies in the latter part of the twentieth century, looking at workplace communication between British-born interview candidates and those born abroad, appear to support this suggestion and invoke parallels with patterns observed in intercultural health interactions (Sarangi & Roberts, 1999; Gumperz, Jupp & Roberts, 1979). Longitudinal research undertaken in collaboration with the Industrial Language Training Service, an organisation which endeavoured to support ethnic minority workers improve language skills in the workplace, found that there were intrinsic disparities in expectations and inferences between participants (Jupp, Roberts & Cook-Gumperz, 1982; Gumperz, Jupp & Roberts, 1979). Yet, differences in features of speech were less to do 'with the surface meaning of what is said, as to do with the conventions used for inferring meaning and attitude' (Gumperz et al., 1979: 9), or utterances which act as, 'contextualisation cues' (1977). For example, when 'born-abroad' candidates are interviewed for prospective positions, some fail to respond in an anticipated way to indirect questions or an unfamiliar interview structure. Similarly, interviewers demonstrate an inability to problematise shared assumptions or adapt interview techniques, instead interpreting interviewees as disengaged or uninterested (Jupp, Roberts & Cook-Gumperz, 1982). Thus the 'discourse misalignments' are due to the ways in which the questions are asked, as well as answered.

Prior to the workplace research by Jupp et al (1982) and Gumperz et al (1979), the lack of interview success of minority ethnic, born-abroad, candidates, was assumed to be indicative of institutional racism – a problem which did not appear to be restricted to industry. The Royal College of General Practitioners (RCGP) also commissioned research to investigate the low pass rate of born-abroad candidates in their oral exam (Roberts, Esmail, Sarangi, Southgate, Wakeford, Wass & May, 2000), in response to accusations of racial discrimination. While close analysis of the exam role-play reveals participant difficulties in blending the culturally (arguably, ideologically) defined professional, institutional and personal modes of talk required by the test, Roberts et al also find that assessment is influenced by examiner expectations

about the participants, as well as about interaction as a social activity. For example, in an oral exam when a candidate responds to a hypothetical problem using a personal frame, instigated by the emotive phrase, 'how do you feel when a patient…?', the examiner reiterates the question using an institutional footing, effectively undermining the candidate's answer and implying a poor response. Such mis-alignment is deduced to be enough to adversely affect exam results, underlying the opaque or implied nature of the knowledge needed to succeed. In these contexts, which feature first language speakers of English and interviewees who use English as a second language, albeit fluently, processes may be equal, in that all candidates are assessed against the same competency frameworks, but they are not fair. Instead, "language/culture needs to be understood as part of the action and interaction rather than standing outside" (Roberts et al., 2005: 466) as this inherently disadvantages participants who draw on alternative resources to those of the dominant group.

4.4 Mediation

4.4.1. Unmediated encounters

Seen in the light of the epistemic and institutional asymmetries attributed to the doctor/patient relationship (see 4.3.1), and the misalignments between interviewees/ interviewers with different first languages (see 4.3.2), the intercultural medical consultation has provided fertile grounds for research, with much of it focussing on the negotiatory nature of communication. In the absence of an interpreter, and perhaps in anticipation of misunderstanding (cf. for the lack of apparent modification in Korsch & Negrete's 1972 study, see 4.3.2), medical professionals are often observed to use some of the resources at their disposal to overcome perceived linguistic difficulties, commonly adjusting speech patterns to accommodate difference, employing gesture and multimodal techniques, codeswitching when possible and using third party resources, such as translation apps (Cox & Maryns, 2019; Gasiorek, Van de Poel & Blockmans, 2015; Gumperz, 1964; see also Chapters 6 and 7). This

section begins by first reviewing unmediated health encounters between linguistic majority medical professionals and their linguistic minority patients.

In 2005, Roberts et al undertook research to examine doctor/patient interaction in a medical practice serving a diverse community in London (and subsequently giving rise to extensive analysis, see Moss & Roberts, 2005; Roberts et al., 2005; Roberts & Sarangi, 2005). Entitled 'Patients with limited English and doctors in general practice' (PLEDGE), the project comprised 232 consultations, and was designed to identify the nature of communication between linguistic minority patients and their physicians. Although 11 of the 19 doctors that took part spoke additional languages, all the medical professionals used English as their first and majority language and, "whatever their linguistic repertoire, each doctor regularly faced patients from a range of language backgrounds and varying degrees of ability to speak English" (Moss & Roberts, 2005: 413). Comprising ethnographic and videotaped evidence, consultations are seen to give rise to "misunderstandings related to issues of language and self-presentation rather than culturally specific health beliefs" (Roberts et al, 2005: 473), which are more commonly perceived as an obstacle to health. The researchers identify four problematic areas of patient 'talk'; pronunciation and word stress, where participants negotiate meaning through repetition and reformulation; intonation and other features of speech delivery, such as overlapping, which often result in confusion and extensive repair; grammar, vocabulary and lack of contextual information, which give rise to extended discussion and longer appointments; and styles of self-presentation, where patients can, for example, arrive with a list of complaints, which cannot be addressed within the time frame. However, despite instances of problematic talk, the medical professionals appear to be able to accommodate differences in communication styles, by engaging active listening skills: rather than focussing on 'processing English' (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 summarise, confirm and clarify, also demonstrate a sensitive approach to patients' linguistic input, echoing findings from Baraldi and Luppi's work with similarly multilingual

encounters in Italy, as well as Baynham et al's (2017) observations of legal advisors using similarly technical language (see 3.5.4). Looking at the strategies used by midwives to overcome language 'barriers', Baraldi and Luppi observed consultations between 4 Italian midwives and 15 migrant patients (2015). Although many of the appointments are mediated by family and friends, and several are conducted in the lingua franca of English (see 3.5), midwives employ strategies of formulation and reformulation to give meaning to the patient's agenda (see also 6.4.2, extract 26 for example). While formulation ostensibly allows midwives to gloss patients' previous utterances and demonstrate shared understanding, the researchers note that this form of intralingual assistance also has the potential to empower women and promote active participation (Baraldi & Luppi, 2015; cf. Baynham et al, 2017; see 3.5). In turn, reformulation, i.e. the rephrasing of a midwives' own utterances, shows a sympathetic commitment to repairing understanding and an orientation to patient-centred care.

> In provider–migrant interactions, the difference between forms
> of communication makes the difference between problems of
> intercultural communication and prevention of these
> problems. (Baraldi & Luppi, 2015; 597)

While recent research on intercultural encounters has moved emphasis from a preoccupation with the management of epistemologies and asymmetries symptomatic of doctors' talk, towards a view of the consultation as co-constructed, contextualised, "shifting and interactionally produced" (Tranekjaer, 2015: 72), it is clear that, at times, communication can prove problematic. Despite the benefits of co-constructed narratives and solutions, offering opportunities for clarification, Baraldi and Luppi (2015) find that reformulations can also inadvertently boost the epistemic authority of the medical professional, as explanations allow midwives to control the medical agenda and explicitly display knowledge (see 6.9, extract 29, for an example in keeping with these findings). Indeed, the researchers also conclude that, if informal assessment of (poor) linguistic proficiency of the patient is

subsequently conflated with cultural (in)competence, patient autonomy is downgraded (Baraldi & Luppi, 2015: 597). This is well illustrated in Chapter 7 (extract 39).

4.4.2 Interpreting

While it is clearly preferable to have linguistic concordance between doctor and patient, in the absence of a shared first language, there is an institutional, legal and ethical, requirement to offer interpreting services during medical interviews between linguistic majority/minority participants, in order to ensure equality of access and healthcare (Piacentini et al., 2019; CMACE, 2011; Karliner et al., 2007; see also 4.2). Not only do differences in ethnicity, race and language affect the relationship between health care providers and their patients (Haith-Cooper & Bradshaw, 2013), but they can have a demonstrably adverse effect, in the instance of antenatal care, on maternal and infant outcomes and experience (Benza & Liamputtong, 2014; Alshawish, 2013; Mullen et al., 2007).

Nevertheless, there are many reasons that an interpreter may not be present: clearly, if a patient feels confident to talk to a health professional directly, they can avoid the distancing effects of mediated discussion and have the opportunity to build a rapport with their physician (Angelelli, 2004). Indeed, Roberts et al (2005), find that even patients with very limited English can be understood in the context of a long-term, established relationship with their doctor. However, for patients who speak a language that is underrepresented in the community, a refusal of interpreted assistance may reflect fears surrounding confidentiality, i.e. worries that the interpreter will be a familiar member of the small, local diaspora (Piacentini et al., 2019; Wallace & Bhatia, 2007; Angelelli, 2004). Similarly, with lesser-spoken languages, there are often difficulties in finding local interpreters, meaning that, even if there is intent to offer linguistic support, there are practical barriers to doing so. On such occasions, midwives interviewed for this study, report having to "just plod [their] way through" (KS, Appendix B, L6). Other institutional reasons for lack

of provision may include poor initial assessment and recording of patients' needs, an over-estimation of patients or midwives language skills, or, in times of austerity and depleted funding, a re-prioritisation of spending. Indeed, in exemplification of the apparent tensions between policy and practice, Mastrocola and Nwachukwu's review (2009) of antenatal, medical notes in South Tyneside, finds that only 23% of linguistic minority patients booked over a six-month period, benefited from the presence of a professional interpreter.

4.4.2.1 Translation apps

Similarly, research by Cox (2017), undertaken in an emergency department at a Belgian hospital almost a decade later, reflects almost identical patterns. While findings undoubtedly reflect the specifically unpredictable nature of urgent care, where speed is of the essence and where the luxury of locating a professional interpreter or booking a telephone appointment may prove difficult, 70% of consultations were found to take place without any form of formal or informal mediation. To mitigate this practical hinderance to communication, on some occasions interactants were able to take advantage of advances in translation software and the convenience of phone apps, in order to augment communication. In a later paper which builds on Cox's previous research, Cox and Maryns (2019) elaborate on a consultation between a French speaking doctor and a Polish patient, who is accompanied by her friend. Although both women are competent in conversational French, they find it hard to relate the patient's symptoms clearly, leading the doctor to introduce the use of an app - the Universal Doctor Speaker Web (UDR). This is a new form of translation software, not widely available, which enables the doctor to ask questions in Polish, and the patient to select an appropriate answer from a drop-down list. However, the interaction is not without problems, as the app cannot translate answers which deviate from those prescribed. In fact, the researchers note that, while it is helpful, the interactants "mobilise a whole range of ad hoc multilingual strategies (non-verbal communication, lingua franca, companion as ad hoc interpreter, UDR)" (2019: 13), and conclude that sole use of the app would be unlikely "to meet the high

communicative demands of the consultation" (ibid). Interestingly, while the UDR is not yet widely available, and the use of translation software in HUH only anecdotal (see 2.3.2.5), Cox and Maryns recognise that it has the potential to become a feature of contemporary interaction in superdiverse, multilingual settings: indeed, it can be construed as a technical extension of some of the communicative techniques that are illustrated in subsequent chapters (see for example, 6.5, extract 28; 7.3.2, extract 39).

4.4.2.2 The 'conduit' model

While the role of interpreters in encounters between those who do not share a common language, may be assumed to have the objective of advancing mutual understanding, brokering can take different forms, even changing several times within one consultation (Hsieh, 2008; Angelelli, 2004). A predominate model of interpreting is that of 'conduit', whereby the interpreter is assumed to relay information word-for-word, with no change of meaning and whose presence in the triadic encounter can be seen as 'neutral'. However, while invisibility, attempting to maintain the medical authority of the doctor, or strengthening the bond between medics and patients may be an aim, it is clear that interpreters cannot operate in a vacuum (Hsieh, 2008; Angelelli, 2004). Contesting early characterisations which see them as 'senders' not 'spokesmen' (Hymes, 1972), or 'animators' not 'authors' (Goffman, 1981), Davidson argues that interpreters are co-participants whose position as social agents means that translations will always differ in their 'social and contextual evaluation" (2000: 380), i.e. no two interpretations, of the same text by different people, will be identical to each other or to the original utterance. Following his research, which involved observing 50 mediated Spanish/English consultations, at a Californian hospital, Davidson (2000) notes that there is considerable 'slippage' between what interpreters do and what they are imagined to do. Instead of 'neutrality' he finds that interpreters often speak in their own voice, instigating symptom presentation or responding on behalf of their patient, short-circuiting valuable Dr/patient questioning. These actions effectively increase the distance between doctor and patient, giving way to

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what Baraldi entitles 'dyadic separation' (2009) and arguably removing patient agency (Moyer, 2013). Instead, Davidson characterises interpreters as institutional gatekeepers, more focussed on keeping the patient 'on track' and accommodating the doctor's hectic timetable, than giving a voice to patients, the consequences of which can lead to breakdown in communication, as well as undiagnosed and untreated patients. Paraphrasing Foucault (1979: 304), Davidson gives a damning indictment of interpreters as institutional agents, performing in "an ad hoc vacuum of accountability" (Davidson, 2000: 386):

> We are in the society of the teacher-judge, the doctor-judge,
> the educator-judge, the 'social worker'-judge; it is on them that
> the universal reign of the normative is based……'the society
> of the interpreter-judge', for it is the interpreters with whom
> and through whom recent immigrants interact with institutions
> of the state (2000: 401)

While Davidson's disparaging evaluation is somewhat hyperbolic, the notion of interpreters as institutional gatekeepers has become widespread, leading to an accepted, and not always justified, understanding that this always the case: in 7.4.2, extract 47, for example, we can see a clear illustration of an interpreter undermining the medical professional as she attempts to align with her patient (see also 4.4.3).

In contrast to Davidson's research which takes place in setting with such a large Spanish-speaking population that the hospital employs a number of Spanish interpreters full time, Moyer's study (2013) of a Catalan health clinic involves interpreters from a variety of linguistic backgrounds. Although employed on a part-time basis, they nevertheless, also demonstrate varying degrees of institutional alignment, thus illustrating the tensions between the interpreter's function as a service provider and as an agent of 'authority and control' (Davidson, 2000). Using an example from one of the observations, Moyer illustrates that a patient appears to align with the interpreter, describing her concerns about the treatment she has been offered, and her subsequent worries about paying for it; she asks him to explain to the doctor. However, the

interpreter is selective in what he chooses to pass on, thus eliciting sarcasm and limited empathy from the physician, as well as reducing the patient's agency (2013: 218). In this way, both language as a resource, and the lack of collaborative mediation, can be seen as contributory factors in threatening the patient's face needs, autonomy and treatment (Moyer, 2013; Goffman, 1981).

Similarly, Gustafsson's paper (2016) comparing one unmediated and one mediated medical encounter between a diabetes specialist, his patients and their Somali mothers, further illustrates the potential effects of interpretation on face needs (Goffman, 1972). During the first, unmediated, consultation, where the mother has a good understanding of English, all participants use a broad range of communication strategies to mitigate any potential threats to face posed by directives and questions, i.e. modals verbs, hedging and backchannelling. These are punctuated by the physician's praise for the child and the mother, for keeping the diabetes under control. In contrast, in the second, mediated encounter, which features a child who is fluent in Swedish, the doctor communicates directly with the minor, while the interpreter relates the information to his mother. Here, the empowering/reassuring strategies are lost, as the interpreter omits words of praise directed towards mother and child. As Gustafsson surmises, this may be because mitigating strategies, and interpersonal effects, are seen as unimportant or simply that the interpreter misses the nuances. Nevertheless, the example highlights the need for heightened awareness of the interpreter as a co-participant, and a recognition that the differing conversational goals of each individual may be at odds (Moyer, 2013; Davidson, 2000).

4.4.2.3 The 'intercultural' model

A model of interpreting that not only acknowledges the presence of the interpreter, but places her/him in the centre of consultations, is that of (intercultural) mediation, where differences in belief systems, values and norms are imagined to impede communication (Flores et al., 2012). Baraldi notes that since interpreters are the only active participants who can

"understand all the contents and the intentions uttered" in triadic communication, they "assume the role of promoting and co-ordinating the interaction" (Baraldi, 2009: 120). Interpreters "cannot avoid functioning as intercultural mediators' (Wadensjö, 1998: 75) as language both illuminates and reproduces 'the contingent and changeable construction of cultural presuppositions" (Baraldi, 2009: 124/5), thus affecting participants. In his observation of over 100 intercultural consultations, Baraldi finds that in some instances, mediators can have a transformative effect. In addition to the accurate relay of information between the medical professional and her/his patient, they are able to voice the patient's emotional 'lifeworld', ensuring patient-centred care is enhanced (2009). However, the majority of Baraldi's research lies in contrast to the conceptualised ideal of triadic collaboration, depicting instead a dyadic separation between participants: on one hand, doctors and mediators can be seen to construct a 'We' identity, which becomes manifest as the doctor explains to the mediator, who then relays it to the patient (see also Gavioli, 2015); on other hand, the mediator can also align with the patient (on how to persist with breastfeeding, for example) without referring to the doctor directly. Hsieh (2008) also observes that, on occasion, mediators can become so confident with the subject matter, that they become 'co-diagnosticians' (see also, Pasquandrea, 2011). Of course, it is also possible for skilful interpreters to vacillate between different modes, especially across the timespan of a consultation. In 7.4.2 (extract 47), the professional interpreter working with a particularly vulnerable patient goes 'off script' to make fun of the attending health care assistant: she also responds to the doctor's instigation of a 'We' identity, to explain to the patient how to reach the labour ward and when to attend (extract 23). However, as we will also see in 7.1.1.2 (extract 32) when interpreters are inexperienced, or unfamiliar with medical terminology, the adoption of 'We' identities can falter.

Although widely utilised as a descriptor to capture majority/minority linguistic interaction – in Italy for example, 'intercultural mediators' are professionally synonymous with interpreters (see for example, Baraldi, 2009) - the term 'intercultural', is not unproblematic: firstly, the term implies a fixed,

homogenising, notion of 'culture', not unlike that of 'language' (see 3.4.1). Secondly, in terms of interpreting, there is an oblique, and unsustainable, conflation of 'culture' and 'language': as is later illustrated in Chapter 8 (8.2.2), where one speaker of a global language like Portuguese may identify with a totally different set of linguistic norms and cultural values, to those of another Portuguese speaker. Moyer's research at a Catalan clinic also demonstrates that culture may not always be a motivation for alignment, giving an example of a young interpreter, who despite sharing a cultural and national origin with an elderly female patient, chooses to identify with the institution in preference to the woman who differs from him in regard to "gender, educational, social status and age" (Moyer, 2013: 217).

4.4.2.4 The 'advocacy' model

There are instances of interpreters receiving requests for advice or choosing to position themselves in the role of patient advocate, i.e. someone who can not only translate but also advise a patient on a course of action (Angelelli, 2004). While it may be tempting to share personal experience or help a patient to make a decision, this position is considered highly unethical, and prohibited within guidelines laid down by the NHS (2018). Advocacy also breaches codes of conduct espoused by the translation and interpreting industry, because of the significant potential to compromise care (see for example, National Register for Public Service Interpreters, n.d.). Nevertheless, despite being encouraged to have no contact with patients outside the consulting room, a disparity in the amount of professional training they receive may leave some interpreters unclear about the boundaries that should be observed, especially if they have had previous contact with a patient. Conducting my fieldwork, the most explicit example of patient advocacy became apparent during exchanges between Ajola, a very vulnerable patient, and an interpreter (I4) (see for example, 6.4.1, extract 23), who had worked with her earlier in the week. Observing them in the waiting room, the interpreter appears to adopt a maternal figure. She is replete with advice for Ajola about swaddling her baby (information she understands to be in direct contrast to that given by the

patient's midwives), as she asks Ajola to ensure she unwraps the baby before the health visitor appointment. While, at face value this could be seen to illustrate Davidson's (2000) accusation regarding interpreters' lack of accountability, there is no suggestion that the interpreter actively seeks to harm either Ajola or her baby. It seems more likely, that she is trying to share personal experience and maintain cultural norms, as she frames the advice as something 'we do at home'. Nevertheless, the example serves to highlight the importance of ensuring interpreters receive consistent training in ethical, as well as practical, matters.

4.4.2.5 Ad hoc interpreters

Having explored the role of professional interpreters in health encounters, I now touch on the contentious use of informal, or ad hoc, mediation, which, while sometimes unavoidable, is generally viewed as problematic, unethical and in contravention of institutional guidelines (NHS, 2018; Cox & Lázaro Gutiérrez, 2016; Angelelli, 2004;). According to Mastrocola and Nwachukwu (2009), while it is common institutional practice to note the presence of professional mediators in consultations (i.e. on the patient record/electronic database), it is not systematic for those who are employed as ad hoc interpreters. Consequently, it is difficult to estimate how often industry guidelines on interpreting provision are breached, but also the extent to which patients are routinely supported (or not) in their understanding of symptoms, diagnosis and subsequent treatment, and, by whom. As will become clear in later chapters, informal contributions from friends and family are not only common but regularly sought by professionals, in pursuit of medical history and informed consent (see for example 6.4.2, extract 26).

Dependent on their social and cultural capital, some migrants may be well informed about infrastructure, institutions and rights in their host country, as well as having access to informal networks and diasporic communities for assistance (Phillimore, 2015). Others may have fewer resources (Piacentini et al, 2019). Nevertheless, there is a well-documented pattern of health-seeking

behaviour associated with recent migrants, lacking familiarity with the health services available in a new setting: firstly, they may initially make use of emergency provision, because of comparative ease of access; secondly, and somewhat paradoxically, they may also delay seeking help until urgent care, or the baby's delivery, becomes unavoidable; thirdly, in the absence of local knowledge, migrants may rely on family, friends or children with a better command of the language, to help mediate medical care (Cox & Lázaro Gutiérrez, 2016; Cox, 2015a; Flores et al., 2012; Vilpert & Hudelson, 2009). While their presence often reflects migrant difficulties in navigating institutional frameworks, the closeness of the relationships, and their familiarity with a condition, can mean that family/friends add a personal dimension to interpreting that professional mediators may not be able to fully communicate. Nevertheless, the practice is not without complications, as patients may experience discomfort at sharing personal information with friends and family, and potentially withhold vital information as a result (Angelelli, 2004; for example, see 7.1.3, extract 36). Similarly, the appropriacy of content can also adversely affect informal interpreters, especially children. Jacobs et al (1995) report on the case of a ten year old girl who was consistently used to mediate on behalf of her parents, who spoke little English, and doctors who were treating her terminally ill siblings. When the younger children subsequently died, the girl suffered from such severe post-traumatic stress, that she required hospitalisation. Yet, the method of using children to assist with translations, a process often referred to as 'child brokering' is far from rare, as it proves to be a quick and easy method of interlingual communication (Banas, Ball, Wallis & Gershon, 2017). However, as Jacob et al's research demonstrates, the process is rife with ethical and practical dilemmas, despite its convenience.

Cox and Lázaro Gutiérrez's comparative studies of emergency departments in Belgium and Spain (2016) find that the unpredictability of the environment, where doctors can be attending to many different patients simultaneously, affects the recruitment of professional interpreters. In addition, not only do physicians perceive professional interpreters to be expensive but the amount of time needed to find an interpreter for a specific language, and the time they

may take to arrive, delays the speed at which doctors can expedite care. In keeping with findings from Vilpert and Hudelson's survey of Swiss medical practitioners (2009), Cox and Lázaro Gutiérrez relate doctors' opinions that ad hoc interpreters save money, are better at putting patients at ease and often have a helpful insight into the patient's complaint. Yet guidelines for independent interpreting assistance do not simply exist to reduce the expense of consultations. They are there to protect patients and ensure they have equal access to medical help, for being able to communicate accurately, be understood, and to understand, is central to patient-centred care and confidentiality (NHS England/Primary Care Commissioning, 2018). In the absence of a professional interpreter, Cox and Lázaro Gutiérrez (2016) find that language difficulties have an effect on the length of hospital stays, with linguistic minority patients staying in hospital for longer than those speaking the majority language(s). In addition, and in scrupulous analysis of consultations recorded with ad hoc interpreters, Cox et al (2019), also find an accuracy rate of only 19%, despite the help that patient companions were perceived in offering in areas such as patient history taking.

According to Angelelli, ad hoc interpreters are said to make 'behavioural' mistakes (2004: 22), in that they commonly contribute personal opinions, respond to questions on the behalf of the patient and fail to consistently translate questions and comments. In addition, Flores et al (2012) observe patterns of mistakes, common to both professional and ad hoc interpreters: errors involve omission, substitution, addition, editorialization and false fluency i.e. where interpreters use a word/phrase that did not exist in the other language and/or considerably alters the meaning. However, while their large-scale observation of mediated conversations, finds little difference in the incidence rate of mistakes made by professional and ad hoc interpreters, Flores et al (2012) also concludes that the latter are more likely to make ones which have clinical consequences (for apparent corroboration, see for example, 7.2.3, extract 42; 7.2.4, extract 44). Substantiating this, Pöchhacker and Kadric's research (1999) based at a Red Cross hospital in Switzerland, records the inadvertent effect of an ad hoc Serbian-speaking hospital cleaner's

interpreting style, as she mediates between two physiotherapists, the patient (a 10 year old boy) and his parents. Displaying a friendly and cooperative stance, the interpreter moderates the illocutionary force of directives given by the medical professionals, effectively subverting their authority and inadvertently distorting meaning.

While incidences of using hospital staff as ad hoc interpreters have been previously recorded, many of the examples given are from research in communities with a substantial migrant population who are speakers of the same language, such as Spanish in the USA (see Flores et al, 2012; Angelelli, 2004), or a European city which recognises several official languages, and in which both patients and staff can be anticipated to have a degree of competency (Vilpert & Hudelson, 2009). Although ostensibly multilingual, these contexts could be said to share elements of linguistic and cultural consistency, unlike that of Hayfield, where midwives regularly draw on their own (equally unpredictable) linguistic repertoires, or those of their colleagues, in order to communicate with patients (see 6.5, extract 29; 8.2.1). The next section of this chapter documents emergent research in similarly superdiverse populations, where the far less predictable nature of linguistic repertoires is examined (Cox et al, 2019; Cox & Maryns, 2019). To paraphrase Heller (2007), when language can be seen as a "set of resources called into play by social actors", caught between the "social and historical conditions which both constrain and make possible the social reproduction of existing conventions and relations", there is the potential to lead the "production of new ones" (Heller, 2007: 13). In such circumstances therefore, it is noteworthy to examine how institutions, and interactants who work within such regimes, recognise and/or respond to the heteroglossic realities of working in a superdiverse environment.

4.5 Interpreting and mediation in a superdiverse environment

Moving on from established literature on intercultural health communication, the majority of which have exemplified bilingual practices, this section explores

evidence of the creative and flexible languaging practices outlined in Chapter 3, and which have been said to flourish under superdiverse conditions (see for example, Baynham et al., 2017; Blackledge et al, 2013). 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 a combination of Italian, Arabic and English to communicate with patients - fewer medical professionals are recorded as making similar efforts. Some exceptions are illustrated in Moyer's research at a Barcelonan health clinic (2013), where several doctors, who are 'native' speakers of Catalan, also use Spanish to communicate with patients and interpreters. In another example, having used a limited amount of French to establish a lingua franca with an Arabic-speaking patient, a doctor relies heavily on the researcher to act as a mediator during a consultation (Moyer, 2013).

In a non-European context, Mori and Shima (2014) give a broad overview of the educational and linguistic background of their participants, as they observe consultations between a Japanese doctor and two African patients, who are first language speakers of Twi and Akan respectively. Although Japan is often considered to lack linguistic and ethnic diversity, the country is not impervious to the effects of migration flows and the global spread of English, as discussed earlier (see 3.3). Nevertheless, the consultations are marked by a degree of linguistic flexibility, where both medical professional and patients are seen to use non-standard communication. In the first example, participants establish a common lingua franca of English: the doctor then elicits symptoms, using prompts, clarifications, gestures and reformulations to translate the patient's lifeworld (Mishler, 1984), into a 'doctorable' condition', which can be treated. Neither participant appears to be a 'fluent' user of English, allowing the authors to make an explicit comparison with earlier influential research, where deviations from a 'standardised' English are said to contribute to confusion and misunderstanding (Roberts et al, 2005). In common with a body of research that focuses on English as a Lingua Franca, Mori and Shima note that it is the lack of a standardised norm with which to compare their communication that

allows both participants the freedom to draw on their linguistic resources creatively and apparently successfully. It highlights that,

> (w)hile their linguistic competence may be perceived as "limited," "sub-standard" or "truncated" with reference to the monolingual standard, the participants made it work to accomplish the problem presentation stage of their medical encounters. (Mori & Shima, 2014: 66)

In the second instance, participants draw on a simplified Japanese register. Choosing to use English loanwords to describe the medical terms, it is of interest that "the patient does not ask the doctor the Japanese equivalents, nor does the doctor offer to teach them to the patient" (2014: 65). Instead, and as a means of co-constructing the complaint, the doctor employs an interlingual technique, reformulating the patient's utterances from an everyday form of English, into what Mori & Shima recognise as a specialised register, e.g. 'mucus' becomes 'phlegm' (Baynham et al., 2017) (although this distinction between registers here is somewhat nebulous). The authors illustration of a somewhat laborious, exchange between participants as they reach an apparent shared understanding of the conditions, a process I earlier referred to as transelucidation (see 3.5.4), simultaneously serves to signify that an over-celebratory emphasis on translanguaging practices may divert attention from possible misunderstanding, i.e. "the very means to repair the breakdown in orderliness may themselves cause the problem" (Roberts et al, 2004: 162). Thus, apparent tensions emerge from observations of superdiverse languaging practices: that is, while the ability to draw on ones' full repertoire can be seen to offer a means to increase communicative output, it can also contribute to the ways in which "communicative difficulties are interactionally produced" (Gumperz, 1999: 469). Before continuing, however, it must also be emphasised that communicative 'malfunctionings', whether perceived or genuine, are not restricted to intercultural communication or idiomatic languaging (Cicourel, 1999; see 3.5.4). Indeed, in the context of a breakdown in monolingual communication, similar misunderstandings are often framed

within the paradigm of health literacy (i.e. the ability to understand and act upon medical information) and can prove equally problematic (Nutbeam, 2000). While this topic falls outside the somewhat limited scope of this thesis, health literacy considerations are certainly pertinent to patient comprehension of information and literature (see for example, 7.3) and would be worthy of further exploration in a superdiverse context.

The most extensive study of linguistic practices in a contemporary healthcare context to date, is Cox's (2017) ethnographic research in a Belgian hospital emergency department. It not only yields comprehensive documentation of translanguaging between both doctors who are first language speakers of French/Dutch and migrant patients, but also between 'non-native' speaking medical professionals and lay people. Observing similar patterns to Mori and Shima (2014), Cox's work illustrates the willingness of participants to draw on extensive communicative repertoires and brings to life the day-to-day realities of flexible languaging in superdiverse health encounters.

> despite the multilingual challenges encountered in these consultations, the participants did their utmost to get by with a bare minimum of readily available communicative resources before seeking professional language assistance (Cox & Maryns, 2019: 13)

Much of Cox's work focuses specifically on patients who are accompanied by companions who function as ad hoc interpreters, and whose linguistic support is seen to bolster patient history and facilitate communication (Cox & Maryns, 2019). Yet, in line with previous studies examining the role of patient companions as interpreters (see 4.4.2.5), analysis highlights 'conversational mechanisms' that give rise to omission and talking on behalf of the patients, issues that not only impact upon the accuracy of translation (estimated at 19%), but also threaten to affect clinical outcomes (Cox et al, 2019). To exemplify, the academics explore the non-verbal ways in which a French speaking doctor communicates with a Punjabi speaking Pakistani migrant. Used in conjunction with very simple lingua franca English, the interactants

manage to build a rapport, without the use of an interpreter. While this is successful to an extent, it subsequently proves difficult for the doctor to elicit a full list of symptoms needed to make a diagnosis and so the patient's companions begin to assist. However, the friends inadvertently edit and omit information, crucially refraining from telling the doctor about the patient's nausea (a key indicator of a heart attack), an oversight that may hold considerable clinical consequence. Cox and Maryns (2019) note that in appearing to communicate without obvious error, the ad hoc companions create an impression of false fluency[5,] and thus the 'communicative swing' (i.e. the fluctuation of understanding) goes undetected (Cox & Li, 2019). It may be this, and the fact that the process of communication is at many times the focus of the consultation, that leads to a lack of repair. This aspect of translanguaging holds relevance to findings revealed in Chapter 7, where, following Cox and Maryns (2019), the consequences of false fluency are furthered explored, when considerable discordance and misunderstanding appear to go undetected by participants.

Drawing on existing research in superdiverse health settings, it appears that as institutional practices adapt to changing populations, linguistic flexibility is very much contingent on the willingness of participants to adopt a convivial approach to communicating across languages and discourses (Simpson, 2016; Wessendorf, 2014; Gumperz, 1999). Despite the professional identities indexing specific hierarchies which are 'brought along' to meetings, local identities are 'brought about' by interaction, apparently communicating on a more symmetrical footing, as participants move away from languaging practices associated with institutional norms (Cook-Gumperz & Messerman,

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[5] Note there is a slight discrepancy in the use of the term 'false fluency'. Introduced by Flores et al (2012), this term is understood to mean "the interpreter used a word/phrase that does not exist in that particular language or an incorrect word/phrase that substantially altered the meaning" (2012: 546). In Cox and Maryn's paper (2019), the implication appears to be that the interlocutor has given a false impression of understanding, and therefore the error goes undetected (see discussion of consultation, 2019: 8)

1999; Goffman, 1981; see 6.5, extract 29). However, although the doctors in the aforementioned studies (Cox et al, 2019; Cox & Maryns, 2019; Miro & Shima, 2014; Moyer, 2013) demonstrate an inclination towards linguistic and cultural accommodation, it is noticeable that it is only at their instigation that such negotiations can be taken up, suggesting that a space for transformative dialogue (see 3.6) may remain at the discretion of the medical professionals. Nevertheless, as doctors are effectively restricted by institutional norms, "in making sure that the institutional order is produced and that it continues to get reproduced "(Moyer, 2013: 199), a move away from the non-dominant language, marks a shift in institutional behaviour, whether 'authorised' or not. This lies in contrast to the numerous earlier studies on health communication, where patients are positioned in relation to the categorisation of fixed linguistic norms (see for example, Roberts, Sarangi & Moss, 2004; Angelelli, 2004).

4.6 Conclusion

This chapter has reflected broadly on the canon of literature relating to the institutional, professional and interactional nexus of language and health. Beginning with an account of current processes, I have documented some of ways in which the NHS is engaging with the new realities of a heterogenous population, through systems of categorisation and institutional practices (see 4.2). While interpreting and translation services can be viewed as evidence of a broad engagement with diversity, day-to-day practices may provide challenges in terms of consistent and effective provision and may hold real consequences for linguistic minority patients (4.3, 4.4). However, section 4.5 also introduces emergent research which illustrates how the specific conditions of superdiversity may offer opportunities for innovative communication practices in a healthcare setting. Whether it is in response to population changes or fiscal constraints, a shift can be seen in institutional practices; not only are medical professionals appearing to utilise their full linguistic repertoire to better align and communicate with their patients, but they are also being given the conditions to do so.

Having established the rationale and contextual background to my study, and located my research within the existing literature, the following chapter elaborates on my methodological and analytical frameworks and documents their relevance for the questions I seek to answer (see 1.3; 5.2). Chapter 5 also contains a detailed overview of the research setting, participants, fieldwork and interviews, as well as some of the ethical considerations which underpinned the research design and implementation.

Chapter 5 - Methodology

5.1 Introduction

Having reviewed the communicative practices which appear to be characteristic of superdiverse settings, and synthesised existing literature on health communication (see Chapters 3 & 4), I begin by this chapter by stating my research aims, questions and linguistic ethnographic approach (see 5.2, 5.3). Following this, and building on the earlier description of the hospital setting (see Chapter 2), I give an account of my research design (see 5.4), firstly outlining how participants were identified, recruited and consented, before giving a detailed account of how observations and interviews were conducted. Next, I present the means of analysis which were used to examine the data (see 5.5). Employing a combination of tools closely associated with linguistic ethnography, I use the conventions of conversational analysis (CA) to detail the situated micro-level practices of everyday communication, enriching this process further through reference to previous literature, multimodality and copious fieldnotes. I also draw on the highly influential field of interactional sociolinguistics, and the work of associated scholars (see for example, Erving Goffman and John Gumperz), which offers scope for a broader contextual interpretation (see 5.5.2). As working in a healthcare context necessarily places ethical considerations at the core of research, the final section (see 5.6) explores some of the ethical and practical challenges which were anticipated or arose during the process.

5. 2 Research aims and questions

As presented in the introductory chapter, this research aspires to make a contribution to two specific fields of study: firstly, to a growing body of work considering contemporary communicative practices in superdiverse (institutional) settings; secondly, to the area of health communication, paying

attention to the practices of a multilingual workforce, as well as patient populations.

In order to shape my research questions, I began by considering an extensive literature on superdiversity and health communication (see Chapters 3 and 4), which utilise a variety of methodological approaches, from narrative enquiry (Moss & Roberts, 2005) to ethnography (Padilla, Alcaraz & Azevedo, 2018), grounded theory (Hsieh, 2010), case study (Mori & Shima, 2014) and linguistic ethnography (Creese & Blackledge, 2018). The advantage of being able to draw on such a rich and varied canon, allowed me to identify linguistic ethnography as the approach I felt would be the most appropriate to my setting and the day-to-day activities at HUH, to which I had gained access. Not only did the methodology offer a way of attempting 'ecological validity' (Cicourel, 2007), but the use of detailed observations, fieldnotes and interviews, would enable the rich sociolinguistic landscape of Hayfield University Hospital to come to the fore (see for example, Baynham et al., 2017; Cox, 2017; Blackledge, Creese & Hu, 2015). Following this, my research questions originate from the aims and rationale presented thus far:

1.   What are the ways in which linguistic difference is identified, experienced and navigated, during everyday antenatal consultations at Hayfield University Hospital (HUH)?

a.   In a contemporary health setting, what are the range of linguistic and semiotic resources drawn upon by participants in everyday antenatal consultations?

b.   (How) do the characteristics which are said to exemplify superdiverse environments, affect the interactional space of the consulting room?

2.   (In what way) do communicative practices appear to have an impact upon mutual comprehension and experience?

5.3 Research methodology

Traditionally, linguistic ethnographers take the view that in order to understand a culture, researchers need to immerse themselves in the day-to-day lives of the group, observing and interviewing participants, and living as part of that society (Creswell, 2013): however, as Blommaert and Dong (2010) note, 'true' ethnographies are rare. As it was neither institutionally nor professionally possible to immerse myself consistently within hospital practices, my research does not fall within traditional conceptualisations of ethnography. Nonetheless, the research was longitudinal: I spent over 6 months with midwives, in an institutional setting, observing day-to-day interaction and professional practice, and paying particular attention to language (see 5.4.4). Within this research paradigm, I collected fieldnotes and interview data , reflecting a purposeful aim to "elicit data from multiple sources "in order to approximate ecological validity" (Cicourel, 2007: 750). While it would have enriched my data to collate discourse materials, such as Pregnancy Notes (Appendix A) or electronic records for further analysis, the practical limitations of word count restricted me from employing this strategy.

Thus, I define my methodology as employing a linguistic ethnographic lens, using a combination of the inductive methods associated with interactional sociolinguistics and the conventions of conversational analysis, to interpret my data.

5.3.1 Linguistic ethnography

Building on the North American ontological and epistemological traditions of linguistic anthropology, which foregrounds the role of language in society (Creese, 2008; Gumperz, 1972; Hymes, 1972), linguistic ethnography has become a hugely influential theoretical and methodological approach in contemporary European sociolinguistic research. Emerging from an understanding that "studying language means studying society" (Blommaert & Dong, 2010: 8), it reflects the epistemological view that 'language and social

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life are mutually shaping" (Rampton, Tusting, Maybin & Barwell, 2004: 2) or constitutive (Karrebaek & Charalambous, 2017). As such, the interplay between the established traditions of linguistics and ethnography, can be said to be compatible with a poststructuralist orientation to epistemology (Creese, 2008), a central feature of which is that reality is perceived as "something produced by social and cultural organization" (Pennycook, 2010b: 106). In this way, realities can be seen to be constructed through language, culture and discourse, and can never be context-less, studied in isolation or separated from their role in social structure (Gumperz, 1972). To exemplify, following earlier discussions of why migrant women experience worse maternal outcomes than indigenous populations we can understand that, while language certainly plays a role in disadvantage, communication is but one piece of a wider contextual jigsaw (see Chapters 1 and 4). Yet, fine-grained analysis of each interaction, can offer indexical glimpses of a wider contexts and structures (Creese & Blackledge, 2018; Blommaert, 2007).

> (f)rom an ethnographic perspective the distinction between linguistic and non-linguistic is an artificial one since every act of language needs to be situated in wider patterns of human social behaviour, and intricate connections between various aspects of this complex need to be specified: the ethnographic principle of situatedness. (Blommaert & Dong, 2010: 8)

Creese (2008) highlights specific tenets which are acknowledged to underpin linguistic ethnography: firstly, following Hymes's ethnography of communication (Hymes, 1972), the approach can be seen to fill the gap between discrete ethnographic or linguistic research, by "reject(ing) the traditional functionalist paradigms in which languages and cultures are seen as separate unitary wholes" (Gumperz, 1982: 155). Instead socio-cultural knowledge is seen to be revealed through "the performance of (specific) speech events defined as sequences of acts bounded in real time and space, and characterised by culturally specific values and norms that constrain both the form and content of what is said" (Gumperz, 1982: 154). Secondly, by using methods closely associated with interactional sociolinguistics, linguistic

ethnographers are able to focus on how "discursive practices in context…index social life and its structures and ritual ….(enabling them) …to understand how presuppositions operate in interactions" (Creese, 2008: 231). Thus, in the contemporary urban context considered in this thesis (see 3.3), and in keeping with the aims of interactional sociolinguistics, linguistic ethnography offers a methodology to problematise assumptions, by "examin(ing) language as it constitutes, and is constituted in, superdiversity" (Blackledge et al, 2018: xxxvii). Linguistic ethnographers begin with language, literacy and discourse as analytical starting points of investigation (Creese & Blackledge, 2018; Rampton, 2007) in detailing the in-situ minutiae of conversation, they give a point of 'analytic entry in to the problems …[researchers]..seek to address" (Creese, 2008: 234), working outwards with a view to linking "everyday linguistic and cultural practices to wider social processes, ideologies, and relations of power" (Blackledge et al, 2018: xxxvii). For example, through detailed interactional analysis of job interviews, Roberts et al (2000) show that linguistic minority candidates are systematically disadvantaged by the prosodic features of interview questions, thus indexing a wider relationship between language, ethnicity and inequality. Similarly, as I later demonstrate, close analysis of midwife/patient interaction reveals repeated references to proficiency in the 'named' language of English, which in turn can be seen to index wider discourses about integration and the right to accessing NHS care (see for example 6.3.1).

Significantly, Tusting and Maybin (2007) note that within the potential for linguistic ethnography to relate analysis of micro interactions, to meso and macro level contexts, often lies hope for *real-world* solutions to *real-world* problems (my emphasis). Indeed, it is often an orientation to 'real-world problems' which (linguistic) ethnographers appear to be drawn (see for example, a study of linguistic discrimination in the workplace by Roberts et al., 2000; embodied governmentality and migration by Del Percio, 2016; and health disparities in a multilingual hospital by Cox, 2017). In a healthcare context, Angelelli's (2004) ethnographic account of the working practices of interpreters in a Californian hospital, reveals occasional examples of

interpreter positioning which give cause for professional concern: once identified through analysis, improved training and better practitioner support are able to give 'real-world' solutions to 'real-world' problems. Yet, this example also highlights an epistemological tension. The implication that ethnographic research can solve a 'problem' or define a 'reality' suggests that there is an objective 'reality' to be pinned down and clarified, and places the approach at odds to the aforementioned poststructuralist stance. In addition, Tusting and Maybin's claim that contextualisation through ethnography can 'open linguistics up' (2007: 581) to real-world concerns, while linguistics can 'tie ethnography down' (Rampton, 2007: 596) through the provision of detailed 'evidence', also implies a metaphorical realism, whilst simultaneously appearing to problematise the use of linguistics and ethnography as independent research methods (Tusting and Maybin, 2007). Nevertheless, while the limits of this thesis restrict a discussion on the individual merits of each method, I argue that linguistics can be seen to offer the possibility for close reading of 'speech as language-in-society' (Blommaert and Dong, 2010: 8), adding detailed texture to the ethnographic methods of fieldnotes and observations: in reciprocation, ethnography opens linguistics up by drawing the eye towards wider contextualisation (Tusting and Maybin, 2007; Rampton 2007).

A linguistic ethnographic lens can also encompass a "very rich and empirically robust collection of frameworks" (Blommaert & Rampton, 2016: 34), the flexibility of which make it an ideal method for superdiverse settings where two key challenges remain (Rampton, 2007): firstly, those of 'pluralise[d] indexical interpretations' (ibid: 28; see also 4.3.2), which highlight aspects of 'non-shared knowledge' and, secondly, the means by which interactants find ways of traversing difference and hybridity, (see 3.5.4). Indeed, one does not have to agree with Blommaert's assertion that "superdiversity is a primarily a sociolinguistic issue" (2015a: 84) to accept that the use of procedures associated with scrutinising language, such as Conversational Analysis (CA) and Interactional Sociolinguistics (IS), for example, can become central to one's approach (see 5.5), in facilitating the combination of ethnographic

'sensibilities' with the 'sensitising' indexicals of linguistics. The 'refurbished toolkit' of linguistic ethnography not only disrupts essentialisms and ideas of 'normative' communication, but also "discloses the ways in which widely distributed societal ideologies penetrate the microscopic world of talk and text… [with a] palpable mundane reality" (Blommaert and Rampton, 2016: 35; see for example 6.3.1, extract 17).

Tracing the years since its inception, linguistic ethnography has developed from an approach with a broadly 'liberal humanist agenda' (Tusting & Maybin, 2007) to one which has become implicitly aligned with superdiversity's "ideological orientation to difference" (Blackledge et al, 2018: xxvi) and sense of "political and ethical consciousness" (ibid: xli). In exemplification, the inter-disciplinary work conducted as part of the longitudinal TLANG project illustrate changes in the linguistic and cultural landscapes across four UK cities, drawing attention to innovative and exciting communicative practices, and contributing to pedagogical and public outreach (see for example, Simpson & Cooke, 2017; Blackledge, Creese & Hu, 2017; Simpson, 2016). Additional aspects of this work also highlight the prevalence of societal inequalities, pointing to areas that would benefit from further scrutiny and/or policy change (Blackledge, Creese, Baynham, Cooke, Goodson, Zhu, Malkani, Phillimore, Robinson, Rock, Tagg, Thompson, Trehan & Li, 2018; Baynham et al., 2017). In one of the contributary studies to the TLANG portfolio, Baynham et al (2015) follow Klara, a Czech-speaking community interpreter, as she gives benefits advice to Roma migrants in Leeds, shifting between professional and everyday registers in order to facilitate understanding. While "meticulous analysis of language and interaction"(Karrebaek & Charalambous, 2017: 75), reveal Klara's ability to draw on her interdiscursive translanguaging skills (see 3.5.4), to help navigate unfamiliar institutional discourses, the interaction also illuminates the potential structural difficulties which may prevent a transient, and socially stigmatised community, from equitable access to public services. Indeed, as Chapters 6 and 7 will illustrate, these tensions appear to occur regularly in the navigation of institutional discourse (see for example 7.1.3, extract 36).

While ethnographic methods are not without criticism, ethnographers both acknowledge the difficulties in extrapolating wider generalisations from ostensibly small-scale observations and recognise that it is not the 'only' method for providing a detailed exposition of how things happen in the 'real' world. However, questions of 'validity', from more quantitatively-oriented colleagues, are viewed contentious given the contingent nature of reality. Many ethnographers, following Cicourel (2007), hold that the validating nature of observations does not lie in what they are, but what they imply. Ethnography is also an inductive process (Blommaert & Dong, 2010), yet recognising that inferences are made based on complex, contextual presuppositions, and "situated social interaction is always embedded in daily life socio-cultural and cognitive/emotional processes that constrain and shape discourse" (Cicourel, 2007: 736), it can be argued that the benefits of an ethnographic lens strengthen the "viability and authenticity of [researchers'] claims" (Cicourel, 2007: 735). In addition, by supplementing the 'thick description' (Geertz, 1973) of ethnographic observations with other primary and secondary data sources, to offer an holistic account, the research is able to gain what Cicourel calls 'ecological validity' (2007). Nevertheless, as I have alluded, the interpretive nature of linguistic ethnography has led to accusations of subjectivity with the presumption being that findings are less reliable than those derived from alternative research methods: the flip side of this implies that other research methods, possibly those with a more quantitative, data-driven approach are able to offer a 'truth' that other methods cannot reveal. In mitigation, I refer to a key component of the ethnographer's toolbox, that of reflexivity, which recognises that while observations "themselves [are] interpretations, and second and third order ones to boot" (Geertz, 1973: 15) attempts at analysing them must first acknowledge that "(t)hey are… fictions, in the sense that they are 'something made', 'something fashioned'" (ibid). This is not to state there is no such thing as 'reality', but to explicitly acknowledge the contingent nature of individual experience and context, and to prompt rigour which instigates further, in-depth, fieldwork and intense reflexivity on behalf of the researcher.

5.4 Research design

> The ethnographic approach is characterised by participant observation over time, in-depth systematic data collection from various sources such as field notes, open-ended interviews and inductive analysis initiated during data collection, a focus on patterns in situated practice, and on the whole ecology of a particular setting. (Baynham et al., 2015: 25)

Adopting a linguistic ethnographic lens, as outlined by Baynham above, but moderated by the institutional and practical considerations previously described (see 5.3), I conducted my fieldwork at HUH (see 2.3.1) over a period of six months. This comprised observing the daily workings of the antenatal clinic on a twice-weekly basis and interactions between patients seeking asylum and their allocated midwife at the local IAA (see 2.3.2). In the ensuing section, I first detail how I selected the research site(s), before explaining how I identified key informants and recruited participants (5.4.1 - 5.4.3), who consented to observations of their routine antenatal, anti-D or diabetes consultation(s). I then reflect on the semi-structured interviews I had the opportunity to conduct with midwives and a professional interpreter (5.4.5.1), but how the impromptu nature of these encounters sometimes led to inconsistencies in the amount/quality of information gathered. Following my earlier discussion of the antenatal ward (see 2.3.3), I end this section by describing how the process of observing appointments and collating fieldnotes quietly revealed commonplace communicative practices of those living in a superdiverse environment.

5.4.1. Selecting research sites

Reviewing the combination of hospital and community clinics that make up the comprehensive NHS antenatal provision in Hayfield (see 2.3.1), my instinct was that, in order to ensure the possibility of observing multilingual encounters,

it would be an advantage to locate myself at the centre which saw the most patients, i.e. the central clinic at HUH.

Following ethical clearance to undertake research at the trust (see 5.6.1), I approached the head of the maternity department (hereafter referred to as KS), for permission to conduct fieldwork on the antenatal ward. As I had been working on a project, based in the hospital and designed to engage migrant women with ESOL & antenatal classes (see 1.1), we had a good working relationship. KS was aware of my both my research and shared my professional interest in language and migration, making her an ideal 'gatekeeper' to help facilitate access (Cox, 2015b). As such, she was very happy for me to conduct fieldwork on the antenatal ward at HUH and helped me to identify the most productive ways to ensure access to consultations. KS also corroborated my thoughts on site selection: although she also oversaw antenatal provision in local clinics as well as the hospital (see 2.3.1), KS anticipated that the unpredictable working patterns of community midwives, could present an issue with reliable access to consultations. Consequently, she advised me that working in the main antenatal ward would offer a better opportunity to build relationships with staff, which, in turn, would help to facilitate the chance of observations.

Simultaneous to receiving permission from KS, I had also been in dialogue with GE, the clinical lead for the local homeless health team in Hayfield. Within his remit lies care for pregnant, asylum-seeking women living in a local initial accommodation centre (IA) (see 2.2.1.2). Although this cohort of women is considered extremely vulnerable, the ESOL project on which I had been working, involved engaging with this transient community, GE and their specialist midwife, AS, on a regular basis. As such, GE and AS agreed to let me observe consultations, subject to patient/interpreter consent. However, while access to this diverse, multilingual group offered a potentially rich and textured insight into both contemporary transnational migration, as well as languaging practices, ethical considerations made me cautious about pursuing this line of enquiry (see 5.6). Unfortunately, while I was contemplating whether

to conduct my research at the IAA, AS became very unwell and was signed off work for six months. The trust did not have the staffing capacity to replace her during this period and, as a consequence, care for this cohort was integrated into the main hospital provision. At this point, I decided to conduct all my research in the main antenatal clinic at HUH, and to consider any ethical issues which may arise, especially in regard to vulnerable populations, on a case-by-case basis (see 5.6).

5.4.2. Key informants

In preparation for undertaking research, KS invited me to join a monthly managerial meeting, which comprised her and 4 team leaders from each of the community clinics (see Table 5.2), as well two members of the senior midwifery team at the hospital. This offered the chance to advise the staff of my research interests, explore the possibility of interviewing some of their teams and to respond to any questions that they had (see 5.4.5). During the meeting, I received verbal and written consent from all the staff present, giving me permission to access the various settings and provisional authorisation to observe midwife/patient consultations (see 5.4.4) (see Appendix E). This permission was contingent on the consent of all participants in the consultation and I was advised that although midwives were allowed to take part in the research, they were not required to agree. While two of the team leaders expressed doubts about the number of midwives wanting to take part in the study, the majority responded that staff were so used to begin observed, that they foresaw no problems with access. Following the meeting, KS recommended that I started to conduct fieldwork in September, when midwives with flexible, term-time contracts, would have returned from annual leave.

On returning in the autumn, KS introduced me to the antenatal clinic matron, BR, who was to become central to my fieldwork, both in terms of access to consultations and staff, and as a key participant in observations of the

specialist, anti-D$_6$ clinic, which she oversees. A very warm, friendly and experienced midwife, BR holds responsibility for staff rotas and oversight of patient care, which placed her in an ideal position to introduce me to members of her team. Not only was she able to give staff a brief overview of my research interests, but as a manager asking for their cooperation, appeared to give the research institutional authority. BR also introduced me to a senior health care assistant (HCA), JW, who became vital in the recruitment of participants midwives and patients (See 2.3.2.2).

5.4.3 Identifying and selecting participants

In the first instance, it seemed advantageous to use departmental receptionists to identify patients who required interpreters or who spoke English as an additional language. As frontline staff, receptionists are typically the first people to engage with patients arriving for appointments, as well as having personal, demographic information simultaneously to hand. However, on observation, it became clear that the large amount of interaction between these staff, patients and midwives, as well as the time they spent delivering hospital notes between departments, would make it difficult to interrupt receptionists without adversely affecting their work. Following Cicourel's conclusion that 'the clinical process (often) begins with the discourse practices of personnel not trained in healthcare delivery' (Cicourel, 1999: 217), as well as personal experience working at an adult education centre, I noted that a reliance on the informal linguistic assessment of receptionists could create an additional, and unnecessary, layer of bureaucratic involvement. Instead, both BR and JW volunteered to assist with recruitment, which brought the benefit of having two informants who were able to talk to patients at length, prior to their appointments. Although neither informant had more training on linguistic

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[6] "Rhesus disease can largely be prevented by having an anti-D immunoglobulin injection – to avoid a process known as sensitisation when a woman with RhD – blood is exposed to RhD + blood and develops an immune response" (www.nhs.uk, accessed 01/09/19)

assessment than the receptionists, the length of time they had with which to communicate with patients, increased the probability of identifying, and encouraging, potential participants.

While I was interested in observing all participants involved in consultations, it became apparent, early on in recruitment, that both BR and JW understood my research criteria to focus solely on migrant patients: they paid little or no attention to the first or additional languages of the medical professionals involved. Indeed, any coincidental observations of multilingual, communicative practices emphasise the superdiverse nature of the local population (Wessendorf, 2014). In addition, although some of the staff at HUH were full-time and aware of my research, there were regularly agency midwives on duty to whom I introduced myself and briefly explained my research. Unsure as to whether institutional permissions would extend to temporary staff, I did not ask any of these midwives to participate in research.

At the beginning of each shift, BR alerted me to planned, routine appointments which had been booked with interpreter support. In addition, during the pre-booking-in assessment, where health care assistants are tasked with recording weight and height measurements, JW identified patients who appeared to speak limited English, but were not accompanied by a professional mediator. There were some intrinsic challenges to recruiting participants. Firstly, although interpreted consultations were planned, there appeared to be a very large number of cancelled appointments, which the midwives attributed to reoccurring issues, including a difference between the languages spoken by interpreters and those used by the patient; interpreters over-running in previous appointments and arriving too late; and patient absence. A second challenge was that of securing the permission of all participants, i.e. patients, interpreters and midwives: observation could clearly not take place if one person declined or if participants did not understand why they were consenting to be observed, the ethical implications of which are discussed at length in 5.6. A fundamental difficulty with observing consultations, therefore, was the unpredictability of participation: not only was

it difficult to estimate how many appointments it would be possible to observe in one day, because of access, but also due to uncertainty about how long each one would take. As Blommaert and Dong (2010: 24) point out, fieldwork can be characterised by long periods of time where nothing seems to 'happen', punctuated by moments of intense, or chaotic, activity. Very often, I sat in the waiting room for hours before being invited to two consultations simultaneously.

Nevertheless, with the help of my two key informants, BR and JW, as well as the efforts of other midwives, whose familiarity with me and the project gradually increased throughout my time on the ward, I gained consent to observe 13 consultations, the participants of which agreed to be recorded, translated, transcribed and analysed. The following table (see 5.1) details the participants by the nature of their appointment, the medical professional working with them and the languages spoken in the consulting room. Where possible, I endeavoured to capture additional languages spoken (but not observed), as well as the country of origin for all the participants. Interestingly, in contrast to earlier research in superdiverse settings (for example, Cox, 2017; Roberts et al, 2004; Mori and Shima, 2014), all participants in my study, including medical professionals, are speakers of non-inner circle varieties of English (Kachru, 1990), with many of them drawing from repertoires associated with different countries.

Given the minimal timeframes afforded by the appointments, there was limited time in which to explain my research and seek consent, and even less to elicit personal details pertinent to my research (but not necessarily to the consultation). As such, there are some omissions (indicated by * and **). In order to maintain confidentiality, patients' names have been changed, whereas midwives, healthcare assistants, interpreters and doctors are identified by initials and numbers to ensure anonymity. While patients' husbands are also identified by numbers, one of the women's friends (George, C12) has been given a pseudonym, given his extensive participation in the consultation. Additional contextualising details of each appointment, identified by the

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number allocated to their consultation (C1, C2, C3 etc), are to be found in 5.4.3.1. For ease of reference, the consultation numbers also accompany the excerpts used in Chapters 6 and 7.

Observation participants - consultations

Transcript	Country of origin	Named 1st lang	Accompanied	Medical Professional	Country of origin	Languages spoken	Languages in consultation
Diabetes Clinic							
C1 Fabiana	Portugal	Portuguese	son/Interpreter 5 (I5)	Obstetrian (O1)	UK	English*	English/Portuguese
C2 Maalini	India	Tamil	Husband (H1) /Interpreter 1 (I1)	Diabetes consultant (DC)	India	Tamil/Urdu/Bengali*	English/Tamil
C3 Sadia	India	Urdu	Husband (H2)/Interpreter 6 (I6)				English/Urdu
C4 Li Ping	China	Mandarin		HCA 1 & 2	UK	English*	English
Anti-D injection							
C5 Agnieska	Poland	Polish		Midwife 2 (MW2)	Sierra Leone	English	English
C6 Gosha	Poland	Polish		Midwife (MW2)/Doctor 1 (D1)		English*	English/Polish
C7 Olga	Poland	Polish		Midwife 2 (MW2)	Sierra Leone		English
C8 Alicia	Portugual	Portuguese		Midwife 3 (MW3)	Sierra Leone	Italian/Spanish/English	English/Spanish
C9 Sharon	England	English			Italy	English	English
Booking-in appointment							
C10 Halena	**	Bengali	Husband (H3) /Interpreter (I2)	Midwife 1 (MW1)	Caribbean	English*	English/Bengali
C11 Karla	Poland	Polish	Boyfriend (Bf)				English/Polish
C12 Melina	Portugual	Portuguese	Friend (George) /Interpreter 3 (I3)				English/Portuguese
High-risk pregnancy							
C13 Ajola	Albania	Albanian	Interpreter 4 (I4)/HCA	Consultant (CT2)	Greece	Greek/English*	English/Albanian

* additional language(s) spoken were unidentified

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5.4.4 Observation

Following several months of meeting staff, selecting the site for research, and identifying key members of the antenatal team to assist in recruiting participants (5.4.3), I began to conduct research in September 2016, visiting the clinic once or twice a week, until completion in February 2017. In total, the research comprised approximately 150 hours of fieldwork, 20 hours of audio recordings and copious fieldnotes.

Each day when I arrived at the clinic at 8am, I was greeted by ancillary staff, cleaning the waiting room, washing floors and wiping chairs with antibacterial wipes. HCAs were also preparing for consultations, re-stocking trolleys with medical supplies and checking the working order of the equipment. As chatting about social events and plans for the weekend merged into patients they were due to see that day, or concerns they had had about ones from the previous clinic, midwives congregated in their small office to check patient records, results and rotas. At this point, BR often highlighted high-risk patients, or results which prompted a cause for concern and subsequently alerting specialist colleagues or organising follow-up. Slowly, as the clock edged closer towards 8.30 and the start of clinic, midwives made their way towards their interview room.

Throughout the morning, as midwives and HCAs regularly emerged to call patients by name, or number for blood tests, I sat in the waiting room, chatting to those waiting, watching the unremitting infomercial and making fieldnotes. When BR, JW or NE alerted me to potential participants, I had but a few brief moments to explain my research and to request permission to observe their consultation. Often explicitly looking for the hospital ID that I did not wear, some of those approached were understandably wary of taking part, while others were happy to participate and sign the consent form.

5.4.4.1 A pilot study

I began my fieldwork by observing the everyday workings of the antenatal clinic over several weeks, with the deliberate intention of establishing a good understanding of the setting, before attending an appointment. I then planned to record a session, take notes, and conduct an inductive analysis to orientate my gaze: I also wanted to familiarise myself with the observation process before beginning the research. In fact, on the day planned for a pilot observation, and in a pattern that very much reflected the unpredictability of the clinical environment, I was invited to three, back-to-back appointments (C1, C9 and C4; see Table 5.1). While I used the process of analysis, to deduce emergent themes, I subsequently decided not to include the content in the main body of data presentation (see Chapters 6 and 7), as I did not feel that my fieldnotes offered enough rich description to add flesh to the bones of the observations. Nevertheless, although more extensive than planned, the pilot proved invaluable for refining the practical aspects of observation i.e. taking of fieldnotes and recording interaction.

5.4.4.2 Consultations

The consulting rooms at HUH differ greatly in size, with some able to comfortably accommodate 5-6 people, others are cramped with no room for more than three. Although this occasionally prohibited access to consultations, especially when midwives were being shadowed by trainees, I was typically invited to join participants, in spite of the room size or the number of people present. In an attempt to make my presence as unobtrusive as possible, I would routinely place my position myself in the corner of the room. However, as I reflect (see 5.6.5), my interaction with participants was very much contingent on circumstance and the medical professional's approach to observers: while some midwives acknowledged me explicitly and invited me to contribute to aspects of the conversation, and in one example, to summon medical professionals (see 6.2.2.3), others gave me minimal attention. In such a small space, it was clearly impossible, or desirable, to be invisible (see 5.6).

Drawing our attention to the rigour offered by a varied methodology, Cicourel (2007) notes that audio and visual recordings can aid the memory of the researcher and can be extremely valuable when used in conjunction with reflexive fieldnotes. Indeed, in many studies of doctor/patient communication, videos have been used extensively to further substantiate interactional analysis through the interpretation of non-verbal communication and gesture (see for example, Baraldi & Luppi, 2015; Roy, 2009; Roberts et al., 2005). However, while there were a number of ethical considerations which underpinned my decision not to video patients, practical concerns prevented me from replicating this model of research. In the first instance, informal conversations with the head of the Research and Development department at HUH established that it would be difficult, as a student researcher, to obtain permission to video record consultations. My subsequent request to only audio-record participants was approved (see ethics 5.6.1). In retrospect, I have few regrets about this decision. Firstly, as I was only visiting the antenatal clinic twice a week, and moving between consulting rooms, it would have been inconvenient and impractical to move video cameras and tripods in response to last-minute consent. As I also anticipated that potential participants may feel self-conscious about being observed either working or sharing personal information, the use of video could have further impeded access to consultations.

As a result of these considerations, I audio-taped 12 consultations, having first received explicit verbal and written consent from all participants (see 5.4.3.1.1, for brief case notes). The recorder was typically placed on the desk and switched on at the beginning of the appointment. Luckily my device worked on every occasion, and because of the small size of the room, managed to pick up all of the participants' utterances: it was systematically switched off when we left the room. Although at no time did anyone ask for the device to be switched off during a consultation, there was an instance where patient was receiving potentially troubling results and requested that the observed consultation remain unrecorded. When I returned home, I catalogued each recording, noting the date, time and length of each one, and allocating unique

identifiers, before saving them on an encrypted laptop. To ensure anonymity, I also pseudonymised participants, ensuring the key was located on an alternative drive (see also ethics 5.6.2). Observations were then translated and transcribed, according to transcription conventions associated with Conversational Analysis (see 5.5.1.2).

5.4.4.3 Observational issues

Ethnographic observation is not without challenges, both in practical access to sites of interest, something which is central to establishing ecological validity (Cicourel, 2007), but also in that, as a participant, the researcher is seen to be as much part of the context as the interactants in which they have an interest (Cicourel, 2007; Saville-Troike, 2003). As neither observations nor consultations take place in a vacuum, independent of the wider sociocultural environment, researchers are also embedded in "activities simultaneously constrain(ed by) and shape(d by) more complex organizational structures" (Cicourel, 2007: 736; see 2.1). Yet, unlike quantitative research, an ethnographic perspective does not make claims of objectivity (see 5.3.1). Rather there is a recognition of the situated subjectivity of the researcher and the effect she has on the participants, as well as what she observes. For example, as I was introduced to staff by senior management, I was aware that midwives may perceive me as an institutional figure, imbuing me with an authority that I did not have and possibly affecting their behaviour in the consulting room. With this in mind, and highlighting the benefits of longitudinal ethnographic observation (Cicourel, 2007), I noted a contrast in the behaviour of several medical professionals over the period of 6 months. At the beginning of the research, during initial observations, NE and DC were noted to make explicit references to languages, nationalities and English. Yet, as they saw me on a regular basis, and in subsequent consultations, this commentary became less obvious, with some midwives even positioning me as an 'insider' (Cicourel, 2007), as they talked to me about procedures, using technical language or acronyms with which I was unfamiliar, and often prompting me to ask for clarification.

A recurrent issue faced by ethnographers is that of "what is to be identified as relevant data, their organization, and the kinds of analysis and inferences to which these data will be subjected" (Cicourel, 2014: 375). Therefore, a great deal of discretionary power about what is to be shared can be said to lie in the hands of the researcher. While such critique can be addressed through longitudinal collation of rich and varied data from multiple sources, the implication is also that ethnographers can include everything in their data. Clearly this is neither possible nor meaningful. Instead there is a continuum of gradual refining, whereby the researcher begins by noting as much as they can about the setting, locating patterns and approximating systems, before gradually focussing on a specific research orientation (Blommaert and Dong, 2010). The process cannot be defined as linear, however, as research is regularly characterised by its messiness and punctuated by practical predicaments which influence research potential (see 5.6). So, while the beginning of my research was motivated by a general interest in communication in the consulting room, it slowly refined as the diverse repertoires employed by participants, the unexpected aspects of conviviality, and the subtle power dynamics revealed themselves.

5.4.5 Participant interviews

Ostensibly appearing disorganised, my interview schedule reflected the fast-moving, demanding and unpredictable environment of the healthcare worker. Despite best-laid plans, there was no way either I or my participants could predict the length of preceding appointments, emergency consultations or the need to cover for sick colleagues. As such, most interviews were conducted as the opportunity arose or quickly adapted to accommodate a limited time frame.

5.4.5.1 Midwives' interviews

As previously mentioned (5.4.2), the focus group interview with midwives was initially planned as an informal meeting to improve my institutional

understanding of HUH and to gain permission to conduct fieldwork in the antenatal department. However, as the five team leaders were unlikely to be meeting again until after I had started fieldwork, KS encouraged me to capitalise on the fact that so many team leaders were present, and to ask any additional questions while I had the opportunity. Consequently, the meeting morphed into an ad-hoc, unstructured interview, which not only gave an insight into the practical workings of antenatal provision, but also revealed glimpses of a lived experience of healthcare in superdiversity.

Despite my relative unpreparedness for the interview, a number of benefits to conducting an ad-hoc, group interview became apparent. In contrast to individual conversations, which can be said to give an asymmetrical advantage to the interviewer, as they both set and guide the agenda, focus groups allow for horizontal communication as well as vertical (Denzin & Lincoln, 2003). By taking part with colleagues, the influence of the interviewer is mitigated, as are any threats to face that midwives may experience when being asked individually about their routine work (Goffman, 1972). Consequently, with the absence of structured pre-planned questions, the group interview bore the characteristics of a conversation, rather than an interview (Blommaert and Dong, 2010). In turn, this reduced the potential for leading or closed questions, as participants were responding to colleagues, as well as to me, the researcher. The plurality of input, ideas and voices undoubtably enriched and broadened the information gleaned. However, as all interactions can be said to be co-constructed (e.g. Baraldi & Luppi, 2015; Blommaert and Dong, 2010;) it is also conceivable that the midwives had a group understanding of my research interests to which they orientated their conversations, corroborating and consolidating each other's utterances, albeit encouraged and directed by my questions. Yet recognition of (a likely) subconscious mutual positioning is not meant to problematise the veracity of the midwives' stories (for what good could be achieved from this?), but to note that they were keen to help and to consider an everyday issue that was not always discussed explicitly (Cicourel, 2014; Blommaert & Dong, 2010).

Following a positive interview experience, two of the team leaders, from the South and East teams, invited me to visit their clinics to talk to the community midwives about their experience working in a multilingual environment. However, both of these appointments were characterised by a degree of hectic (dis)organisation: despite extensive, confirmatory emails, to establish that I would arrive before the community clinics in order to cause as little disruption as possible, none of the midwives realised that I was hoping to interview them. Consequently, after agreeing to participate and signing consent forms, interviews were conducted as informal 'walk and talk' conversations, while the midwives were preparing for community visits. Although these snippets only provided a small quantity of data, the information gave invaluable insight into the enterprising ways in which midwives communicated with their patients. My final interviewees were two midwives and a healthcare assistant, who worked on the antenatal ward. Arriving early one morning, I was able to talk to them, about their experience as multilingual workers in a multilingual environment.

In retrospect, it would have also been advantageous to return to the teams after the fieldwork had been completed, in order to reflect on initial observations, and also to ensure that I was able to capture missing small, but important details, such as additional languages spoken or country of origin. However, as KS had left HUH by the end of my research, I no longer had insider access to individual staff rotas, which consequently restricted my ability to contact specific midwives.

Interview	Name	Position	Languages spoken	Country of origin		
Group	Karen (KW)	Community midwives and team le	English/ *	UK		
	Dolores	team leader	English/ *	**		
	Moira	team leader	English/ *	**		
	Amina	team leader	English/ *	**		
	Sylvia	team leader	English/ *	**		
Individual	Stephanie	Midwife	English/ *	Uganda		
Individual	Andrea	Interpreter	English/Spanish/French/Italian	Spain		
Individual	Linda	Health Care Assistant	Latvian/Russian/English	Latvia		
Individual	Luca	Midwife (MW3)	Italian/English/Spanish	Italy		
Individual	Maria	Midwife	English/*	Africa**		
Individual	Rachel	Midwife	English/Welsh	Wales		
Group	Trish/Helen	Midwives	English/*	UK/South Africa		
Group	Student 1 / Student 2	Midwives	English*/English, Urdu, Punjabi, ,	UK /UK		

*additional langauges spoken were unidentified; ** country of origin was unidentified

5.4.5.2 Interpreter interview

In the preceding chapter I outlined some of the challenges in accessing interpreting and translation services, as well as the variety of different interpreting models, utilised by familial, community and professional interpreters (see 4.4.). Having disregarded the option of interviewing informal interpreters, for ethical and practical considerations (see 5.6.3.2), I initially sought to interview professional interpreters as a means of adding depth to collated data. However, it soon became apparent that the time constraints imposed by the pressures of rushing between interpreting appointments, allowed them little time to be interviewed. Fortunately, having worked in an adult education centre which ran interpreting courses, I was able to contact the course leader, Andrea, a very experienced, well-qualified professional who agreed to be interviewed about working in a healthcare environment and training interpreters, something she did regularly (see Table 5.2).

Following a similar process to the observed consultations, on returning home each of the interviews was saved on my personal computer on an encrypted drive. Interviews were given a unique identifier, interviewees were allocated pseudonyms and the key stored on an alternative drive. I was also keen to write up my fieldnotes, where I had made a few notes during the interviews, and to which I subsequently added as soon as was physically possible, after I had left my participants. This was to ensure that I had included anecdotal details, as well as my instinctive reactions on rapport and content. Unlike the detailed, nuanced CA conventions adopted for transcribing observed consultations, participant interviews were transcribed verbatim, without annotations (see 5.5.1).

5.4.5.3 Patient interviews

I did not pursue the idea of patient interviews, as the procedure posed several ethical questions pertaining to informed consent and power dynamics. As Copland highlights (2018), would potential patient participants feel able to deny

access to someone ostensibly presenting as an authority figure, in an institutional setting? On a practical level, it would have proved difficult to recruit participants, because of the lack of time, space and potential interpreting services needed.

5.4.6 Fieldnotes

The process of taking extensive, detailed fieldnotes is a crucial part of ethnographic research. Not only do they add flesh to the bones of interviews and participant interaction, but they can act as an aide memoir for the researcher, reminding her both of the physical event and her initial reflexive response (Cicourel, 2007). In the absence of video recorded material, fieldnotes can document (the effects of) gestures and expressions but also the other senses, which contribute to one's experience of an event or setting, such as smells, temperatures, sounds and emotions (see Appendix D, for example fieldnotes).

During my research, I attempted to describe as much of the physical and linguistic landscape as possible, from non-verbal, semiotic communication in consultations to the hustle and bustle of the waiting room and the banality of infomercials, playing on a relentless loop (see 2.3.3). Fieldnotes are also an obvious place to note the some of the unexpected moments which arise during observations, i.e. events which surprise you. Indeed there were numerous occasions during the consultations that I witnessed unusual events (see 6.2.2.3), multilingual encounters (see 6.5.), explicit reflections on linguistic ideologies (see 6.3.1) and behaviours which could be seen as highly atypical of previously recorded health consultations (see for example 7.4.2), all of which prompted me to revisit personal expectations and problematise imagined conceptions of 'normality' (Blommaert and Dong, 2010). While as an observer, I was unable to directly engage with these interactions, fieldnotes offered the opportunity to record the events, and my reaction to them. However, the practicalities of doing so could sometimes prove problematic. For example, despite originally creating a personal observational protocol,

designed to capture events and reflections as they unfolded, I found that as I endeavoured to capture both simultaneously, my fieldnotes quickly deteriorated to an unstructured combination of the two. While this not did not cause difficulties in the setting, deciphering their intended meaning at a later stage contributed to the labour-intensity of analysis.

In the following data chapters, I reflect on the usefulness of fieldnotes, noting that they are, like the observations they accompany, but a snapshot of a series of events, of which it cannot be claimed represent reality, conceived of as a shared experience, but shaping my interpretation of such. In addition, their descriptive qualities also cannot be said to equate to ecological validity per se, but to contribute valuable pieces to a messy ethnographic jigsaw. Through their use in conjunction with interviews, participant discussions and observed interactions, fieldnotes helped to enhance detailed descriptions (see for example, 6.2.2.3) or to elaborate on particular phenomena (see 6.5) (Cicourel, 2007).

5.5. Approaches to analysis and interpretation of data

As this chapter demonstrates, while the interpretative nature of ethnography is strengthened by the breadth of methods used to collate data, it consequently emphasises the need "for meticulous analysis of language and interaction, and for analysing language as an entirety of form" (Karrebaek & Charalambous, 2017: 75). In order to look at the 'total linguistic fact' Silverstein (1985) identifies four aspects of language use that must be considered in analysis – form, use, ideology and domain. One must not only examine how lexis is used, but also examine how communicative events are organised, for example in turn-taking (e.g. Schegloff & Sacks, 2009; Jefferson, 1979) and how medical professionals and patients orient themselves in consultations (Goffman, 1972): the analyses must then be examined in its relationship to wider institutional, societal and ideological contexts.

The ensuing section describes some of the practicalities involved in data transcription and translation. Within this, I compare the denaturalised transcription employed for participant interviews, with the naturalised, micro-analytic conventions commonly associated with conversation analysis (CA), which are used for detailing medical consultations (see 5.5.1). However, in contrast to the traditionally emic focus of CA, which rigidly avoids the interpretation or wider contextualisation of data, it is through an 'impure' use of CA that I seek to link nuanced interaction ritual actions to broader sociocultural patterns (Creese & Blackledge, 2018). In addition, by paying detailed attention to the complex rules which govern communication, light is shed on 'interaction rituals' (Goffman, 1971), and illuminates (a lack of) shared cultural assumptions. Following an explication of Goffmanian notions of facework and footing (1981), I continue with a brief overview of multimodality, tracing the influence it has had on my data analysis but subsequently exploring practical restrictions to a full methodological commitment, given my inability to video record consultations. The section concludes with an overview of how I approached the coding of emergent themes.

5.5.1 Transcription and translation

Transcription is an interpretive process, and plays a foundational role in data analysis, in that what a researcher decides to include or exclude, and how they decide to do so, 'ha[s] equal potential to serve as politicised tools of linguistic representation" (Bucholtz, 2000: 1439). Not only does the immersive nature of ethnography 'fully implicat[e]' (ibid: 1440) the researcher as a co-participant, but "embedded in the details of the transcription are indications of purpose, audience, and position of the transcriber toward the text" (Bucholtz, 2000: 1440). So, if as Bucholtz notes, it is not possible for transcriptions to be neutral, researchers should exercise a responsibility in acknowledging the role of practices, as well as the wider sociocultural context, in 'shap[ing] our knowledge' (Bucholtz, 2000:1463) (Creese & Blackledge, 2018; Cicourel, 2007; Bucholtz, 2000).

5.5.1.1 Transcription: interviews

As I indicated earlier (see 5.4.5.1), during my research I had the opportunity to conduct a number of ad hoc, and therefore fairly unstructured, interviews with midwives and an interpreter. A benefit of this relative informality was that the interviewees were relaxed and felt able to share personal experience: on the other hand, improvisation meant that questions occasionally lacked focus. Indeed, the impromptu nature of the interviews prompted personal reflections, similar to those highlighted by Blommaert and Dong:

> (there was) a painful confrontation with badly formulated statements, errors in comprehension, missed opportunities in the interview, your own accent, your irritating insistence on particular points and so on. (Blommaert and Dong, 2010: 49)

Re-listening to the interview recordings also highlighted the co-constructed nature of interaction, where my questions could be seen to steer and mould conversations (Bucholtz, 2000). Despite my ensuing embarrassment, an obligation to the transcription process necessitates detailing all contributions, however uncomfortable. In respect of the interviews, and because my interest lies in the content of the conversations, rather than the way in which participants express themselves and interact with one another, I use a 'denaturalised' form of transcription (Bucholtz, 2000). This method favours chunking words into punctuated sentences, rather than transcribing speech as a stream of utterances, breaths, pauses and hesitations. While imposing such structure may not reflect the emphasis of the speaker, denaturalised methods improve the readability of texts, which offers a clear advantage when examining themes.

5.5.1.2 Transcription: Conversational Analysis (CA)

In contrast to the previous method, I utilise a naturalised convention to capture the nuanced interaction of medical consultations: this elaborate system of signs and symbols in combination with words, attempts to illustrate the micro,

communicative items which make up, and intersperse, speech (Jefferson, 2004, see Appendix F). Commonly associated with Conversational Analysis (CA), naturalised transcription places detail at its core, in that by examining the minutiae of interaction, it can "cultivate an emic perspective on conversational interactions (encouraging us to) consider how the conversation is structured and meaning is shaped from the participants' own perspective" (Canagarajah, 2013: 77). The micro approach can capture an expanse of detail, from illuminating the role of small talk in developing relationships and mitigating potential difficulties (Zhu, 2014; Maynard & Hudak, 2008), to differentiating between laughter as a marker of trouble and as a diversionary tactic (Fatigante & Orletti, 2016; Hudak & Maynard, 2011; West, 1984; Jefferson, 1979). It has also been used extensively in the documentation of doctor/patient communication (Baraldi & Luppi, 2015; Baraldi, 2009; Haakana, 2001; Heath, 1986; Frankel, 1984).

There are a number of limitations with strict adherence to the guiding principles of conversational analysis: firstly, by limiting ones' gaze to sequential organisation, it is only possible to draw elements and categories from the immediate context, without consideration of the wider institutional or ethnographic context (Cicourel, 2014). It also restricts a more holistic approach, in which hypotheses drawn from communication could be further informed by interviews, fieldnotes or participant corroboration. Secondly, a set of somewhat inflexible presuppositions which underpin CA, assumes that the participants, researcher and reader all share the same terms of reference and are therefore mutually comprehensible (Frankel, 1984). As Cicourel notes, "the investigators ability to comprehend these exchanges is assumed to be self-evident and is seldom if ever an aspect of the analysis" Cicourel, 2014: 376): this becomes especially problematic when the researcher is both responsible for the selection of material, as well as being present, and therefore part of the interaction (Blommaert & Dong, 2010). In order to have a fuller ethnographic portrait then assumptions must be set aside:

> Knowing something about the ethnographic setting, the perception of and characteristics attributed to others, and broader and local social organizational conditions becomes imperative for an understanding of linguistic and non-linguistic aspects of communicative events (Cicourel, 2014: 376)

Therefore, in order "to understand language and social interaction in everyday life" (Cicourel, 2014: 77), my analysis builds on Cicourel's words of caution, employing an 'impure' version of conversational analysis (ten Have, 1990), which examines intricate participant communication, but goes beyond the constriction of situational categories that "fix people in a particular way within a particular social landscape" (Tranekjaer, 2015:90), to examine their relationship to the wider social environment. It is here that additional methods associated with International Sociolinguistics (IS) can also be utilised (see 5.5.2).

5.5.1.3 Transcription: translation

Subsequent to earlier discussions regarding the extent to which Hayfield's population could be considered superdiverse, and some of the characteristics which typify such a demographic (see Chapters 2, 3 and 4), it is unsurprising that participants were observed using languages other than English, with which to communicate. In the observations which comprise this thesis, participants were witnessed to draw from repertoires which included Tamil, Urdu, Polish, Spanish, Italian, Portuguese, Albanian and Bengali: as I am not a competent speaker of these languages, I was placed in the position of having to find translators to assist.

In the first instance, I chose to postpone contacting professional translators, primarily because of the cost implications for unfunded research. A second option could have been recruiting students from the ESOL classes I taught at my local adult education college. However, this idea was swiftly dismissed when I considered the ethical implications of engaging a student to transcribe content which may accidently involve a friend or family member from the local

diaspora (see 5.6). I did not want my translator to know/know of the participants. My third choice proved the most productive, as I recruited friends who were contemporary doctoral students, to aid with the translation. Not only were my peers able to call upon extended personal networks to help me, but they (and their friends) were familiar with the ethical aspects of the research, such as retaining confidentiality and pseudonymisation (see 5.6.3.3). When I was unable to find a Portuguese translator to conduct a large amount of translation, I then approached a colleague, and Portuguese teacher, to assist.

Given that friends and colleagues were sacrificing a large amount of time to translate and transcribe, I made the decision to pay them. This also removed any guilt I felt, when I had to ask them to meet deadlines or to clarify translations, as, on occasion, content appeared to be so bizarre, that I requested confirmation. For example, in chapter 7, extracts 44 and 46(C12) were also listened to by four independent Portuguese speakers (and back-translated by one), to ensure accuracy. Nevertheless, despite double-checking translations, as much as I could, extracts are included with the understanding that translations are not context free. Similar to the interpreter in the consultation, each professional translator will bring their own history to bear upon their work, and that, with no intention to distort meaning, translations are as individual as those who are rendering them (Gavioli, 2015).

5.5.1.4 Transcription: challenges

In the introduction to this section (see 5.1.1.) I noted that the process of transcription is not without challenges, especially in regard as to whether one chooses to indicate accents or idiomatic forms of speech, potentially transcribing them using a system such as the International Phonetic Alphabet (IPA). As may become apparent in the following data chapters (see for example, 6.3.2, extract 19, and 7.2.3, extract 41.), many speakers use idiomatic forms of English, differing grammatically and lexically to standard forms. However, although my research is particularly oriented to multilingual repertoire, I follow Bucholtz's concerns, i.e. wanting "to balance…my desire to

represent (x) as a legitimated linguistic variety, with my recognition that to call attention to nonstandard forms introduces problems of social evaluation" (2000: 1453). As such, while I chose not to alter participants' syntax, I avoided using phonetic transcription to illustrate accents or pronunciation. Not only is IPA difficult to read, but it marks difference in a way that counters the reality of everyday superdiversity which this thesis seeks to capture. However, on one occasion I transcribe a word phonetically, in order to demonstrate the participant's endeavours to 'sound' 'Spanish' (see 6.3.2, extract 18).

Following an understanding of social semiotics, which notes that primacy is often given to content on the left hand side of the page (Kress & Leeuwen, 1996) I was faced with a choice of prioritisation: placing English on the left could be seen to emphasize a dominant linguistic hegemony, while separating the languages into two columns also seemed to contradict earlier discussions dismissing the ideologies of one nation/one language (see 3.4.1). In an attempt to reflect the languages as spoken in the consulting room, but also with consideration of readability, I italicised languages other than English, marking the original utterance in bold italics, and the English translations to the right, in unmarked italics.

Having examined some of the issues involved in translation, I now detail the process of analysis which, in regard to this thesis, is informed by interactional sociolinguistics (IS), the work of Erving Goffman and multimodality.

5.5.2 Interactional sociolinguistics

In previous sections (see 5.5.1.2), I have explored the ways in which fine-grained analysis of talk can help to establish how relationships and meaning are shaped through interaction, but also the ways in which they can shed some light on the local context. As this form of analysis does not explicitly address the effects of wider 'macro-societal conditions, political and economic forces, and the relationships of power in which they were acquired" (Gumperz, 1999, p.453), linking the micro to the macro can be therefore be considered

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problematic. In response to this tension, interactional sociolinguistics (IS) "seeks to bridge the gap between these two approaches by focussing on communicative practices (Hanks 1996), as the real world site where societal and interactive forces merge" (Gumperz, 1999: 454). From the contextualisation cues which function as implicit signs in interaction, indicating how messages are to be construed, there is also an understanding that speakers may rely on 'extralinguistic knowledge', in order to infer meaning (Gumperz, 1982: 157). In a superdiverse setting, "the dynamic mutability of context is complicated further by the ability of participants to rapidly invoke within the talk of the moment alternative contextual frames." (Duranti & Goodwin, 1992: 5), challenging the taken for granted assumptions which are implied by previous notions of homogeneity or speech communities (Gumperz, 1999). As a "main purpose of IS analysis is to show how diversity affects interpretation" (Gumperz, 1999: 459), it offers an ideal approach to examining intercultural encounters and consideration of "how these interactions are embedded in wider social contexts and structures" (Blackledge et al, 2018: xxxvii). Employing the tenet that, "If the social world is produced in ordinary activity" (ibid, xxviii), a premise of this thesis is that interaction in routine antenatal appointments not only reflects the superdiverse nature of the town, but the aspects of institutional practice. Indeed, by paying close attention to data analysis, and drawing heavily on the seminal work of Erving Goffman, the following chapters seek to illustrate this.

The next section gives a brief outline of some of the terminology coined by Goffman, and which is used extensively in the subsequent data chapters.

5.5.2.1 Erving Goffman: facework

Underpinning Goffman's approach to interactional analysis is the notion of 'interaction ritual' (1971), a complex set of rules that guide behaviour, and which are driven by an array of (cultural/social) assumptions as well as past personal experience. However, it is clear that individuals do not always share mutual understanding, often prompting a breakdown in communication and the

need for repair. While arguably, in a superdiverse population, the potential for misunderstanding may be increased, and the 'filigree of trip wires' (Goffman, 1971: 106) may lie thick in anticipation of misinterpretation, Goffman notes that individuals ordinarily work hard to retain interactional harmony, or to preserve 'face'. Everyday social interaction involves the subconscious taking of a 'line' or "a pattern of verbal and nonverbal acts by which he expresses his view of the situation and through this his evaluation of the participants, especially himself" (Goffman, 1972: 5). The moral implications of this stance reflect a participant's need to maintain interactional harmony, a positive self-image and a consideration of others. In doing so, the participant can be seen to be concerned with his/her 'face' needs and those of the listener, while the strategies he/she employs to do so, Goffman recognises as 'facework' (1967; see for example, 6.2.2.3). An individual can present a positive or negative face need, depending on their intention: the former refers to the need to present oneself as likeable, the latter to want to proceed unimpeded.

Goffman's conceptualisations of facework have become fundamental to interactional analysis, underpinning Brown and Levinson's theory of politeness (1987; see 5.5.2.3.), and proving invaluable in analysis of healthcare encounters (see for example, Linell & Bredmar, 1996; Baraldi & Luppi, 2015; Baraldi, 2009).

5.5.2.2 Erving Goffman: footing

In examining a 'participation framework', (i.e. the way in which individuals (integral or peripheral) align themselves to others who are involved in interaction), Goffman uses a theatrical metaphor to describe the roles that interactants may take during an exchange: comparing speakers to actors in a play, individuals can adopt the role of animator (through whom utterances are made), but this may differ from the role of the author (the person who thinks of, and utters, the words). These roles, in turn, may differ from that of the principal (the person or body whose beliefs are represented): to contextualise, an interpreter may be considered the animator as she translates words uttered

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by the doctor, the author, whereas the principal may be the patient about whom they are talking. However, Goffman also alerts us to the fact that roles are interchangeable, with participants changing 'footing' during exchanges, in response to, or in order to bring about, a change in discourse practices.

> A change in footing implies a change in the alignment we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance.
> (Goffman, 1981: 128)

Exemplifying this, it appears common for medical professionals to change footing, or the ways in which they engage with patients, to make the latter feel at ease or to express a mutuality of experience (see for example, 6.2.2.3, extract 14, C6). Indeed, employing theatrical metaphors, Goffman recognises changes in footing as often involving a move between 'front' and 'backstage', as participants step in and out of their professional frame to oil the wheels of communication (1981). However, it is not just midwives who are able to vacillate between footings. As I discuss further in my data analysis, on occasion, patients and their family or friends make dramatic changes in footing, either to align with the other layperson (see, 6.2.2.1, extract 6), or in a way which seems to challenge the authority of the medical professional (see extract 46). Nevertheless, activities are anchored by the roles assigned to individuals, and framed in specific ways. All midwives are professionally trained, governed by a code of practice and guided by hospital regulations, to which they must adhere. To undertake the role of patient in this department, you must be pregnant, and are expected to conform to a number of sociocultural, and medical, constraints. This takes the form of adopting or developing a high degree of self-responsibility (tacit within which is foetal care) by accepting the need for possible intervention, agreeing to routine injections/blood tests, eating the right food, avoiding drugs and alcohol, and attending every antenatal appointment. Whilst both of these roles are anchored within the frame of antenatal care, Goffman notes that in 'the performance of any given role the performer will apparently have some right to

sustain or fall back upon a self that is separate from the one relevantly projected. Role gives way to person" (1986: 273). He also notes that it is the participant accorded with the most power in that relationship, usually the medical professional, that is able to move more freely between roles (see for example, 6.2.2.1).

5.5.2.3 Politeness theory

Expanding further on Goffman's notion of positive and negative face, is the work of Brown and Levinson (1987), who use the concept as a foundation for a theory of politeness. They build on an understanding of 'verbal interaction as the expression of social relationships" (1987: 2), and thus view 'face' as a "public self-image" (1987: 61) that needs to be maintained during communication. Following the dichotomy of positive and negative face, Brown and Levinson also introduce additional terms that can be utilised to interpret a connection between the form and inference of dyadic interaction. The directness of a 'bald-on-record' statement, for example, can be understood as an unequivocal threat to face (see for example, 7.1.1, extract 31), whereas an utterance made 'off record', is an indirect or tactful way of approaching a subject. Additional examples of what constitutes a threat to face needs are also clarified: in the context of this research, a threat to a speaker's positive face (the desire to be seen as likeable) may be asking a patient to change their diet or behaviour, whereas at threat to the midwife's negative face may be having to apologise (see for example, 6.2.2.3). Alternatively, a threat to a hearer's positive face may be to receive criticism or a complaint, if she is not following medical advice, whereas a threat to negative face could be being asked to complete a medical history form.

However, Brown and Levinson's work has not been without critique. More recently, Locher and Watts (2005) have drawn attention to what they see as the limitations of the theory, arguing that its narrow focus on "the mitigation of face-threatening acts (FTAs)" (2005: 9), not only ignores the fact that politeness is a discursive concept, open to pluralised interpretations, but is also

only one aspect of facework. Instead, the scholars call for a consideration of what they refer to as the 'discursive struggle' of 'relational work' (2005: 9), i.e. "the "work" individuals invest in negotiating relationships with others, which includes impolite as well as polite or merely appropriate behaviour" (ibid). For example, while the administration of an injection as a preventative measure may present a face-threatening predicament (see 6.2.2.2), the process is both predictable and essential. As such, behaviours associated with the approach, dispensation and reception of treatment may be anticipated to be 'unmarked',

> demonstrate[ing] that much of what has commonly been thought of as "politeness" may in fact be perceived by participants not as politeness…but rather as the kind of behaviour appropriate to the current interaction, i.e., what we refer to as "politic behaviour" (Locher & Watts, 2005: 17)

In the context of this study, where consultations often comprise routine processes, the concept of relational work can therefore shed additional light on situations where politeness holds less relevance than appropriacy.

5.5.3 Multimodality

Throughout this thesis there are allusions to the multimodal nature of communication in a superdiverse environment (see for example, 3.5.3, 6.5), and the ways in which semiosis is a key feature of translanguaging (Li, 2018). In this brief overview of methods, I hope to clarify some of the immediate, and practical, challenges to conducting a full multimodal data analysis.

Cicourel draws our attention to taking a multimodal (MM) perspective, where the researcher's attention is not only given to speech but to semiotic resources of non-verbal communication, such as gaze, sign, gesture, expression and movement:

the perception and comprehension of speech events or actual
communication (speech acts, prosody), facial expressions,
body movements, and eye contact or avoidance are essential
conditions for bringing a frame of reference into existence and
making decisions about what is happening and taking action
in a given setting. (Cicourel, 1999: 186).

Although a medical professional and patient talk about health concerns, copious information can be gleaned from looking beyond speech and the written form of medical records. To those considering multimodal analysis, additional objects which can aid interaction, such as phones or other electronic devices can also be included as methods or means of communication (Bezemer & Abdullahi, 2019). In consideration of the medical apparatus, for example, what do the beeps on a baby monitor, or blood pressure machine, communicate to the healthcare professionals and patients alike, as they interrupt verbal communication? Drawings can also be employed to aid understanding: as Chapters 6 and 7 demonstrate, midwives frequently rely on illustrations to clarify and supplement their explanations of the development of a foetus or medical treatment (see for example, 6.5, extract 28).

MM can produce accounts of, and theoretically reframes,
phenomena with which LE is centrally concerned.....[firstly],
this is visible in concerns about ideology, power, structure and
agency, voice, identity, social change, mobility, diversity.
Second[ly, in], a commitment to relatively detailed
documentation and analysis of social action, interaction, and
human artefacts. (Bezemer & Abdullahi, 2019: 125)

Although multimodality 'shares an understanding of the world' (ibid), with linguistic ethnography and the assumption that 'a social world can be opened through scrutiny of each and every grain' (Bezemer and Abdullahi, 2019: 126), there are a number of practical constraints which prevent most linguistic ethnographers from wholeheartedly adopting the method. In order to capture 'every grain', multimodal researchers commonly video-record their object of

study, often from several angles and sometimes employing several researchers to document different strands of interest: attention is also given to linguistic and written forms of communication. As Blommaert and Rampton note, such focus can highlight unintentional indexical signs, such as dress or posture, which have subconscious consequences, 'increas(ing) our sensitivity to a huge range of nonshared, asymmetrical interpretations' (Blommaert & Rampton, 2016: 28): in superdiverse environments, this is significant.

Given such an extensive toolkit, there is no questioning the depth of description, explanation and interpretation available to a multimodal researcher, but also the extent to which videoing could inhibit the access of a linguistic ethnographer, who often seeks to work/live as unobtrusively as possible with research participants. As such, and in consideration of the ethical and practical considerations discussed earlier, while the research methods used in this study strive to capture as much semiotic detail as possible, reflection acknowledges the partial nature of that which has been recorded.

5.5.4 Emergent themes

Having fully transcribed interviews, annotated consultations, and written up field notes, the huge amount of data was initially overwhelming. However, by returning to each data set, and repeatedly reviewing context, content and interaction, broad themes began to emerge from the inductive process (Creswell, 2013): on one hand, issues of institutional behaviours and processes of categorisation became apparent; on the other, the role of language, repertoire and resources were clear. Over a period of months, I re-read, reviewed and added to my literature, returning in a dialogic process to my data, until emergent patterns became established themes. It was at this stage, that I could begin to bring a critical eye to each interaction and begin to carry out my analysis.

5.6 Ethics

In this section, I begin by revisiting my initial approach to gaining ethical approval from HUH, (see 5.4.1 for earlier description), before outlining the procedures required by the Institute of Education Ethics Committee. I then establish why I chose to follow guidelines by the British Association for Applied Linguistics (BAAL, 2016). Having earlier detailed how I sought permission from different participants (see 5.4.3), section 5.6.3 describes the process of designing differentiated consent forms and information sheets for a diverse participant population, whilst simultaneously striving to ensure institutional compliance. Included in this section are a series of personal reflections, which consider the highly sensitive nature of the research, the potential vulnerability of participants and the ethical responsibilities of an ethnographer. Somewhat unusually, I also include short case notes to illuminate subsequent readings of data (see 5.6.3.1.1; also Chapters 6 & 7). I then conclude by deliberating more widely on the influence of subjectivity and limitations of research design.

5.6.1 Ethics permission

Ethical approval for conducting research in health settings is notoriously difficult to achieve (Cox, 2015b). As such, and in anticipation of a long journey, medical colleagues advised me to apply for ethical approval very early in the doctoral process. Existing working relationships facilitated easy access to the Research and Development (R&D) team at HUH, and I was encouraged to submit a proposal prior to my upgrade, in case permission was not granted. At this point in time (October 2014), student research which involved human participants, but which did not involve the taking of bodily fluids or physical interventions, was considered on a local level by the head of R & D. In addition, the proposed research was seen as a student project which had the potential to improve maternity care, at a time when it was under a particularly negative spotlight (see Chapter 1). Fortunately, I received ethical approval quickly, and without revision.

However, since ethical consent for my project was received, the system of conducting research in the NHS has become more complex: in September 2016, the application process was centralised, and new proposals were to be submitted via the Health Research Authority portal (HRA). Further revisions were made in 2018, when the HRA was extended to include research in Wales: it is now referred to as 'HRA & HCRW Approval'(HRA, accessed 21/7/19). While changes to the approval process initially caused personal concern about compliance with ethical guidelines, I was reassured by the R & D team at HUH, that an application for retrospective approval was unnecessary.

In adherence with university ethics procedures, permission was also requested and gained from the IOE.

5.6.2 Ethical guidelines

As applied linguistics is a way of 'understanding language issues in the real world' (BAAL, 2016: 2), guidelines from the British Association for Applied Linguistics appeared best suited to both support research questions with linguistic orientations, as well as the methodology I sought to use. Therefore, my initial IOE ethics application identified this code of ethics as a primary source of guidance. However, as I was also researching in an NHS context, I was keen to ensure that I also my research aligned with their guidelines (Health Research Authority, n.d.), and additional generic principles, drawn up by the Academy of Social Sciences (AcSS, 2015).

From the beginning of my research journey, it became clear that ethical issues required ongoing consideration and review as different situations and participants were encountered (British Educational Research Association, 2018). Thus my approach aimed to ensure democratic and inclusive research practices, which prioritised the 'privacy, autonomy, diversity, values and dignity of individuals, groups and communities' (AcSS, 2015). I also strived to conduct research with integrity, in a socially responsible way, using the most

appropriate method(s) and underpinned by the aim of 'maximis[ing] benefit and minimis[ing] harm' (AcSS, 2015).

5.6.3 Research participants

5.6.3.1 Informed consent: patients

"Informed consent is often considered to be a cornerstone of ethical research, and the foundation upon which trust and openness between researcher and informant is built" (BAAL, 2016: 4), but the complexities of working in a superdiverse environment with a variety of different types of informant, cannot be underestimated. In an earlier exploration of superdiversity and the demographic profile of Hayfield (see for example, 2.2.1 & 3.3), I sought to illustrate the number of expectant mothers who could be considered vulnerable or having experienced a trauma. While the key tenet of ethical research, 'to do no harm', is always at the forefront of a researcher's mind, with the unpredictability of a superdiverse environment, ethical considerations become fraught with potential difficulties. To mitigate risk, I relied heavily on the midwives' professional sensitivities and years of training to select women who they did not consider 'vulnerable'. While recognising that this method was both subjective, contingent and unsystematic, it removed an element of professional anxiety (although not all). Secondly, if any of the women, their families, interpreters or midwives expressed, or displayed, any concern, discomfort or lack of understanding at my explanation of research objectives, I withdrew my request and did not pursue recruitment. Although I paid acute attention to the sensitivities of potential research participants, often spending several days without observing consultations, this prioritisation helped to build midwives' trust, which in turn encouraged them to identify women who may be of research interest.

In anticipation that it would prove difficult to recruit participants for the project, and given that I had 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. For the purpose of making

the forms both syntactically and epistemologically comprehensible, and therefore ethically robust, I followed principles underpinning the creation of differentiated resources for language learners, and those proposed by NHS Health Education (NHS Scotland, n.d.) to address readers with low literacy skills (Learning & Work Institute, n.d.). Consequently, Form 1 was designed for a reader with an English competency equivalence of Level 1/B2 (ESOL/CEFR respectively) (Appendix E1); Form 2 was designed for an Entry 2/A2 reader of English and was accompanied by pictures (Appendix E2); Form 3 was designed for those with limited English and comprised mostly pictures (Appendix E3). Moving away from presumptions of literacy skills in English, I also designed a series of picture prompts to enable me to talk through my research with potential participants: ideally these were to be used with interpreting support. To mitigate the amount of paperwork to be given to participants, I made two copies of each consent form, giving one to patients, as well as keeping one for my records.

5.6.3.1.1 Case notes

While I concede that it is unusual to include such information in the methodology chapter of a thesis, the following section provides a crucial snapshot of each of the consultations which comprise this study, including those observed for the pilot. This brief glimpse is intended to enrich the subsequent analysis of data (see Chapters 6 & 7), by giving an indication of context and personal circumstances.

Diabetes Clinic

C1- Fabiana (Portuguese)**

Patient (F), son, Interpreter (I5), Obstetrician (O1)

Fabiana is in her mid-thirties and is accompanied by her 9 month-old son, and a LL interpreter, who she met during the previous pregnancy. When I meet them in the waiting room, the two are deep in conversation, and making jokes about the short space of time between Fabiana's pregnancies.

Fabiana's appointment is with an obstetrician, rather than a midwife, due the size of her first baby and subsequent emergency caesarean. When the doctor arrives, the convivial tone of the conversation changes as Fabiana is advised on the possible risks of attempting a natural delivery, based on her previous experience: instead, she is encouraged to consider a caesarean. Once the doctor has established the baby's due date, Fabiana is referred to a clinic which specialises in women who have had caesareans before. Her interpreter is skilled at transdiscursive translation, breaking down information for the patient and managing the triadic interaction very effectively.

C2 – Maalini (Tamil)

Patient (Ma), Consultant (DC), Interpreter (I1)

Maalini is pregnant with her first child and is accompanied to the appointment by her husband and a LL interpreter: both Maalini and her husband speak limited English, although they appear to understand the consultant's questions and advice. Consultant DC is advising Maalini on how to manage her gestational diabetes, as her high sugar levels are affecting the size of her baby and increasing her chances of caesarean delivery. Despite the potential seriousness of the consultation, this appointment is noticeable for the convivial atmosphere. DC, originally from India, follows the conversation between the other three participants, interjecting with Tamil vocabulary to joke with the patient and her husband. This is one of three consultations where Dr DC uses a language other than English.

C3 - Sadia (Urdu/Hindi)

Patient (S), Consultant (DC), Husband (H2), Interpreter (I6)

In another consultation for a very high-risk pregnancy, we meet Sadia, a heavily-pregnant patient from Afghanistan, with gestational diabetes who is

expecting her fourth child. I arrive just after the consultation has started. Sadia is accompanied by her husband and an interpreter. However, the interpreter appears redundant, as DC conducts the whole interview in Urdu. Unlike the previous consultation with DC, the tone of the exchange is very serious and is marked by DC's dominance of the conversation, as she gives Sadia a list of instructions on what to do when she goes into labour. Sadia and her husband listen passively, as they realise the potential gravity of the situation.

C4 - Li Ping (Mandarin) / Glucose testing **

Patient (LP), HCA2, HCA3

While I have seen a number of ex-students around the hospital as I have been conducting research, Li Ping is the first that I have met on the antenatal ward. We chat briefly about her children, her English classes and my research as she is waiting for her glucose test, before she invites me into the consultation with her. Both HCA 2 and 3 are very chatty as they complete Li Ping's blood test: similar to findings from other observations, the health professionals make copious jokes about the pain of injections, in an apparent attempt to distract the patient from the accompanying discomfort. In turn, Li Ping responds with the use of the reciprocal face-saving strategies - excessive thanks and apologies.

Anti-D Clinic

C5 - Agnieszka (Polish)

Patient (Ag), Midwife (MW2)

Agnieszka is receiving an anti-D injection, which is offered to pregnant women whose child has been identified as having Rhesus disease (RhD): the injection helps to protect against sensitisation, which may happen if their blood is exposed to RhD positive blood and develops immunity against it. She has received the treatment in five out of her six previous pregnancies,

and appears to be either impatient to have the injection and go home, or very nervous. In contrast to the convivial atmosphere noted in the majority of consultations, Agnieszka appears humourless: she is reluctant to make eye contact with either the midwife or me, or to respond to the medic's gentle jokes. Nevertheless, the patient demonstrates a high degree of autonomy, asking questions about medication and rejecting the offer of the newly introduced whooping cough vaccine. Interestingly, it is only after MW2 has administered the injection in a sensitive and painless way (anecdotally, unlike her previous injections), that Agnieszka begins to thaw.

C6 - Gosha (Polish)

Patient (Go), Midwife (MW2), Doctor (D1)

Although this is Gosha's third pregnancy, she has only received the anti-D injection once before and admits to being very nervous: this anxiety is also amplified by her fear of needles. Consequently, she makes several attempts to seek additional guarantees from MW2, who tries to reassure her by joking and sharing her exemplary track record. However, in an alarming turn of events, Gosha collapses on receipt of the medication. At this point, MW2 seems as shocked as I am and, while she administers adrenalin, hurriedly asks me to go and find help – a request which seems to exemplify the notion of the observer as part of the action. Having helped to stabilise the patient, and following MW2's extensive strategies of repair, colleagues then work with the patient to establish a diagnosis of 'panic attack'.

This consultation highlights a number of issues pertinent to my research, in that, in a time of distress, Gosha expresses her frustration at not being able to describe her symptoms and emotions in Polish. At the same time, her collapse also highlights the ethical considerations of including such a potentially sensitive incident, as part of the data set. To re-establish initial consent, permission was sought several times and advice on its inclusion was sought from senior colleagues at the IOE.

C7 - Olga (Polish)

Patient (O), Midwife (MW2)

I join this appointment, after MW2 has introduced herself and confirmed that the patient is willing to take part in the research. As soon as I walk in, I recognise Olga as a student from the college where I teach and we chat quietly while MW2 prepares the medication: indeed, Olga's anti-D appointment appears to be routine. Similar to the other sessions at the clinic, both she and MW2 are observed to employ extensive face-saving strategies, such as laughter, before and after the injection, in an apparent attempt to alleviate the imposition of the treatment.

C8 - Alicia (Portuguese)

Patient (AL), Midwife (MW3)

MW3, a midwife originally from Italy, calls me into this appointment, after it has become evident that his patient has very limited understanding of English. Although I have missed the processes of negotiation that have established Spanish as a lingua franca, it is very interesting to observe MW3's explanations of the treatment: drawing heavily on his broad repertoire, the midwife uses a combination of language and semiotics to communicate. In contrast with all the other observed instances in this clinic (for Rhesus disease), this interaction takes place with very little humour, even prior to the injection itself. Nevertheless, the implicit conviviality of the consultation is evident from the superdiverse stance that the participants take.

In a short interview with MW3 later in the day, he admits that while such extensive translation is rare, he has previously drawn upon his repertoire to

communicate with patients: "I have used Spanish a few times … Italian just probably a couple of times with some Albanian patients …. a couple of times I had a chance to use Italian because many people foreign people ….and with Portuguese [people] I use Spanish because strangely I understand 99% of what Portuguese people say."

C9 - Sharon (English) **

Patient (S), Midwife (MW3)

Sharon has experienced the anti-D injection in seven out of her previous eight pregnancies, so it is possibly unsurprising that she remains fairly sanguine about the process. This consultation was interesting, primarily because of the efforts of the English-speaking patient to engage MW3 in a humorous exchange. When asked whether she is okay with needles, she responds "nope, but y'know …been there done that ha ha ha gotta be okay now", and it is the patient who seeks to reassure the (much younger) midwife, "I won't pass out on you don't worry ha ha."

Booking-in Appointments

C10 - Hafiza (Bengali) **

Patient (H), Husband (Hs), Midwife (MW1), Interpreter (I2)

Hafiza is a young Master's student from India, who is attending this booking-in appointment with her husband. As the couple appear to speak fluent English, MW1 expresses her annoyance that they are also accompanied by an interpreter. It transpires that the patient made a mistake in indicating that she would need assistance, despite her husband's assertion that "she understand very well English". The consultation makes an ill-humoured start, as MW1 vacillates between urging the couple to send the interpreter home and begrudgingly agreeing that they may they need assistance for 'medical stuff'. In the end, the interpreter remains and goes on to help the couple with

technical language: the conviviality which becomes so apparent in other bookings, gradually begins to emerge.

C11 - Karla (Polish)

Patient (K), Boyfriend (Bf), Midwife (MW1)

I first meet Karla in the waiting room, where she and her partner are discussing the information required for the first page of 'Pregnancy Notes': when I approach them for permission to observe the consultation, they are happy to oblige. As the booking-in interview covers extensive history-taking and copious amounts of information-giving, it offers the potential to reveal much about an individual's communicative repertoire. It also reflects the extent to which a they feel, institutionally and personally, comfortable to take advantage of the liminality and conviviality which appear to be characteristic of this superdiverse space. While Karla is a very competent speaker of English, she both asks questions and uses her boyfriend to double-check understanding. MW1 is also keen to share knowledge with her patient, and provides (long and overly) technical explanations, which contain so much information that Karla often seems over-whelmed. On these occasions, the expectant mother changes footing to consolidate a 'we' identity with her partner.

C12 - Melina (Portugal)

Patient (M), Interpreter (I3), Midwife (MW1), friend (George)

In this extraordinary booking-in session, I observe Melina, a patient who speaks little English, and MW1, as they navigate the complexities of 'Pregnancy Notes'. They are assisted by Melina's friend, George, a talkative and (very) informal character, who appears to flirt with the midwife (approximately 20 years his senior) throughout the session. An LL interpreter (I3) is also present for half of the consultation, before leaving early for another appointment: at times, I3's understanding of health information seems to somewhat lacking, meaning that explanations receive a

considerable amount of multi-authored co-construction. Thus, even before having the transcripts translated, there is clear evidence of breakdowns in communication. Nevertheless, this consultation can be seen to embody notions of conviviality, as George consistently tries to divert the midwife from her epistemic and institutional goals through humour, small talk and the invocation of 'backstage' footings.

C13 - Ajola (Albanian) / High risk pregnancy

Patient (AJ), Interpreter (I4), Consultant (CT2)

Ajola's migration trajectory is both complex and tragic. Having lost her previous baby as a result of domestic violence, she fled Albanian to find hope with a new partner who promised her refuge and fresh start in Austria. However, when it later transpired that the man was a people trafficker, and Ajola was forced into prostitution, the young woman fled to the UK to claim asylum. Now living in an initial accommodation centre for refugees, Ajola is 36 weeks pregnant. She is anxious that she may experience another stillbirth: this consultation is designed to identify the cause of previous problem and to ensure that all steps are taken to prevent recurrence.

The patient is accompanied by a professional interpreter (I4) who works very regularly with Albanian victims of trafficking. I4 appears to be focussed on sustaining Ajola's self-esteem, and distracting her from the inherent anxieties of the appointment, by trying to disrupt the authority of the attending medical professionals.

Ajola's consultant is a middle-aged Greek man, who conducts the appointment with the air of gravity one would expect in such circumstances: he talks to his patient very gently, and only refers obliquely to her circumstances. Although he appears reluctant to do so, he eventually responds to the interpreter's teasing.

**These case studies are included to give a broad overview of the participant population: however, as the observations comprise the pilot study fieldwork, extracts are not used during the data chapters.

5.6.3.2. Consent: medical professionals and interpreters

Whilst acknowledging that the information gained in consultations could be used to inform future practice, steps were taken to facilitate participant understanding and confidentiality. The process was outlined and explained for practitioners via face-to-face meetings, personal communication, managerial input and team meetings, so that any concerns could be addressed and fears allayed.

My primary informants were midwives, doctors and health care assistants, to whom I gave information and consent sheets, outlining the objectives of research, with a clear outline of how it would be conducted and emphasising their right to withdraw at any time. However, the role of researcher/informant was often ambiguous, as some midwives were intricately involved in the identification and recruitment of other participants. On one hand, this could have potentially compromised their comfort at being able to withdraw, on the other it positioned them as co-researchers, and helped to establish a relationship of reciprocity (Sarangi & Roberts, 1999).

Bespoke information and consent sheets were also created for interpreters, who, like the midwives, were also able to retain a copy for their records (see Appendices E4 & E5). As before, all participants were informed that they had the right to refuse to take part in the research, as well as to withdraw consent at any time during the process.

5.6.3.3 Confidentiality and data protection

All participants were advised of their right to decline or withdraw at any time. BAAL, AcSS, NHS and BERA guidelines state that all research is underpinned

by respect for the participant, equality and knowledge. Whilst it was prudent to recognise that it could be difficult to recruit patients, the process of informed consent is vital and researchers must demonstrate a responsible approach. As I was privy to very personal information, it was important to fully inform women on how their information would be kept secure, and their privacy maintained at all time. Central tenets of ethical guidelines are also to ensure confidentiality is maintained (if and when necessary), in order to protect vulnerable participants. To ensure these principles, transcripts were anonymised, and kept in a locked cupboard at my home. Electronic copies were stored on an encrypted memory stick and on a secure IOE database. A key containing participants' pseudonyms was also kept separately from both the data, in order to ensure anonymity.

5.6.4. Dissemination of research findings

Working as a doctoral researcher, with no funding or corporate incentives, I was able to design research in a way that enabled me to respond to specific questions, with as little impact on participants as possible and with academic freedom regarding publication. Permission to conduct research was not contingent on publication or dissemination in a way that would profit me, as an individual, or the institution.

As a means of demonstrating my gratitude to HUH staff, for giving me the benefit of their time and experience, I will submit findings to the Head of Midwifery. Copies of the findings will also be given to other informants working in the borough.

5.6.5. Reflections and limitations

In the spirit of reflexivity which characterises ethnographic research, I now consider several limitations to my study (Cicourel, 2007; Geertz, 1973). I first acknowledge that the observer is not without baggage, but can only view their subject matter through an intersectional lens coloured by features such as

gender, ethnicity, or experience. Therefore, there may be unintended elements of observational bias created by my research questions, consolidated by my data selection or shaped by my habitus. For example, the fact that I am a white, middle-class, educated woman, who grew up, worked and lived in Hayfield, may influence the way in which I view and interpret my data, the selection of which will undoubtedly be further informed by my extensive experience as an English language teacher.

In addition, as Cicourel (1999) notes, what one chooses to include or exclude can distort participant reality or the ways in which people are represented. Although rigorous reflexivity may go some way to mitigating subjectivity, ethnographers must thus recognise the raft of ethical considerations posed by selective sampling (Cicourel, 1999; Geertz, 1973), and the implications of inclusion or exclusion. In exemplification of this concern, key examples spring to mind: first, the misunderstandings which so characterise Melina's consultation (see extracts 43, 44, for example), are so extreme, that I was unsure whether inclusion could compromise the professional representation of the midwife and/or interpreter; second, as a victim of human trafficking, Ajola's personal circumstances are so distressing (see extract 35), that I was anxious not to contribute further to her exploitation by appearing to commodify her tragedy for academic consumption. Following these apprehensions, I sought advice from both my supervisor and academic ethicists based at the IOE, who counselled inclusion of data, but with focussed attention on rigorous pseudonymisation and selectivity of material (see 5.4.2). By excluding sections of the consultations which could either identify or compromise participants, I then felt able to include aspects which could contribute to sociolinguistic discussion on superdiverse language use in medical settings, but without jeopardising my ethical obligations. Following Becker et al (1991), I note that

(o)ur purpose is not criticism, but observation and analysis. When we report what we have learned, it is important that we do so faithfully. We have a double duty – to our own profession of social observation and analysis and to those who have allowed us to observe their conduct. We do not report everything we observe, for to do so would violate confidences and otherwise do harm. (Becker et al, 1961: 15 in Sarangi, 2019: 111)

An observer's integral presence as part of the data must also be recognised, as must the potential effects. As "a foreign body which causes ripples on the surface of smooth routinised processes" (Blommaert and Dong, 2010: 27), I acknowledge that my presence, and the way my habitus may be perceived by others, will have not only affected interactions in consultations, but may have drawn attention to specific aspects of communication that participants had not previously considered, thus altering their behaviour (Cicourel, 1999; Labov, 1972; see 6.3.1). On this understanding, augmenting observations with fieldnotes aided personal reflections on day-to-day interaction, and the potential effects of my presence (Hymes, 1977). The additional advantage of interviews also offered me the chance to dispel potential misconceptions about research foci, and enabled participants to feel comfortable contributing opinion on the topic of language and (see for example, 6.3.1) and intercultural communication (see Appendix E). Similarly, while the scope of this study did not offer the opportunity to involve participants as co-investigators, I recognise that in observing consultations and interviewing medical professionals, I nevertheless acquired additional knowledge of antenatal care and processes, which enabled me to make sense of the data captured (see 8.2 and 8.4 for limitations and future recommendations).

5.7 Conclusion

This chapter documents my approach to capturing the superdiverse nature of contemporary healthcare in a London suburb, and the emergent communicative practices therein. Building on robust contextualisation (see

Chapter 2), and established literature from the interlinked fields of language and health (see Chapters 3 & 4), I begin by revisiting the questions which underpin this study, and explaining the ways in which they have influenced research design (see 5.2). Next I chronicle the development of linguistic ethnography and explore the ways in which my chosen method lends itself to the research project in hand (see 5.3). This is followed by a description of how participants were identified and recruited, and how the observation process unfolded (see 5.4), noting that while a linguistic ethnographic lens can only be said to offer a glimpse of lived reality, the associated toolbox can equally generate rich and ample data. In order to analyse findings, I employ several layers of analysis, the conventions of which are outlined in 5.5: beginning with conversational analysis (CA) to first detail the minutiae of interaction between participants, I then use methods from interactional sociolinguistics to inform links to wider institutional and societal contexts (see 5.5). The chapter draws to a close with reflections on the ethical considerations which underpin this research (see 5.6).

Organised in such a way as to roughly correspond to individual research questions, the following two chapters present and analyse data from observations and interviews at Hayfield University Hospital. In the first of these, Chapter 6 introduces the contemporary communicative environment, which appears to offer space for the conviviality and linguistic flexibility, said to be central to the superdiverse experience (Wessendorf, 2014). Investigating further, Chapter 7 scrutinises the negotiatory processes which are apparent to navigating epistemic and linguistic divides, and problematises the implications these may hold for comprehension, and by extension, equal access to health.

Chapter 6 – Data Analysis: language and communication in the consulting room

6.1 Introduction

In this first analysis chapter I shall present data to address my first research questions regarding how midwives, patients, and occasional interpreters, communicate in a contemporary, urban healthcare environment. Data reveals how their methods of communication share many of the key features previously observed in other informal and semi-formal superdiverse settings such as the linguistic creativity and flexibility seen in the Bullring market in Birmingham (Blackledge, Creese & Hu, 2017); the languaging spaces of a multicultural shopping district in Belgium (Blommaert, 2014); and the sociocultural awareness seen in an advice centre, serving diverse communities (Baynham et al., 2015). While individual repertoires, or idiolects, index diverse biographies and migration trajectories, (Canagarajah, 2013; Blommaert, 2012a), a willingness to employ a range of linguistic and multimodal resources, to ensure mutual understanding, is reflected in many of the health encounters: linguistic, cultural and ethnic differences, although noted, tend to be marginalised, as participants work together to bridge potential obstacles. In effect, differences appear to take a back seat to the practical goals of achieving positive health outcomes for mother and child.

I shall first demonstrate how conviviality (see 3.3.2), which underpins much of the research on superdiverse communities (e.g. Blommaert, 2012b; Wessendorf, 2014), is an integral thread weaving through the 'guided doings' (Goffman, 1986:.22) of the observed patient/medical professional consultations. Within this feature, I explore the use of small talk (Hudak & Maynard, 2011; Holmes, 2014) as well as humour and laughter (Haakana, 2002; West, 1984), to examine how these resources are used to facilitate smooth and stress-free consultations. Returning to the salience of language in a superdiverse context, I then explore how the consulting room, despite its

formality, appears to offer a translanguaging (Li, 2018), or third space (Bhabha, 1994), allowing linguistic creativity and flexibility to flourish (Canagarajah, 2013), especially for individuals in possession of, what has been referred to as, a translanguaging instinct (Li, 2018).

6.2 Conviviality

As earlier discussions (see Chapter 3.3.2) have illustrated, conviviality is "lodged not in spectacular features and interventions, but in the generosity of small stuff of everyday contact" (Blommaert, 2014: 444). Characterised by "a relationship of mutual dependency" (Blommaert, 2014: 448), conviviality acts as a form of social glue, underpinning cooperation and effective communication. A 'civility towards diversity' (Wessendorf, 2013: 7), which is fuelled by acts of creativity and imagination (Gilroy, 2006a), conviviality enables inhabitants of superdiverse communities to operate harmoniously, despite difference. In a micro reflection of the local population, a commitment to conviviality appears to extend into the consulting room, as patients and medical professionals at HUH work towards achieving positive outcomes for mother and child. As booking-in interviews are typically the longest consultations a woman will experience during a healthy pregnancy, midwives help them to navigate the institutional aspects of pregnancy and give participants the opportunity to strike up a more personal rapport than may be afforded in the standard, ten minute consultation. 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.

Yet, although medical appointments can be seen as 'collective socialised activities' (Goffman, 1986:) they are also loosely inhibited by conventionalised boundaries that bracket events, for example, in a broad sense, both sitting in the waiting room, prior to an appointment, or returning to reception desk afterwards, in order to book a subsequent meeting, constitute the bracketing of a consultation. In a more narrow sense, although frames (see 5.5.2.2) are

subject to changes, across time and cultures (Goffman, 1986), the routine use of small talk to bracket appointments appears to be embedded in the medical consultation framework, frequently occurring at the beginning, end or even in the middle of an interview, interspersing more formalised medical talk (see for example, Maynard & Hudak, 2008). Despite ostensibly appearing "minor, informal, unimportant and non-serious" (Coupland, 2014:1), it is evident from the observed consultations that attention to small talk, "oils the social wheels" (Holmes, 2014) of an encounter. The complexity of sustaining conviviality across potential language, cultural, epistemic and institutional divides, also requires extensive facework (Goffman, 1972; see 5.5.2.1), especially on the occasions where participants may lack the shared 'sign-vehicles'(Goffman, 1971), used to facilitate understanding, i.e. "the cues which select for a person the status that is to be imputed to him and the way in which others are to treat him" (Goffman, 1951: 294). The following sections (6.2.1, 6.2.2) illustrate the wide variety of strategies used to diffuse potential or actual face-threatening acts and to ensure a congenial atmosphere.

6.2.1 Small talk

6.2.1.1 Introductions

The ensuing extract from a booking-in interview (C11), exemplifies the use of small talk in establishing a convivial atmosphere: MW1 welcomes her patient, Karla, and her boyfriend, to the booking-in appointment, introducing herself and beginning with an explanation of midwife provision at the hospital. Prior to this, the couple have been sitting in the antenatal waiting room, completing forms requesting personal information.

K= Karla; MW1= Midwife 1;

3   MW1: >right my name is _____ one of the midwives here I do the booking some of the

4   bookings on a Friday (.) I will book-take your information give you your book and then

5   you go back to your respective teams and I'll tell you what team you're under depends

6   on where you live< (7) ∘one one sixty nine∘
((clicks biro on and off whilst reading the semi-completed notes))

7   (23) first of all I apologise I do speak fast if I'm speaking too fast stop me ask

8   me and I'll repeat what I said

9   K: (1) okay h it's what I try to want to ask you about

10   MW1: wha'sat ↑

11   K: because I don't know when you're talking is too fast=

12   MW1 =I speak fast↑(.)Yeah and >(   ) £And you was afraid to tell

13   me ↑£< nah tell me man //(   )

14   K: //I don't want to be rude=

15   MW1: =£ SPEAK TO ME I'M NOT A BEAST (.3)£> NO NO NO< I KNOW I

16   DO SPEAK FAST (1) no tell me you can tell me (2)

Extract 1, C11

A typical medical consultation can be seen to consist of a number of frames, which are "built up in accordance with principles of organisations which govern events" (Goffman, 1986:10) and are characterised by certain communicative and institutional conventions to which participants traditionally adhere. Deviations from expected patterns can threaten successful communication and the speed of MW1's delivery, which we will see is integral to her idiosyncratic speech, causes Karla's initial, smiling expression to change to one of confusion. Attentive to her patient, MW1 makes a pre-emptive move,

apologising for her rapid speech and, stepping briefly out of role, to use a more informal idiolect, "and you was afraid to tell me↑ Nah, tell me man" (L 13). As it has become evident that the activity "is itself fragile or vulnerable in regard to definition and likely to produce framework tension" (Goffman, 1986), both participants are eager to redress the threat to conviviality. Although MW1 apologises for her habit of speaking fast, it is the change in volume and tone, accompanied by a smiling voice (Jefferson, 2004), which consolidate the apology. The acceptance demonstrates the implicative power of prosody (Gumperz, 1982). Following Goffman's note that "if a person is to employ his repertoire of face-saving practices, obviously he must first become aware of the interpretation that others may have placed upon his acts" (1986: 13), Karla is keen to deny any intent to reproach MW1, stating "I don't want to be rude' (L14). In turn, the midwife shifts her tone once again, asserting her openness and humorously emphasizing her humanity, "SPEAK TO ME I'M NOT A BEAST". While MW1's apology in the first stage of the interview could also be interpreted as an attempt to address her failure to bracket the medical consultation with mundane pleasantries, the protracted display of apology-acknowledgement shown by participants, with repair to face complete, indicates that they are now ready to approach 'medical talk' (Maynard and Hudak, 2008).

6.2.1.2. The medial and closing phases

In superficial analysis, small talk may initially appear superfluous to the task in hand, a peripheral aside, but as Hudak and Maynard (2011) insist, it is not always possible to divide talk into on and off-task, so interwoven is the technique into everyday communication. In her analysis of work-based communication, Zhu notes that small talk can occur "in the middle of task-oriented talk, sometimes triggered by a topic in the talk. The shift towards small talk and back to task-oriented talk is often managed smoothly among the participants involved" (2014: 31). This claim is also substantiated by Linell and Bredmar (1996), who find that while certain parts of the routine booking-in interview yield different registers of formality, with the taking of medical history

requiring the most formal approach and the least room for conviviality, some stages, such as dietary and lifestyle advice, lend themselves to a more informal, 'chatty' stance.

In extract 2, (C12), MW1 is conducting a booking-in interview with a Portuguese patient, Melina, and her friend George, who is acting as an informal translator in this section of the consultation.

M= Melina; G= George; MW1= Midwife 1

754   MW1: none of those things (.5) however you can eat nice fresh fruits and

755   vegetables but you remember to follow basic food hygiene

756   G: *já viste↑ Tens de comer*   *Did you see ↑You have to eat*
      ve:tetais… fru:ta hhhh   *ve:getables...fru: it hhhh*

757   MW1: yeah↑   (2) yeah ↑

Extract 2, C12

Following the medical advice to eat lots of fruit and vegetables, a recommendation which George appears to translate rather facetiously, possibly in response to the threat to his friend's positive face (Brown & Levinson, 1987), MW1 is prompted to initiate a change in the conversation. Although the midwife admits to not understanding Portuguese, she nevertheless appears to interpret the exaggerated vowels and gentle laughter accompanying George's translation as subversive, and is keen to re-establish common ground.

M= Melina; G= George; MW1= Midwife 1

790   G*: leite=(   )*   *milk=*

791   MW1: =look at her face (.) Just the milk you don't like milk ↑

792   G: no it's only coffee (1) coffee coffee

793   MW1: yeah I know South Americans drink a lot of e:rm a lot of coffee you

lo:ve your coffee (1)

94   M: yeah

795   MW1: yeah you do you love your coffee (1) quite a lot I know that (1)

796   M: hhhhh

797   MW1: that I know of you guys you like your coffee (1) the whole of you

798   Chile Argentina the whole lot of them (   ) they love coffee

799   M: hhh

780   MW1: yes (1) they even drink coffee all day (2) oh yes

781   G: me (1) 10 10 coffees a day

782   MW1: mm coffees yeah I know I know the groups the groups they love

783   coffee cos you see they're coffee growers (1) so its they're historically

784   M: mmmm

785   MW1: they're coffee growers so along that region here yeah ↑(.) coffee
        grower producers

786   so you know that they e:r Columbia:ns, Chilea:ns, Argentinia:ns they all
        love it =

787   M: =mM=

788   MW1: because of the historical you know there's whole lots you know that
        they like

789   their coffee(1) right we're digressing lets go on now she can she can she's

790   entitled to free prescription for medication also dental care (3)

Extract 3, C12

By initiating a conversation about coffee, MW1 breaks frame, paying attention to the patient's face needs in a display of "cultural skills that facilitate

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communication and interaction with others" (Wessendorf, 2015). The midwife's appreciation of South American culture and food (L 793-806), is appears to be accepted by Melina as a commitment to cosmopolitanism (see 3.3.1), although apparently not to the extent that satisfies MW1's face needs. While MW1 attempts to solicit further alignment, Melina responds with embarrassed laugh tokens (L796, 799) (Jefferson, 1979), as the ensuing stereotyping of Latin American traits appears to overlook the fact that Melina grew up in Portugal. In shared unease at the error, George tries to change the focus of this face-threatening exchange, by interjecting with information about his own excessive coffee consumption (L781), but, so focused on the task of repair is the midwife, that she misses the opportunity to recommend a reduction in caffeine intake, sacrificing a potential change in focus, for rapport-building. In line 786, by elongating the pronunciation of nationalities "Columbia:ns, Chilea:ns, Argentinia:ns", MW1 emphasises her geographical knowledge and cultural awareness, to actively promote her positive face (Brown and Levinson, 1987). However, at this point, Melina's limited response instigates a return to role, and the task in hand. Similar to Wessendorf's observation on the use of cultural stereotyping in a superdiverse London suburb (2015), where participants drew on positive categorisations as a way of bridging a linguistic divide, MW1 seeks to display her cosmopolitanism to redress the perceived imbalance sensed earlier in the conversation, and employs her sense of humour to ensure a distinctively positive, or "prosocial" encounter (Hudak & Maynard, 2011).

Whilst moving from phatic to work-oriented talk, can require hard work (Roberts et al., 2005), Holmes conceptualises changes in alignment, or what Goffman names 'footing' (1981) (see 5.5.2.2), as part of a negotiated continuum of everyday necessity to facilitate conviviality. The contribution of small talk to the "blurring and reconciling" of "transactional goals" (Zhu, 2014: 31) is often accompanied by humour, helping to create a "collegiality" (Holmes, 2014:28) of experience, and acting as a "supportive interchange" (Goffman, 1971: 62-63). Small talk is also used at transition points, to bracket activities or to mark the close of a phase (Maynard & Hudak, 2008), and is often initiated by the medical professional as a means of indicating a change in footing

(Heath, 1986). In an earlier example from consultation 12, there is an extended sequence, in the middle of the booking-in session, where the interpreter moves behind the midwife's desk to have her time-sheet signed, before she leaves for another scheduled appointment. In crossing this physical and metaphorical barrier, both medical professional and interpreter move from the 'frontstage' of the consultation, which can be interpreted as their 'professional' face, to their 'backstage' selves (Goffman, 1971, see 5.5.2.2): MW2 thanks the interpreter effusively for her help, "thank you thank you thank you" (L 488), which prompts the highly informal response "love you see you later".

I3= Interpreter 3; G= George; MW1= Midwife 1; R= researcher

488   MW1: =thank you thank you thank you=

489   I3: =love you see you later ((kiss sound))

490   MW1: alrighty=

491   G: =bye=

492   R:=bye

493   ((door closes))

494   MW1: (2) date of birth↑

Extract 4, C12

In an accompanying multimodal move of extreme conviviality the interpreter blows a kiss to the participants, as she picks up the child's scooter with which she arrived, and literally scoots out of the consulting room. Bidding her goodbye, none of the participants' comments on the interpreter's behaviour, and the consultation continues as normal, in an apparent confirmation of Wessendorf's (2014) remark that everyday conviviality is so embedded in a superdiverse environment, that its routineness no longer raises eyebrows. However, this atypical example of closure contrasts strongly with a more characteristic example of a "terminal exchange" (Schegloff and Sacks, 2009), which involves "the participants breaking each other's presence so that they are no longer interactionally or physically available" (Heath, 1986: 129).

I5= Interpreter 5; O1= Obstetrician 1

367   O1: You'll also then book this scan (.) and then we'll also see you after this

368   scan this is the one at 34 weeks (1) okay↑

369   I5: ***Depois tabém marca o… a***   *Then also book a scan at 34 weeks*
      ecografia para as 34 semanas e   *and then we will see you after the*
      depois nós vamos vê-la depois da   *scan (.)* okay↑
      ecografia↑ okay↑

370   O1: okay↑ here you go (.) nice to meet you then (.) bye bye

371   I5: bye bye   *Extract 5, C1*

Here a series of orderly utterances which are designed to end the conversation (Heath, 1986; Schegloff and Sacks, 2009), are initiated by the obstetrician: after giving her patient guidance on what she needs to do next, the medic checks understanding with the use of the question tag, "okay↑" (line 367). Interestingly, although the information is echoed in the interpreter's reformulation (line 369), the obstetrician's concluding remarks are not translated. This omission is open to interpretation, with the apparent assertion of self (interpreter) potentially increasing the 'dyadic separation' (Baraldi, 2009) between doctor and patient, while simultaneously establishing the interpreter's dyadic affiliation (Moyer, 2013). Alternatively, the absence of translation may reflect the interpreter's assumption that the patient will recognise the pauses that intersperse the closing comments as a universal method of conclusion.

6.2.2 Humour and laughter

While small talk has the potential to smooth and mitigate linguistic and cultural difference (Wessendorf, 2015), laughter often plays an important accompanying role in medical settings, as it is used to disattend from the potential threats to face, often prompted by the sharing of personal information and bodily contact (Hudak and Maynard, 2008) (see 3.3.2.2.). Although currently under-examined in superdiverse settings, the following excerpts from

some of the encounters observed in this research, appear to reflect established scholarship where laughter or humour is used to disattend from dispreferred situations (Maynard & Hudak, 2008), as a device of alignment (Maynard & Hudak, 2008); and as a method of recovering from a face threatening act (Goffman, 1986).

6.2.2.1 Humour to disattend a complaint

Returning to C11, where the booking-in session is nearing the end, Karla's medical history has been recorded and lifestyle recommendations given. MW1 has just taken weight and height measurements and is putting the information onto the computer database. However, the patient is unsure of the accuracy of the height measurement, and, after a long pause, decides to query the numbers:

K= Karla; Bf= Boyfriend; MW1= Midwife 1

688   K: (5) I have 2 centimetres less

689   MW1: 168.5 maybe you measure when you have your shoes on ↑

690   K: no: ↑=

691   MW1: = no no before

692   K: no: ↑

693   MW1: your body's shrinking //in the UK↑

694   K: I know   //from school //I am 17

695   MW1:   //(   ) £your body
       shrink £

696   well I (.) I put what I saw (.) er (.) er (2) //on the a (3) thingy

       ((midwife is simultaneously writing up notes))

697   K: //I know

698   MW1: £you must be shrinking you never know (1) huh↑£

699   K: (.) huh (.) Sorry↑

700   MW1: your body shrinking↑

701   K: (   ) sorry I don't understand

702   MW1: you're getting smaller (.) you're getting shorter

703   K: £ ah yeh maybe maybe (.) £ my mum is like that ((indicates tiny person))
      (   )

704   MW1: £ really↑// (2) serious ↑£

705   K: //yes she is

706   MW1: (1) your dads tall↑

707   K: yeah he was tall//(.) he was tall

708   MW1:   //okay so (2) excellent BMI ((checking form))

709   K: (.) £mum was a small little ball£

710   MW1: (.) mumm↑

711   K: hhhhh (3) Why are you laughing like that↑((to boyfriend)) Why are you

712   laughing↑ I know I feel it, I know I'm blushing hhh

713   BF: (   )

714   K: ◦hhh◦

Extract 6, C11

Initially MW1 responds distractedly to Karla's query, using smiling as a backchannelling device and employing humorous small talk to "disattend" (Maynard and Hudak, 2008: 673) the patient's concerns. In an attempt to redress the possible face threatening effects of the exchange, MW1 then initiates a joke about Karla having shrunk, which she has to repeat four times (line 693, 695, 698, 700), before realising, upon prompt, that Karla has not understood at a locutionary level. While previous research on intercultural medical consultations (Roberts et al., 2005) identifies lexical confusion as a

common cause of misunderstanding, it has also shown that the ability to reformulate is key to ameliorating any potential damage to face (Baraldi & Luppi, 2015). By rearticulating the joke, MW1 offers Karla the opportunity to respond, alleviating the social stress of her embarrassment. MW1 also facilitates further repair, by backchanneling a series of questions, "£really↑// (2) serious ↑£; your dads tall↑" (lines 704, 706). Karla is encouraged by her midwife's jocularity and, missing the change in footing "okay so (2) excellent BMI", continues to joke about her mother's size (L709). As MW1 disattends her patient to update medical notes, the utterance "mhmm" (L710) demonstrates the midwife's tact as she pretends not to recognise Karla's misreading of the situation, or lack of composure (Goffman, 1972: 102). Nevertheless, Karla's loss of face has triggered her boyfriend's quiet laughter. As this has the potential to further her embarrassment, Karla changes footing to engage in subordinate communication or 'byplay' (Goffman, 1981: 134). The distraction technique allows her to address her boyfriend's reaction, "why are you laughing like that ↑ why are you laughing↑" (L711-714), before quietly acknowledging her embarrassment and offering an apologetic laugh token (L714).

In the above example, MW1 uses humour to divert attention from an unanticipated threat to her patient's face, i.e. as Karla's English is so proficient, MW1 expects her to understand the joke proffered about her height measurement. However, there are occasions in medical practice where professionals can predict a face-threatening act (FTA), and so use measures to ameliorate difficulties before they present themselves. Physical examinations, talk of personal behaviours and medical interventions all impose upon the patients' face needs (Linell and Bredmar, 1996; Brown and Levinson, 1987) and may require sensitive facework to reduce the threat to both participants. In the following section, I note that as "a marker of trouble… laughter triggers topical talk" (Fatigante & Orletti, 2016: 181), but also helps to minimise potential conflict.

6.2.2.2 Laughter to disattend a FTA

During pregnancy, women are offered a number of routine screening appointments which identify any potential areas for concern. Following an ultrasound test, some babies are identified as having Rhesus disease (RhD), a condition which may require treatment when the child is born. As a result, a routine anti-D injection is offered to pregnant women who have been identified as having RhD negative blood which differs from the RhD positive blood of their unborn child. It helps to protect them against sensitisation, which may happen if their blood is exposed to RhD positive blood and develops immunity against it. This fairly common condition requires an injection in the third trimester (and possibly after delivery, case dependent). As the thick needle necessary for administration is known to cause women considerable discomfort, midwives may anticipate that patients may express fear or unhappiness at receiving the treatment. In the following extracts, three out of the four patients have previously experienced the uncomfortable anti-D intervention and are evidently apprehensive. As such, the midwife is seen to go to

> certain lengths to save the feelings and the face of others present…. willingly and spontaneously because of emotional identification with the others and with their feelings. [The midwife is] …disinclined to witness the defacement of others."
> (Goffman, 1972: 10)

Nevertheless, while midwives seek to minimise potential threats to face and diffuse tensions, they also have an ethical and legal imperative to communicate medical information effectively and efficiently, as well to alert their patients to the possibility of side effects (NHS, n.d): this balancing act gives rise to nuanced relational work (Locher and Watts, 2005).

In Extract 7, MW2 double-checks her patient's understanding before requesting permission to give her the injection. In response, and in keeping

with Haakana's observation (2001) that patients offer laughter more frequently than medics, Olga laughs in anticipation of the potentially painful treatment.

O= Olga; MW2= Midwife 2

30   MW2: so you understand that↑

31   O: yes, yes I understand

32   MW2: still want an injection then↑

33   O: ∘hhh∘ yeah

Extract 7, C7

However, while the verbal exchange of request/acceptance ostensibly indicates an adherence to norms of politeness, the consensual presence of both participants at the specialised clinic already implies a premeditated intent to proceed. Thus, the relational work may be seen to function more as politic behaviour in the face of an impending intervention, rather than an episode which invokes spontaneous face-saving strategies (Locher & Watts, 2005; see 5.5.2.3): here, the proffered laugh (L33) demonstrates the patient's wry recognition of inevitability. Continuing to administer the anti-D injection in a gentle and considerate manner, MW2's smiles appear to indicate the routine nature of the process. When Olga queries whether she has to remain behind after the procedure, a protocol which is only necessary for first-time patients, MW2 also demonstrates a sensitive awareness of the threat to Olga's negative face (i.e. the right to go unimpeded) that could be posed by such an inconvenience.

O= Olga; MW2= Midwife 2

65 O: (5) I don't need to wait here because the first time I have the injection (

66) It's been on the paper we have to wait //here (   )

67 MW2:   //£look at my smiling mouth hhhh £ (2) I don't

68 have to hhhh you don't have to wait hhhh   *Extract 8, C7*

Unusually, the midwife responds with a bald-on-record (Brown and Levinson, 1987), yet convivial, retort which emphatically underlines an alignment with Olga, as well as a disinclination to restrict her movements. The combined efforts of smiling and the direction to look at her face, "look at my smiling mouth hhhh" (line 67), further consolidate MW2's conciliatory laughter, offered in anticipation of an interaction which may impose on Olga's sense of self.

In contrast, the following encounter (C5) differs from the good humour of previous consultations: Agnieszka is expecting her 7th child, and has received an anti-D injection in all but one of her other pregnancies. Despite MW2's jovial demeanour and endeavours to sustain conviviality, Agnieszka seems to adopt an uncooperative stance, possibly reflecting (previous) experience or anxiety about the impending injection. Prior to this extract, she has resisted engagement in small talk, appearing to take a functional 'let's get it over with' approach. Questions about her preference for the injection site are dismissed, as Agnieszka appears to show "disalignment, through … practices associated with dispreferred response" (Maynard and Hudak, 2008:20), i.e. a series of minimal acknowledgements (L12, 14, 16). Following Locher and Watts' observation that "appropriateness [of behaviour] is determined by the frame or the habitus of the participants" (2005: 17), it becomes evident that MW3 interprets her patient's response(s) as marked. It appears that the two interactants are drawing on different notions of habitus, in that what Agnieszka perceives as socially appropriate responses to mundane questions, MW3 recognises as impolite (Locher & Watts, 2005). In anticipation of the mutual threat to face that she understands her patient's minimal responses to imply, the midwife uses contestive humour (Zhu, 2014) to joke that Agnieszka is "weird", nevertheless carefully interjecting her questions with laugh tokens (L13), in an attempt to mitigate offence.

AG= Agnieszka; MW2= Midwife 2

11   MW2: okay (1) so which arm are you (.) the right↑ =

12   AG:=it doesn't matter ↓

13   MW2: (1) you weird woman hh so which arm you normally use

14   AG: (1) ah I don't really remember

15   MW2: no, to eat

16   AG: oh (.) that one

17   MW2: your right arm (.5) so can I give it on the left

18   AG; no no it will be alright↓

Extract 9, C5

In lines 13 and 14, the rejection of an offered laugh, can be seen as a kind of interactional 'violation' and, when it is clear from Agnieszka's demeanour that she will not reciprocate the humour, MW2 retreats. Instead of pursuing conviviality, MW2 reverts to the institutional discourse of patient-centred care: by glossing Agnieszka's dismissive answers on her preferred injection site, MW2 clarifies her choice "your right arm (.5) so can I give it on the left" (L17). Following protocol, the midwife also asks the patient, somewhat paradoxically, if she is happy to have the injection:

AG= Agnieszka; MW2= Midwife 2

36   MW2: (   ) so are you happy to have this injection today↑

37   AG: no not //really but do I have a choice ↑ (.) no hh

38   MW2:   //hhhhhh (3) okay

Extract 10, C5

It is this incongruent question that, at last, brings a faint smile to Agnieszka's face: she jokes "do I have a choice↑" (L37) and offers a laugh token, perhaps in recognition of the affront to face her disattention has caused. In full commitment to conviviality, MW2 accepts the offer and moves to recover face through reciprocal laughter: the 'okay' which follows, acts as a discourse

marker for the change of footing, and a return to common ground of conviviality.

6.2.2.3 Laughter in adversity

As previous excerpts have shown, the role of laughter in healthcare can be multifaceted: the following exchanges, which document an unpredictable consultation, now illustrate the speed at which the strategy can fluctuate in terms of function, moving between alignment, mitigation and repair. In C6, a patient, Gosha, is nervous about having the anti-D injection, despite having received it once before. To placate her, MW2 proudly asserts her professional record of never having witnessed an adverse reaction, "so far I've been doing it for the last thirty years" (L 67). She then reassures the patient further by dismissing the potentially face threatening response of "it's fine", with a laugh.

Go= Gosha; MW2= Midwife 2

67   MW2: =so far I've been doing it for the last thirty years and //so far

68   Go: //yeah it's fine=

69   MW2: =don't you want to know (   ) ↑   hh//hh

70   Go: //I had last time so I think it's

71   safe if it would have it would happen last time

72   MW2: (.) so I'm happy to give it and I'm happy for you to go after you have it okay↑

73   ((sounds of wrapper coming off needle)) (2) are you happy to have it today↑

74   Go: (.) no because I hate the needles hhh//h

75   MW2:   //HH (.) but you're still going to have it

76   Go: yeah I know

77   MW2: for the baby h

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In declaring herself "happy to give" Gosha the injection, MW2's iterative use of "happy" (L72,73), reinforces positive face needs (Brown and Levinson, 1987), as she seeks to both comfort the patient and receive permission to impose upon her. In a humorous, bald-on-record denial of the request, Gosha expresses her fear of needles but mitigates her face-threatening refusal with an anxious laugh (L74). However, although MW2 accepts the invitation, her loud reciprocal laughter overlaps that of her patient's, and acts as a subtle affirmation of authority. The ensuing statements, "but you're still going to have it" "for the baby" (L77, 79), albeit delivered with a smile, reassert her position as a medical professional tasked with a medical intervention. The epistemic and institutional asymmetry, however convivially framed, is clear, and accepted in good humour by Gosha. However, medical interventions are not always predictable and, on receipt of the injection, and in spite of MW2's unblemished record, Gosha appears to have an allergic reaction to the treatment: she turns very pale and collapses on the hospital bed.

Go= Gosha; MW2= Midwife 2

99   Go:◦ I feel bit dizzy◦

100   MW2: (.) you feel dizzy↑ ((walks back to patient (3)) okay (3)

101   MW2: >((sounds of equipment being moved))< oh my god

102   ((patient now collapses backwards onto bed. MW2 quickly takes the

103   adrenaline and unwraps it, ready to administer))

104   MW2: (   ) first time (3) >((opens EpiPen very quickly))<

105   Go: oh::::::

106   MW2: okay >lie down lie down lie down for me just lie down< just go to
        the side

107   Go: a::::h::::::::::

108   MW2: >to the side to the side<

109   Go: o::h my go:d

In line with Brown and Levinson's suggestion that 'rational actors' only forego the mitigation of FTAs when urgency takes precedence over the hearer's face needs (1987:68), MW2 responds instantaneously and immediately administers emergency adrenalin, without asking permission. An alarm is raised and several other midwives working on the ward, rush to assist the patient and their colleague. The ensuing minutes are spent ensuring that Gosha is conscious and comfortable as her body recovers from the shock of the reaction: MW2 is attentive and repeatedly murmurs reassurance to her patient.

When an event occurs, "of the kind that is difficult to overlook", such as the collapse of a pregnant patient, then it is accredited as an 'incident', which requires ratification as a 'threat that deserves direct official attention" (Goffman, 1972: 19; see also 7.2). To re-establish equilibrium, or what Goffman calls a "satisfactory ritual state" (Goffman, 1972: 19), participants are compelled to repair the mutual loss to face. The event, which is later diagnosed as a panic attack, has shaken both patient and midwife: Gosha has lost bodily control and her sense of autonomy; MW2 has lost face by, albeit unintentionally, causing harm to her patient, and professionally, by damaging her unbroken record of successful drug administration. In the first, of what Goffman identifies as classic moves in redressing FTAs, the participants call attention to the event. When she recognises that her patient is having an adverse reaction, MW2 responds with a shocked, "oh my god" (L101), to call attention to the incident (Goffman, 1972). The phrase is also echoed by Gosha (L109), less as a surprised injection, and more as a cry for help. MW2's initial panic is reflected in her accelerated speech as she gives rapid instructions to

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her patient (L106, 108). However, although directives are commonly perceived as potentially face-threatening, as they give little opportunity for anything other than a direct response, MW2 still manages to mitigate possible offence by asking the patient to move a little, "just", as a favour, "for me" (L106).

In the second stage of repair, MW2 expresses regret at having used her professional reputation as a form of assurance, "I wish I didn't open my mouth" (L169) prefaced by a quiet laugh and followed by loud laughter, inviting the patient to disattend from the incident. This form of "self-castigation" (Goffman, 1972:19) is accepted by Gosha, who excuses the midwife from the imposition with a rueful smile: she had previously received the injection, with no adverse reaction and implies that MW2 has done nothing different from other midwives. In an attempt to retrieve a degree of professional pride, MW2 displays her knowledge "what did I say to you I said when I give this if you going to get anything, it happens within seconds" (L72-72), which Gosha accepts as a "satisfactory means of re-establishing the expressive order" (Goffman, 1972, 22), the third phase of repair.

Go= Gosha; MW2= Midwife 2

169   MW2: ((midwife is breathing heavily)) ∘hh∘ I wish I didn't open my mouth
        HHHHHH

170   Go: (.) £yes but last time£ the lady she told me exactly same I asked same

171   I had nothing like that

172   MW2: what did I say to you↑ I said when I give this if you going to get

173   anything (.)   //it happens within seconds

174   G: // yes I know I know

Extract 13, C6

Although neither Gosha nor her baby have been harmed by her reaction to the injection, Gosha is monitored in the consulting room for an hour. During this

time, both the patient and the midwife, reiterate and recycle the stages of facework repair, with MW2 "not allowing the matter to rest until [s]he has received a second or third acceptance of…[her]..repeated apology" (Goffman, 1972:22), albeit indirectly given. In the next extract, MW2 steps out of frame to align with her patient, demonstrating a personal commitment to being "other-attentive" (Hudak and Maynard, 2008: 678) and, in making eye contact with me, seeks to incorporate me in the collaboration.

Go= Gosha; MW2= Midwife 2; R= Researcher

251   Go: it start shaking //inside my body

252   MW2:   //I had the experience to this on Tuesday

253   R: really ↑

254   MW2: mhmm I was having a (   ) test (.) and so I understand exactly how
        you feel=

255   R: =yes

256   M: I had it a few days ago (.) ∘I thought that I was dying ∘ (1) ∘hhh ∘

257   Go: (   )

258   R: I can remember it when I was in labour with my first baby (.) having a

259   similar thing where you feel like you're // (.) you're

260   MW2:   // oh yes it's a bad feeling (1) I had to

261   have two lots of Adrenalin 300 milligrams each (.) before it=

262   R:=before it calmed down=

263   MW2: =before my blood pressure came (1) crashing=

264   Go: =ohh

265   MW2: hhhh (1) it's okay

266   Go: yeah I'm fine now I'm fine now

Extract 14, C6

Further to the discussion in 5.6.5, the concept of non-participant observer is problematic: a researcher's presence in a medical consultation, however unobtrusive, is likely to have some effect on participant behaviour and/or reactions. It is also clear from this consultation, that it is difficult for observers to remain detached, and to do so may cause "informants to infer indifference or even hostility on the part of the researcher" (LeCompte & Goetz, 1982: 46). Nevertheless, it is in a spontaneous reaction to the incident that I follow MW2's change of footing to that of a 'backstage' position (Goffman, 1981). The sharing of personal experience (L256), instigates an alignment with both participants and contributes to the mitigation of mutual damage to face. As is illustrated by the subsequent latching (L261-265), overlapping talk (L251/252; 259/260) and interrupted stories (L252, 259), it appears that all participants, consciously or sub-consciously, work hard to co-construct a dialogue of repair.

Significantly, extract 15 (below) demonstrates a reframing of the collapse and panic witnessed in earlier interaction (extract 12). Having ostensibly bonded through the sharing of adverse experiences, MW2 invites participants to commit to a triadic 'we' identity (Baraldi, 2009). All are thus manoeuvred in to a shared position where, "we don't think about ourself anymore" (L309) – therefore any threats to face are effectively flattened. The strategic use of small talk co-constructs a supportive "collegiality" (Holmes, 2014:28) and propels participants towards a reconciliation. In the 'terminal' move (Goffman, 1972) necessary to reconcile the incident, Gosha offers an elaborate display of forgiveness and gratitude, "thank you for saving my life hh" (line 31).

Go= Gosha; MW2= Midwife 2

307   MW2: (1) £what about you↑£hhh=

308   Go:= hh (   )

309   MW2: see now we are (   ) we don't think about ourself anymore hh//hh

310   Go:=   //hh yeah

311   MW2: (1) okay h

312   Go: why thank you for saving my life hh//hh

313   MW2:   hh//hh=

314   Go:= I'm feeling that seriously hhhhhhh

315   MW2: nothing here //(.) hhh no you're fine (.) don't worry (.) there's nothing

316   was going to happen to you (.)

317   Go: //yeah

318   MW2: hh (1) hhh sometimes you better not ask someone these questions=

319   Go: = hhhh=   Extract 15, C6

The role of laughter in this consultation also illustrates Schegloff's claim that "there seems to be a deep relationship between laughter and repair" (2000:219). MW2, the 'offender' (Goffman, 1972), offers laugh tokens (L307, 309, 311, 315), reciprocal laughter (L313) and mitigatory laughter (L318), to bolster the repairing strategies, which range from reassurance to alignment. Accompanied by frequent changes in footing, moving between 'front' and 'back' stage (Goffman, 1971), alignment and reassurance, the midwife demonstrates extensive skill in navigating a complex event. However, although this example may appear to contradict previous claims that patients are more likely to offer laugh tokens or laugh alone (Haakana, 2002; West, 1984), the atypically, high prevalence of midwife-initiated laughter, is likely to have been as a result and subsequent reparation of the incident, rather than attributable to a superdiverse environment.

6.3 Linguistic repertoire

While much of the data presented thus far, i.e. conviviality in superdiverse environments, the role of small talk in medical interviews, and humour in medical situations, echoes findings from previous studies (Wessendorf, 2014; Hudak & Maynard, 2011; Haakana, 2001), there has, to date, been little

research on how a linguistic repertoire, which incorporates features other than those of the dominant language, is performed, deployed or accepted in formal environments such as the consulting room. This is not to say that cross-cultural communication in medical practice has been under-researched (see Chapter 4 for an earlier discussion) but, as the linguistic landscape has changed, so must the foci.

With over 100 languages spoken in the community, the population in this study can be characterised as linguistically diverse, with medical and auxiliary staff as likely to speak English as an additional language, as the patients. In the following section, I will firstly illustrate how participants frequently reflect explicitly on language (mostly usually identifying them as 'bounded' concepts, see 3.4, for further discussion) during periods of small talk, appearing, on one hand, to promote an English-only discourse and, on the other, attaching high value to the notion of multilingualism. Next, I illustrate how the emergence of a linguistic 'translanguaging space' (Li, 2018) in superdiverse consultations, gives "rise to something different, something new and unrecognisable, a new area of negotiation of meaning and representation" (Bhabha in Rutherford, 1990:211). The conspicuous presence of creativity, multimodality and lingua francas, exemplify broad linguistic repertoire, indexing not only biographies (Blommaert & Backus, 2011: 2), but "the polycentricity of the……environments in which the speaker(s) dwell(s)" (Blommaert and Backus, 2011:15). Whether by design (interpreters) or circumstance (unmediated appointments), all participants exhibit an inclination to accommodate and negotiate linguistic difference, giving rise to co-constructed, multilingual speech events.

6.3.1. Do you speak English?

Although inhabitants of superdiverse communities are used to living with, and normalise, accumulated experience of difference, Wessendorf (2014) notes that people's backgrounds do not go unnoticed, and medical professionals are frequently moved to comment on language, as either countable, bounded units or as a competency. In a superdiverse community, where medical

professionals encounter linguistic diversity on a daily basis, this is unsurprising. The topic often emerges at the beginning of a consultation, where fluency, and subsequently notions of understanding, are explored. In the following extracts, small talk between patients and medical professionals, strays from typically 'safe' topics such as weather or recent activities, to one of language. As consultations cannot remain context-free, contrasting commentaries echo wider, societal, discourse surrounding proficiency as a sign of 'integration' (see 3.2, 3.3), where acknowledgement can range from a reiteration of a 'one-nation-one-language' hegemony, to congratulatory (Simpson, 2016: 17).

In extract 16, the antenatal appointment has just started: Karla and her boyfriend are sitting in silence while the midwife begins logging on to the computer and locating the patient's online medical file.

K= Karla; MW1= Midwife 1

76   MW1: What country you born in↑

77   K: Poland

78   MW1: ((types)) (8) and you speak fairly good English↑

79   K: sorry

80   MW1: YOU SPEAK FAIRLY GOOD ENGLISH

81   K: yes you think so↑ hh

82   MW1: yes I do ↓yes

83   K: I try my best=

Extract 16, C11

Asking an introductory question about country of birth, MW2 initiates dialogue, to which the patient can be seen to respond (L76,77): although the midwife may appear abrupt, the routine question typifies that of record-taking (Berg &

Bowker, 1997), and follows an earlier, friendly exchange (see extract 1). The apparent terseness may also reflect the fact that the demands of accessing the electronic record, divert MW2's attention from her patient (Swinglehurst, Roberts & Greenhalgh, 2014). Nevertheless, in recognition of the change in footing, or of the possible threat to face arising from the next statement which requires an answer, the midwife neutralises "Has difficulty understanding English" (see Appendix A, page 2), amending it from a yes/no decision made by the medical professional, into a compliment involving patient agency, "you speak fairly good English ↑" (L78). Ironically, Karla does not understand the praise for her English proficiency the first time, prompting MW2 to reiterate her statement loudly (L80). This somewhat stereotypical 'foreigner talk' (Long & Porter, 1985) in response to a misunderstanding, appears to embarrass the patient and Karla asks for reassurance, "you think so hh↑", mitigating her request with a soft laugh, before asserting how hard she is trying.

Karla's anxieties about her level of English, as well as the need to both improve and to demonstrate a willingness to do so, may be seen to reflect wider societal discourses surrounding language, migration and integration in post-Brexit referendum Britain, (see 3.2). Whilst it is certainly not unreasonable to expect people living in the UK to have a degree of competence in the dominant language, we can understand that in social interaction "both everyday racism and everyday cosmopolitanism… [are].. coexistent, and not mutually exclusive" (Blackledge et al, 2017: 14). With extensive discussions about migrants accessing NHS services, and the ensuing interpreting costs (McFadyen, 2017), it is clear that medical professionals are also unlikely to remain immune to hegemonic linguistic ideologies (for example, Haith-Cooper and Bradshaw's (2013) research on the attitudes of trainee midwives to pregnant asylum seekers reflects a substantial amount of suspicion and prejudice).

In the subsequent extract (C17), DC, an experienced diabetes consultant, has been advising Maalini about diet and exercise during pregnancy. Although the patient is accompanied by her husband and interpreter, DC has an

understanding of Tamil and the appointment is interspersed with jovial codeswitching (Gumperz, 1982). However, during a pause while she is completing medical notes, the consultant turns the conversation to a gentle, but explicit, remonstration.

M= Maalini; DC= Diabetes consultant

222   DC: and the tablets (   ) blood pressure still one tablet three times↑

223   Ma: yes (10)

224   ((Sounds of equipment, rustling paper and murmurs between husband and wife))

225   DC: £when baby comes you're going to talk to baby in English (.) and the

226   baby's going to talk back to you in English so you will learn English quicker

227   (2) next pregnancy ((gesticulates)) you are talking to me£

Extract 17, C2

In their reconceptualization of the genre in medical encounters Hudak & Maynard (2011) identify minimal small talk as a thwarted attempt at changing topic. DC's utterance may be intended to fill time during a lengthy pause (Zhu, 2014) and, in keeping with the tone during the earlier part of the consultation (see 6.4.1), her encouragement to speak English is delivered with a smile, as her arms move back and forth in a gesture of affiliation. However, the topic proffered (Schegloff, 2007) is not taken up by any of the participants, and the room returns to silence. In this instance, it is the incongruence of the topic which holds salience. Prior to the comment, there is no apparent breakdown in communication or mention of linguistic proficiency: indeed, the appointment is replete with linguistic play (see 6.4.1) and marked by conviviality. It is unlikely that DC's exhortations to speak English arise from a latent linguicism (Skutnabb-Kangas & Phillipson, 1996) as she later demonstrates her extensive linguistic repertoire (see 6.4.1, 7.1.1.3). Instead, I interpret her atypical comments to have been made in line with the 'monolingual orientations' (Canagarajah, 2013:1) promoted by the 'hostile environment'

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(Kirkup & Winnett, 2012) in regard to migrant access to healthcare in the UK, as well as an "unconscious distortion performed to provide what …[she]…believe[s] the researcher wants to see" (LeCompte & Goetz, 1982: 46). That is, while the consultant's earlier actions represent a performance of medical expertise, in her reproduction of a wider hegemonic discourse, she assumes the role of a 'compliant' government employee, possibly for my benefit.

6.3.2 Linguistic reflections and cosmopolitan pragmatism

Whilst this thesis regards linguistic repertoire as "using one's idiolect, that is one's linguistic repertoire, without regard for socially and politically defined language names and labels" (Li, 2018: 19), it is arguable that the concept is more familiar to an academic audience, and for most individuals, languages are accepted as discrete entities, retained and deployed strategically. As such, although the site of research represents the wider ethnically and linguistically diverse population, a number of participant discussions concerning explicit reference to language, construct languages as a countable nouns, which are commonly associated with bounded territories. As previously mentioned, in a superdiverse environment, ethnicity, nationality and language do not go unnoticed, but as Wessendorf (2014) argues, people learn strategies and skills to cope with difference. Returning to Melina's booking-in appointment (see also, extract 2), the midwife's opening move is one of linguistic affiliation, as she strives to create a convivial atmosphere.

G= George; MW1= Midwife 1

1   MW1: (   ) Spanish (.5) they say communicate (/komu:nɪka:teɪ/)

2   thing (.) little things you can pick up ( ) Spanish=

3   G: = ( ) but Spanish is different from Portuguese

4   MW1: ( ) but some of the words you say you it sounds similar to Spanish // (.) isn't it↑

5   G: //yeah (.5)

6   yeah I speak Spanish, Portuguese and erm French //(.) and English=

7   MW1:   //oh right (.) =oh wow (2)
     four languages

8   G: yeah because in Portugal now you learn (.) French (.5) you learn

9   Spanish because it's //similar

10   MW1:   //similar it is similar yes it is

11   G: =and English because when I come to here I don't understand nothing

12   y'know (.) two years ago

13   MW1: hhhh well you're doing very well you're doing very well (.)

Extract 18, C12

MW1 promotes a positive face as she demonstrates her appreciation and knowledge of different languages, through her appropriation of a 'Spanish' pronunciation of "communicate" (2). Interestingly, this 'stylisation' echoes previous observations on the heteroglossic practices of adolescents in an multi-ethnic, urban environment (Rampton, 1995), where language is used to fashion identity and negotiate relationships. Thus, the topic of language is used to find common ground and to build rapport (Spencer-Oatey, 2005), during the initial part of the consultation. In an overt display of, what I have termed epistemic flattery (L13)(see 7.3.3 for further discussion), MW1 praises George for his multilingualism (L7, 13) while, in reciprocation, he reverses his initial rejection of her offer on the similarities between Spanish and Portuguese (L3), to then agree with the midwife (L5, 8/9). However, although "[u]nderstanding 'the other' is not so much a matter of identifying difference, as of raising awareness of multiple repertoires and expanding points of overlap" (Creese, Blackledge & Hu, 2016:15-16), establishing conviviality can be laborious and time-consuming, as we see below.

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M= Melina; G= George; MW1= Midwife 1

55 M: yeah yeah (.) er country of birth↑// the date is me come here ↑

56 MW1:   //Portugal (1) no Portugal (1) (   ) no
    country of birth

57 MW: is it's the country where you were born that's Portugal

58 G:=Venezuela

59 MW1: oh she born (.) now you tell me↑££ (.) NOW you tell me >Venezuela ↑
    (.)

60 Venezuela ↑is she Venezuelan↑<=£

61 G:=yeah no go away=

62 MW1:=where was she born↑

63 G: yeah no she born in Portugal go to Venezuela and go back to Portugal=

64 MW1: a::h she born in Portugal but grew up in Venezuela ↑ (1)

65 G: yeah yeah=

66 MW1: =a::h so she can speak Spanish// (2) very well (.) a:h:

67 G*:   yeah *(1)Tu falas español*↑   *//*yeah *(1) do you speak //Spanish*↑

68 MW1:   //so she should be able to

69 speak Spanish=

70 M: =ah: little bit hhh

71 MW1: *no habla español*   *not speak Spanish*↑

72 G: *sí habla un poquito español*   *yes she speaks a little Spanish*

73 M: yeah yeah

74 MW1 =really ↑ (.)//*poquito poquito* ↑   =really ↑ (.)// *little bit little bit* ↑

75 G: //hh

76 M: *poquito poquito*   *a little a little*

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77 MW1: little bit (.) really↑ (1) *español* ↑Spanish↑ (1) oh do you speak more
     Portuguese↑

78 M: yeah=

79 G: =   //of course

80 MW1: //a::h=

81 G: =but I //can't understand

82 M: //but I can't Venezuela without Portugal I have three years

83 MW1: //aaahh alright (.5) is it that you favour Portugal more than Venezuela↑
     //(   )

84 G: // in here in the school you speak Spanish in here↑=

Goffman (1986) reminds us that in asymmetrical encounters, it is the more powerful participant, here the midwife, who has the ability to show an "'expression' of personal identity…. something, in short that is characteristic not of the role but of the person." (Goffman, 1986). While MW1's interruption of Melina's request for clarification could be interpreted an assertion of power (L56, 57), the iteration of 'Portugal' and 'Venezuela' (L59-64) are more likely an idiosyncratic feature of repair, as the midwife acknowledges the threat to her positive face, made by her confusion over Melina's country of birth (Brown and Levinson, 1987). The good-humoured rise in volume accompanying "Venezuela ↑ (.) Venezuela↑ is she Venezuelan↑<=£" (L59, 60), and the use of reformulation as a backchannelling device, "a::h she born in Portugal but grew up in Venezuela" (L64), also contribute to the repair, masking the misunderstanding and encouraging further explanation.

The relatively informal opening frames then allow MW1 to step out of role to display her linguistic repertoire and cultural knowledge. In line 66, the midwife expresses relief as she 'identifies' a possible lingua franca that she may share with her patient, "a::h so she can speak Spanish". Although we have no

indication how much Spanish MW1 speaks, she appears keen to secure "common ground" or a familiar categorisation (Creese, Blackledge & Hu, 2016), repeatedly seeking confirmation of "points of overlap" (ibid) (L 66, 68). Yet there is tangible tension between the midwife's need to pursue 'categoric knowing' (Lofland, 1973), i.e. the information about the patient's status which will be required for Melina's medical notes, and 'cosmopolitan pragmatism' (Wessendorf, 2015), a civil approach to 'getting along' which exemplifies communication in a superdiverse environment. While medical appointments are time-bound encounters (Harvey & Koteyko, 2013), MW1 appears to exhibit frustration at the time taken to clarify routine information: the inclusion of the modal verb, "so she should be able to speak Spanish" (L67) implies assumed ability or obligation, which, when followed with "very well", seems insensitive; in addition, the midwife's attempt to engage in interlingual communication (Baynham et al., 2015) by asking questions in (her) Spanish (L71), not only emphasizes her pride in her linguistic capital, but adds to the tension to which she seems oblivious (Gumperz, 1977). Melina's use of laugh tokens (L 69) and repetition of "poquito poquito" (L 75) indicate her discomfort and begin to threaten her positive face, a position she finds linguistically hard to defend (L 82). In a strategy of deflection, George averts further FTAs by pointedly changing the subject to language learning in the UK, a circumlocution that returns the conversation to neutral ground (Goffman, 1967).

6.4 A Translanguaging Space

As I reflected in Chapter 3, many scholars have drawn on Bhabha's concept of 'third space' (1994, 1990) as a paradigm to capture the cultural and linguistic hybridity of superdiverse communities (see for example, Li, 2018; Flores & García, 2014), as well as to challenge specific changes to nursing roles (Chulach & Gagnon, 2016). Contesting the essentialising notion of cultures as binary, the third space is proposed as "interruptive, interrogative and enunciative" (Bhabha, 1994: 103), offering a place for hybrid identities and repertoires to flourish. Building on this, as well as the work of Soja (1996), Li's reconfiguration of the concept as a translanguaging space (see 3.6), is of

particular relevance in contemporary healthcare, as participants can be seen to "flout norms of behaviour, including linguistic behaviour" and "push boundaries between named languages and language varieties" (Li, 2018:23). Indeed, the following data illustrate how linguistic bricolage is not merely confined to markets, community centres or shop windows (Blackledge, Creese & Hu, 2015; Baynham et al., 2015; Blommaert, 2013a), but infuses the formal, day-to-day routine of life in a superdiverse hospital. Whilst not all the participants employ a 'multilingual' repertoire in the conventional understanding of such (see 3.4), the apparently mutual recognition of idiolects as legitimate "biographically assembled patchworks of functionally distributed communicative resources" (Blommaert & Backus, 2011:.29) extends the concept of translanguaging space to an institutionalised setting.

6.4.1 Flexing repertoires

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 crosses both categories as the condition can be somewhat self-managed, yet simultaneously, holds the potential for complications or long-term effects for mother and child. As such, one could assume that in these circumstances, critical discussions with a diabetes consultant would be sombre. However, as extract 20 exemplifies, humour can be employed to both diffuse potential anxieties and to support the patient in decision-making strategies. Beginning with the systematic questioning, characteristic of a medical consultation (ten Have, 1991), DC tries to elicit Maalini's every-day eating patterns, in an attempt to understand her patient's fluctuating sugar levels. The patient's husband and interpreter are also present.

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

2   DC: is it a white bread or brown bread↑=

3   Ma:= brown bread

4   DC: okay everyday you eat brown bread=

5   Ma:= yes (   )

6   DC: some days you don't eat some //( )

7   Ma: //(   )

8   Hus: //sometimes is ( ) biscuit=

9   DC: =uhuh

10 Hus: and (2) um **porcus***↑   And (2) um *pork*

11 DC: uhuh

12 Hus: and (   ) sometimes this   And (   ) sometimes this Asian
     Asian food **idiyappam****   food *string hoppers*=

13 DC: =uhhhh ((sharp intake of breath) hh

14 Ma: string hoppers =

15 DC: £((sharp intake of breath))£   £ ((sharp intake of breath))£ *string*
     idiyappam not good   *hoppers* (.) hhh not good

Extract 20, C2

**Idiyappam (also known as string hoppers) is a traditional South Indian dish made
of starchy rice and coconut milk, and is not recommended for diabetics

The consultant shows a keen, professional interest in her patient's diet: her
active listening is apparent through her use of strategies such as reformulation
(L4, L6), backchannelling and the repeated use of 'uhuh' (L9, 11, 13). DC's
receptive skills are also finely tuned, reflecting the polycentricity of the
environment in which she works (Blommaert & Backus, 2011:15), as well as
her linguistic and cultural knowledge. Fatigante and Orletti note that laughter
often occurs when a problem has been identified (2016): as DC listens to the
couple discussing their food intake, the consultant gives a humorous sharp
intake of breath (L13) at the mention of 'idiyappam' (L12), which Maalini

glosses with an English translation (L14). When DC repeats both the comic gasp and 'idiyappam', followed by 'hhh not good' (L15) she is showing her disapproval of Maalini's diet. The doctor's reproaches are consistently ameliorated by humorous responses and gentle laugh tokens (L13, 15). Indeed, in line 26 (below), DC frames her admonitions as a personal preference (L26), further mitigating any potential mutual threat (Canagarajah, 2013) and before continuing with her questioning.

Ma= Maalini; Hus= Husband; I1= Interpreter 1; DC= Diabetes Consultant;

26   DC: I don't want that h (1) and what do you eat for dinner ↑

27   I1: இரவு என்ன சாப்டீங்க   *What did you eat for dinner ↑*

28   Ma: ந்தானை முன்னாள் இரவு   *Yesterday's dinner↑*

29   Hus: இடியாப்பம் தான்   *Idiyappam is what we had*
      சாப்டீங்க

30   DC: roughly like every day

      ((very quiet discussion between interpreter, husband and patient))

31   I1: வழமையா என்ன சாப்பிடுவீங்க   *Usually what do you eat↑*

32   DC: **puttu**=   *puttu*=

33   Ma: =>no no no no< (   )//(   )<

34   DC: //hhhh

35   Ma:=two weeks or three weeks, no puttu

36   DC: no puttu no idly no dosa hh

37   Ma: na (.) na (.) na (.)=

Extract 21, C2

*Puttu is a breakfast dish made of steamed cylinders of ground rice layered with coconut; **Idly are a type of savoury rice cake made from batter consisting of black lentils and rice; *** dosa is a type of pancake made from rice

Significantly, extract 21 sees the "emergence of a re-defined or transformed identit[y" (Chulach & Gagnon, 2016: 54), as the consultant begins to flex her linguistic repertoire, although, her actions appear to contrast markedly with previous comments on the use of English in the consulting room (see extract 17). Instigating a change in footing, DC now straddles the realms of medical professional and co-participant. Although the doctor's aims have not changed, the methods of gleaning information have, and DC combines her 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 interrupts mediations and answers the interpreter's question with an interjection of "puttu" (L32). Although the speedy, emphatic denial from her patient ">nononno<" (L33) draws overlapping laughter from the doctor, she nevertheless continues to tease her patient by listing other unhealthy foods, "no puttu no idly no dosa hh" (L36). Skilfully personalising the interaction by utilising her ability to codeswitch (Gumperz, 1977) the doctor is also using humour to mask the potentially face threatening nature of the exchange (Goffman, 1986). By prefacing the list with 'no', DC is checking Maalini is not eating unhealthily, as well as emphasising the threat the foods pose to her health. This approach does not offend. Instead, the patient's comparatively measured response (L37), as she pauses with each denial, indicates a growing realisation of the importance of diet during pregnancy. Later, as DC moves towards a standard "terminal exchange" (Schegloff & Sacks, 2009) with the utterance, "any questions" (L237), Maalini asks the interpreter whether her baby is in the correct position for delivery.

Ma= Maalini; Hus= Husband; I1= Interpreter 1; DC= Diabetes Consultant

237   Dr: any questions

238   ((murmur between husband and wife))

239   I1: *ஏதாவது கேக்கோனோம்*   *You want to ask anything*

240   Hus: *So (↑)*

241   Ma: position *எல்லாம்* okay - *ஆ*   *no. Is the position and all okay↑*

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242   Dr: Position and all are okay (.)//only baby is big

243   Ma: //HHHHH(4) s' okay (6)

244   Dr: I can understand her language (.) I can't speak=

245   Ma: =hhhhh

Extract 22, C2

Rather than allowing the interpreter to translate, DC replies directly, causing Maalini to erupt with loud laughter. Whereas this response may be an indication of the patient's surprise, it may also function as a means of recovery from the face-threatening realisation that the doctor has understood everything she said during the consultation (Goffman, 1986). When DC's comprehension is confirmed (L244), Maalini's laughter expresses slight unease. Displacing "the histories that constitute it" (Bhabha in Rutherford, 1990:211), the consulting room is transformed into a translanguaging space (Li, 2018), enabled and enriched by the fluidity of repertoires, and offering a glimpse of the ways in which superdiverse populations can disrupt expectations of interpreting and consulting norms.

Indeed, in the context of HUH, shared repertoires appear commonplace: in extract 23, CT2, a consultant obstetrician, also demonstrates highly effective receptive skills, as he listens and participates in a discussion between his patient and her interpreter. Ajola is a victim of human trafficking, who has been referred to CT2 because of her high-risk pregnancy. Having earlier concluded that a previous stillbirth was most likely caused by domestic violence (see case study for further information; 7.2.1), the consultant is keen to ensure an alertness to possible complications, whilst trying to ensure that Ajola does not worry excessively. In a sign of trust, symptomatic of a good, ongoing, working relationship (Gavioli, 2015), CT2 involves the interpreter further by asking her to explain what Ajola should do, if she experiences any concerns or unusual symptoms.

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AJ= Ajola; I4= Interpreter 4; CT2= Consultant 2

327 CT2: explain please if any problems if the baby's not moving so well if she's got PAIN

328 I: *thotë, të lutem n.q.s. ke* problem *të lëviz bebi ke ndonjë gjë ti vetë a më kupton apo ndjen e ke parasysh që e ndjen vetë, të lutem për cdo gjë duhet të shkosh te spitali e ke parasysh te materniteti duhet të shkosh aty Ke qënë apo s'ke qënë ndonjëherë Ku është klinika*

He is saying, please, if there is a problem *with you, the baby moves, is anything with you, do you understand* ↑*Or you feel, can you imagine, something you feel yourself, please, for everything, you must go to the hospital, you know, at maternity, you must go there. Have you been there or not* ↑*Where the clinic is* =

329 AJ: =yes=   =Po=

330 I4:= *e ke parasysh ku është klinika matanë klinikës e ke parasysh ku është rruga një rrugë e vogël matanë klinikës=*

on the other side of the clinic, you know where a road is, a small road behind the clinic.

((doctor is listening, nodding))

331 AJ: *Te GU ja*   At GU yes

332 I4: *Po, te GU-ja, ku është rruga që e ke të shkruar me të vogla*   Yes, at GU, where the road is, which is written with small letters….

33 AJ : *Po, me derën blu, më duket.=*   Yes, with a blue door, it seems to me.

334 I4: *Me derën blu është materniteti, dhe është ajo, e ka të shkruar, dhe del vetë aty* sorry I'm explaining //what

With a blue door is the maternity, and there it is it is written, and you go there sorry I'm explaining //what

335 CT2:   //I understood whatever you are saying

336 it's erm >where is the labour ward where is triage< I understood

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The consultant attempts to mitigate Ajola's concerns by emphasising the hypothetical nature of any potential symptoms: by reiterating 'if' (L327), he underlines the importance of keeping vigilant, with the loud utterance of 'PAIN' (L327), prioritising the most significant warning sign. In response, as a 'visible interpreter', "capable of actively and consciously managing...issues as the interpretation unfolds" (Angelelli, 2004: 11) the interpreter expands on the consultant's guidance and goes "beyond that of transparent language modem to opaque co-participant" (Angelelli, 2004:11). She exhorts Ajola to seek help should she feel any changes and gives further information on where to go in an emergency, checking her understanding repeatedly (L328, 330). During this exchange in Albanian, the doctor appears to be listening and nods without comment, occasionally making imperceptible sounds. However, as the interpreter begins to realise that the doctor can understand her divergence from the script, there is a change in footing (Goffman, 1981) as she moves from Albanian to English (L334). Changing alignment from patient to consultant, the interpreter is quick to mitigate the face-threatening possibility of her non-scripted advice. Yet the doctor, originally from Greece, interrupts to indicate and evidence his understanding through reiteration of the interpreter's instructions, "I understood whatever you are saying it's erm >where is the labour ward where is triage< I understood" (L335, 326). The adjacency pair of proffered apology and tactful acceptance avert the possibility of a resultant FTA but, also demonstrate the normative approach to multilingualism as observed in more informal environments (Blackledge, Creese & Hu:2015; Wessendorf, 2015).

6.4.2 Linguistic creativity

Superdiverse environments appear to offer a translanguaging space that not only supports broad repertoires, but also encourages the way in which they can facilitate improved communication between participants (Li, 2018). As the subsequent contributions exemplify, "the influences of one language on the other can be creative, enabling and offer possibilities for voice" (Canagarajah, 2013: 6) and help to forge deeper understanding (Garcia, 2009).

Whilst general consensus (Berg & Bowker, 1997; Swinglehurst, Roberts & Greenhalgh, 2014) acknowledges the collaborative aspects of co-constructing a patient record, i.e. where midwives and patients work together to create an accurate representation of health, the consulting room can comprise additional contributors. In a superdiverse setting, this may involve interpreting and/or several languages working contemporaneously. In extract 24, MW1 is continuing with Melina's booking-in session (see extract 2 for earlier introduction): the patient is accompanied by her friend, George, and an interpreter. Following a set of routine questions, pre-determined by the prescribed text, 'Pregnancy Notes' (Linell & Bredmar, 1996), the participants are attempting to navigate the medical history section where the patient is asked about previous pregnancies, health conditions and vaccinations. They have reached 'f' on the alphabetical list, where they are required to tick yes or no in response to the noun phrase 'female circumcision/cutting' (see Appendix A).

I3= Interpreter 1; MW1= Midwife 1

194	I3: circumcision circumcision ( ) circumcision is the female ↑
195	MW1: for the female yeah the cut the female private part (.) its more to do with the erm=
196	I3: =Africa (.)
197	MW1: hm

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198	I3:	***Eles cortam órgão mulher***	*They cut female organ* // I dunno
		***(.)/*I dunno	
		((reads medical history questions)) (.)	
199	I3:	*Tem algum problema com*	Do you have any problem with your
		seu estómago	stomach ↑
200	M:	// nn	

Extract 24, C12

A question about female genital mutilation has "symbolic implications" (Goffman, 1990:12) due to the taboo nature of the subject. As such, the midwife counteracts the potential FTA with a series of mitigating strategies including euphemism, 'female private part', pauses, and vagueness (Linell & Bredmar, 1996) (L195). In a collaborative, and apparently face-saving move, the interpreter elides to complete the sentence, uttering "Africa" (L196) to dismiss the question. However the interpreter does not appear to recall the equivalent term in Portuguese and her attempt, '***eles cortam órgão mulher***" (approximated as 'they cut female organ') does not describe the procedure in standard terms or standard Portuguese. While, on one hand, this may illustrate an unfamiliarity with medical terminology, it could also call in to question the interpreter's ability to engage in intralingual discourse, which Simpson defines as the ability to "shift…. from specialized registers into everyday English, in an endeavour to explain technical terms" (2016: 15). By erroneously making the assumption that the practice of FGM is limited solely to women of African origin, dismissing the challenges of communicating the concept, "I dunno" (L198), and neglecting to explicitly ask Melina about the issue, the interpreter's actions unwittingly compromise accepted notions of informed consent, a subject which is explored further in Chapter 7.

Much of consultation C12, exemplifies individuals 'talking-it-through in multiple languages however incomplete or truncated their knowledge of the individual language may be" (Li, 2018: 16), a process which Li observes to be

characteristic of superdiverse communities. In the following examples, participants navigate a combination of familiar and unfamiliar vocabulary in the medical notes.

G= George; I1= Interpreter 1; MW1= Midwife 1

148   I3: **O (.) sangue↑**   oh blood↑

149   MW1: blood clotting yeah

150   I3: yeah (.) ((turns at this point to George who is sitting behind them on the bed))

151   **I3: Esse é o quê↑ Se pensa↑ em**   *That is what↑ //you think in relation*
         relação (.) o clotting   *(.) the clotting…*

152   G: //(   )

153   I3: (   ) <u>clot</u>ting (.) how //can explain it↑

Extract 25, C12

Reaching 'blood clotting' on the questionnaire, the interpreter queries the phrase pertaining to 'sangue↑ /'blood', and it is unclear whether her question is lexical or cognitive. The midwife initially misunderstands the interpreter's utterance (L148), and glosses the phrase in English (L149), in a tone which indicates agreement, as if she understands 'o sangue' to be a Portuguese translation. In embarrassment, I3 agrees and pauses, before checking with George, who, at this stage, cannot help her (L152). This results in an explicit request for the midwife's help, but, as we see below, it is a difficult complaint to explain:

M= Melina; G= George; I1= Interpreter 1; MW1= Midwife 1

154   MW1:   //yeah blood blood(.) I don't speaka da Spanish (.) like

155   if you have the normal flow of blood and it just clots ((shows lumps by creating

156   circle with hands)) little clumps of clots=

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157 G:= is like bubbles //or something

158 MW1:   // yes (.) little bubbles clots (.) where it can cause problems to

159 the heart to the organs (.) she would know if she ever had it (.)cos they would

160 have to give you medication to stop it or to (.) to decrease it (.) so she would

161 know it if she had it (.) it affects the blood flow in your body

162 I3: ye( )=

163 MW1: =>I want you to ask her< has she had any problem <with her blood
flow> in her body

164	G: *á tiveste algum problema no ( )Não* ↑	*have you ever had a blood problem*↑
165	I3: *fluide (.) sangue*↑	*Fluid (.) blood*↑
166	M : *Não*	*no*
167	G: no	*Extract 26, C12*

MW1's interruption (L154) demonstrates recognition of the lexical confusion,
but her impatient repetition of 'blood blood', followed by the stylised utterance,
'I don't speaka da Spanish', does not offer the other participants much help.
Despite this, as she "slip[s] into… [her]… speech an other-ethnic form as if it
were…[her]..own" (Charalambous & Rampton, 2012: 490), MW1's stylisation
is used to demonstrate a sympathetic alignment with Melina and the
breakdown in communication. 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 (L155). In an extraordinary
display of co-construction (L155-167), participants draw on their linguistic and
epistemic repertoire to elucidate the relatively abstract term 'blood clotting': in
lines 9-11, MW1 and George's utterances elide, as he responds quickly with
helpful synonyms, 'is like bubbles or something' (L157) and the midwife
agrees. However, realising that the participants still haven't completely

understood, MW1 continues, changing reformulations to not only explain the medical condition but to shift the "medical agenda" (Baraldi & Luppi, 2015: 585) and confer the patient with epistemic authority (ibid), "she would know if she ever had it" " she would know" (L159/160). The repetition of the word 'blood' (L154, 155, 161, 163) is also used to aid comprehension.

In their seminal study of misunderstandings in multilingual health consultations, Roberts et al (2005), recognise that when participants who have been "socialised into a variety of English other than standard' (Roberts & Sarangi, 1999: 491), their "choice of words and idioms" are affected (Roberts & Sarangi, 2005: 637). In extrapolation, it stands to reason that in a superdiverse population, many participants may have also been socialised in to non-standard varieties of other 'bounded' languages. Not only is the interpreter's 'fluid () blood' (L165) an idiosyncratic translation of 'blood clot', the midwife's choice of 'blood flow' is also a non-standard reformulation. As negotiations in a superdiverse environment "become context specific, fluid and flexible" (Chulach and Gagnon, 2016: 57), the idiomatic synonyms are functional: "interlocutors end up giving …[the words their] ..own indexicality and achieving their communicative objectives" (Canagarajah, 2013: 72).

6.5 A Translanguaging instinct

As this chapter has illustrated, the unremarkable nature of mediation in a multilingual environment can be characterised by the ways in which participants draw on a combination of multiple, and multimodal, resources and individual repertoire(s) to both accommodate difference, and achieve understanding, thus becoming a place where discrete languages and shared repertoires are institutionally acknowledged (Flores & García, 2014; see extracts 22 & 23). That is, the unpredictability of superdiverse populations transforms the consulting room into a unique space which is "neither this nor that" (Chulach & Gagnon, 2016: 54), but a space of communicative fluidity. In this section I explore how some speakers, specifically those in possession of a 'translanguaging instinct' (Li, 2018), intuitively navigate and negotiate the

space using strategies that cannot be immediately anticipated and "transcend defined language boundaries to achieve effective communication" (Li, 2018: 22).

In extract 27, MW3 has reported initial difficulties in communicating with Alicia in English: the midwife is originally from Italy, the patient is Portuguese and neither speaks the other's language. However, "[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), and once MW3 establishes that Alicia speaks some Spanish, he decides to conduct the appointment using a combination of languages. I join the consultation at this point. Once again, as Alicia is due to have an anti-D injection for the first time, the midwife is obliged to advise the patient of the reason for the injection and to warn her of potential side-effects. In contrast to the humorous small talk, designed to put the patient at ease, and which appeared to characterise previous illustrations (see 6.2.), the midwife begins by double-checking Alicia's gestation (L1), and then addressing the topic directly.

AL= Alicia; MW3= Midwife 3

1   MW3: ((moves things off chair for Alicia)) put your things here okay (3) and take

2   a seat here okay↑ so how many weeks are you↑

3   AL: er 29

4   MW3: 29 very good okay (1) do you know why you're having this injection ↑

    ((Alicia has a blank expression and does not acknowledge the question))

Extract 27, C8

In his formulation and, by framing the next question in a way that needs Alicia to explain (L4), the midwife initially prepares to employ a model of patient-centred communication, which promotes a more symmetrical form of patient participation and is in keeping with current NHS guidelines (NHS, n.d). Yet, as

Alicia's expression does not change, and as she makes no attempt to answer MW3's question, it becomes clear that the patient does not realise that she is being addressed.

AL= Alicia; MW3= Midwife 3

5   MW3: (2) no ↑okay so (2) ((papers rustle as he turns pages to check details))

6   your   blood is rhesus negative okay↑ so that means (3) let's take it very very easy okay↑

     ((bending slightly, to show Alicia a drawing of a red blood cell, drawn on a paper towel))

7   this is a red blood cell okay ↑this is the negative

8   and this is the positive the positive around it has got kind of let's call it protein

9   okay↑ so (1) this means that if your baby is rhesus positive (.) > baby you're

10   carrying <if the baby is rhesus positive and during your pregnancy you have a bleeding

11   in between you and your baby (1) okay↑ do you understand what I'm saying↑ (1)

12   Okay, if you don't(.) just stop me okay ↑so so let's say again everything in Spanish (.)umm↑ what d'you think ↑Okay ↑

Extract 28, C8

The midwife pauses sensitively (L5). As "involvement is an interlocking obligation" (Goffman, 1986:346) MW3 changes footing in an attempt to further engage Alicia and to explain why anti-D intervention is recommended. The premise underpinning the anti-D injection is complex, yet there is the potential to endanger life 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

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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 & Luppi, 2015). The repetition of 'okay↑' as a discourse marker, throughout the explanation (L5, 6, 7, 8, 11, 12), 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. Blackledge, Creese and Hu note that "semiotic repertoires…. are by no means limited to the linguistic…[as]… they are responsive to the places in which, and the people with whom, semiotic resources may be deployed" (2015: 16). MW3 bends his head to make eye contact with Alicia and to draw attention to an illustration of a red blood cell (L7) he has drawn on a paper towel from the dispenser (see figure 6.1).

Replica of MW3's illustration of blood cell, Figure 6.1

As he explains 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 (Goffman, 1972) through his 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 (L11, 12), and to verbally engage the patient, MW3 begins to reformulate in Spanish.

AL= Alicia; MW3= Midwife 3

13 MW3: okay **so esta es tu celula de**   okay *this is your blood cell*
    sangre *(.)* okay ↑ *(.) Es negative. Esta es*   *okay↑ It's negative. This is (1)*
    (1)positivo   *positive.*

14 MW3: **Si hija o hijo es positivo,** okay ↑**Si**   *If your daughter or son is*
    tu tienes un sangramiento ↑   *positive, okay↑ If you have a*
                                                   bleeding↑

15 what do you say in Spanish ↑u:m (1) exchange of blood

16 AL: yes=

17 MW3: =**cambio de sangre**   *blood change*

18 MW3: between you and your baby which can happen in pregnancy (.) u:m
    (.5) the baby

19 MW3: will be sick (1)okay↑ okay ↑because your blood your body will not
    recognise

20 MW3: **tu cuerpo no conoce el positivo**   *your body does not recognise*
    porque tu estas negative(.)   *the positive because you are*
                                                   negative

21 MW3: **por eso tiene que destruir (.) la**   *and because of this it will*
    sangre de tu hijo, okay ↑   *destroy your child's blood,*
                                                   okay↑

22 MW3: **(.) Puede ser muy malo,**okay↑   *This can be very bad,* okay↑

23 MW3: So that's why you're gonna have this injection okay↑ (.2) you're gonna

24 have one now at 28 weeks

25 MW3: **Te damos uno ahora a las 28**   *we give you one now at 28*
    semanas   *weeks*

Referring throughout to the drawing, MW3 reiterates his explanation in Spanish, once again utilising 'okay' (L13, 14) followed by a pause, as a repeated method of checking understanding and slowing down the information transfer. 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' (used earlier in Lines 5, 9 and 10 in extract 28) in his second reformulation, no longer using it as a prefix for 'negative' or 'positive' blood (L13, 14, 20). Initially unsure of how to translate 'exchange of blood', the midwife employs positive politeness (Brown & Levinson, 1987) to bolster Alicia's epistemic authority, and asks her to confirm the translation (L15). In this instance of intersemiotic (the movement between spoken and visual) and intralingual translanguaging (the epistemic flattening of technical discourse, see Baynham et al., 2015), MW3 demonstrates a translanguaging instinct which "draw(s) on as many different sensory, modal, cognitive and semiotic resources as [he has] available" (Li, 2018: 23), and through which he seeks to make meaning in 'ensemble' (Garcia & Li, 2014). However, from line 23 we see a change in footing, where, although the midwife continues to move between Spanish and English, he moves 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" (L23), removing the potential for patient participation, and more significantly, choice. Although the bald-on-record (Brown & Levinson, 1978) 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' (L23), at this point in the consultation, the reality of the interaction is stark. MW3's summarising tone not only indicates to the patient that he needs to administer the anti-D injection within a fixed, institutional time-frame, but also

that having completed his explanation, he intends to do so whether Alicia has understood all the information or not.

6.6 Conclusion

This data analysis chapter has revealed how communicative practices associated with superdiverse populations, permeate the institutional environment of a 21st century hospital, creating a translanguaging space in which difference appears to be not only acknowledged, but legitimised. It begins by illustrating the ways in which conviviality underpins consultations, as midwives attempt to make patients feel at ease, through the use of small talk, laughter and humour (see 6.2). Although these strategies could also be seen as consistent with an NHS commitment to 'patient-centred care', i.e. "coordinated and tailored to the needs of the individual [where] healthcare professionals work collaboratively with people who use the service"(NHS, n.d.), it is salient to note that when a convivial orientation is employed in combination with the ability, and space, to use flexible languaging practices, it appears to offer participants a way of traversing sociocultural and linguistic 'difference', in a way that is only beginning to be captured in fieldwork (see for example, Cox, 2017; Mori & Shima, 2014). Whereas a considerable amount of established intercultural health communication literature identifies difference in terms of barriers or obstacles (see for example, Fransen et al., 2012; Vilpert & Hudelson, 2009; MacFarlane, Singleton & Green, 2009; Abbe et al., 2006), or something in need of mediation (Baraldi & Gavioli, 2014; Karliner et al., 2007; Wiener & Rivera, 2004), this chapter has demonstrated that difference is not automatically an impediment to effective (or attempts at) communication (see 6.3). Instead, as sections 6.4 and 6.5 illustrate, the biographies of both staff and patients reflect the complex realities of transnational migration: individuals combine shared repertoires, multimodal resources and a commitment to convivial negotiation, as a means of achieving their objectives.

As previously noted (see 3.5), intrinsic to a translanguaging approach is also a specific epistemological orientation, where communicative practices are held

to be transformative and empowering, challenging existing normativities (Li, 2018). However, while in the context of this data analysis chapter there is extensive evidence of linguistic flexibility and broad repertoires, the transformative effects of such are less obvious, as are the notions of parity to which translanguaging scholarship appears to allude (Flores & García, 2014).

Thus, the following Chapter 7 seeks to interrogate these issues in more detail, and in relation to how individuals navigate epistemic and linguistic differences, as they strive to establish mutual comprehension. Findings are also further contextualised as existing within a medical system widely considered inherently hierarchical and a superdiverse population characterised by linguistic and sociocultural unpredictability.

Chapter 7 Data analysis – intercultural health communication

7.1 Introduction

Following discussions in Chapter 6 which demonstrate how individuals work hard to establish the effective, and convivial, communication of complex information, this data analysis chapter seeks to address my second research question. Here, I examine how meaning is negotiated in interaction (Roberts and Sarangi, 2005: 2), and investigate to what extent the strategies observed in a superdiverse setting may hold possible situational consequences for participants. Within this I explore whether the communicative flexibilities characteristic of superdiverse environments which can appear to enhance experience and efficacy, may also have the potential to disguise the ways in which "inequalit[ies] [are] often solidified or intensified within multiplicity and fluidity" (Kubota, 2014: 4), contribute to the asymmetries of power said to be inherent to medical discourse (ten Have, 1999), or "generate new identities, values and practices" (Li, 2018: 23).

Underpinning all successful health consultations is the ability to confirm and achieve understanding. In addition to translation, recent studies on health communication between medics, migrants and mediators have shown that comprehension can be enhanced by employing communicative strategies such as checking, reformulation and negotiation (see 4.5). It is to these strategies that I first turn, acknowledging that while indirect questioning can protect potential threats to face, a direct approach is often necessary to establish clarity (7.1). Similarly, as it is clinically and ethically advantageous to ensure comprehension in health encounters, participants who are able to draw on flexible and multimodal repertoires can transform interlingual communication, especially for patients who have little or no understanding of the dominant language (7.1.3). Nevertheless, interweaving interactions, can be glimpses of asymmetry between participants, a recurrent theme in the field of patient/doctor communication, and echoing concerns that "hybridity and

related notions are neither neutral nor apolitical: they involve contextual and relational arrangements of power" (Kubota, 2014: 9). As the following section goes on to illustrate (7.2), this is not to say that authority is necessarily used to disempower or 'other' participants who draw on alternative linguistic or sociocultural resources than those associated with the institution. Rather that, on occasion, those in positions of authority (here the medical staff) draw on particular aspects of their repertoire(s) to manage some of the challenges which characterise the unpredictability of superdiverse populations. To exemplify, in section 7.2, a consultant can be seen to employ a 'tactful overlooking' (Goffman, 1972) in order to disattend from the circumstances that have led a trafficked patient to attend his clinic (7.2.1), but in a way that could be interpreted acontextually as dismissive. Equally, when a midwife is forced to navigate the sensitive topic of sexual health with a patient's male friend, rather than the woman herself, she relies on a mixture of technical, euphemistic and vague language to avoid face threatening discourse, even though this may contrast with communicative guidelines for clarity (see for example, NHS England Patient and Public Participation and Insight Group, 2016). Unfamiliar topics and knowledge are introduced and co-constructed, occasionally affecting patients' agency in spite of participants' ostensible orientations towards conviviality (see 7.2.2. & 7.2.3). In sum, these incidents point to the fact that differential access to linguistic and epistemic resources does not inevitably position participants asymmetrically, but rather forces participants to recognise, navigate, and accommodate the contextual continuum upon which understanding lies (Cox & Li, 2019). Section 7.3 discusses just this, illustrating a broad range of epistemic mediation, from the flexing of authority (7.3.1) to a flattening of discourse (7.3.2) and acknowledgment of patients' epistemic agency (7.3.3). Yet, as earlier examples in Chapter 6 may have implied (see for example, extracts 26 & 27), even with the most collaborative, and convivial, approach some

> resources may fall markedly short of giving an accurate and
> sophisticated response to the communicative challenges [of]
> consultations [in a superdiverse setting] as participants
> …clearly lack… the linguistic and interpreting subtleties
> needed to perform the more complex linguistic-interactional
> tasks (Cox & Maryns, 2019: 13).

Following this, the remainder of 7.3 details the extent to which comprehension can appear to ebb and flow over the length of a consultation, changing in response to context, the type of information being requested and whether any extra-linguistic resources can be drawn upon to consolidate meaning. While examples document extended periods of interdiscursive translanguaging (Simpson, 2016), and what I earlier described as transelucidation (see 3.5.4), issues of false fluency (following Cox & Li, 2019) appear to obscure substantial breakdowns in comprehension (7.3.4, 7.3.5).

Moving on from the focus on complex, communicative concerns, this chapter concludes by illustrating the ways in which the liminality of the superdiverse consulting room also provides space for personal, or vicarious, resistance, giving participants the opportunities to challenge implicit, imposed or inherent power dynamics, in often quite surprising ways. To extrapolate, section 7.4 begins by exploring the ways in which pregnant women may be implicitly positioned as epistemically deficient, and illustrates how the ability to access a wide and technical repertoire can not only accelerate agency, but resist institutional discourse (Moyer, 2013; see 7.4.1). In contrast, more vulnerable patients can be disadvantaged by the lack of sociocultural or linguistic capital needed to navigate an unfamiliar health system, and also by the circumstances which have thrust them there. The interaction in 7.4.2 illustrates how the presence of a third party, empowered with the ability, and intent, to flout convention (Li, 2018), can disrupt the stigmatising effects of categorisation and help to redress parity of experience.

7.1 Strategies for checking ensuring understanding

Key to a medical consultation, is the need for checking understanding. Not only is this part of the NHS commitment to ensuring voluntary, informed consent

(Department of Health, 2009), by a person who has the capacity, and arguably agency (Moyer, 2013), to make decisions, but it is also necessary to establish effective communication. In addition, medical professionals need to know that they have a full picture of a patient's health so they can treat them appropriately. As the majority of people are also intrinsically motivated to understand their own personal health conditions, the pursuit of mutual comprehension is central to communication between medical professionals and their patients, whether or not they share elements of linguistic repertoire. Notwithstanding the bluntness of questions such as 'do you understand?' which can imply confusion, uncertainty or non-comprehension, and thereby threaten the conviviality which facilitates effective talk, midwives appear to go to varying lengths to mitigate potentially face threatening acts by formulation, reformulation and consistent checking (Linell & Bredmar, 1996; Maynard & Hudak, 2008; Baraldi & Luppi, 2015).

7.1.1. Direct questioning

Following the phatic introductory phase of an antenatal appointment (see 6.2.1.1), midwives routinely check patient identity, such as date of birth and due date, predominantly as a universal safety precaution to prevent mistaken or inappropriate medical treatment. As an example, the extract below demonstrates MW2 performing this ritual check with her patient, Agnieszka. While direct questioning pertaining to simple facts is unlikely to threaten the patient's face needs, the midwife nevertheless deploys a number of mitigating strategies to reduce potential offence. In possible anticipation of the impending injection, which will require extensive mitigation to cushion the imposition (see for example, 6.2.2.2), the midwife begins by situating the need for a direct request as something that is taking place outside the frame of administration of medication (L21), i.e. separating it from the imminent FTA.

 A= Agnieszka; MW2=midwife 2

 21   MW2: before I give it before I take it can I just check that this is you↑

22   A: yes me↓

23   MW2: okay (1) how many weeks exactly are you today↑

24   A: e:rm=

25   MW2: =( )=

26   A: =31 plus something (.) //32

27   MW2:   //32 (1) you're 32

Extract 30, C5

The midwife also offers the vial containing anti-D medication to the patient for her to confirm identity. She accompanies this with an indirect question, modified by the adverb, "just", to further restrict possible intrusion. Secondly, when checking the patient's week of pregnancy, MW2 glosses Agnieszka's answer, "31 plus something", to reformulate it to the correct week, "32": repetition to confirm thus avoids a face-threatening correction, while simultaneously asserting an epistemic authority (Baraldi & Luppi, 2015). Nevertheless, different conversational styles lead to alternative approaches to clarification. In stark contrast, the following extract (31), shows MW1 adopting a very direct communicative stance, in which the substantial threat to face is consistently mitigated by smiles and loud laughter.

M= Melina; G= George; MW1= Midwife 1

34   MW1: no uh (.) are you understanding it ↑

     ((referring to the form on which Melina is concentrating))

35   MW1: cos I only >wanted you to see< what to what extent you know how to

36   fill it out (.) if you can't (.) we'll help you (.) alright↑ (1.5) Melina look at me //(.)

37   do you: understand what I say↑// (2) £look at me: £=

38 G: //***hhh estás a entender*** = ↑   // *hh   do you understand*=↑

39 MW1: =you you looking so intent and studying it so well I want to make sure
    that you understand

40   what it is you you reading (.) if you ca:n't (.2) we can help you↑ that's what
    we're here for=

41 M: (◦ okay ◦)

42 G: =Can you…↑

43 MW1: =>you need help↑<

44 M: yea:h //hh

45 MW1:   //hh=

46 M: =hhhh

47 MW1: hhhh that's that's what we're here for

Extract 31, C12

At the beginning of this consultation (C12), the patient, Melina, stares at the 'Pregnancy Notes' in apparent confusion, prompting MW1 to make a direct bald-on-record request for confirmation of understanding: in order to ameliorate the possible FTA, the midwife talks in a smiling voice (Jefferson, 2004). She also bends her head down, in an attempt to make eye contact with her patient, in a submissive move of recipiency and to demonstrate her 'gaze of availability' (Heath, 1986). Through simultaneous movement and an explicit invitation to meet her gaze, MW1's multimodal approach demonstrates her commitment to interactional, intercultural work (Pasquandrea, 2011) and goes some way to reduce the asymmetries, which can be implied by institutional discourse inherent in the complexity of the notes (ten Have, 1991; see 2.3.2.2). By echoing MW1 with a direct translation and softening laughter, George also indicates a mutuality of support, which is then acknowledged by the midwife's repeated offers of help, using the pronoun "we" (L40): in contrast to Baraldi's observation that 'we' can be used to demonstrate dyadic affiliation, here it

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appears to include all other participants (Baraldi, 2009). Following an iteration of the inquiry (Lines 38-41), and reassurances of the group, Melina offers a mitigated response and laugh token (L44). Once again, participants use laughter as a diversion from the FTA of a bald-on-record request for clarification (Brown & Levinson, 1987) and the bracketed event ends (Goffman, 1986) as the group re-establishes interactional footings and the consultation continues.

Significantly, the homogenous 'Pregnancy Notes', which are designed to encourage "two-way communication so the expectant mother and her family are fully informed and able to contribute to the decision making process" (See Appendix A), also act as guide for the midwives' information gathering. As such, during a booking-in session midwives move systematically through the notes, asking questions and recording requisite paperwork. However, as we see in extract 31, even the personal information section of the complex document can prove difficult for many patients to navigate independently. Although at times midwives find extensive linguistic and multimodal resources upon which to draw (see for example, extracts 20, 26, 29 in Chapter 6), at others they need to rely on either formal or informal interpreters to assist.

7.1.2 Clarifying understanding

Whilst the presence of a professional interpreter can aid communication and ensure mutual comprehension, the mediation of information by a third party is not without problems. A "complex interactional space" (Pasquandrea, 2011) can involve a combination of languages, sometimes being spoken simultaneously; medical professionals must both manage the interaction yet cede institutional power and responsibility to the interpreter, who in turn relays information (see 4.4); the patient must also share personal information with a non-medical professional, and trust that it is being accurately construed and transmitted. Underlying these institutional exchanges, all professionals present hold a tacit commitment to accuracy and ethical behaviour. However, as there is currently no statutory requirement for specialised healthcare training for interpreters working for the NHS (NHS England/Primary Care Commissioning, 2018), and as each interpreting job may involve a different

area of medical specialism, it is evidential that professional interpreters will, at times, need to check their own understanding regarding information to be relayed and to possibly expound on responses, whether made by doctors or patients (See 4.3, 4.4). In the following extract from Melina's consultation, we see the interpreter checking her understanding of both process and medical information.

M= Melina; G= George; MW1= Midwife 1; I3= Interpreter 3

112   MW1: =right right let's go through this now (.) erm just go through this with her(.) and there's

113   a tick (.) answer the questions as they are (.) anything you don't understand ( ) I'll wait

114   I3: all these questions↑=

115   MW1: =all these questions and then you can go=

116   I3: =okay (.) *É historia médica dele que*   =okay (.) *this is his medical*
        te está perguntanto   *history that she is asking // you.*

117   MW1:   //>ask her the main term just tick

118   them off yes or no< (.1) she has the pen

119   I3: ask her to (.) if she understands↑

120   MW1: ( ) has she ever been (.) seriously ill in erm (.) where she has to be

121   admitted in a high dependency unit (.1) yeah↑

122   I3: ITU //okay

123   MW1:   //yes or intensive care

124   I3: okay (.)*Tu já foi admitido no ( ) erm*   Okay *Was you admitted in (.) I*
        ( ) acho que é "sala de emergencia ↑   *think it is (.) emergency room.. ↑*

125   M: no

126   I3: no=

127   MW1: =alright just put no   Extract 32, C12

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Before beginning to translate the medical history questions, the interpreter's voice both rises to express surprise and increases in volume, creating the impression that she is daunted by the task, "all these questions↑" (L114). Once confirmed, the pause following the ensuing response "okay(.)" implies a degree of uncertainty, prompting MW1 to interrupt her to quickly reformulate and gloss the instructions on how to complete the form (L117) (Baraldi & Luppi, 2015). Whilst "talking with patients takes time" (West, 1984: 2), MW1's impatient, and authoritative, reaction to the interpreter's hesitant approach, appears to support the idea that civility towards diversity can sometimes "emerge from indifference…rather than from a specific appreciation" (Lofland in Wessendorf, 2010:15). In contrast to MW1's previous display of intercultural awareness, where she shows an appreciation of her patient's unfamiliarity with institutional discourse (extract 1), the midwife instigates a rush to start the questions (L117-118), arguably not allowing the interpreter time to familiarise herself with the text and expectations surrounding its completion. The interpreter attempts to clarify once again, "ask her to (.) if she understands↑" (Line 119), and embarks on a confused translation between HDU/intensive care and emergency (Lines 120/121), couching her uncertainty with "I think it is" (Line 124).

As we follow this interpreter through the consultation (see Chapter 6, extracts 24, 25, 26: Chapter 7, extracts 37, 42), it becomes evident that she has a complex repertoire, displaying features often associated with other 'named' languages such as Spanish and a linguistic creativity which Li characterises as a "translanguaging instinct" (2016) (see 6.5). However, in the absence of specific personal information, we must also acknowledge that the "dynamic interplay of variables" (Blommaert in Creese & Blackledge, 2010: 552) that contribute to the complexity of superdiverse environments, reflect the linguistic practices of settled communities as well as more recent migration trajectories, thus indicating that specific assumptions about characteristics of specific groups, languages, ethnicities or nationalities need to be challenged (Bradby et al., 2017). In extract 32, although the interpreter makes what appears to be an epistemic, rather than lexical, error in confusing two medical 'departments', her non-standard use of Portuguese becomes evident: for example, in L116,

the patient is told that the midwife is asking about George's medical history, and later addressed by the informal form of you, 'tu' (L124), instead of the polite form, 'Você', which is typically used with strangers: taken in combination with an idiomatic grammar and strong Brazilian accent the other Portuguese speakers are alerted to an unpredictable repertoire (see 8.2.2).

In contrast, the interpreter in extract 33, appears more adept, or perhaps just more experienced, at medical interpreting, as she translates a consultant's advice to her patient. DC has just finished instructing Maalini about how to manage her diabetes (see also Chapter 6, Extract 20).

Ma= Maalini; DC= Diabetes consultant; I1= Interpreter 1

72 DC: =there's no point increasing insulin again and again (.) what I WAnt is you

73 WAlking 20minutes, 30 minutes after every meal //(1) breakfast

74 I1: //*என்ன விளங்குதா சொல்றது? இருவது நிமிஷம் எண்டாலும் சரியா வரும் எண்டு* | //*Do you (.) understand what she is saying↑*

75 Ma: Yes I understand

76 I1: *ஒவ்வொரு சாப்பாட்டுக்குப் பிறகும் இருவது நிமிஷம் நடக்க சொல்றா. நடந்த கூட்டி வேலையில்ல. நீங்க ஒவ்வொரு சாப்பாட்டுக்குப் பிறகும் நடந்தீங்க எண்டா,* | *After every meal, she is asking her to walk for 20 minutes*

77 Ma: Everyday↑

78 I1: *ஒவ்வொரு சாப்பாட்டுக்குப் பிறகும் இருவது நிமிஷம் நடக்க சொல்றா. நடந்த // கூட்டி வேலையில்ல. நீங்க ஒவ்வொரு சாப்பாட்டுக்குப் பிறகும் நடந்தீங்க எண்டா, (1)=*

After walking, there is no work to be done. After every meal, even if you were to walk for 20 minutes… (1)=

79 DC:=//promise↑

80 I1: = //it will be fine

Extract 33, C2

As Linell and Bredmar (1996) note, medical professionals are aware that advice on lifestyle, implies an intrusion which can impinge heavily on the patient's sense of self. As such, much of DC's advice during consultation 2 has been delivered through methods employed to mitigate any threat to face, e.g. convivial code-switching, jokes and teasing (see 6.4.1, extract 21). In Line 72, there is a distinct change in footing as DC seeks to emphasise the importance of managing Maalini's insulin intake and reducing symptoms through diet and exercise. The consultant is no longer laughing, as she refuses to increase her patient's medication. By employing the personal pronoun 'I', and emphasising the verbs, DC makes a pointed change to her previous stance of alignment, imposing her epistemic and institutional authority on Maalini, however briefly: 'what I WAnt is you WAlking' (L72).

Having listened to the consultant's advice, it is now the interpreter's task to check the patient's understanding. Demonstrating her recognition of the potential urgency of directives, I1 omits any hedging or mitigating strategies which she could employ to protect Maalini's face needs, (Brown & Levinson, 1987), and utters a direct question (L74). Although the patient has confirmed understanding (L75), I1 reformulates the consultant's requests but directs the instructions to the patient's (silent) husband (L76). While the reasons for this could be interpreted as challenging to Maalini's autonomy, fieldnotes confirm that I1 appeared to be trying to encourage the patient's husband to recognise

the care that his wife will need during her pregnancy (see Appendix C). As she subsequently seeks to clarify what Maalini does, or does not understand, the interpreter displays a complex set of professional skills: firstly, she breaks information into small, manageable chunks; the time frame of walking for '30 minutes' (L73), is subsequently reduced to '20 minutes' in a possible move of affiliation (L76); and the iterative effect of repeating instructions, accompanied with the adverbial phrase 'after every meal' (L76, 78), emphasises the importance of the message the consultant has been trying to communicate.

When Maalini L77) asks whether she needs to walk every day, the interpreter confirms that she should, although her response is interrupted by DC. The consultant's terminal move is significant: while the overlapping talk (L79), could be interpreted as an attempt to re-impose her interactional dominance (Pasquandrea, 2011) it is likely that DC's actions are focussed on her patient. Given that mediated encounters are understood to increase the distance between doctor and patient (Angelelli, 2004), by asking Maalini to 'promise' (L79), DC is attempting to mitigate any potential FTA, and re-establish the previously convivial tone. These efforts are further consolidated through the demonstration of her receptive skills, which imply linguistic solidarity and affiliation.

7.1.3 Ensuring clarity

In the previous examples, we have seen how medical professionals strive to reassure patients, while using interpreters to help facilitate clarification of health information: permeating many of these encounters has been a sense of conviviality and a patient-centred commitment to explanation. However, as previously noted (See 6.2.2.3, extract 12), when there is a situation which presents substantial risk to patient and child, the tone of the consultation can change from informally convivial to serious and direct.

The following extract introduces Sadia, an Afghan patient, who is accompanied by her English-speaking husband and a professional interpreter. She speaks very little English, and is attending an appointment in the diabetes clinic, towards the end of her third trimester. As Sadia is pregnant with her fourth

child, her current pregnancy comes with the additional complication of a potentially short labour, which could give her very little time to get to the hospital. As before, the diabetes consultant, DC, is seen to draw upon her broad linguistic repertoire to communicate with Sadia. Unlike previous appointments, much of the consultation is conducted in a shared language of Urdu[7], with few interventions forthcoming from the other participants present in the room. 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.

S=Sadia; DC=Diabetes Consultant

1	DC: okay **sab samajh mein aa gaya**↑	*Okay have you understood everything↑*
2	S: Hmmm	
3	DC: **toh aap chaar baar sugar ka test karoge…**Monday ko Wednesday ko Friday **ko teen dafa, magar chaar baar karoge**	*So (.) <you will have to test your sugar four times >(1) on Monday Wednesday and Friday thrice a week but four times each day=*
4	HCA: number 1 ((quietly to colleague))=	
5	DC: **aur tera (13) taarikh ko apka induction hain, saare saath (7:30) baje haspatal mein** phone **karke…kabhie 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** midwife **aapko** examine **karke dekhengi (.)**	*= 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 (.)*

---

[7] Transcription given in Anglicised script

6   S: mm

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*   *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*

8   S: Ye (.)   Okay

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*   *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   S: mm

12   DC: phone *karne ki zaroorat nahin*   *No need to call*

13   S: *ha theek hain*   *Yes*

14   DC: *theek hain↑ Turant aa jana*   *Okay (.) come quickly (.)*

15   S: uh

16   DC: *chautha bachcha hain na toh jaldi aa sakta hain↑*   *Because this is your fourth baby, might come very quickly(.5) Okay↑*

17   S: *hhh theek hain*   *yes okay hhhh*

18   DC: (4) ((doctor averts gaze to write in Pregnancy notes/clinical notes))

19   DC: *kuch aur poochna hain*   *Do you have any questions*

20   S: *nahin*   *No*

Extract 34, C3

Calling to mind an oft problematised model of power in doctor/patient relationships (see 4.3.1), the consultant can be seen to shape the agenda, dominating the conversation, as she leads the patient through a series of instructions and explanations (Fairclough, 2015). As previously noted (see 6.2.2.3), in times of urgency, potential threats to face are ignored (Brown & Levinson, 1987; Goffman, 1972): in this instance, it may be that in order to establish certainty, the patient receives vital information directly, rather than accompanied by normative features of mitigation (Harvey & Koteyko, 2013) or via the interpreter. DC's use of imperative verbs "you will have to" (L3), "you need to" (L5), and repeated use of "okay" as a device for checking comprehension (L1, 9, 14, 16), emphasises the degree of urgency which may accompany the onset of labour. In addition to a series of ventriloquised 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 (L2, 6, 8, 11, 13, 15), this sequence positions the participants asymmetrically. However, by line 17, the patient's agreement is accompanied by uneasy laugh token, potentially as a subtle indication for the obligatory discourse to cease because it is impinging on her sense of self (Goffman, 1972), or to indicate her rising concern. In response, the consultant diffuses the FTA by averting her eyes and beginning to write in Sadia's Pregnancy Notes. Although by withdrawing her gaze, and indicating that the didactic section of the interview is closed, DC is also displaying a degree of symbolic power (Pasquandrea, 2011). Sadia remains unperturbed, possibly because "if patients are tolerant of medical authority, they are also tolerant of the linguistic strategies that give rise to interactional authority in the consultation" (Harvey & Koteyko, 2013). An experienced mother, the patient indicates her understanding of potential risk associated with the birth and acquiesces to the consultant.

While it is possible to construe extract 34 solely as a display of institutional power, with DC addressing Sadia in an apparently simplistic and patronising tone, her communicative approach can also be understood as displaying

elements of sensitivity towards her patient.. For example, her use of Urdu may be used in order 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 (L1, 3, 5, 7) and flattening epistemics when describing the medical procedure of induction, (she replaces 'cervix' with the word "opening") 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.

Evidently, and echoing methodological reflections (see 5.3), there a number of interpretations that can be placed upon this interaction, which cannot be surmised from either this excerpt alone, or without further contextual information. For example, as I only joined the consultation after the physical examination, I was not privy to earlier discussions as to why the professional interpreter did not interpret for her client, in line with institutional guidelines (NHS, 2018). What can be inferred however, is that while the consulting room has been appropriated as a translanguaging space, where individuals appear free to draw on personal repertoires in order to improve communication, linguistic accommodation appears to remain at the instigation of the consultant. Here, the space offers less a perspective for transformative dialogue (Li, 2018), as the doctor's didactic approach does not appear to explicitly alter Sadia's experience, but more the opportunity to reproduce institutional order, albeit in a different language (Kubota, 2014; Moyer, 2013).

7.2 Changing populations

Nonetheless, not all the challenges posed by a superdiverse population are linguistic. Diverse demographics will reflect differing belief systems and expectations of provision, informed by alternative healthcare models, and previous (potentially, lack of) exposure to health education. As these determinants intersect with sociocultural and economic factors, migration status and entitlement to services, antenatal care in a superdiverse setting can require complex navigation (Piacentini et al, 2018). Indeed, many of the women giving birth at HUH may have potentially experienced pre-migration

trauma, whether as victims of environmental disasters, conflict or the journey itself (see 2.2). The proximity of Hayfield to the Home Office, and the global increase in people trafficking, also gives rise to a disproportionate number of patients who have been trafficked for sex or slavery (see 2.3.2.1). It seems evident therefore, that in the light of such vulnerable patient populations, that there is an implicit ethical and institutional responsibility for health professionals to not only anticipate linguistic and sociocultural difference, but to be able to negotiate these in a particularly sensitive way (Linell & Bredmar, 1996). The following extracts detail several carefully nuanced interactions, which appear to illustrate such an appreciation.

7.2.1. Tactful overlooking

As DC has demonstrated (see extract 34), although they are bound to the goal-oriented agendas of consultations, medical professionals working in a superdiverse environment appear to have an acute awareness of the experiences and expectations of their patients. In Chapter 6 I introduced Ajola, a victim of human trafficking who lost her previous baby as a result of domestic violence (see extract 23). Now in her third trimester, her consultant obstetrician is advising her on care. This is the first time doctor and patient have met, although the conversation is mediated by a professional, female interpreter, with whom both participants have previously worked. In a fluent triadic episode, each utterance is immediately translated by the interpreter who "operates as the hinge of the whole communicative process" (Pasquandrea, 2011: 548), helping to expedite the smooth completion of Ajola's painful medical history.

AJ= Ajola; CT2= Consultant 2; I4= Interpreter 4

38   CT2: erm this is your second pregnancy yes↑=

39   I4: **Shtatzania e dytë është**   *Is this the second pregnancy↑*
       kjo↑

40   AJ: **Po**   *Yes*

41   I4: yes (.) yes

42   CT2: ◦you lost the first one◦↑

((consultant is checking medical history and turns pages slowly as he formulates questions))

43   I4: ***E ke humbur fëmijën e***   *Have you lost the first baby* ↑
      parë↑

44   CT2: with placental abruption↑

45   I4: ***Me placentën që e kishe***   *With the abrupted (1) placenta you had,*
      keq apo qysh↑   *or what*↑

46   AJ: ***Nga goditjet e bëra.***   *Of the beatings done*

47   I4: ah yes◦

48   CT2: ◦when did this happen↑◦

49   I4: ***Kur ka ndodhur***   *When did it happen*

50   AJ: ***Ka ndodhur nga viti*** 20█   (.) *It happened in year 20*█

51   I4: 200X=

52   AJ:= (   )

53   CT2: that was in █████↑

54   I4: ***Në*** █████i?   *In* █████↑

55   AJ: ***Po***   *Yes.*

56   I4: Yes

57   CT2: (2) that was about 34 weeks↑

Extract 35, C13

In a stark contrast to the convivial opening of the consultation, (see 7.5, extract 47), the doctor's <mark>tone marks a change in footing</mark> as attention is turned to the matter in hand. Due to Ajola's personal medical history and circumstances, which have the potential to threaten the faces of all participants (Goffman,

1972), but specifically that of his patient, the consultant initially hesitates as he decides how best to begin (L38). Without naming the incident, or asking for a full account of the actions which led to the previous stillbirth, the doctor glosses Ajola's medical history from her notes, "you lost the first one↑" (L42) "with placental abruption↑" (L44). However, while CT2 seeks only to confirm prior events, using technical language to distance and mitigate any prominence given to the incident(s), in an attempt to protect Ajola's positive face needs, it appears that the patient wants to further acknowledge the event that led to her baby's death, albeit minimally. Following the interpreter's iterative gloss of the doctor's technical term, "abrupted placental you had" (L45), Ajola deflects the imposition of agency implied by "you lost" (L43) and retorts that the baby died as a result of "hard beatings' (L46) i.e. not as a result of her actions. At this point, the interpreter's voice softens empathetically, although she refrains from relaying Ajola's explanation to the doctor. This action is open to interpretation: I4 may be protecting the faces of both doctor and patient, because any implied threat by CT2's 'you lost' (L43), was unintentional, or because the interpreter is also collaborating to prevent an expansion on Ajola's medical history. Indeed, rather than rely on reformulations to gloss Ajola's responses, a strategy which can be seen as evidence of patient validation, as well as a means of encouraging reciprocity (Baraldi & Luppi, 2015), the consultant chooses to move quickly through her painful medical history. He uses a number of avoidance strategies associated with a "kind of tactful overlooking … when a person openly acknowledges an incident as an event that has occurred…. not as an event that contains a threatening expression" (Goffman, 1972: 18), but, nonetheless, one that should be ignored. By chunking the information into short utterances, the sentences become questions through the use of rising intonation and are designed to elicit only minimal response from Ajola (L40, L55), therefore protecting participant face needs. In addition, although the directness of his utterances have the potential to negate his intention, CT2 mitigates this by attempting to complete the medical history quickly and reducing penetration of the sensitive topics, represented by Ajola's antenatal and recent history (Linell and Bredmar, 1996).

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7.2.2. Moral implications

In linguistically diverse environments, where it may be difficult to locate an interpreter for a minority language, participants often rely on informal interpreters such as friends and family (Piacentini et al., 2019; Mastrocola & Nwachukwu, 2009) who may, understandably, require assistance with clarification. Returning to a previous consultation (C12), when the professional interpreter has to leave for another appointment, MW1 assesses Melina's friend, George, as competent enough in English to translate. As part of the booking-in process, the midwife is required to discuss Melina's sexual history and establish the date of her last smear test. Although screening for cervical cancer is routine, Linell and Bredmar note that sensitive topics threaten the face needs of participants, as they have "'moral' implications...[touching] upon interlocutors' responsibilities for leading their lives in good or bad, acceptable or blameworthy ways" (1996: 348). For example, asking women about their sexual health carries implicit notions of embarrassment, as questions touch on subjects such as sexually transmitted infections, multiple partners or abortions, thereby threatening patients' positive and negative face (Linell and Bredmar, 1996; Brown & Levinson, 1987). In this instance, MW1 reflects ruefully on the difficulty of asking George, Melina's friend, not partner, to translate personal questions "now this is where the interpreter comes in (2)" (L626), pausing slightly in an expression of discomfort.

M= Melina; G= George; MW1= Midwife 1; MS= Student midwife

626　MW1: ask her if she ever have a smear test done (1) now this is where the interpreter comes

627　in (2) smear test (1) does she know what a smear test is↑

628　G: (.) £I don't know either£=

629　MW1:=hh

630　G: hhhhhh

631   MS: ask um // if they check

632   MW1:   // ( ) (2) how old are you↑

633   G: 30

634   M: 33

635   MW1: 33 right (3) <we do all women all women> girls in this country when they reach 25 years

636   old after more than 24 (1) we always check for something they call cervical u:m (.)

637   cancer and in order to check for that we always do a swab down in your private area.

638   G: a:ah I know what you're telling me (1) Yeah (.)I know (.) Ah ↑Yes (1)

639   G: because in my country is the same (.) but it's another word e:rm

640	G: **As mulheres depois dos 25 anos ou 24, eles fazem um teste à tua erm pachahca, que é "pa" ver se tens alguma coisa de mal.**	*Women over (.1)after 25 years or 24 hey do the test on your erm pussy that is ta see if you have something wrong.*
641	G: **Eles "raspem" ou fazem coisa e vêem quanto é que ( ) se "tás" bem ou se não**	*They scrape away or do something and see how much it is that ( ) if you are okay or if not.*
642	M: **eu fiz e "tava" tudo bem.**	*Yes. I did it and it was okay =*
643	G:=mm	
644	M: **Mas foi lá não foi aqui**	but it was there. It wasn't here
645	G: in Portugal it is the same thing and she she go to that that stuff=	
646	MW1: =what year↑↑	
647	G: **Em que ano↑**	*What year was it↑*
648	M: **Eu tinha 25**	I was 25 years old.
649	G: it's 25 (.) 33	

650 G: 8 years ago

651 M: 25 (.) 26

652 MW1: When was the last time she had it done↑ 8 years ago↑

653 G: yeah

654 MW1: 8 years ago ↑

655 G: I told, 45=

656 MW1: = (   ) alright then

<div align="right">Extract 36, C12</div>

The midwife defers the introduction of a difficult topic through reframing the topic as an indirect check of epistemics, "does she know what a smear test is?" (L627). Unfortunately, the technique of delegation, backfires: George cheerfully makes a bald-on-record admission of ignorance (L628), causing MW1 to laugh gently at her redundant strategy. In recognition of her embarrassment, George reciprocates with loud laughter, which next prompts the student midwife (who remains almost silent throughout the whole consultation) to suggest an alternative, face-saving, frame - "ask her if they check" (631). In the ensuing exchange, MW1 uses a range of strategies to mitigate the potential threat to face implied by the such a personal line of questioning: as Goffman notes "just as the member of any group is expected to have self-respect, so also he is expected to go to certain lengths to save the feelings and the face of others present" (1990:10).

In their research on midwife/patient consultations, Linell and Bredmar (1996) note that in sensitive situations, midwives employ a number of hedging devices to ameliorate or avoid possible confrontation and embarrassment. Following this, MW1 is initially hesitant as she decides how best to approach the topic of smear tests, first using pausing and checking the age of the patient (L632/637): in the UK women are routinely invited for tests every 3 years from the age of 24. However, MW1 does not assume that her patient has had a test and, reducing a direct threat to face that may imply Melina is careless with her

health, MW1 obfuscates patient agency, emphasising that screening is something medical staff 'do' – "we always check" "we always do" (L636, 637) - as part of a universal offer in the UK. Reflecting the everyday parochialism of a superdiverse environment, where "social relations developed in the public realm become habitual and frequent", Wessendorf (2010) argues that public spaces, such as hospitals, "can become meaningful sites of interaction and intercultural engagement", and that it is in these spaces, where "intercultural competences are learned" (Wessendorf, 2010: 22). As an experienced midwife in a superdiverse environment, MW1 not only demonstrates a sensitivity in her approach to a delicate topic (which we may safely assume she would adopt with all patients, regardless of nationality) and slows down her speech, but recognises how the diversity of patient experience (or lack of) can be both unpredictable and detrimental to health.

MW1 further mitigates possible loss of face, by limiting what Linell and Bredmar call the 'depth of penetration' (1996: 351) she gives to the topic. The implied routineness of the idiomatic generalisation, "we always do a swab down in your private area", avoids the use of formal medical terminology, such as 'cervix' or 'vagina'. By circumventing their mention, talk of cervical cancer as a disease is avoided and "topically framed as targets of …tests" (Linell & Bredmar, 1996: 369). As such, the midwife's efforts preserve both face and a professional footing, as she accepts George's confirmation of understanding (L638). Here the friend's role changes from that of 'animator', i.e. a conduit for information, to that of a principal (Goffman, 1981; see 5.5.2.2.), giving George the agency to offer his own interpretation and jeopardising MW1's face-saving efforts. Through his spontaneous use of the epithet 'pachahca / pussy' (L640), George's language can be interpreted as an idiosyncratic attempt to break the formality of a medical appointment (see also extracts 2, 44), as well as to detract from the implications of an oblique admonishment. Bringing the topic to a close, the participants work collaboratively to confirm Melina's last test: MW1's voice rises in surprised concern, as she repeatedly queries the length of time "8 years ago↑" (L651, 654), masking her medical concerns with a reframing of the time. However, to mitigate the protracted negotiations, and in order to restore equilibrium, MW1 then neutralises threats with a concluding "(

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) alright then" (L656). Nevertheless, as Moyer points out, despite the sensitivity shown by MW1 and the cooperation of her friend, Melina's agency is compromised in this exchange: with limited understanding of English, she is unable to contest either of the implied interpretations of her health-seeking behaviours and may be unaware of possible "negative categorisations" (Moyer, 2013: 220), that have been written on her medical notes.

7.2.3 Co-constructing knowledge

In her research examining agency in migrant healthcare, Moyer highlights the importance of language as "a resource for negotiating agency" (2013: 197). As a patient who speaks "fairly good English" (extract 16, L78), Karla, is confident, and able, to question medical terminology. The following extract illustrates the notion of intralingual languaging (Baynham et al: 2015), i.e. working across languages, as MW1 endeavours to explain the technical term, blood clotting, to her patient. As we saw in the previous chapter (extracts 25, 26), it proves to be a difficult condition for the midwife to define:

K=Karla; Bf= Boyfriend; MW1 = Midwife 1

324   MW1: (.) anybody in the family has blood clotting problems↑

325   K: what does it mean blood clot//ting

326   MW1:   //okay blood clotting when the blood doesn't clot when

327   the blood clots sorry

328   Bf: ***Krzepliwość krwi***   *Blood clotting*=

329   K: =aah

330   MW1: =when the blood just clots //and you have big lumps//

331   and ( ) can go to the heart and=

332   K: //ahha (1)   //no no okay

33   MW1: ( )

334   K: =no no it's okay ( )

335   MW1: you understand that ↑

336   K: yeah

337   MW1: you understand that↑

338   Bf: yeah yeah

339   MW1: you translate it

340   K: that's right that's why we are together now hh//hhhh

341   MW1:   //hhhhh

Demonstrating her desire to support shared understanding (Baraldi & Luppi: 2015) MW1 responds enthusiastically to Karla's question, indicated by the slight overlap, "okay" (L326), in which she confirms the noun phrase which Karla is querying. Although she initially makes a mistake, describing the condition as "when the blood doesn't clot" (L326), there is no hesitation in the midwife's repair: MW1 immediately apologies to acknowledge the error, thus limiting the potential loss to face (Brown & Levinson: 1987). Karla's boyfriend, who has been sitting quietly during the consultation, only speaking when spoken to, then interjects (L328) to translate the condition for Karla. This begins a series of overlaps, as the participants jointly co-construct meaning and clarify understanding. In lines 329 and 330, Karla and MW1 speak simultaneously, the patient expressing her understanding of the translation, 'aah' (L329), and the midwife continuing with her explanation. As MW1 reformulates (L330), she appears oblivious to Bf's display of epistemic authority, as she pursues her own agenda i.e. to successfully explain a medical condition. Karla is keen to indicate her understanding, and tries to interrupt the midwife with her reassurances (L332). This triggers a change in frame as MW1 (L333) moves from her adopted position of epistemic authority, to a more symmetrical one of active listening. In alternative circumstances, the midwife's directness may have posed a threat to her patient's positive face, but it is likely that the repeated querying of understanding (L335, 337), indicate a delayed

realisation that the term has been successfully translated, thus placing MW1's positive face in a more vulnerable position than her patient's. Once comprehension is confirmed by Bf, MW1 glosses his answer (L339) before Karla changes footing to align explicitly with her partner. The dyadic separation (Baraldi: 2009) emphasized by the use of the pronoun 'we' and strengthened by the adverb 'together' in line 340, demonstrates the linguistic and social affiliation between Karla and her boyfriend, what Baraldi calls a 'we' identity (2009), and simultaneously increases the distance between the midwife and the patient. As the change in stance further places the midwife at an interactive disadvantage, Karla attempts to mitigate the issue with a laugh token (L340): by reciprocating the laughter, MW1 can be seen to accept the remediation, therefore restoring interactional equilibrium.

7.3 Negotiation, asymmetry and power

In light of the inherent risks associated with pregnancy and the maternal and infant mortality rates, which are disproportionately higher among migrant women and those from BAME communities (see 1.2, 2.2), it is strongly recommended that all women engage with primary health care as early as possible during their pregnancy. Indeed, the compelling obligation to ensure a healthy pregnancy becomes "a powerful social imperative for patients to defer to the authority and technical superiority of health professionals" (Harvey and Koteyko, 2013: 33). However, it must also be acknowledged that the NHS has also seen a broad change in footing in recent years, with movements to towards a more 'democratised' model of 'patient-centred care' (NHS, n.d; Fairclough, 2010). Predominately characterised by an emphasis on patient 'voice', sharing access to medical records, and offering detailed information on health conditions, this form of democratisation, at least superficially, seeks to empower patients to facilitate their participation in decision-making processes (NHS, n.d).

Having previously demonstrated that consultations in a superdiverse health setting appear to thrive in a third space which offers the potential for linguistic creativity and conviviality, this section explores whether the contemporary consulting room can be seen to contribute to the "the social reproduction of

existing conventions and relations" (Heller, 2007: 15), i.e. a somewhat universal understanding of established inequalities/power asymmetries in medicine (see for example, ten Have, 1991; Korsch & Negrete, 1972), or whether, in fact, it may produce new ones (Heller, 2007). Building on previous research in multilingual health settings (see for example, Moyer, 2013; Roberts et al., 2005; Baraldi & Luppi, 2015; West, 1984) and superdiverse communities (see for example, Blackledge, Creese & Hu, 2017; Simpson, 2016; Wessendorf, 2015) I consider how medical professionals, patients and interpreters "jointly operate and negotiate meaning in interaction" (Harvey & Koteyko, 2013: 17). However, as consultations may be constrained by institutional concerns (see 4.2), or shaped by contextual limitations (se 4.5), I also note the situational consequences that may be inferred.

Beginning with an example of the ways in which midwives' epistemic authority emerges in interaction, I next move to examine the interdiscursive languaging practices employed to make information accessible to patients (or not). In addition to epistemic flattening, midwives reinforce their convivial approach by engaging in, what I call for the purposes of contrast, epistemic flattering, i.e. praising patients for demonstrating proactive health concerns (see also 6.3.2, extract 18). However, technical medical language regularly proves both difficult to explain and understand: in 7.3.5, I explore the negotiatory processes that are utilised to make sense of the words and the potential pitfalls caused by misunderstandings, poor translation and lack of successful knowledge transfer.

7.3.1 Epistemic authority

Defining epistemic authority as "the participants' rights of and responsibilities for access to and production of knowledge" (2015: 583), Baraldi and Luppi note that knowledge distribution "depends on both patients' initiatives and providers' support of these initiatives, that is, respectively on how patients show their rights of and responsibilities for knowledge, and how providers show acceptance of these rights and responsibilities" (ibid). In the following extracts, MW1 and Karla (see also extracts 1, 6, 16, 37), negotiate the epistemic landscape, employing a range of strategies to ensure mutual understanding

and communication. Significantly, although there is an ostensible orientation to establishing epistemic parity and sharedness, it becomes evident that this commitment may be hard to sustain, especially when navigating technicalities of antenatal care: as the demands of the 'booking-in' routine prompt a display of institutional and epistemic authority, so the patient's active participation recedes.

At this point in the consultation, MW1 has collated her patient's medical history, and is informing Karla of the series of routine blood tests she will need in her upcoming appointments:

K= Karla; MW1= Midwife 1

538 MW1: (1) right so now the tests now (1) apart from the blood tests you did

539 today (.) she will have done tests for full blood count or your iron level (1)

540 she'd have done bloods again for your blood group =

541 K:=mm=

542 MW1: =then we do virology which includes the hepatitis B (.) the syphilis test (.) yes ↑and the

543 HIV (1) those are all the tests we do (.) blood tests (.) so far (.) we later on we do with the erm

544 (.) when you go Monday for your scan they'll offer you a screening test blood test as well (.)

545 because you'll be too late for you'll be too late for (.) what we do (.1) we do

546 a nuchal thickness test but usually it's done up to 12 weeks

547 K: mhm=

548 MW1: =or (.) between up to 13 weeks plus 6 days

549 K: mhm (.) mhmmm

Extract 38, C11

Much of antenatal history-taking involves discussion of a woman's intimate health, touching on sensitive topics which may hold 'moral implications' i.e. the potential for judgements to be made about the patient's personal responsibility for leading her life in a 'good' way (Linell & Bredmar: 1996). As the task, as we see above, carries an inherent threat to face (Goffman: 1972), Linell and Bredmar note a number of strategies which are employed in order to maintain 'interactional harmony' (1996: 348). They note that talk across potential face-threatening topics can be divided into three sections: 'an approach phase, a central phase, and a retreat phase" (1996: 361). Preceding the tests with the 'rather empty, verbal material' (Linell & Bredmar, 1996: 356) of 'right so now the tests now (1) apart from the tests you did today" (L538), MW1 postpones introducing the topic of sexually transmitted infections (STIs) and HIV. However, when she does mention them, in Lines 542-546, the midwife reads through the list, pausing briefly after each noun, indicating her resistance to direct expression and expansion (L 542,543), e.g. at no point does she ask Karla directly if she has had an HIV test before. In this central phase, the midwife continues to employ a series of negative politeness (Brown & Levinson: 1987) strategies, such as indirectness, to distance herself from the taking of blood. Reflecting earlier findings by Linell and Bredmar (1996), diseases are not framed as conditions but as the target of blood tests: when referring to Karla's previous tests, MW1 also confers others with the responsibility, "she will have done tests" "she'd have done bloods" (L538). Faced with further, more sensitive tests for STIs and HIV, which she herself will have to request, MW1 changes footing and adopts an institutional 'we', in order to place distance between her agentive self and institutional requirements. However, despite this mitigating strategy, MW1's repeated iteration of "we" (L542, 543, 545) has the effect of imposing upon the patient, leaving little room for personal agency and emphasising institutional power. The exception to this is in Line 544, where when Karla is told that she will be offered a screening test, the midwife implies there will be a choice to accept or decline. Yet, in reformulating 'screening test blood test' (L544) to 'nuchal thickness test (L545, 546), agency reverts to the health provider and the patient, once again, becomes the object of something 'we do' (L546). Marking

her retreat from the face threatening topic, MW1 reformulates "usually it's done up to 12 weeks" to "between up to 13 weeks plus 6 days" (L546/548) in recognition of Karla's late access to antenatal screening procedures.

Throughout extract 38, MW1's procedural information is met with minimal backchannelling by the patient, "mhmm" (L541, 547, 549), likely, in part, to the lack of reformulation given to the challenging medical vocabulary, but nevertheless demonstrating active listening. In contrast to her vague introduction of the topic (L538), the midwife's direct use of technical words, 'blood count' (L539), 'blood group' (L539), 'virology', 'hepatitis B' 'the syphilis test' (l542) , 'the HIV' (L543), 'nuchal thickness test' (L545), are made without explanation, and lie in stark contrast to extensive explanations which appear to characterise her earlier approach to patient centred care (see for example, extract 26). However, as Linell and Bredmar (1996) highlight, the limited depth given to each disease may reflect the speed at which the midwife wants to finish this potentially face-threatening sequence of the consultation. Rather than interpret the midwife's utterances as agentive positioning (Moyer: 2013) of epistemic authority, I interpret MW1's directness as an avoidance technique, a limited depth of perturbation (Linell and Bredmar, 1996) employed to avoid the FTA implied by the topic.

7.3.2 Epistemic flattening

As the previous example demonstrates, the consultative approaches adopted by midwives can be interpreted in alternative ways: on one hand, by rushing through the potentially embarrassing topics, MW1 can be seen to demonstrate a sensitive, patient-centred intent; on the other, her use of technical, medical terminology is so opaque as to hinder patient comprehension. Nevertheless, as the appointment continues, MW1 not only displays her epistemic authority, i.e. that she is in possession of more medical knowledge than Karla, but also her commitment to sharing her understanding and flattening the hierarchy. Stiver, Mondada and Steensig summarise, '(i)nsofar as interactants hold each other accountable for the rights and responsibilities associated with epistemic access, primacy and responsibility, knowledge is a moral domain with important implications for managing social relationships' (2011: 19). The

extract below reflects a co-constructed dialogue, characterised by the equal turn-taking and participation.

K= Karla; Bf= Boyfriend; MW1= Midwife 1

735   K: what does it mean placenta↑

736   MW1: oh placenta is a little a medical name(2) it's the lifeline of the foetus or the

737   baby (.) that's the only nutrients gets all its nutrients (1) it's filtered (.5) it's a (.)

738   K: I dunno hhhh ((   ))

739   ((noise as MW1 gets pad to help/ flutters papers))

740   MW1:excuse my drawing thank you very much excuse my drawing say this is the baby (1)

741   Bf: yeah=

742   MW1: =growing here (.) right↑ (.) from the baby is a cord here umbilical cord

743   leading away from the cord is a big thing here

744   K: aha ↑ (1) *łożysko placenta*=   aha ↑ (1) *placenta*

745   MW1: =that's the placenta=

746   K: oh okay yeah

747   MW1: and the uterus right say this is the uterus

748   K: mhm

749   MW1: well the baby should be inside here of course

750   K: yeah hhhhhhhh all

Extract 39, C11

As we have seen in previous examples (see extracts 1, 6), Karla is a patient who feels empowered enough to ask questions if, and when, she encounters unfamiliar vocabulary. Line 736 begins with 'empty verbal material' (Linell and Bredmar, 1996), as MW1 initially gathers her thoughts to respond: marking this process, she modifies the importance of the queried word, "oh placenta is a little a medical name", as if it were an irrelevant concern for a patient. Although MW1 pauses before then reprioritising the importance of the placenta, "it's the lifeline of the foetus or the baby" (L736), her formulations are difficult to follow. While the iteration of 'nutrients' emphasizes their importance to the placenta, the relationship is not clear. Paying attention to the face needs of her midwife, Karla laughs nervously as she admits her confusion. At this point, MW1 takes advantage of the liminal, translanguaging space (Li, 2018) offered by the superdiverse consulting room, to use her full communicative repertoire. Finding some paper, the midwife begins to draw a picture of a baby attached to a placenta by an umbilical cord: as she does so, Karla and her boyfriend lean collaboratively over the desk to look at the illustration. MW1 is talking as she draws, pointing to the position of each feature, "from the baby is a cord here umbilical cord leading away from the cord is a big thing here" (L742-743) and simultaneously checking understanding, through discrete pauses and uptalking, "growing here (.)right↑". Suddenly, the patient has a 'lightbulb' moment, indicating her comprehension with a translation of the term "aha ↑ (1) **placenta łożysko placenta**" (L744). In confirmation, the midwife glosses the translation and goes beyond the initial enquiry, identifying the uterus, and reiterating the word, for her patient in a way that has "positive consequences for the promotion of migrant patients' understanding and active participation" (Baraldi & Luppi, 2015: 596). Recognising that her patient has understood, MW1 moves towards a more prosocial footing (Hudak & Maynard, 2011), as she shares a joke about the uterus missing a baby. The convivial offer transcends cultural and linguistic divides, as Karla accepts the alignment, laughs heartily and, in a move of co-construction, completes the midwife's joke "yeah hhhhhhhh all"(L750). While there are considerable difficulties in using reformulations to describe parts of the body, MW1's collaborative, multi-modal approach to complex vocabulary has increased Karla's agency and bolstered

understanding, as well as reducing the potential for confusion (Baraldi and Luppi, 2015).

In their ethnographic research conducted in a legal advice centre in a superdiverse borough of Leeds, Baynham et al (2017) note that the monolingual advisor is able to successfully 'translate' technical legal language into information that her clients can understand, a feat of epistemic flattening that the researchers label intralingual translanguaging. Similarly, while MW1 also converses entirely in English, it is clear that she too is committed to explaining complex terms to her patients, employing a multimodal repertoire to facilitate this. However, in contrast to the advisor in Baynham's research, MW1 often finds it difficult to shift "from the specialized technical lexis……to ordinary everyday language"(Baynham et al, 2017: 40). As the consultation with Karla continues, the midwife appears so encouraged by her success in exemplifying 'placenta', that she is tempted to embark on an unsolicited interdiscursive explanation of how a foetus is measured in utero.

K= Karla; Bf= Boyfriend; MW1= Midwife 1

760   MW1: yeah (.) and if they can pick up one of the bone density they will do it because

761   that scan doesn't give them a good picture as yet because the foetus is still developing

762   (.) but when it reaches 18 (milli?)metres the baby or foetus is fully developed yes↑(1)

763   you don't call a baby in utero you don't call a baby (.5) we tend to say baby inside of

764   you (.) but from a clinical point of view we call it a foetus (.) yes until it's born it then

765   (1) so it becomes a baby the foetus you measure for the 15 week scan here to here

766   and maybe and this (.5) here ((   )) and they'll want to measure this bit here

767   and that's all (.) the 18 week scan they will do a detailed they will measure the head

768 (1) they will measure the arms (2) and they will measure the legs and in the arm they

769 only measure the femur length yes↑(.) in the legs they only measure the humerus (.) and they measuring the torso

770 K: mhm

771 MW1: yeah↑ In the torso you wanna make sure they for (.) the heart is there the four

772 cha and you want to make sure there's chambers //there (.) okay↑

773 K: mm

773 MW1: so doing this first bit and they're measuring the bladder (2) and they measure

774 the bladder (.5) and they measure the liver the vi all the vital organs they measure (.)

775 yeah↑ they always do that (.) brain and that's the 18 week scan 18-20 week scan

776 K: okay and when I can tell that it's girl or boy↑

Extract 40, C11

Extract 40 marks a change in footing for MW1 (Goffman, 1981). In contrast to her previous approach, the midwife's communicative style moves from one of co-construction to hierarchical, consolidating her epistemic authority and downgrading that of her patient (Baraldi and Luppi, 2015): this is evidenced by the lack of turn-taking and active patient participation. Although Karla appears to be listening as she follows MW1's fingers trace the drawing, the midwife's utterances are met with minimal patient response (L 770, 773), as she talks at length (L760-769), using explicitly technical vocabulary e.g. 'humerus', 'torso' (L769), 'chambers' (L772), 'bladder', 'liver' and 'vital organs'' (L774). While MW1 appears to recognise the difficulties that may be posed by some words, e.g. reformulating 'foetus', to 'baby' (L 763) and providing a gloss for the alternative terms (L763-765), she employs a number of techniques to distance herself from the potential threat to face, posed by talking about scans. Routinely conducted at 12 and 20 weeks, the later scan to which MW1 is

referring, marks a point during pregnancy where foetal anomalies can be detected, potentially prompting a conversation about the morally loaded issue of abortion (Linell and Bredmar, 1996). As such she avoids the use of personal pronouns and agency is given instead to an abstract 'they'(L 760, 767-770, 774-776), implying, but not stating, radiographers, who 'do' (L760) things to Karla, and 'measure' (L765-770, 774-775) things related to the baby, placing the patient in a passive position in the process. Interestingly, MW1 also only uses the pronoun 'you' once to refer to the patient, "we tend to say baby inside of you' (L763/4), but more frequently to describe the 'guided doings' (Goffman, 1986: 82) of an abstract medical professional (L763, 765, 773, 774). Linell and Bredmar note that this kind of "anonymization may be understood as the speaker's attempt to not speak in his/her personal identity ......and to speak as if the topic did not directly concern the individual other" (1996: 372). The use of multiple, non-deliberate pauses throughout, also function as a distancing technique.

Drawing on notions of interdiscursive translanguaging (Simpson, 2016; Baynham, 2015), MW1's explanation of ultrasounds can be seen as an act of mediating across discourses "which occurs when there is an unfamiliar discourse that needs to be negotiated" (Simpson, 2016: 15). A practice that is frequently observed in superdiverse settings, interdiscursive translanguaging can be seen to reflect the midwife's commitment to epistemic flattening, awareness of 'other' and furthering patient-centred care. This is further consolidated through established techniques used to ensure comprehension, such as the use of illustrations to engage and elaborate, and frequent checking of participant understanding through the use of uptalk (L762, 769) and discourse markers 'yeah' (L771, 775) and 'okay'(L772). However, MW1's spontaneous initiative marks a shift from the patient participation in extract 39, to one that is, albeit inadvertently, midwife-centred. It reproduces a hierarchical interaction, based on the midwife's own expectations about Karla's understanding and interest, "without checking the patients' access to the knowledge produced in the interaction and the possible upgrading of the patients' authority in producing this knowledge" (Baraldi and Luppi, 2015: 595). Once MW1 has completed her knowledge display (L775), Karla politely

initiates a change in frame, through the use of the discourse marker 'okay'. Although she signals an end to MW1's dominance of the interaction, it is unclear whether this is because Karla has understood everything, nothing, or that she is not interested in ultrasound details. However, an alternative interpretation of extract 40 may not be one of patient disempowerment: it is equally valid to interpret Karla's passivity as a mark of respect, i.e. her minimal back-channelling reflects skilled attention to face needs (Brown & Levinson, 1987), as she waits for the midwife to finish. Subsequently, and reflecting Ainsworth-Vaughn's comment that "to ask questions is to claim power over emerging talk" (1998: 462), Karla demonstrates an "active participation in the production of [personally relevant] knowledge" (Baraldi and Luppi, 2015: 583), as she changes footing to ask about the subject that interests her - the sex of her baby (L776).

7.3.3 Epistemic flattering

While the complexities of a superdiverse environment have the potential to threaten patient autonomy (see for example Extract 34,43, 44), it is clear that medical professionals in possession of a translanguaging instinct (Wei, 2017; see 6.5) and an orientation towards communicative and linguistic flexibility can enhance both patient experience and understanding. Key to successful consultations, especially in a multilingual setting, is active listening (Moss & Roberts, 2005) as it demonstrates the willingness of medical professionals to recognise patient's epistemic authority and to downgrade the power asymmetries which, it is argued, are inherent in institutional discourse (ten Have, 1991; Foucault, 2000).

In extract 41, we return to consultation 2, where Maalini and her husband, are talking to the consultant, DC, via an interpreter, I1, and discussing various options for the delivery of their child. While DC is not keen to commit to definite mode of delivery until an upcoming scan has been conducted, Maalini expresses her concerns about the baby contracting a bacterial infection - Group B Streptococcus. Although many women carry the bacteria and remain unaffected, in a small number of vaginal deliveries it can be passed to the baby, causing life-threatening complications. The gestational diabetes which

Maalini has developed, does not increase the likelihood of carrying, contracting or passing on Group B Streptococcus bacteria.

Ma= Maalini; DC= Diabetes consultant;

144   DC: =whether there will be any problem during delivery all I will know after the scan

145   I1: *அடுத்தமுறை* scan *செய்த பிறகு தான் அவருக்குத் தெரியும். எப்படி இருக்கு,* normal delivery *- ல பிரச்சனை இருக்குமா? மற்றது தேவையா என்று அவ பாத்த பிறகுதான் சொல்லுவா*

Only after she does the scan the next time, she will know if there will be problem in normal delivery. She will check and let you know.

146   Ma: *சில நேரம்* delivery *நேரம் அந்த* Group B

Sometimes during the time of delivery Group B=

147   DC: =Streptococcus=

148   Ma: =yeah=

149   DC: =that has nothing to do with caesarean or delivery (.5) hh that is very

150   good (1) what we'll do is (.)when you are delivering we will give antibiotics=

151   Ma:=okay=

152   DC: =to prevent (.)if you are going for a caesarean no antibiotics needed (.)

153   you're fine (.) that's very good you to tell us h=

Extract 41, C2

As we have seen in earlier extracts (see extracts 21, 22), I1 chooses to adopt a supporting, rather than coordinating role, in this consultation, as Maalini, her husband and the consultant appear to share mutual comprehension of the others' language, if not production. Nevertheless, the interpreter is still visible (Angelelli, 2004), assisting unobtrusively, when necessary, to reformulate and gloss the utterances of the other participants in order to ensure understanding.

Following DC's idiomatic summary (L144), I1 reiterates the information in Tamil, not translating word for word, as in a conduit model but agentively (Angelelli, 2004) moderating syntax to emphasise the conditional nature of the consultant's speech, e.g. inserting the adverb "only" and using 'if' (L145). Initiating a dyadic turn with the interpreter, and reflecting a personal concern rather than responding to DC's utterance, Maalini queries how the consultant's decision will affect her risk of contracting Strep B, "Sometimes during the time of delivery Group B" (L146). Interestingly, and demonstrating that "even during dyadic interactions, the doctor is always responsible for the resolution of interactional or practical problems" (Pasquandrea, 2011: 472), DC interrupts Maalini's Tamil utterance, to finish her sentence and complete the name of the bacterial infection. Once Maalini has confirmed her query (L148), there is a change in footing: while DC reassures her patient about the likelihood of contracting an infection during delivery, the elision and speed of turn-taking (L149-153), marks a move towards co-construction and collaboration. Although DC initially dismisses her patient's concerns "that has nothing to do with caesarean or delivery" (L149), the ensuing hesitation and laughter appear to reflect a delayed surprise at Maalini's in-depth knowledge and impel the consultant to further consolidate. Rather than emphasize the asymmetry between doctor and patient, this exchange (L149-153), demonstrates DC's acknowledgement that Maalini is on equal epistemic ground to her. Sandwiching her explication with praise, "that is very good" (L149), "that's very good you to tell us" (L153), DC's linguistic flattening reduces asymmetries, while her epistemic flattering (L153) also places the patient in an active position of authority. In recognising Maalini's knowledge, the consultant actively facilitates her agency and empowerment.

Extract 41 demonstrates that, while a patient-centred commitment is key to extending comprehension, the ability to draw on one's own linguistic repertoire can further improve understanding. As we have seen in previous extracts (21, 22, 23, 33, 34, 37), a patient's agency to "talk and control topics" (Moss & Roberts, 2005: 417) can be encouraged by a multilingual approach, allowing participants to focus on medical issues rather than potential challenges posed by speaking a different language (Baraldi & Luppi, 2015). Indeed, the

communicative affordances of a superdiverse consulting environment can encourage linguistic inclusivity, improving understanding, and boosting the agency of migrant patients who can arguably be disadvantaged by a monolingual encounter (Moss & Roberts, 2005; Roberts et al., 2005; Moyer, 2013; Baraldi & Luppi, 2015).

7.3.4 Negotiating meaning

While it is not possible to assume the presence of a multilingual health professional at each consultation, even in a superdiverse setting, it is a legal obligation for patients to be offered access to interpreting services in order to ensure accuracy, understanding, informed consent and positive patient experience (NHS, n.d). Nevertheless, provision can be both erratic and temporary, offering participants no choice but to rely on informal interpreters (see 4.4). In exemplification, I return to Consultation 12 where, although an interpreter is present, she has been double-booked and must leave halfway through the appointment. Assessing the time limitations, the midwife directs the interpreter to the most vital part of the booking-in, the taking of medical history.

In many ways, Consultation 12 characterises the unremarkable nature of mediation in a multilingual environment where, through the combination of multiple resources and negotiation, an understanding is achieved. However, negotiated meanings in a superdiverse environment hold potential implications for the heath of an expectant mother and her child, as mediation is employed simultaneously across languages and epistemologies. In extract 43, we witness some initial confusion caused by the term chicken pox, a very common, mild childhood illness but one which can cause complications if contracted during pregnancy.

M= Melina; G= George; MW1= Midwife 1; I3= Interpreter 3

172   I3: (2) chicken box↑ Eh (.5) Eh(.5)   is ↑
      Chicken pox

173   MW1: in childhood

174	I3: *Quando tu era pequeno…* ((Turns to G)) *o que era a palavra* chickenpox *erm é em*	*When you was small* (2) ((turns to G)) *what was the word* chicken pox *erm (.) in*
175	I3: *Português↑Vocês é…?*	*Portuguese ↑You all…*
176	G: chicken box↑	
177	I3: *É* chickenpox, *aquele do*…	yeah Chicken pox *that one of the (.) ↑*
178	MW1: (.) yes (little?) //skin (.) spots	
179	G: // aah Varicella	
180	I3: *Rabies*	*Rabies=*
181	M:=(ok//ay)(okay)=	
182	I3: *Rabies. Rabies de pequeninho. Quando tu era pequeno*	*=rabies (.5) little rabies () when you were little ()*
183	M:(okay? (.) // okay?)	
184	I3: // ( )	
185	G: ( )	
186	I3: yes	
187	MW1: she said yes↑(.) put in yes (.) yeah↑(.) okay ↑	

Extract 42, C12

Making her way through the alphabetical list of conditions on the medical history section of 'Pregnancy Notes', Melina's interpreter raises her eyes from the form in query. Initially mispronouncing the word 'pox' as 'box' (L172), I3 corrects herself and repeats the noun phrase 'chicken pox', with a rise in intonation to indicate a question. In response, MW1 works collaboratively to clarify that that the disease is often contracted in childhood, although her minimal input (Line 173) suggests that she expects the interpreter to be familiar with the condition and therefore able to translate. However, I3 remains unsure. In a move of dyadic separation (Baraldi, 2009), the interpreter turns away from

the midwife and Melina to discuss the term with George, the patient's friend, who is sitting on the bed behind her and, at this point, paying little attention to the conversation. Glossing MW1's earlier clarification, I3 makes a bald-on-record (Brown & Levinson, 1987) request for translation of the condition to Portuguese, "When you was small (2) ((turns to G)) what was the word chicken pox erm (.) in Portuguese ↑You all" (L174/5). The interpreter also utters a request for help without the use of any mitigation to protect her face needs, and by deferring to a lay participant, I3 exposes her lack of epistemic authority. Nevertheless, her reformulation of George's response, 'chicken box', is collaborative in nature, and it becomes clear that I3 recognises the patient's friend as a helpful ally. Although one cannot assume "that linguistic similarity equals sociolinguistic similarity" (Blommaert 2016: 5), from lines 178-187, the participants work in collaboration to negotiate meaning. While she does not speak Portuguese, MW1 realises 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, George understands the explanation almost immediately and identifies the disease by its medical name, "Varicella", whereas I3 translates 'chicken pox' as the more improbable "rabies", a term she reiterates in L182. The ensuing exchange between interpreters proves too difficult to hear (L184-185), making it unclear to which condition Melina indicates having had in the past. As she utters 'okay' (L 181, 183) the patient demonstrates an understanding of something but, with her contributions overshadowed by those of other participants (L182-187), she falls quiet. Observing the negotiations, MW1 appears to sense some disagreement between the formal and informal interpreters and urges clarification, through her use of rising intonation and repeated checking, "she said yes ↑ (.) put in yes (.) yeah ↑ (.) okay↑" (187). Despite the protracted negotiation, the participants reach an understanding and, unaware of the potential confusion, the midwife receives an answer.

In extract 43, participants appear to have successfully negotiated meaning of a disease and achieved a response that was anticipated by the medical professional. Indeed, Canagarajah notes that "deviations or misunderstanding need not be dysfunctional. They are productive and generative…..part of a

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continuum where through negotiation strategies, misunderstandings evolve with new understandings" (2013: 75). However, the exchange is also somewhat problematic. As mentioned in 4.4., earlier literature (Defibaugh, 2014; Angelelli, 2004) highlights the distancing effect of triadic consultations, asserting that the relationship between medical professionals and patients can be distorted through the use of interpreters. In Melina's consultation, the bulk of discussions about her previous and current health are mediated by others (see, for example, extracts 31, 32, 36), appearing to remove much of her agency. Not only does this compromise Melina's epistemic understanding of her pregnancy but, in this instance, it shifts the footings so that the focus is on the triadic mediation of Melina's health, rather than the patient.

7.3.5 Misunderstandings

Communication in superdiverse contexts is both dynamic and emergent, "continuously readjusted to the contingencies of action unfolding from one moment to the next" (Blackledge et al, 2017: 11), and where "social interactions are shaped by the complex interrelationship between the historical and contemporary context of the interlocutors, and the larger societies in which they are embedded" (ibid). Within this, encounters in a superdiverse health setting are also affected by a number of intersecting epistemological, sociocultural, environmental and linguistic factors, which have the potential to hinder effective communication, understanding and care, "even when there is goodwill on both sides" (Gumperz et al., 1979: 1). It is to these that I now turn.

Continuing with Consultation 12, MW1 has advised Melina that she will be offered routine vaccinations against influenza and whooping cough, two conditions which can carry adverse effects during pregnancy. As the professional interpreter has left, George once again adopts linguistic and epistemic responsibilities, as he attempts to guide his friend through an elucidatory process of interdiscursive translanguaging (see 3.5.4): Although participants work together to make-meaning across language, institutional and clinical discourse, it is clear that George lacks the skills to support his friend effectively. In the first stage of the process, George urges Melina to have the vaccinations.

M= Melina; G= George; MW1= Midwife 1

865 G: ***Não,(____) tens que levar vacinas*** *no (   ) You must do the vaccines.*

866 M: ***porque é que eu tenho que levar vacinas↑*** *(2) But why do I have to take the vaccines↑*

867 G: ***porque tens eu não quero levar vacinas*** *Because you have to take the vaccines*

868 M: ***eu não quero levar vacinas*** *I don't want to take vaccines*

869 ((sounds of pages turning))

870 G: ***olha, tens que levar vacinas. É obrigatório*** *Look. You have to take the vaccines (.) It´s a must (*

871 (2) but is the two is from this week↑

872 MW1: yeah

873 G: (.) okay=

874 MW1:= til 20 weeks (.) the flu vaccine can be given at any time=

875 G:=what is that↑=

876 MW1: =the flu vaccine can be given at any time but the whopping cough

877 vaccine it's a disease that sometimes if a woman contracts it it can e:rm it's

878 a bad cough its like it's a bacterial infection and if you contract it it can

879 cause pneumonia and pneumonia can lead to brain damage pneumonia is

880 like (2) you're quite ill you get a high temperature you have high fevers

881 sometimes it affects the brain really bad when you feel unwell

882 G: yeah yeah yeah

Extract 43, C12

Repeatedly using modal verbs of obligation/necessity, "you must" (L865), "you have to" (L867) "it's a must" (L870), George is insistent in urging Melina to

have the Flu and Whooping Cough injections. However, after a series of questions, querying the relevance of vaccination, and the reason for having them, "Why do I have to take the vaccines↑" (L866), in frustration, Melina makes a bald-on-record declaration, "I don't want to take vaccines" (L868). While Brown and Levinson (1987) note that this form of negative politeness can cause an FTA for both interlocutors, it is George who is put into a position of insecurity. As the patient's friend has only partially understood the midwife's previous recommendation, he must now reveal his lack of knowledge as he asks for clarification. Rather than do this directly, George is able to protect his face needs in a number of ways: initially, he approaches his query with a question about time frames which suggests he understands the recommendations (L871), thus mitigating a threat to face; secondly, while he does admit uncertainty directly, "what is that'↑" (L875), George can be confident that he is unlikely to meet MW1 again, which "leaves him free to take a high line that the future will discredit" (Goffman, 1972: 7).

Simultaneous to Melina and George's conversation, the midwife is busy completing paperwork, apparently authorising the participant byplay 'without trying to interfere' (Pasquandrea, 2011: 461). However, although her gaze is fixed on the computer, MW1 is attentive to participant needs and once she hears George's hesitant 'okay' (L873), she appears to detect uncertainty and embarks on an attempt at epistemic flattening. Instead of expanding on George's query about the flu vaccine, MW1 describes symptoms of whooping cough, using a combination of technical words, "disease" (L877), "bacterial infection", "pneumonia" (L880) and complex syntax, made more confusing by the amount of repair. Following similar findings to Baraldi and Luppi's (2015) observations of midwives and their patients, MW1's constant reformulations (e.g. "the whooping cough vaccine it's a disease" (L876/7), "it's a bad cough it's like it's a bacterial infection" (L878)) can "be understood as attempts to adapt patient-centred communication to situations in which patients do not understand midwives' words" (Baraldi & Luppi, 2015: 594). However, MW1 does not appear to "show sufficient concern for precision and effectiveness of medical information. Therefore, reformulations are rather ambivalent actions for what concerns the promotion of patients' participation and epistemic

authority" (ibid.). Although the hypothetical nature of the whooping cough is also emphasised through the conditional use of 'if' (L877, 878) and the modal verb 'can' (L876, 877, 878, 879) to imply possibility, MW1 uses the language of illness (L876-883) rather than that of prevention in order to persuade participants. In this instance, her approach is certainly a contributory factor to the confusion which ensues (see Extract 44 below).

Towards the end of MW1's explanation, George ostensibly displays signs of understanding: he nods and smiles gently, before emphasising his understanding of the vaccination, through the repeated use of "yeah" (L882). Although these utterances could also be read as an attempt to halt the midwife's extensive epistemic display, it is likely that MW1 recognises the iteration as a demonstration of full comprehension, for she subsequently yields her interactional power (Pasquandrea, 2011), without appearing to consider that while participants "may have sufficient linguistic resources to engage in casual conversations, it is more challenging to talk about more specific terms that are not used so often in common talk" (Cox & Maryns, 2019: 8).

M= Melina; G= George; MW1= Midwife 1

885   MW1: yeah ↑ We ask all our pregnant women to (//)

886	G: ***É tipo isto… a vacina é se tu…Tipo***	*// It's like this (.) the vaccine is if you (.) like (.)*
887	G: ***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	M: ***menopausa***	*menopause.*
889	G: ***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	M: =mhmm=	

891	G:	**mas não é pra prolongar.**	=*but it is not to prolong it. It*
		Acontece porque se tu estás	*happens because you are pregnant*
		gravida	
892		**eles dão para combater isso.**	=*they'll give you the vaccine to fight*
		certo=	*it right=*
893	M:	**=mhmm=**	
894	G:	**eh↑ você tem que ir**	=eh↑ *You have to go*

Extract 44, C12

Mirroring George's utterance, "yeah" (L885), as a method of indicating conversational alignment, MW1 is willing to expand further (L885), but, as we can see, George appears keen to end her turn and to speed up the consultation. In his enthusiasm, he interrupts the midwife, overlapping her continued explanation and begins to translate his interpretation of the vaccinations offered. At this point, the midwife ratifies a change in footing (L886) (Goffman, 1981), by withdrawing her gaze and allowing George to take the floor. Following MW1's earlier explanatory stance, he begins by eliciting the word for menopause from Melina, confirming her bemused answer with 'that stuff' (L889), before explaining his understanding that the condition can be contracted during pregnancy. Melina's active back-channelling (L888, 893) also demonstrates her attention to his explanation, as they take turns in co-constructing meaning. However, although George successfully reiterates the importance of antenatal vaccinations (L894), and persuades Melina to agree to treatment, his epistemic comprehension is fundamentally flawed. While there are indications that George may have understood some of MW1's previous explanations, i.e. in L891 he reassures Melina that the injections are not for the lungs, a deduction which could possibly have originated with MW1's reference to pneumonia (L880/881), he has clearly misunderstood the midwife's attempt at intralingual discourse, i.e. the transformation of technical words into everyday language (Baynham et al, 2017). Unlike previous work on misunderstandings between practitioners and patients in a multilingual environment (e.g. Moss & Roberts, 2005; Roberts et al., 2005; West, 1984), George's confusion in this extract cannot be rectified through midwife

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reformulation, as his explanation of the vaccinations is in given in Portuguese, a language that MW1 does not speak. The midwife remains oblivious to the misunderstanding and, having received Melina's consent, she does not further probe epistemics. While it is unlikely that Melina will be harmed by the consequences of this particular misunderstanding, it highlights the potential clinical consequences of false fluency and the unpredictability of the 'communicative swing' (Cox & Li, 2019; Cox et al., 2019; Cox & Lázaro Gutiérrez, 2016; see 4.5).

7.4 (Disrupting) the ritual order

When pregnant women first present at the antenatal clinic, they are framed in a certain way by their condition, the circumstances by which they come to arrive at HUH at a specific point in time, and within the parameters of institutional norms (Cicourel, 2014; Sarangi & Roberts, 1999; Heller, 2001; see also 4.2). To paraphrase Cicourel,

> the notion of….[pregnancy] is not only a linguistic construct that presumes to index objectively a common human experience, but also an expression of a moral universe bounded by culturally and historically specific norms, values and beliefs about that which is good, bad and beautiful in the world… (Cicourel, 1999: 188)

Although expectations of what a consultation should comprise will differ according to personal beliefs and pre- and post-migration experience, the antenatal environment is one that is uniquely saturated with efforts to confirm and maintain a sense of 'normality', in order to achieve the 'normal' delivery of a 'normal' baby (Linell & Bredmar, 1999). Interaction rituals prove central to this, as they are "oriented to the maintenance and recovery of stability" (Blackledge et al, 2018, xxix) (Rampton, 2014), and provide reassurance. In fact, while the processes of institutional order can only 'derive their legitimacy' through participants' willingness to comply with the iterative practices, and the medical interventions, associated with antenatal care (Sarangi & Roberts, 1999: 3), there is a clear advantage (for all participants) to doing so i.e. the uncomplicated delivery of a healthy baby. Nevertheless, patients are also

autonomous individuals who may not always align with institutional advice, and who have the right to give or withdraw consent at any time. Similarly, their companions may be equally unpredictable.

7.4.1. Resisting medical discourse

Having earlier explored some of the ways in which the superdiverse consulting room offers room for creativity and hybridity (see for example, 6.4, 7.3.), this concluding section explores some of the ways in which its liminality also appears to offer a space for varying types of resistance (see 3.6). Starting with a quietly conventional display of personal agency, the following extract features a misalliance between Agnieszka (see also extracts 9, 10), a patient who draws on her linguistic resources and sense of 'lifeworld' (Mishler, 1984) to disattend medical advice, and her midwife, an institutional figure who can be seen to represent the 'voice of medicine'.

     AG= Agnieszka; MW2= Midwife 2

46   AG: (.) yeah (.) is this interfere with my injection of Fragmin* ↑I'm thinking=

47   MW2: =no it doesn't this doesn't interfere with Fragmin or any other vaccine

48   that you've had (.)have you had your whopping cough vaccine ↑

49   AG: no

50   MW2: so you're going to have it that with the GP↑

51   AG: (.) I don't think so (.) I never had it so=

52   MW2: =you don't want the whooping cough vaccine (.) okay (.2) do you know

53   why we're giving you=

54   AG: =yeah (.)

55   MW2: it's supposed //to prevent the baby having whopping cough before

56   it has its own whooping cough vaccine

57 AG: // to prevent (.) yeah (1)

58 MW2: but you've never had it

59 AG: no

60 MW2: okay (.) we're happy you know anything you want we support you

61 with (.) so we just document it

This extract is taken towards the end of Agnieszka's consultation: MW2 has just administered the routine anti-D injection, which Agnieszka has received in five of her six previous pregnancies. As MW2 holds cotton wool on her patient's skin, in order to prevent bleeding, Agnieszka seeks to double-check that the treatment will not interfere with an existing prescription (L46). Reflecting Ainsworth-Vaughn's (1998: 462) claims that questions assert "power over emerging talk", the patient may also be using the technical language of medication in an epistemic display of knowledge, and as a proactive attempt to repair the damage to her face, following the imposition of an injection (Goffman, 1981). Having already demonstrated a disalignment to the way she has been positioned as a patient, i.e.as the object of a medical intervention (see 6.2.2.2.), Agnieszka instigates the intralingual discourse as a move of disattention, and to change footing (Goffman, 1981). Her move is rapidly accepted by MW2, who is thus reminded to ask her patient about a whooping cough injection (L48). At the time of the observation, this vaccination had only just been introduced, and while MW2 engages in a form of epistemic flattening to establish the reasons for offering it, Agnieszka makes a series of minimal responses (L49, 51, 59), using the fact that she "never had it" (L51) to explain the rejection. Interestingly, the interaction between lines 52 and 59, can be read as a form of epistemic negotiation: the midwife tries to maintain the institutional footing of recommendation, while the patient simultaneously attempts to both assert her epistemic agency (L54, 57) and position herself as

an expert on her own pregnanc(ies) (L51)(Moyer, 2013). Agnieszka's terse responses, are thus acknowledged. Indeed through the iterative use of 'you' in line 60, MW2 emphasises acceptance of her patient's informed (non)consent. As the mother of six children, Agnieszka is not only empowered enough to reject the updated medical advice but she also has the linguistic resources to do so.

A more, perhaps extreme, example of disrupting institutional hierarchies, takes place during Melina's booking-in interview. During the stage of medical-history taking, when Melina and the interpreter are in dyadic dialogue, George "flout[s] norms of behaviour" (Li, 2018: 23) to invoke a change in footing.

M= Melina; G= George; MW1= Midwife 1; I3= Interpreter 3

348   MW1: can you spell it for me=

349   G: =it's with not the p h

350   MW1: p it's the f right↑=

351   G: yeah f =

352   MW1: = //f i l l p

353   G: f i l l l p=

354   MW1: e↑=

355   G: =yeah

356   MW1: and surname↑

357   G: Periera=

358   MW1: //P e r r i (1)

359   G: // P e r (2) no no no

((during this time G has got up and is standing behind MW1 looking at the computer screen. He then leans over the keyboard to spell the name correctly))

372   MW1: and he works full time ↑

371   G: full time by the hour=

288

MW1: =and what does he do↑

372

373   G: he's a builder

374 ((clicking of keyboard as MW1 completes form, G is standing over   her and watching what she is writing))

375   MW1: (5) are you just going to stand here↑

376   G: ( ) (3)£ it's better like this eh £↑

Extract 46, C12

MW1 is encountering difficulties with the accurate spelling of Melina's partner's name (here pseudonymised). In a rapid exchange, marked by a high degree of overlap (L352/353; 358/359), and ellipsis (L349, 350, 351, 352, 353, 355, 357), the interactants engage in collaborative, symmetrical, exchange to achieve accuracy. During this time, George has made a physical and metaphorical move from frontstage to backstage, walking behind the midwife's desk (see 5.5.2.2). After offering verbal corrections, the companion then leans over MW1 to use the keyboard. Such an extraordinary change of 'frame space' (Goffman, 1981) can be seen to not only transgress the institutional norms of formality, but to force the midwife into a backstage, informal position, i.e. if MW1 uses her authority to demand he return to his side of the desk, this will constitute an 'incident' that will need extensive (time-consuming) repair (Goffman, 1981). Instead, the midwife pauses, almost to draw a line under the incident, before joking about George's impropriety, "(5) are you just going to stand here↑" (L375): he accepts this subtle admonition somewhat flirtatiously "£ it's better like this eh £↑" (L376), but returns nevertheless to the other side of the desk.

7.4.2. Resisting and (re)positioning

In contrast, the following extracts return to Ajola (C13, see extracts 23 and 35), who relies on her interpreter, I4, to navigate the complex sensitivities of her appointment. Sitting in the waiting room, prior to Ajola's consultation, I4 is keen

to talk about the trafficked women, who comprise the bulk of her interpreting work: she notes their youth, their lack of familiarity with the systems they need to navigate and their sense of inevitable stigmatisation, despite there being no outward indication of their experiences or personal trajectory.

The first episode of interaction occurs before the doctor enters the room; the second is in the final minutes of the consultation. Similar to findings highlighted in Chapter 6, the opening and closing of the session is replete with conviviality, small talk and humour (see 6.2), despite the nature of the consultation. The incongruity of such features illustrate the complexities of interaction in the face-threatening circumstances of treating a victim of trafficking. On this occasion, I4 illustrates an acute perception to her client's face needs, by beginning and ending the consultation with a strategic use of 'byplay' (Goffman, 1981). Instigating, and consolidating, a 'we' identity (Baraldi, 2009), I4 appears to resist institutional norms of categorisation (Goffman, 1981), by deflecting the focus from Ajola and reducing the authority of the attending medical professional.

Similar to earlier discussions regarding the production format of an antenatal consultation, the appointment appears to be separated into several bracketed events, each serving to prepare the patient for her meeting with the doctor (Goffman, 1986; see 6.2). Following a period of time in the waiting room, we are ushered into a consulting room, before JW, a health care assistant (HCA; see 5.4.2), arrives to attend the patient. A brief medical encounter is bracketed by an introduction and a final message that the doctor will arrive soon. JW then leaves the room. To borrow Goffman's theatrical metaphor, while this short play within a play has the effect of building tension before the main 'scene' is to be enacted, the actors can be seen to inhabit very different footings on the stage (see 5.5.2.2.).

    AJ= Ajola; I4= Interpreter 4; JW=Health care assistant

1   JW; My name is ██████ working with Mr ███ team today=

2	I4: ***Ajo flet per doktorin qe do zesh. Thuj dy fljalë edhe zor tuj fol, sido me qën ato.***	*Is speaking about the doctor you will choose. Say two words, even with difficulty speaking, whatever they be.*
3	AJ: =uhuh=	
4	I4: = Connected me doktorin	Connected with the doctor.
5	AJ: oh //okay	
6	JW: //your urine sample is normal	
7	I4: ***Shurren e ke normale***	*your pee is normal*
8	AJ: okay (2)	
9	I4: ***S'paska bythë***	*She has got no ass*
10	((Ajola smiles)) (ffffff ffffffff- HCA takes blood pressure (24))	
11	JW: blood pressure's normal too ((takes off cuff and washes hands (15))	
12	((interpreter gestures towards the HCAs bottom and raises her eyebrows)	
13	AJ: ***O të marrtë dreqi, po na bën me t'qesh***	*Oh fuck you, you're making us laugh, hhh*

Extract 47, C13

From the moment that JW enters the room, she appears to position herself as a 'voice of medicine' (Mishler, 1984), speaking only to introduce and align herself with a medical team, and to offer an assessment of 'normality' on the results of tests. Aside from a gentle smile, she makes little attempt to engage with the patient and interpreter, as she busies herself with the 'frontstage' tasks of routine checks. Initially, I4 and Ajola appear to take up the institutional framework: the interpreter adopts the role of animator in translating JW's utterances (L2, 4, 7), while the patient demonstrates understanding through a series of back-channelling agreements (L3, 5, 8) and follows the non-verbal cues to offer her arm for a blood pressure reading (L10). However, the interpreter soon instigates alternative footings, subversively inviting her client to move a more informal 'backstage' position (Goffman, 1981), where they can

laugh at the size of JW's bottom (L9). This 'byplay' (Goffman, 1981) is accepted by Ajola who initially smiles (L10) before being drawn into laughter, and rebuking, I4's gestural encouragement (L12, 13).

This somewhat unconventional behaviour can be construed in several ways, not least by recognising that all individuals have their own "mental grammar that emerges in interaction with other speakers" (Otheguy, Garcia & Reid, 2015: 289), but also by acknowledging the uniquely facilitative space offered in linguistically and socioculturally diverse settings (Li, 2018). Nonetheless, I4's subversive invitation to collusion may be open to additional interpretation. By commenting on the health care assistant's bottom, it certainly appears that the interpreter is attempting to forge a 'we' identity with her client (Baraldi, 2009), ahead of a potentially stressful health care appointment, where her client will need to talk about the circumstances that led her to Hayfield, and discuss her previous stillbirth. It is perhaps JW's remarks on the 'normality' of Ajola's results that trigger a response from I4's. As Bredmar and Linell note, in antenatal care, "normality considerations are involved at least at two different levels: (1) pregnancy *in general* as a normal (biological and social-psychological) process, and (2) the *individual* woman's pregnancy as a normal case" (1999: 238 - their emphasis). Although JW does not necessarily have access to Ajola's full medical history, and may not be aware of the salience such information may hold to a woman whose experience of conception and pregnancy has been far from routine, I4 appears to interpret the HCA's actions as insensitive. Here, I argue that, in the absence of her client's ability to redress institutional asymmetries and/or perceptions of stigmatisation, I4 takes advantage of the liminal space offered by the superdiverse setting to creatively resist an imposition of authority, on her behalf.

Interestingly, although the interpreter continues to address Ajola in an affectionate tone throughout the rest of the consultation (see extracts 23, 35), I4 does not use the collaborative strategy of byplay again, until the end of the appointment. Heath (1986) notes that indications that a consultation is due to terminate, are invariably initiated by the medical professional: in fact, the use of an explicit remark, a change in footing, a move to a more phatic interaction

or request for questions, are common ways of bracketing the end of a phase (Maynard & Hudak, 2008; Goffman, 1981).

AJ= Ajola; I4= Interpreter 4; CT2= Consultant 2

356   CT2: Clear what I explained here↑

357   I4: ***Je e qartë për cdo gjë që***   I4: *Are you clear for everything we*

       spjeguam? S'dua që të kemi   *explained↑ I don't want having*

       probleme, kur të shohim…,   *problems, when we see next time…*

       sepse ky të shkul veshin   *because this one will tear your ear off*

358   AJ: hhhh

359   CT2: what did you say ↑

360   I4: £I'm saying he's serious£ (.5) sometimes

361   CT2: I'm serious indeed

362   I4: (1) sometimes he can=

363   CT2:   = sometimes I'm really £serious£=

364   I4: = hh no it's all the time serious hhh (2) no when it comes to the woman

       with babies it's very serious situation

Extract 48, C13

In the above extract, when the consultant asks Ajola if the information she has received is clear (L356), I4 interprets this as a terminal move. Anticipating a change of footing, the interpreter moves to that of a 'backstage', 'prosocial' encounter and attempts to break the interactive tensions by encouraging her client to engage in 'byplay' at the expense of the doctor (Hudak & Maynard, 2011; Goffman, 1981). Yet, as we saw in earlier examples (see 6.4.1, extract 22; 7.2.1, extract 35), in a superdiverse environment, one cannot make assumptions about homogeneity or linguistic repertoire: while the consultant

may not have heard, or necessarily completely understood, the joke, he certainly seems to understand the subversion (L359). Following previous conceptualisations of a translanguaging, or third, space as offering room to flout boundaries (Li, 2018: Bhabha, 1990), the interpreter's joking seeks to de-legitimise the consultant's authority, not for epistemic considerations, but in possible response to the positioning of her client as a victim. Indeed, the entire consultation could be said to be one that has threatened her client's positive face needs (Goffman, 1981). When I4 responds to the consultant's query by repeatedly teasing him about his seriousness (L360, 364), she sustains her alignment with Ajola, by using the third person to 'other' CT2 (L360). Although the two professionals have met at previous consultations, the consultant is is uncooperative at first. Reluctant to have his authority downgraded, he reasserts his right to be sombre (L361), before consolidating it with "really £serious£" (L363). Yet here his face crumples into a faint smile: the interpreter's strategic use of language to position and redistribute agency has succeeded. With this, she then reiterates her understanding of the gravity of the occasion and symmetrical relations are (re)established.

7.5 Conclusion

Throughout this second data analysis chapter, I have sought to illustrate the ways in which "[t]he participation framework and speech situation are …shaped by the institutionality of the interaction, [but] are also shaped by the participants' cultural, linguistic and social resources, as well as the knowledge available to them in a given context" (Tranekjaer, 2015: 54). As such, I begin by documenting the extensive range of linguistic strategies that are used to establish understanding (see 7.1), as well as the complexities involved in communicating, across discourses, within a socioculturally and linguistically diverse population (7.2). I note that, just as communicative repertoire can vary in breadth and complexity between individuals, so too can the extent of institutional authority invoked by medical professionals as they traverse a network of epistemic high wires between comprehensibility, knowledge distribution and patient health (see 7.3). Throughout the chapter, it also becomes evident that interaction is often complicated further by the presence

of a formal, or informal, interpreter: as Moyer notes, when "a third person mediates the medical encounter [it] has important consequences for the way patients express agency, position themselves and resist institutional categorisation" (Moyer, 2013: 197), or how they are, in effect, positioned or categorised by others (see for example, extracts 31, 34, 36, 45, 48). In fact, similar to extensive findings from Cox's ethnography (Cox et al, 2019; Cox & Lázaro Gutiérrez, 2016), we can see that mediation often gives rise to mistakes, misunderstandings or breakdowns in communication, some of which can have situational, or clinical, consequences (see sections 7.3.4 and 7.3.5). Yet it is the very unpredictability of the superdiverse consulting room, that also offers space to disrupt norms and 'common-sense' understandings of (a)symmetries, allowing interactants to resist authority (see for example, extract 40, 46), in a way that can further personal, or vicarious autonomy (see extracts 41, 48).

In the concluding chapter of this thesis, I seek to bring together the findings from this research project, demonstrating how they can contribute to the field of translanguaging and the field of health communication research.

Chapter 8 – Conclusion

8.1 Introduction

This study has sought to contribute to the inter-related fields of applied linguistics and health communication: guided by the understanding that all interaction takes place within a social context (Cicourel, 2007; Gumperz, 1972), the use of a linguistic ethnographic lens has enabled me to establish the ways in which midwives, interpreters and patients can be said to reflect the wider superdiverse population of Hayfield. As participants draw on a range of linguistic, semiotic and epistemic resources, in attempts to bridge understanding, the research not only explores translanguaging practices in an institutional setting but also reflects on the potential real-world consequences for health, which may be inferred from the data. My study has been informed by the following questions:

1. What are the ways in which linguistic difference is identified, experienced and navigated, during everyday antenatal consultations at Hayfield University Hospital (HUH)?
   a. In a contemporary health setting, what are the range of linguistic and semiotic resources drawn upon by participants in everyday antenatal consultations?
   b. (How) do the characteristics which are said to exemplify superdiverse environments, affect the interactional space of the consulting room?
2. (In what way) do communicative practices appear to have an impact upon mutual comprehension and experience?

In this concluding chapter, I summarise and evaluate my findings in the light of these questions and consider the implications for, and contributions to, the inter-related fields of applied linguistics and health communication. By way of additional illustration, I also draw on the voices of midwives in order to enhance my conclusions, before reflecting on the limitations of my research and suggesting possible avenues for future investigation.

8.2 Summary of findings

8.2.1 Institutional response(s) to multilingualism

As an over-stretched trust in a superdiverse suburb of London, Hayfield University Hospital faces a number of challenges on a daily basis. Not only does it care for a growing, ageing and highly diverse population, but it does so within the structural and financial constraints of the National Health Service - provision which was established over 70 years ago for a smaller, more homogenous demographic, and which is regularly rendered vulnerable by the vagaries of political change. Nevertheless, as an institution which 'belongs to the people', the NHS strives to ensure equal access to healthcare, free at the point of contact (see 2.3). Underpinned by these founding principles, and informed by protected characteristics outlined in the 2010 Equality Act, the NHS has in place systems of categorisation to ensure full compliance with legislation, in regard to parity of care for patients, as well as equal employment opportunities for staff (see 4.2.1, 4.2.2): it is thus positioned as an employer that champions cultural, linguistic and gender diversity (see table 2.6) and an organisation committed to social justice (see for example, NHS Commissioning, 2016). Indeed, if we understand the categorising processes of protected characteristics to be derived from extrasituational contexts, i.e. as constructed in terms of the societal values that are considered important at a particular point in time, we can also comprehend why the NHS is seen as a healthcare system which is considered to be beyond reproach in terms of equality and parity of care, and as a unique cornerstone of British democracy (Tranekjaer, 2015; Heller, 2001; Gumperz, 1972; see Chapter 4).

Focussing in further on intercultural healthcare - the heart of this research - the centrality of language to effective health consultations remains undisputed (see for example Cox, 2017; Moyer, 2013; Roberts et al, 2005; Bredmar & Linell, 1999), with institutional guidelines attempting to ensure, as far as possible, that encounters are facilitated through shared, impartial, linguistic concordance (NHS England/Primary Care Commissioning, 2018; see 2.3.2.4). Nevertheless, while institutional objectives are at pains to safeguard equity, they may be at odds with extrasituational discourse(s). Following Duchêne's

(2019: npn) observation that, "knowledge production is inherently related to the particular moment in which it is produced", I note that this research was undertaken at a time when the UK was still reeling from the results of the Brexit referendum, and anti-immigration rhetoric was particularly widespread. Indeed, an extract used in Chapter 6 (see 6.3.1, extract 17) illustrates that even skilled, multilingual, international health professionals are not immune to the reproduction of a wider, societal discourse, albeit incongruous to the setting or their apparent habitus. In this instance, the consultant, DC, is seen to urge her patient to talk to her baby in English – "when baby comes you're going to talk to baby in English and the baby's going to talk back to you in English so you will learn English quicker" (L225/226). In addition to the rather inappropriate commentary on a patient's linguistic repertoire, what makes this exhortation all the more extraordinary is that through her own use of vocabulary associated with Tamil, DC is observed to enhance communication, build rapport and ensure a convivial consultation. The somewhat loaded sentiments expressed by the consultant also contrast starkly with her interaction with Sadia (see 7.1.3, extract 34), where the entire conversation is conducted in Urdu – here, there is no reference to the patient's lack of fluency in English and the professional interpreter is rendered redundant. When DC later reveals that she can speak over five discrete 'languages', and articulates the professional advantage to be gained by learning Polish, Romanian, Albanian and Bulgarian (personal conversation), the tensions in the consultant's stance highlight a tangible ambivalence that surrounds institutional and societal positioning(s) of 'language'. As an employee in a superdiverse hospital, DC is one of many medical staff in this study observed to be using their repertoire to communicate more effectively with patients: MW3 uses Spanish as a lingua franca (see for example, extracts 27 and 29), while MW1 makes extensive use of drawing to clarify gynaecological/foetal details (see extract 39). These do not appear to be isolated instances of resourcefulness. Following group and individual interviews, midwives share numerous examples of using colleagues as informal interpreters (see also 4.4.2.5).

> I was booking a Czech lady whose history was really quite
> strong ..... quite sort of detailed and difficult and I knew I had
> a Czech student working with a colleague in the same clinic
> even though the Czech lady's English was very good, I felt we
> were missing bits so I went and asked the Czech student if
> she could actually come and join me and I said to her you talk
> to her about her past while I fill in all these documents and she
> got so much more out of this lady which she hadn't been able
> to say in English so we got a much more detailed background
> (Dolores, Appendix B, L122-128)

Nevertheless, despite an ostensible perception of (an) additional language(s) as "a skill, a talent, and a property that will generate benefits for the individual, the company, the community, the state, and society at large" (Duchêne, 2019), the midwives also highlight some of the inherent difficulties involved in drawing on the goodwill of fellow, multilingual, health professionals.

> We did have an Albanian interpreter for .....a lady.. and he
> worked as a doctor in clinic … no in A&E.. and he came up to
> interpret for this lady but it was very difficult because he was
> on duty and he had to come to interpret but he was being
> called and bleeped to go so we had to things quickly and then
> something else came up and we had to phone him back and
> he said I can't come back, I'm busy so it was really difficult.
> (KS, Appendix B, L107-112)

In this instance, the Albanian doctor in question is being requested to support a patient in a different department, in an unofficial capacity: this not only adds to his (heavy) workload but, to borrow from scholars concerned with political economy, appears to exploit his resources for institutional benefit (Duchêne, 2019; Heller & Duchêne, 2016). Although, it is arguable that expedited patient care can be taken as a form of informal or personal compensation, the doctor's linguistic capital goes unrecognised and unrewarded institutionally. To pursue this line of thought further, the fact that the doctor's intervention also goes unrecorded, can be seen to essentially delegitimise his multilingualism and simultaneously obfuscate the need for additional (interpreting) provision.

8.2.2 Approaching linguistic difference

Nevertheless, the day-to-day realities of working in a superdiverse environment necessarily requires interactants to acknowledge and traverse difference both in spite of, and because of, structural conditions. As such, the data presented thus far demonstrates that midwives seem to be fully aware of the potential limitations or effects of (mis)communication and endeavour to respond to patients to the best of their ability, especially in interlingual consultations: in the absence of interpreters, KS notes that "it's tricky…language is hard and it does pose some real difficult situations for us" (Appendix B, L86). However, so frequently do interpreting issues arise in this context, that even midwives in possession of so-called 'monolingual' repertoires, are familiar with employing intralingual, intersemiotic and interdiscursive techniques to communicate with patients (Simpson, 2016; see 3.5.4; 7.3). In the following description of how she speaks to patients who have non-standard repertoires, Stephanie, a senior midwife, appears to exemplify what Vertovec calls "multiple cultural competence" (2009: 7):

> the initial part of communication is about ….mirroring everything the other person does…so when you actually listen to how they speak how they construct their sentences and then you start to construct sentences exactly the same you find that they understand cos often I book an interpreter cos I've been informed that a woman requires an interpreter and then she will walk into here and when you start to speak and then I understand your English is good and you're like well my English is same but different. (Appendix C, L80-90)

I don't know whether the ability to change the way you speak also ties in with having had to change cultures and to learn how to live differently and behave differently because you've moved to a new culture that wasn't your original culture so you're more adaptable to different environments adaptability and the ability to adapt to where you are is a very important part to achieve communication so the way I look at it is I left Uganda when I was 13 years old came to this country and everything was totally and completely different to the way …..and so we learnt to change the way we speak (2) in order to get other people to understand us.   (Appendix   C, L92-99)

Originally from Uganda, Stephanie expresses her ability to communicate across cultures and languages as an expertise refined from her own experience as a midwife and a migrant: indeed her perceptive metalinguistic awareness, illustrates strategies which are generally understood to bridge understanding, such as reformulation, repetition and differentiation (Cox & Maryns, 2019; Baraldi & Luppi, 2015; see for example, 6.4.2, extract 26). However, while her cosmopolitanism, can be seen as 'a combination of attitudes, practices and abilities gathered from experiences of travel or displacement, transnational contact and diasporic identification" (Vertovec, 2009: 5; see also 3.3.1), it may also be Stephanie's conviviality, what Blommaert describes as "generosity of everyday contact" (Blommaert, 2014: 444), that acts as a form of social glue to facilitate relationships. For example, during her interview, the midwife describes how an antenatal patient that she had treated two years earlier, returned to see her with her toddler. Despite living in a different borough, and not having seen Stephanie since the birth of the child, the patient describes the midwife as the only medical professional who she understood, or who understood her (see Appendix C). The data analysis chapters further substantiate the copious ways in which medical professionals at HUH consistently draw on their communicative repertoire, as they seek to ensure a convivial atmosphere for patients: for example, MW1 regularly jokes (extracts 1, 6) with her patients, and draws on aspects of her cultural competence to establish her cosmopolitanism (extract 3), as well as

using strategizing skills to flatten epistemics (extract 16) or co-construct meaning (extract 26); by regularly changing to 'backstage' footings, where she can also share an overlap of experience during Gosha's adverse reaction to medication, MW2 is able to redress a face-threatening situation, but also to prevent possible litigious action (Goffman, 1981; extracts 13, 14 & 15); indeed, even in extremely sensitive encounters, it appears possible to relieve tensions with humour (extract 48).

However, as I noted in Chapter 3, a convivial stance neither precludes tensions, as we see in extract 9 when Agnieszka resists her midwife's good humour, nor does it erase the visibility of difference, despite its ubiquity (Creese et al, 2016; Wessendorf, 2014). During MW1's protracted consultation with Melina and George, the two Portuguese speakers raise a concern about their interpreter (whom we meet in extracts 26, 32, 43). Expressing confusion that a speaker of Brazilian Portuguese should been employed, rather than an interpreter who is native to Portugal, George describes the languages as "two different languages really" (L998) "like English of UK and English of America"(L1005). This then prompts an extensive group discussion, led by the midwife, as to the interpreter's country of origin, where she begins by questioning the interpreter's ethnic heritage, i.e. "yeah she didn't look Brazilian look Chilean" (L1011). MW1 subsequently decides the interpreter is Spanish or Argentinian, before concluding that she actually looks like "people from the Pampas region ( ) Argentina in terms of historically…Argentina Chile she more looks like a Chilean" (L1019-1020). To this, George can only respond by confirming the interpreter's Brazilian accent, and agreeing that "she definitely lived sometime in Brazil" (L1022). Initially, MW1's efforts to (re)locate the absent interpreter appear to represent an epistemic display of geographic cosmopolitanism, as she vacillates between South American countries. On a less superficial level, the exchange may be interpreted as a discursive, co-constructed 'othering' of the interpreter, designed less as an exclusionary practice (for I3 has left by this time), and more as process of marking her difference, in order to divert attention from a perceived institutional insensitivity to linguistic nuance. For while diversity is integral to the landscape of HUH, and professionals seek to engage with, and respond to, difference

(Wessendorf, 2014), convivial orientations can also function as inevitable communicative adaptations necessary to ensure the maintenance of institutional and personal (self-) presentation (Gilroy, 2006a, 2006b; Goffman, 1972).

8.2.3 Complex(ifying) repertoires

Although specific features have been intrinsically linked to superdiverse interaction (Vertovec, 2019; Wessendorf, 2014; Wise & Noble, 2014; see 3.3), effective interlingual communication is clearly not based on conviviality and humour alone. Through the perspective of translanguaging (Li, 2018), this research has documented the breadth of communicative resources utilised by patients, interpreters and doctors, as they seek to address "a resolution of the differences, discrepancies, inconsistencies, and ambiguities, if and when they need to be resolved, and manipulate them for strategic gains" (Li, 2018: 19). In some instances, individuals are seen to employ what could be identified as discrete 'languages' associated with specific nation-states: for example, DC talks to her patient in Urdu (extract 34), whereas MW3 communicates in Spanish (extract 29). Indeed, it would be disingenuous to ignore the dominant socialisation processes which link language and place, especially in an institutional context, where interpreters are employed on the basis of linguistic specialism. Nevertheless, following translanguaging scholars (see for example Li, 2018; Otheguy et al, 2015) this research has illustrated an understanding of language in terms of unique, personal idiolects, which transcend "the boundaries of named languages" (Li, 2018: 19), and has shown how those in possession of a translanguaging instinct are able to draw on their "multilingual, multisemiotic, multisensory, and multimodal resource[s] for sense- and meaning-making" (ibid: 22) (see 3.5). Equally, the importance of gaze, gesture and haptics in non-verbal communication cannot be underestimated, as midwife Moira notes:

> even though you can't communicate verbally to them, they will know by your facial expression what's actually going on the seriousness of the situation because they watch other people in the room or they will actually know whether someone actually cares about them by facial expression and it's sort of like some tactile touch or something like …. the reassuring touch you're going to be okay sort of thing.

(Appendix B, L93-97)

Findings from this study echo the negotiatory aspects of communication across language and cultures seen in earlier translanguaging research (Blackledge & Creese, 2017; Blackledge et al, 2017): but by also drawing attention to the particular epistemic divides between those in possession of knowledge, and those who seek help, this research contributes further to the growing canon of literature which examines translanguaging in formal, and medical, settings (see Cox & Maryns, 2019; Cox, 2017; Simpson, 2016). Translanguaging can perhaps be exemplified most dramatically in Melina's consultation, where in the face of more than one epistemic or linguistic impasse, participants are seen to draw on their varied, multisemiotic repertoires to co-construct, mediate and enhance communication. While the messiness of such interdiscursive translanguaging may involve several stages of negotiation (e.g. extract 20) or transelucidation (see extracts 43 & 44), as a process of establishing understanding it compels interactants to navigate the contextual and linguistic continuum, enabling epistemic and structural asymmetries to be disrupted (Cox et al, 2019; Baynham et al, 2017; Simpson, 2016; Otheguy et al, 2015; see also 3.5). The fluidity and dynamism of translanguaging practices, can therefore be seen to offer the potential to problematise knowledge displays and technical discourse, empower patients and (re)organise experience (Heller, 2001; see 7.4).

It appears also that such observable practices are contingent not only on the orientations of interactants, who are equally likely to have broad (but not necessarily shared) linguistic repertoires, but on the superdiverse context from which individuals cannot be separated (Heller, 2001; Gumperz, 1972). As my

research demonstrates, this in itself invokes complex tensions: on one hand, the NHS is intertwined with the nation state, hospitals are saturated with authority (Foucault, 1973; Korsch & Negrete, 1972) and the epistemics of consultations are intrinsically asymmetrical (Mishler, 1984); on the other hand, the specific context of antenatal care involves professionals who are frequently recognised for their metalinguistic and cultural sensitivities (Baraldi & Luppi, 2015) and affiliative stance (Defibaugh, 2014; Linell & Bredmar, 1996), features which offer the unique environmental affordances for a translanguaging space (Li, 2018; see 3.6; 6.4). However, as has become apparent, to assume that hybridity, liminality, a superdiverse stance or an orientation towards health equity, dispel interactional mechanisms of power, may be misleading. For what it is noticeable in almost all the observed encounters (C12 notwithstanding), is that the invocation of linguistic resources not associated with a 'standardised' form of a 'language', comes at the behest of the medical professionals (c.f. Pasquandrea, 2011). For example, it is MW3 who selects the most appropriate linguistic resource with which to address his Portuguese patient (extract 28); vacillating between Melina's friend and a professional interpreter, it is MW1 who makes an assessment of the best (or cheapest?) course of action (extract 32); and quite strikingly, it is DC who draws on her broad repertoire to tease her Tamil-speaking patient into dietary compliance (extract 20). In fact, this consultation, where Maalini frequently appears bemused by her doctor's unexpected repertoire, is open to alternative representations. Rather than illustrating the convivial model of creativity alluded to in earlier analysis (see extracts 22, 41), DC's linguistic flexibility could equally be interpreted as an additional method of augmenting institutional authority (see 5.3.1 for an extended discussion of pluralised interpretations).

Interestingly, while interpreters themselves often display little personal agency (see extracts 21 and 32), and appear to speak only when they are spoken to, their contributions remain integral to oiling the wheels of interaction (see for example, extracts 24 and 43), and have the potential to wield considerable influence. An observable example of this can be seen during the opening and closing phases of Ajola's appointment, when the interpreter makes attempts to

vicariously redress the asymmetry of (anticipated) stigmatisation (extracts 48 and 49). In addition, their presence also seems to bolster confidence, as patients can seem reluctant to pick up the translanguaging baton extended to them by their interlocutors (Alicia in extract 29, and Sadia in extract 34), unless they are also joined in a wider intralingual dialogue by an interpreter and/or companions (see extract 43). And so while it appears that translanguaging practices are woven into the everyday fabric of superdiverse societies (Blackledge et al, 2018; Simpson, 2016; Wessendorf, 2015, 2014), it may be that the opportunity to flex a personal repertoire in medical consultations, may lie very much at the discretion of those in positions of authority.

> Language differences play an important, positive role in signalling information as well as in creating and maintaining subtle boundaries of power, status, role and occupational specialization that make up the fabric of our social life. Assumptions about value differences associated with these boundaries in fact form the very basis for the indirect communicative strategies employed in key gatekeeping encounters….. which have come to be crucial in determining the quality of an individual's life in urban society.

> (Gumperz, 1982: 6/7).

Thus findings from this thesis suggest that although the power dynamics between medical professionals and their patients, which have long been a source of interest to researchers concerned with health communication (see for example, Moyer, 2013; Harvey & Koteyko, 2013; Fairclough, 2010; ten Have, 1991; Mishler, 1984), may not manifest as explicitly as historical research has illustrated (e.g. Korsch & Negrete, 1972), power continues to remain a fruitful area for exploration (see 8.2). For while the communicative flexibilities afforded by a superdiverse population (see Chapter 3), and institutional commitments to a model of patient-centred care (see Chapters 2 and 4), clearly have the potential to contribute to feelings of wellbeing and ethnolinguistic acceptance, there still exists an epistemic imbalance which proves difficult to resolve.

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8.3 Limitations

A number of practical and methodological limitations to this research must be acknowledged. Firstly, from a linguistic ethnographic perspective, the breadth and depth of data collected at HUH was inevitably limited by the amount of time I was able to access the research site. As a part-time student I was restricted by my working patterns, and also those of my key informant, BR, who proved invaluable in helping to recruit colleagues and identify patients. This also points to a second tension, in that as far as I strove to achieve a 'thick description' (Geertz, 1973: 153), I recognise that an immersive, longitudinal approach would have given greater scope for this process. That is not to say that an increased quantity of material would have increased my epistemic understanding of day-to-day life on the antenatal ward, but that a

> sustained ethnographic focus on everyday diversity [would allow more] insight into the processes… that shape urban encounters; everyday negotiations with difference and practices of accommodation; of belonging as practice; the embodied, affective and sensory dimensions of lived difference.   (Wise & Noble, 2016, p.427)

Despite the relatively limited opportunities afforded by the circumstances under which this research was conducted, the richness of the data captured by adopting a linguistic ethnographic lens, allowed me to challenge an understanding of healthcare as 'morally neutral' (Cicourel, 1999: 184) and to problematise contemporary communication practices in the consulting room (Blommaert, 2010; see 5.3.1). Yet I also acknowledge, as may be recalled (see 5.3.1), that the interpretations that can be drawn from ethnographic observations should be recognised as slivers of "fiction [or] something made" (Geertz, 1973: 155), located in a particular setting, at a specific point in time (Tusting and Maybin, 2007), and are thus, as personal as they are contingent (Blommaert & Dong, 2010).

8.4 Implications for applied linguistics research in health communication

Taking as given, an understanding that health information should be communicated clearly, in a manner and language that is comprehensible to the patient (NHS/Primary Care Commissioning, 2018), the data in this research demonstrates the lengths to which all participants will go, including medical professionals, to achieve mutual intelligibility (see 8.1). Conversely, it has also illustrated the considerable amount of breakdown in communication that can occur when traversing linguistic and epistemic difference, and co-constructing meaning, the consequences of which hold the potential to adversely affect patient experience and clinical outcomes (Sarangi & Roberts, 1999; ten Have, 1991). In exemplification, Melina's consultation, characterised as it is by conviviality and flexible, creative languaging (see extract 26), succeeds in drawing attention to possible dilemmas that may not always be self-evident (see extract 44), and problematises inherent assumptions that interpreters, either professional or informal, both understand the information they are given, and are able to translate it accurately (see extracts 25 and 44).

A related implication is therefore for the field of translanguaging, which is often conceptualised as a linguistic panacea (c.f. Jaspers, 2018), and on which, it appears, the superdiverse consulting room may be seen to rely. In much of the pedagogical research looking at the practice in the classroom, translanguaging has been attributed with transformative effects in both comprehension, learning and experience (see for example, Flores & García, 2014; 3.5 for further discussion). With such results, it is argued, the ability to access one's linguistic repertoire rebalances some of the social injustices that are experienced by those not in possession of dominant registers and resources, and offers equal access to a curriculum that, in monolingual circumstances, may prove difficult to achieve (García & Li, 2014).

In relation to health consultations in a contemporary context however, researchers may find it more beneficial to take as a starting point an explicit recognition of both the positive, but also potentially problematic, consequences

of translanguaging, particularly as "discourses that celebrate linguistic flexibility or project language as key for emancipation [may inadvertently obscure] the material dimensions of [/for/] inequality" (Jaspers, 2019: 86). Indeed, to follow Blommaert and Rampton, it is an ethical responsibility to recognise the limits of the concepts with which we engage:

> (i)t is important not to let a philosophical commitment to negotiation (or co-construction) as an axiomatic property of communication prevent us from investigating the limits to negotiability, or appreciating the vulnerability of whatever understanding emerges in the here and now to more fluent interpretations formed elsewhere, either before or after (Gumperz, 1982; Roberts et al, 1992; Maryns, 2006).

(Blommaert and Rampton, 2016: 29)

Translanguaging, and the contributory co-construction of meaning, may mask more than potential misunderstandings. For example, as I noted in 6.5, when MW3 meets his Portuguese patient and decides to conduct the appointment using a combination of English and Spanish, his ability to recognise, manage, and cope with difference, is in many ways, creative and commendable (see extracts 27 & 28). Yet, to make a decision to communicate in a lingua franca, rather than to seek support in the form of a Portuguese interpreter, is to enact a privilege which compromises Alicia's linguistic and legal right to give informed consent (Jaspers, 2019; Kubota, 2014). 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 which must take precedence. But the consultation does raise broader concerns. Not only may the lack of documentation requesting an interpreter, adversely affect the booking of mediated provision for Alicia's future appointments but, more widely, it glosses over the demand for such support and thus renders heterogeneity invisible. Similarly, as MW3's intervention goes unrecorded and unrewarded institutionally, his multilingual repertoire is effectively erased. With HUH neither aware of the demand, nor the internal 'resource', its response to

a linguistically diverse population will not only be limited but remain structurally unaccountable (see 1.1; 2.3) e.g. complexifying ongoing analysis of increased mortality rates among migrant populations (CMACE, 2011).

8.5 Recommendations for policy and practice

Findings from this study have drawn attention to paradoxical tensions between institutional and personal approaches to languaging practices, made all the more salient as they are observed in an organisation where difference is ostensibly celebrated and whose "rich diversity [is said to enable] a greater understanding and respect for individuals, cultures and diverse health needs" (Hayfield Health Services NHS Trust, n.d.). Significantly, while it is clear that the linguistic diversity of staff is as broad as that of Hayfield's patient population, language (in)congruence is nevertheless a feature of consultations that appears to be routinely navigated. Similar to findings in a superdiverse emergency department (Cox & Lázaro Gutiérrez, 2016; Cox, 2015a), I also note that although there may be institutional guidelines as how best to approach linguistic mediation (see 2.3.2.4), the pressures of clinical expedience mean that they are as likely to be followed inconsistently, as they are to be interpreted creatively (see Chapters 6 and 7). Such inconsistencies therefore make it difficult to gauge the extent and frequency to which personal repertoires are invoked, or to establish a good understanding of workforce repertoire. Indeed, without evaluative processes of categorisation in place to inform essential linguistic support, it is arguable that the existing NHS systems may fail to ensure equitable access to care, even with the additional flexibility for commissioning upon which some trusts may be able to draw (see 2.3; 4.2).

Therefore, it is in the light of *applied* linguistics in contemporary, superdiverse healthcare environments, that I seek to make several recommendations for both practice and policy.

- An ambitious, and in light of this study controversial, recommendation begins at the level of national policy, where I note the advantages to be gained by incorporating 'language' (sic) as a protected characteristic into the Equality Act. Although this appears to fly in the face of earlier

argumentation surrounding the essentialisation of language(s) (see 3.4.1; 3.6, for example), as a first step on the road to recognising the realities of repertoire, changes to legislation would enshrine the linguistic rights of patients and staff alike. It would also go some way to ensure the facilitation of informed consent and ensuing parity of care.

- In recognition that changes in legislation may be somewhat aspirational, a more feasible proposal is to approach the Primary Care Commissioning team at NHS England with a short policy brief. Summarising my research findings, this may be able to instigate discussion on a potential revision to current interpreting guidelines (NHS, 2018), particularly in relation to recognition of staff linguistic repertoire and guidance on ad hoc interlingual communication.

- This research project has highlighted some of the possible difficulties faced by both professional and ad hoc interpreters, in navigating the epistemic and linguistic challenges of translating medical discourse and technical vocabulary (see for example, 7.3.4). Illustrating the complexities involved in understanding health information and interpreting it in a way to be epistemically accessible to the patient, transcriptions draw attention to the need for more specialised, training for formal interpreters. As such, I hope to approach the hospital's professional interpreting service, Living Language (LL), with a view to sharing findings and recommendations.

- More generally, there is also the potential for superdiverse hospital trusts to employ professional, in-house interpreters in diasporic communities where it would be advantageous to do so - as seen in alternative settings (Angelelli, 2004) and recommended by others (Li et al, 2010). In this way, there could exist a consistent pool of well-trained interpreters, who could have access to specialised, departmental training, which in turn would boost working relationships with medical staff, increase the accuracy of translation and subsequently improve patient outcomes. Nevertheless, I acknowledge that as one of the difficulties facing institutions situated in superdiverse communities is an

(in)ability to ensure parity of representation, this aspect of linguistic equality needs further consideration.

- Moving from a national to more local level, an inherently practical recommendation would be to introduce an audit of staff language(s) at Hayfield University Hospital, to stimulate institutional recognition of linguistic repertoire and potentially pave the way for a more co-ordinated and bespoke 'matching' of midwives to patient. However, it must also be emphasized, that this recommendation is not made on the understanding that improved linguistic awareness or interpreting provision will in any way supersede translanguaging practices. For, as this thesis has illustrated, the liminality of the consulting room appears to create a space for "innovation and creativity" (Li, 2018: 23), and present an opportunity for "a person's own unique, personal language, the person's mental grammar [to] emerge.. in interaction with other speakers and enable… the person's use of language" (Otheguy, Garcia & Reid, 2015: 289). As such, changes to interpreting provision can only augment and further underpin the flexible communicative practices that have been demonstrated to enhance communication and patients experience (see for example, extract 40).

- Research findings have already been shared with Hayfield University Hospital. Prior to submission of this thesis, I drafted a short report and summary for the Head of Research and Development, Head of Midwifery and key participants. I am currently in discussion with the Head of Homeless Health team in Hayfield (see 2.3.2.1) and the local Clinical Commissioning Group (CCG), to explore the use of results to inform staff training and provision. It is possible that additional avenues for utilising data to supplement continuing professional development (CPD) or degree programmes may also present themselves in the future.

- A final recommendation can also be drawn from this research. Although there is little evidence arising from the particular observations documented in this thesis, several midwives allude to the advantages of using contemporary media to improve intercultural communication

(see 2.3.2.5). Indeed, following Cox and Maryns (2019), it seems that advances in technology may prove invaluable in superdiverse healthcare consultations, and may be a fruitful, future area of research. As a starting point, I intend to explore the potential for developing a visual aid to assist midwives in the specific area of medical history, which appears to present a significant stumbling block for professional and ad hoc interpreters alike (see for example, extracts 24, 36 and 42). While ongoing conversations with a firm that specialises in creating visual, paper-based resources to support patients with limited communication skills have been very helpful, I may also explore the possibilities for the development of digital solutions/an app.

8.6 Recommendations for future research

An additional recommendation is methodological. Following Candlin and Candlin's assertion that "working from within at understanding the nature of the relationships among interaction, diagnosis, treatment, and care, and conscious also of the implications of such analyses for institutional and organizational change" (2003: 15), future research would benefit from being jointly conducted with medical professionals, in an iterative cycle of observation, analysis, reflection and action. There would then exist the potential to address some of the challenges that present themselves in superdiverse settings: for the researcher, improved insight could shed light upon the clinical and institutional constraints through which interactions are shaped, therefore informing analytic practice; for the medical professionals, such collaboration could also facilitate reflective practice. In addition, to approach research in antenatal care with a superdiverse stance, would be to reinforce understandings of patients as individuals, whose communicative repertoires are as uniquely shaped by their biographies, stance, and identities, as are their pregnancies (Piacentini et al, 2019; Phillimore et al., 2018; Bradby et al., 2017; Rampton, 2007): such understandings could also extend to midwives.

8.7 Conclusion

Through the complementary frameworks of superdiversity and translanguaging and the contextual advantages of a linguistic ethnographic lens, this study has illuminated emergent patterns of communication in an contemporary healthcare setting. It has drawn attention to the ways in which the use of flexible repertoires can offer creative solutions to interaction, but also hold the potential to inadvertently affect understanding, and subsequently experience and outcomes. Indeed, as urban landscapes continue to shift with the ebb and flow of migration, the increasingly complex repertoires of local populations reflect new ways of redefining experience and knowledge, and hold implications for institutional change.

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Appendix A: Pregnancy Notes

Your Details

Single ☐ Married / CP ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed ☐

Family name at birth _____

Country of birth _____   If not UK, year of entry _____

Have you had a full medical exam since coming to the UK? (If no refer to GP) No ☐ Yes ☐

Faith / Religion _____   Citizenship status _____

Sensory/physical Disability No ☐ Yes ☐   Details _____

Partner's Details

First name _____   Surname _____

Address: if different _____   Postcode: _____

Date of birth _____

Employed ☐ LIFE ☐   Occupation _____

Citizenship status _____   If not born in UK, year of entry _____

Social Assessment – booking
record also on page 6

	No	Yes	2nd Assessment No	Yes	Referred
Has difficulty understanding English	☐	☐	☐	☐	☐
Any difficulties reading / writing English	☐	☐	☐	☐	☐
Needs help understanding Pregnancy Notes	☐	☐	☐	☐	☐
Needs help completing forms	☐	☐	☐	☐	☐

Employment status

Occupation _____   Age leaving full time education _____

F/T ☐ P/T ☐ Home ☐ Student ☐ Sick ☐ LIFE ☐ Retired ☐ Voluntary ☐

Housing: Own ☐ Rents ☐ With family/friends ☐ UKBA ☐ NFA ☐
Care services ☐ Temporary accommodation ☐ Other _____

How long have you lived at your current address? _____

How many people live in your household? _____

Entitled to claim benefits (income support, child tax credits, job seeker etc.) No ☐ Yes ☐

Do you have support from partner / family / friend ☐ ☐

Any household member had/has social services support ☐ ☐

Name of social worker(s)/ Other multi-agency professionals _____

Does your partner have any other children. If yes, who looks after them? ☐ ☐ _____

Tobacco use – booking
record also on page 6

	No	Yes
Are you a smoker?	☐	☐
Have you ever used tobacco?	☐	☐
Was this in the last 12 months?	☐	☐

When did you stop? _____

If in pregnancy, how many weeks? _____

Anyone else at home smoke? ☐ ☐

Do you:	No	Yes	1st No. per day	No	Yes	2nd No. per day
Smoke cigarettes	☐	☐		☐	☐	
Smoke roll ups	☐	☐		☐	☐	
Use e-cigarettes	☐	☐		☐	☐	
Use NRT	☐	☐		☐	☐	
Chew tobacco	☐	☐		☐	☐	
Smoking cessation referral	☐	☐ Declined ☐		☐	☐ Declined ☐	
CO screening?	☐	☐ Result ☐		☐	☐ Result ☐	

Drug use – booking
record also on page 6

	1st No	Yes	2nd No	Yes
Have you ever used street drugs, cannabis, or psychoactive substances (legal highs)?	☐	☐		
Have you ever injected drugs?	☐	☐		
Have you ever shared drugs paraphernalia?	☐	☐		
Do you currently use?	☐	☐	☐	☐
Details _____				
Are you on counting (if relevant)?	☐	☐	☐	☐
Any drug or alcohol concerns in the home?	☐	☐		

Details _____

Alcohol – booking
record also on page 6

	No	Yes	2nd No	Yes
Do you drink alcohol?	☐	☐	☐	☐
Alcohol units per week				

Pre-pregnancy ____ Currently ____

In the last 12 months. How often have you had a drink containing alcohol? _____

How many units of alcohol do drink on a typical day when you are drinking? _____

Substance misuse referral (Consider using an alcohol screening tool eg. AUDIT C)   Declined ☐ ☐   Declined ☐ ☐

Ethnic Origin
(If mixed, tick more than one box) - is to describe where your family originates from, as distinct from where you were born. This information is needed to produce a customised growth chart for your baby (page 18).   Declined ☐ ☐

	Yes	Baby's father		Yes	Baby's father		Yes	Baby's father
British European (e.g. England, Wales)	☐	☐	East African (e.g. Ethiopia, Kenya)	☐	☐	Pakistani (e.g. Pakistan)	☐	☐
East European (e.g. Poland, Romania)	☐	☐	Central African (e.g. Cameroon, Congo)	☐	☐	Bangladeshi (e.g. Bangladesh)	☐	☐
Irish European (e.g. Northern Ireland, ROI)	☐	☐	Southern African - Black (e.g. Botswana, S. Africa)	☐	☐	Chinese (e.g. China)	☐	☐
North European (e.g. Sweden, Denmark)	☐	☐	South African - (non South Africa)	☐	☐	Other Far East (e.g. Japan, Korea)	☐	☐
South European (e.g. Greece, Spain)	☐	☐	West African (e.g. Gambia, Ghana)	☐	☐	South East Asian (e.g. Thailand, Philippines)	☐	☐
West European (e.g. France, Germany)	☐	☐	Middle Eastern (e.g. Iraq, Turkey)	☐	☐	Caribbean (e.g. Barbados, Jamaica)	☐	☐
North African (e.g. Egypt, Sudan)	☐	☐	Indian (e.g. India, Sri Lanka)	☐	☐	Other _____	☐	☐

CP - Civil Partner, F/T- Full Time P/T-Part Time, GP - General Practitioner

Medical History Complete risk assessment page 14 and management plan page 15.

Do you have / have you had:	No	Yes
Admission to ITU / HDU	☐	☐
Admission to A & E in last 12 months	☐	☐
Anaesthetic problems	☐	☐
Allergies (inc. latex)	☐	☐
Autoimmune disease	☐	☐
Back problems	☐	☐
Blood / Clotting disorder	☐	☐
Blood transfusions	☐	☐
Cancer	☐	☐
Cardiac problems	☐	☐
Cervical smear	☐	☐
Chickenpox/Shingles	☐	☐
Diabetes	☐	☐
Epilepsy / Neurological problems	☐	☐
Exposure to toxic substances	☐	☐
Fertility problems (this pregnancy)	☐	☐
Female circumcision / cutting	☐	☐
Gastro-intestinal problems (eg Crohn)	☐	☐
Genital Infections (e.g. Chlamydia, Herpes)	☐	☐
Gynae history / operations (incl. caesarean)	☐	☐
Haematological (Haemoglobinopathies)	☐	☐
High blood pressure	☐	☐
Incontinence (urinary / faecal)	☐	☐
Infections (e.g. MRSA, GBS)	☐	☐
Inherited disorders	☐	☐
Liver disease inc. hepatitis	☐	☐
Migraine or severe headache	☐	☐
Musculo-skeletal problems	☐	☐
Operations	☐	☐
Pelvic injury	☐	☐
Renal disease	☐	☐
Respiratory disease	☐	☐
TB exposure	☐	☐
Thrombosis	☐	☐
Thyroid / other endocrine problems	☐	☐
Medication in the last 6 months	☐	☐
Vaginal bleeding in this pregnancy	☐	☐
Other (provide details)	☐	☐
Folic acid tablets	☐	☐

Details

Date ☐☐☐☐☐☐☐☐   Result ☐

On epilepsy medication? ☐

Hepatitis B ☐ C ☐

Start date ☐☐☐☐☐☐☐☐   0.4mg ☐ 5mg ☐   Dose changed? No ☐ Yes ☐

| Physical Examination performed | ☐ | ☐ |

Details

Family History The term 'family' here means blood relatives only – e.g. your children, your parents, grandparents, brothers and sisters, uncles and aunts and their children (i.e. first cousins). Update management plan (page 15) if indicated.

Has anyone in your family had:	No	Yes
- diabetes? Type	☐	☐
- thrombosis (blood clots)	☐	☐
- high blood pressure / eclampsia	☐	☐
- hip problems from birth	☐	☐
Is your partner the baby's father	☐	☐
Is the baby's father a blood relation	☐	☐
First cousin ☐ Second cousin ☐ Other ☐		
Age of baby's father ☐☐		

Has anyone had:	in your family No / Yes	in family of baby's father No / Yes
- a disease that runs in families	☐ ☐	☐ ☐
- need for genetic counselling	☐ ☐	☐ ☐
- stillbirths or multiple miscarriages	☐ ☐	☐ ☐
- a sudden infant death	☐ ☐	☐ ☐
- learning difficulties	☐ ☐	☐ ☐
- hearing loss from childhood	☐ ☐	☐ ☐
- heart problems from birth	☐ ☐	☐ ☐
- abnormalities present at birth	☐ ☐	☐ ☐
- MCADD	☐ ☐	☐ ☐

Details

MCADD – Medium Chain Acyl Dehydrogenase Deficiency
* Signatures must be listed on page 30 for identification

Name
Unit No
NHS No

Appendix B: Midwifery team leaders/group interview

Karen (K), Dolores (D), Moira (M), Amina (A), Sylvia (S), Emma (researcherE)   (   )=pause of several seconds

1 - K: so Medico-legally if a woman comes in and doesn't speak English then what we're meant to do is go through an official body and it's ████████████ However, and they will get an interpreter but we have had a lady who spoke a very unusual dialect I think she was from ██████ and in that case we really struggled cos we couldn't get that dialect and there was no one with her she was on her own so you just plod your way through it's not ideal but that's how you do it and then there are times when people will bring a phone into the room with a woman and you have those conversations that's with ██████ ██ or if they have a family member and they need

10- something done really quickly or a member of staff will get someone to come in and interpret

E: Does anyone feel there's something different to that?

D: No I the same happens (   ) in the houses y'know you'll be in the house and they'll and you their mobile phone and say I'll just put you through to my husband and then you're talking to the husband who wouldn't normally be there cos he's out at work so or erm they'll bring in their relatives so

E: that must be really quite hard if they're trying to describe symptoms and you're looking at the person and this person is remote and trying to….their describing the act that must be

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20- D: quite often though you do find that they understand what you're saying but they're unable to communicate back so um you kinda get him relaying what they're saying back to you.

M: cos I've recently had an episode where I was ringing up to give some screening results and the mum had enough English to know I was ringing about the screening, the dad had enough English to know I was ringing about the screening but neither of them had the comprehension so then what they did was they handed me over to the daughter when I asked the daughter what age she was, she was fourteen so I said I'm sorry but I can't speak to you and she's going please, please please my mum was crying. I said I'm really sorry

30- I'll come back with an interpreter she goes no, no, no hold the line and she handed me to someone else in the family who happened to be the brother who was fifteen and I go I'm really, really sorry but I will ring you back really quickly so I rang them back with an interpreter and we got through it but it was just like this you had created a state of anxiety for them cos they knew they were going to get some news that possibly wasn't particularly good but then they were trying to get a fourteen year old and a fifteen year old who legally you can't speak to so it was one episode where it was actually quite difficult but then they were so grateful afterwards that I'd managed to get the interpreter and spend as long on the phone with them as they needed so it's a **40 -** D: But even sorry using ▮▮▮▮ ▮▮ you hit problems and as like (   ) said they often don't have the language or the dialect and I've had a situation where I've had a face-to-face interpreter turn up for a French speaking lady that's the totally wrong dialect so you know it's a complete waste of time and (   ) so that lady had to be sent away again and come back with the correct one.

M: and I've had an interpreter and where I'm trying to give information and I knew by the shortness of the sentences there was one or two words .. this person actually hadn't the knowledge to describe what I was trying to describe to the family so I said can explain to me if you understand the condition that

50- was explaining and tell me what you know about it in English so that I know you're relaying this back to them in their language and it turned out that this chap didn't couldn't speak couldn't explain what I needed him to so I had to terminate and go back through █████████ and get another interpreter that had a good knowledge and was able to use the language this couple understood so it does present its problems

S: Yeah I've found that a lot

A: And saying that the bias .. I'm sometimes quite conscious of a bias when you're using interpreters, particularly a cultural bias if you're talking about very sensitive things and we were really lucky a few weeks ago we had somebody

60 - who spoke absolutely no English and we had a medical student a student midwife who actually came in to interpret for us and it was wonderful because we she know she was going to get completely impartial advice from her which was really good whereas that we felt that there was a bias a cultural bias

D: Yeah because we you use an interpreter and especially round the issue of FGM and that I ask the question and before the woman will answer the interpreter will say no and answer=

?: =Has answered so then you'll challenge and say well did you and no it's not done in our culture (   ) so well actually I need you to ask her and they can be problematic (   ) so

70-they'll answer and you do sometimes wonder actually y'know like A said,

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I'm not convinced

M: yeah ((0verlap))

D: That they relayed that information properly or if they did sometimes you will ask a very simple question that should be a yes or a no and the conversation goes on for hours and you think what else are they throwing in here?

K: there are some cultures where they don't want caesarean sections ( ) and I do know of a case in another hospital and it was from a ████████ family and they don't the men don't like their wives having caesarean sections and

80 -parable CCG the woman needed a section the husband was interpreting shouldn't have been and he kept saying no she doesn't want a section no doesn't want a section but you're just thinking how do we know that that's what she's really saying and it was really difficult and you're watching the demise of this child and the solicitors saying there's nothing we can do so there are those things that are very difficult to stand around and watch ( ) yeah so it's tricky (   ) so language is hard and it does pose some real difficult situations for us and sometimes you have to do what's in the woman's best interest so the lady comes in and she doesn't speak English and she's really sick you have to do what's in the best interest for her that's lifesaving and hopefully be

90 - able to stand both it must be quite frightening for the ladies if they don't speak English and we're all running round and we're doing things to her and she doesn't understand

M: what I find in those scenarios even though you can't communicate verbally to them, they will know by your facial expression what's actually going on the seriousness of the situation because they watch other people in the room or they

will actually know whether someone actually cares about them by facial expression and it's sort of like some tactile touch or something like that the reassuring touch you're going to be okay sort of thing. They mightn't understand the language but they'll know that you actually care about how

100 - they're feeling and what you're doing for them and they'll sort of its almost like they're going right fine, they know what's wrong with me, they're going to make me better type thing that sort of thing

E: do the interpreters have any medical training or do they just just have ethical training?

K: as far as we're aware=

E:=yeah

K: We did have an Albanian interpreter for (   ) lady erm who and he worked as a doctor in clinic er no in A&E and he came up to interpret for this lady but it was very difficult because he was on duty and he had to come to interpret

110- but he was being called and bleeped to go so we had to things quickly and then something else came up and we had to phone him back and he said
I can't come back, I'm busy so it was really difficult=

> E: = yeah do you find that you have many members of staff who share languages?
>
> A: Yeah absolutely we've got got a diverse culture here of
>
> ((here various voices over each other))
>
> ? =Some staff
>
> A: I call on them sometimes
>
> D:I had a student so

120-((pager is bleeping))

K: Is it me or you?

D: I was booking a Czech lady whose history was really quite strong (5) quite sort of detailed and difficult and I knew I had a Czech student working with a colleague in the same clinic even though the Czech lady's English was very good, I felt we were missing bits so I went and asked the Czech student if she could actually come and join me and I said to her you talk to her about her past while I fill in all these documents and she got so much more out of this lady which she hadn't

130 - been able to say in English so we got a much more detailed background

M: that's quite common actually because people can even though they can speak English it's the everyday English like going to the shops and buying something it's not when you come into a hospital because they don't understand conditions or medical treatment or any medical terminology so that's when the issue often arises with people who have English as a second language

E: Do you find that sort of is a problem for native speakers of English as well?

So would you ever find that y'know your ordinary English woman also struggling a lot with terminology?

140 - M: Yes

S: oh absolutely.. depending on their education as well you've got some people who absolutely convinced that their baby will have a full-course meal through the placenta and trying to explain to them that that's not how it happens or I always remember one when I was in Newcastle and they were convinced, they were both really heavy smokers, horrendous really, but this baby was I.E.G.R and they could not

E: What's that?

S:They..small for dates

E: Small for dates? Sorry

150- S: but they could not they could not comprehend that for them there was something wrong with the baby's stomach. It it they couldn't understand the physiology of the fact that it was their smoking that was causing this IEGR it must be because the baby's not growing there's something wrong with the baby's stomach and we could not get across that point

?:I also think

D: how we're so used to saying things in our=

A: =as I just did

Yeah, sorry? we are saying something but

M=as she just did=

160 - ?=but we are so used to saying things that we don't think about the implications of what we're saying like students that when they're palpating say I can't find the head (   )

?:   (indistiguishable)

A: You can see the panic on this lady's face

Laughter and background noise

K: what you mean's the head's engaged

S: or the scanner says I can't see their head and (   )

        ?:   the baby hasn't got a head
(laughter)

        K: or I can't see or I can't feel the back so actually because you're palpating

170 - you use the back of the baby to help you with the lon..lie of the child and wh..what position it's in and so when you palpate you go *(models palpation of mother's stomach)* You go back again and you can't feel the back because it's either right over the front or right around the back so I can't feel the back and they worry y'know there's silly things like that there we don't think about what we're saying cos we don't think of the implications but we know clinically what

we mean   so yeah (

)

?: yeah

D: so y'know you can't find the foetal heartbeat (   ) which is often

180 - which is common especially in early stages and you're fishing around and yeah you might say er it's here somewhere sort of thing but you see the panic. You have to remember they don't understand any of that.

?: Yeah

You have to kind of say, don't worry this is quite normal and sort of communicating that otherwise y'know it's a very negative experience for them (   ) but I think we are a little bit glib with what we say erm and we forget

E: Mmm and I think that's the thing, it's very unnatural to think about every word you say all the time=

D=yeah=

190 - ?=everytime you speak=

?=yeah

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E: especially when you're working and you're doing things which, as you say,

are very matter of course, very natural for you (   )

You know the green notes that the women get, have carry with them how do you find sort of doing taking the medical history and using those and how do you find patients

D:You often find

E: Understand?

D: um they will say to no everything and they actually haven't got a clue what

200 - you're asking them

E: hmm

D: (   ) and you find that out because they'll say no to things and you'll go a bit further on and they'll say oh actually I've had this xx so you did have a heart condition and you (   ) so they sort of they I don't know whether probably don't understand what you're asking them so=

E:-= this is medical terminology again isn't it?

((sounds of agreeing))

K: and I think also there's situations where they know something terrible's happened but they don't want to accept it so they bury it and they won't

210 - disclose everything about that condition. It's something very similar to what (   ) has said y'know they'll say that they went to intensive care and this is what happened but later on you'll ask them about a lung condition or a heart condition no, no nothing like that and so they then don't get on the right pathway of care and then something might happen later and

you go back over it and then there is a GPs letter and it'll be in there what's happened so it's quite difficult

E: Mm

K: (   ) so it can have huge implications if English isn't the first language or their comprehension and their understanding cos they're just thinking of pregnancy

220-whereas we look at the holistic person and the medical history and the implications for that and also makes a difference to the amount of scans they have and consultants input whether they have midwifery input or they just have completely hospital care

D: it's sort of quite interesting how they perceive what you say. I do remember years ago I booked this lady who was very large and the husband was very large so I said to them you have to have a consultant appointment because you're

(Slight interruption ██████████████ *comes into room)*

so I said to you have to have a consultant because you have

a high BMI and

230 - apparently she wouldn't see me again because she said I called her fat so she actually said I called her fat when I never said the word fat you have a high BMI so she heard the word high BMI, decided she was fat and decided
I called her fat (1) lucky I had a student with me to say I didn't

(   )

it's how they hear things and perceive things

(introductions to ████████████████ *)*

E: It's about working out what works well and sharing that with each other.

You all sound like you have very similar ways of doing things

K: well I think it's only because there's nothing else that we have

240 - E: yeah

K: y'know we have to make sure women have informed choice

E: yeah, well yeah, is that, that must be difficult to ensure that they know exactly

M: yeah

E: of course=

A: but that's not every single job y'know

E: of course

A: um education, understanding things like that you can have a very highly educated person but they don't actually have the perception

250 - ?: Yeah

?: The perception or (   )

K: isn't there some cultures where they nod and they mean no?

E:=yeah

All, yeah

K: so there's lots of things you learn as you go along, isn't there about people

((shares story))

M: well that's something else like y'know with or without language if someone doesn't understand the language when you bring a professional into the room, be it particularly a doctor, once they see that white coat and stethoscope it

260 - could be anybody, it could be the cleaner but once they see that, whatever the person says they are a doctor and they are going to make me better or whatever and that is like 1 another non-verbal form of communication

E: it's a kind of power dynamic isn't it?

M: yup

D: it's true though my sister said she'd been for a blood test and I said really, what was that for? Well, I don't know (1) you didn't think to ask? the doctor said I needed it and

M: yep=

D: =and you didn't ask him why?

270 - (   )

D: Oh dear and I thought she was quite intelligent

      E: well it's just very trusting isn't it well I need he'll tell me when I need to know or she'll haha yeah

      A: which in a way makes us feel very humble that people do trust us so much the vast majority and it's terrible it makes you feel terrible when that's abused

      M: mm

      ?: yeah

      A: (   ) that kind of trust in the doctor

      E: so do you ever, in a hospital setting, have children parents bringing children

      280 - to help to kind of interpret for them? What do you do in that situation, if you're not do you sort of say no?

      M: No no

A: you have to be very nice but you cannot go down that route under any circumstances (   )

E: yeah I know

K: I think also cause it's the intimacy of the questions that we ask as well because it's the reliability and the understanding of the child plus

E: = the exposure to=

K: =cos it's hard enough when you've got to assess whether the woman's got **290 -** the ability to understand, let alone the child.

E: mmm so if someone came with a child, you'd send them back with an interpreter booked

K: or we try and do it ourselves or try and get someone on ██████████

E: ok so how quick is ██████████? Is it? Can you just pick it up and say I need (   )

M:
it's   quite efficient actually

Others:

?: (   )

300 - K: it's only if you get the unusual dialects you have to hi (   )
(x enters the room)

E: and then what's it like cos I've never seen this I'm really interested to see this, where you so you have your patient opposite you and then a phone communicating=

D:=it's so difficult

E: is it?

S: yes especially I mean I (   ) yesterday in here (   )
the facility to have two phones connected but if you've only got
one phone you're really passing it back and then it's back and
forwards and it's know it's trying to work

310 -   out how much information to ask them to ask at any one time

E: yeah

S: cos y'know you want to try and condense that time down to
how long it takes so you want to ((Someone coughs))

?: (   )

Find you want to ask them too much because otherwise bits of it will
get lost

?: yeah

?: (   )

so it is quite difficult and the phone just goes back and forward, back
and

320 - forward d'you find that?

M: I find a different sort of perspective one a thing that I do with
a two way call out this is when I'm trying to deliver like tell them
bad news these are some results that I need to discuss and
that I need them to either come in or see me or go through
what they need to do Well then it's I have an interpreter who's
on I'm on one phone the interpreters on another phone, we're
not in the same room he's wherever he is or she and we've got
the couple at home sort of thing and it's going around and you
have to wait for the responses back and it's backwards and
forwards and I actually like to see people's responses

        ?: yep

330 - To things because it actually helps seeing what they've understood as well for me and it is quite a difficult concept to have this (mimics phone) and you're not actually seeing what the response is

E: so =

M: = you can hear it but you can't see it it's a it's a you then develop shall I say better listening skills for the like the sharp intake of breath or the subtle change in the tone of the voice or things like that you can hear that what you've been trying to say has been communicated cos they've got some

understanding of what's going on and sometimes the seriousness of it=

K:=and there's also the cultural aspects when you've got cos it's all about

340 - women isn't it and they you have a male interpreter that'll be on the phone or a male interpreter will turn up because all you've done is requested an interpreter unless you've said male or female then you'll get what they've got so (   ) and sometimes we've had situations where the husbands there, the wife is there, the male interpreter turns up she's having a scan and the man will say no she can't come in so that becomes really difficult and you have to rebook the lady for a scan which can have its own implications then

E: do you think sometimes, I'm just thinking off the top of my head that if you had a male interpreter, as a patient, you may not give (4) as full a picture because you don't want him to think of you er you just don't want to give that

350 - personal information for him to hear

(   )

A: we wouldn't because some of the questions we have to ask are very very intimate and the women just wouldn't disclose they won't have male doctors or male midwives so there's no way they'd have a male interpreter.

Appendix C: Midwife interview

Stephanie (S), Emma /Researcher (E)

1 -S: it's a very changing area in terms of our practice it's existed as long as I've been in midwifery and it was a passion of mine in the beginning because I felt that because we're not consistently using y'know the interpreter services we're relying on relatives and partners and children to provide the interpreting of information for women there was no reassurance that women were being given true choice but on top of that you had the problem that because a lot of women who don't speak English as a first language tend to be the more vulnerable=

E:=mhmm=

10- S: =they won't necessarily know what the system is you tended to find that if you pulled in a woman who needed an interpreter and you had booked an interpreter then what should have been a 30 minute appointment or 15 minute appointment becomes a 1 hour appointment=

E:=mhm=

S:=because they'll pull out everything that they need to understand=

E: =yeah yeah yeah

S: because they actually are suddenly in a position where they feel safe and understood and they feel they've got someone who'll actually listen to them=

E: =yeah

20 -S: and it's also ensuring cos a lot of the women whose where English is not their first language you'll often find come from a paternalistic medical environment where they'll just do

what their told rather than actually questioning and understanding that any recommendation that comes from a health professional is a recommendation and is not an order they have to complete so it's to me being empowering women is about getting them to understand what their choices are and as long as someone doesn't understand that they've got not choice they're not empowered=

E:=yeah=

S:=so that's that's where it stems from for me

30 - E shares previous research findings where women shared experience

S: as █████ said we work as part of a screening team and we do come across it a lot where we have women where English is not their first language and xx we do hepatitis B a lot of new patients that's where we tend to find that amongst women who have only been in this country for a short time if they've been here a while they haven't integrated and therefore they haven't learnt enough English to be able to understand let more than just the basic English so and unfortunately sometimes with some languages you cannot access them via ████████=
E:=well yes=

40 - S:=that is y'know=

E: =some of them are regional dialects and they don't have the interpreters who speak=

S:=exactly so interestingly enough I had a lady yesterday who spoke Fula a:nd luckily I found out that there was a midwife who speaks that language so I was able to ( ) GE speaks Fulla so I got she was going to a conference but I told her what I needed and I asked can you please translate it on a message to me then I can play it for this lady when she first comes in=

E: =yeah

S:=y'know so that we can then have a discussion after that because y'know

50 -the woman could speak very good English but did not understand what

Down's Syndrome Screening is=

E:=yes this absolutely=

S: =and when she said that she didn't understand what Down's Syndrome Screening was because I could tell she had an accent my first question was what language do you speak normally and she said English [laughs] so I said no no no what language do you where're you from originally? What language did you speak before? In order that I then could try and work out I knew that there was no way I was going to be successful with Fula as a language on ▮▮▮▮▮▮▮▮ at short notice because she was due to come in

60 - and see me within an hour or so so I got midwife to do the translation and because she could speak English perfectly fine it was about simplifying the language explaining it very basically but getting her to understand using pictures as well as words and at the end of it she understood what it is she'll be offered when she comes in to attend her Down's Syndrome Screening and surprisingly ▮▮▮▮▮ had a similar incident yesterday as well because we had to pull a women back in because she hadn't been offered screening because they felt that that she didn't understand English well enough to understand what she was being offered and when ▮▮▮▮▮ sat down with them ready to use an interpreter they said no we don't need an interpreter so

70 - there it becomes a case where if xxxx speaking English you're never going to be able with people who speak English differently to you=

E: =yeah=

S;=so=

E: so you you it's about kinda changing reformulating what you say

S: yeah yeah you you change your grammar I mean sometimes you'll sit in and you hear me speaking to someone and you'll actually think [laughs]=

E: =well, I'm an ESOL tutor and that's what I do all the time so

S:Change you're there just giving words speaking to and when you think that part of communication is mimicking what the other person does and children

80 - do it a lot better than we do in that the initial part of communication is about

E: yeah

S: mirroring everything the other person does=

E: yeah yeah=

S:=so when you actually listen to how they speak how they construct their sentences and then you start to construct sentences exactly the same you find that they understand cos often I book an interpreter cos I've been informed that a woman requires an interpreter and then she will walk into here and when you start to speak and then I understand your English is good and you're like

90- well my English is same but different

E: yeah

S; y'see but you see some people do not have that ability I don't know whether the ability to change the way you speak also ties in with having had to change cultures and to learn how to live differently and behave differently because you've moved to a new culture that wasn't your original culture so you're more adaptable to different environments adaptability and the ability to adapt to where you are is a very important part to achieve communication so the way I look at it is I left Uganda when I was 13 years old came to this country and everything was totally and completely different to the way I

100 - E: mm mm

S: I spoke Queen's English I understood English perfectly fine I could understand BBC news I could understand y'know the proper channels but put me on the street with your local basic person and I spent my days saying pardon pardon pardon pardon [laughs] and the most interesting thing is when I spoke they did not understand and yet I was speaking English and at school y'know we were talk about groups we actually knew English better than they did so it was I was

E: very interesting

S: and so we learnt to change the way we speak in order to get other

110- people to understand us=

E:=mm

S: (2) so you change and learn that people speak differently so depending on who you speak to you sound different

E: mm

S: so the way I speak to someone at home will be different from the way I speak at work the way I am at work will be different from the way I am with a friend=

381

E:=mm

S; so it c it chops and changes [laughs]

120 - E: there I I'm so glad I spoke to you today when this lady came I'm not I know about telephone interviews I've not actually seen one happen. How often do you conduct one?

S: aah anytime I need it I would use ▮▮▮▮▮▮▮ normally on speaker if I'm not in an area where there is a speaker I I'll get a work mobile and actually stick in on speaker or get them to call the woman and basically what would happen is although you have an interpreter in the background obviously you maintain your contact with the woman always and so even if we're on the phone I'll actually be looking at you as I'm speaking on the phone=

130 - E:=yeah=

S: and although there is a pause as the interpreter repeats what I've said its still like I'm trying to maintain contact cos read you as well as giving you information

E: yeah (2) yeah yeah yeah

S: to understand where you're at and how you're coping with what I'm telling you (1) whether you want to pause to ask questions cos sometimes you see there's something they want to ask and then it's about consistently stopping after bits of information to ask whether they understand what you've said do they have any questions about what you've just said that's very important

140 - E: yeah yeah

S: I think the worst I ever did was having to give a HIV diagnosis via an interpreter on the phone face-to-face

E: that's horrendous

S: it was how do you convey compassion whilst you're on the phone?

E: I'm sure you did it   ( ) it's not going to be it's not going to be great so what?

S: oh yes I did it but

E: so then obviously somebody would be offered counselling

150 - S: I also do the counselling

E: you do the counselling

S: so basically something like a HIV diagnosis is something that is horrendous=

E:=that's life-changing=

S:=it's life-changing indeed it's almost like you die a little death and you have to grief grieve your life as you knew it and that takes time so er the initial consultation is always set for one hour with me before they then go on to the GUM clinic for another 1 to 2 hours which is spent with a health advisor who also continues the counselling so the one hour allows not only for me

160 - to impart the information but allows them the space to actually break down and to cry if they need to and to totally and completely lose it and then allowing them time to pull themselves together enough that when you're walking out of the room with them no one will actually know what has gone on by just looking at them obviously you don't always succeed because there's some ways totally and completely devastating and therefore even the end of a whole hour they're still nowhere near ready

E: (   ) I can I can only imagine

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S: [laughs]=

E: = I can't imagine having to do that for a job actually and having to tell=

170 - S: =do you know what I think that it's something that I've always been drawn to I've always been even as a very young child I've always been drawn to people I consider to be vulnerable or are more likely to be y'know at risk of attack and discrimination from others and therefore it's something I've always wanted always wanted I've always had this urge to protect and empower and actually make people see things differently to the way they think they are=

E:=yeah

S: cos sometimes it's all about perception and if someone actually gets the realisation that yes you will grieve yes it's horrible no one would wish it on **180 -** anyone else however I think there is a life after this and if you actually take control and lead it rather than it lead you you can continue with your life and you can actually have a full and well-fulfilled life with a career and everything else you've ever wanted so that is what I try to impart in them in the time we have with them which is until they go off to have the babies and my aim is always that by the time they go to have a baby they yes they're HIV positive yes it hurts but it's not the end of the world

E: yeah it's not like 30 years ago it's completely different

S: no it's totally and completely different and this is me speaking as someone who actually saw it when it first came in y'see I was a very young child I saw

190 - my first person with Aids we didn't call it HIV sp the first person with Aids was the cousin of one of my best friends

someone that we had grown up seeing then we saw him waste-away until he died by the time he died you could barely see him because he was all skeletal so that's something that you see it's something that I saw before I came to this country then I came to this country and then initially you found out about that er initially when the treatments were available there was discrimination against the ethnic minority groups in that they weren't being offered the best treatments available=

E:=mhmm=

S: = treatments were being offered y'know to the British, English people and

200 -that was some and I actually heard that at a talk when I was young my parents got us to attend a talk about HIV and Aids and what services are available and what was happening and that has totally and completely changed

E: mm

S; so:

E: that's fantastic I mean it should it's terrible it happened but I can imagine it did it kinda (   )

S: it did it did but there was acknowledgment=

E:=yeah

210 S: cos I remember the talk was in Tooting and we had people from St
Georges who came in and admitted that that had been the case

((share personal stories))

S: and y'know you never told anyone so yeah so but in terms of communication as I said it's about changing the way sometimes I say I was telling people Romanian English y'know you can speak in Romanian English it's like y'know I have a

lady who came in once she'd never ever attended a specialist she had an infection that required specialist review and she'd never attended it ever so I managed to get her to an appointment with me and we had a discussion and one thing I learnt with her is if you change your language

220 to

[interruption, another midwife comes in and appears to hurry Stella along]

If you change your language to hers and I spoke exactly as she spoke and she was perfect and she attended every single antenatal appointment told me straight that she no go to Kings y'know me no go ███ too far=

E:=yeah=

S: =it's too far is big problem

E: yeah you've got her trust and she's going to work with you=

S;=and y'know she more than 6 months after she had the baby she turned up goes y'know her two year old had a problem she said y'know doc GP

230 - he say no no antibiotics [laugh] and I'm like why you want antibiotics? Your problem what ? and I thought in my head y'know sometimes it is sad that they will go to a GP and they don't take the time it's almost like [sighs] tired of seeing so many people who do not speak English

E: mm=

S:=cos this lady has been here nearly long enough to have learned English but she hasn't because she lives within her community she interacts with her community she doesn't see any need to learn English I met a Greek lady who unfortunately

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has been working for the last six years she's been working in an Indian restaurant so she can actually understand

240 - Hindi but she can't speak English [laughs] so and her husband I keep telling her that she needs to practice English but all she does is speak Greek

E: [laughs]

S: at home and yet at work she's speaking Hindi [laughs]

Appendix D: Fieldnotes (extracts)

<u>**Antenatal waiting room -**</u> September 2016

The antenatal waiting room is divided into different sections, which are hard to differentiate and have two reception desks: one is manned by two receptionists and the other is a work station for midwives and HCA. Sitting by the second midwife led desk, I watch streams of women, some with partners, some without, trickle past slowly. Some require blood tests, the results of which are given within two hours, so a handful of women are sitting in the waiting room for a long time.

Midwives appear very responsive to 'drop-in' patients. A heavily pregnant woman with a pushchair asks to see B the diabetes midwife: she whisks her in immediately. Later when a patient asks for her and explains that 'I need to book something… sorry my English not good', B manages to find her notes and makes her an appointment. One young Polish couple who haven't received any communication from the midwives, request an appointment with the early pregnancy team, as a doctor, also Polish and dressed in operating scrubs, also drops by for a check. As she tells the receptionist that she is experiencing pain and numbness down one side of her body, she is referred instead to A and E triage. All staff make a concerted effort to talk to women and chat casually when they are less busy. They explain, give information, and even talk to them about maternity benefits, as patients are in the waiting room

Throughout the morning, women pick up sample tubes from the trolley next to reception, either prompted by staff or as a matter of routine and go to fill a sample for midwives. However, there are also a number of women arriving at reception in error, instead of their local community health clinic or alternative

department: they are offered redirection, but frequently walk off in the opposite direction!

<u>Linguistic landscape</u> – October 2016

I arrive at the glucose clinic at 8.45, a little late, this morning. The midwives are arriving and greeting each other – mostly in English but a few in Punjabi and Spanish. Exchange between Pakistani HCA and African colleague –

"Morning, Cómo estás?' 'Bien, thanks'. Two women come in – one is pregnant and goes to desk whilst other sits; they then move to the other area (diabetes clinic). They codeswitch between English and an unidentifiable language: later they are joined by a friend who draws on a similar repertoire. As the morning progresses, and more women/couples arrive, the volume in the waiting room goes up, with an interestingly diverse number of languages being spoken: can identify Polish, Spanish and Urdu, but range of African languages with which I am not familiar e.g. a patient chats to a midwife sitting behind the reception desk, laughing and joking in unknown language.

Two women chat animatedly in Turkish, before pausing briefly to lend a little boy (a stranger) a phone to watch dinosaur cartoons. As he returns to his mother, the child completes the actions to 'stomp, stomp, stomp roar, roar, roar, I'm a dinosaur", before going back to the women when the phone 'timesout'. It is delightful interaction across language boundaries, as the child does not speak and neither do the women.

Soundscape: The increase in sound in this area reminds me of an orchestra tuning. Beginning with silence first thing in the morning, the sounds swell to a cacophony of clashing noises by midday, before fading and restarting again in the afternoon sessions. Generally, there is a gentle background noise of erratic beeps which emanate from some of the consultation rooms, combined with the murmur of multilingual conversations. As fans buzz in the overheated waiting room, children alternate between running, climbing on chairs and playing games/watching videos on their mothers' phones. As 'Baby' TV, continues on an iterative loop, many women are transfixed by the relentless advertising and baby-oriented commercials.

Smellscape: When I arrive most mornings, the cleaners have just cleaned the floor and there is a strong, over-riding smell of bleach.

Patient consultations – Sept 2016-Feb 2017

Fabiana

This patient has a 9-month baby and is now 23 weeks pregnant, although confusion over dates is later clarified. When MW2 recognises that Fabiana has an interpreter booked, she alerts me as soon as she arrives, and subsequently asks for permission (to observe) on my behalf. When I then follow, a few minutes later, the interpreter also agrees to participate and reads through the consent form with Fabiana, who speaks little English. We then head into the room where HCA takes the patient's blood pressure and reports normal blood tests results.

When they are chatting, the interpreter uses her hands a lot. The Dr talks to the patient, pauses the interpreter is watching the Dr the whole time. When the Dr starts talking for a long time, the interpreter asks her to pause, whilst she translates

and then asks her to start again. The Dr takes her cues from the interpreter, and chunks her language appropriately.

Maalini

From another side door, behind her standing husband, comes the doctor and a trainee. The consultant (DC) is a very confident, middle-aged Indian lady who initially reprimands Maalini for not speaking English (in English). Hard to tell if this is something she says to all women with interpreters or if it is for my benefit. As she is talking, she gesticulates and uses fingers – this time to demonstrate the walking the patient should be doing after every meal.

DC uses Indian words to describe how fat her child will be if she doesn't exercise ' gunda, gunda'. Maalini nods when consultant is explaining in English, but the interpreter also repeats the information in Tamil (?) - interestingly, here, she switches between addressing the patient and her husband, appearing to try to involve the latter in his wife's antenatal care. As the interpreter is relaying the information, the Dr is also nodding because she appears to understand Tamil (check) too.

Later, when I seek out DC, to request written consent, she is very positive. Explained that she was Indian and spoke several languages. As she had also lived in Dubai, she spoke some Arabic. DC emphasised the importance of employing interpreters was so that she could ensure that women understood what she had said but also to double check the interpreters were translating correctly!! She said she also needed to learn to speak Polish, Romanian and Bulgarian and Albanian, as it would support the client base she sees.

Mandarin speaking patient

At about 1.40 a Chinese woman and her husband walk in to the clinic, looking a bit lost. MW2 recognises her and beckons her over – then directs her to where she needs to go. MW2 explains that when the woman (who lived at the initial accommodation centre) was first registered, it had proved so difficult to communicate over the phone, that MW2 had hand - delivered the letter to ensure attendance at hospital. The woman is 33 weeks pregnant and has had no antenatal care, until this point. MW2 explains to her husband that an interpreter had been booked for her.

Melina

Antenatal booking-in appointments are held on Friday mornings at the hospital. On the occasion that an interpreter is needed, it is highlighted by the patient's GP at her initial medical appointment so that provision can be made for the booking-in session.

████ (pseudonymise) is a Portuguese patient who has arrived half an hour late for her appointment. As she speaks little English, she has brought her friend ████ with her to assist with translation. However, an interpreter has already been booked by the hospital and the appointment begins with protracted negotiations as ████ the midwife, tries to assess the need for additional support. As the consultation starts, MW1 decides to retain the interpreter for most important part of the session – patient history – before dismissing her to rely on ████████ and interpreter, The interpreter sits next to the patient, opposite the midwife: the friend sits behind them on a hospital bed. A trainee midwife is also present as part of her training: observing the consultation, she only occasionally participates in conversation, and sits at the side of the room.

The room is very small, hot and over-crowded: it also smells very heavily of hospital bleach.

The interpreter does not appear to be very confident as she keeps checking (her own?) understanding with ███ Due to ██████ lateness, the interpreter is then delayed for her next appointment. Very happy to pass the interpreting job to ████ – is this time or difficulty of the work? When she leaves, she picks up (her child's?) scooter, blows a kiss to everyone, says she loves them and scoots out – very (!!!) informal.

==Very convivial!!== This consultation is noticeable for the degree of informality with which the participants interact, challenging conventional understandings of medical communication as asymmetrical.
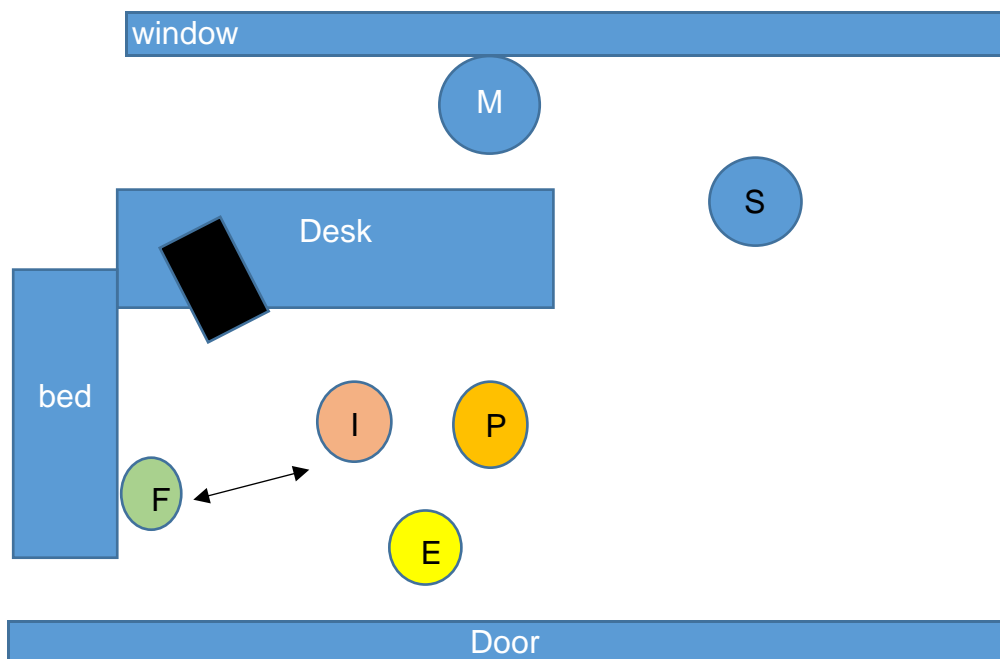
M=MW1;   S=student   midwife/SM;   P=patient/M;
I=interpreter/Su; F=friend/George; E= researcher

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There is a running joke, which is maintained throughout the consultation, where MW teases ████ that he is, in reality, ██████ partner and the father of her child. The first time she makes the suggestion is prior to taking
Melina's medical history, especially when MW alludes to the highly personal nature of the information to be shared and the upcoming change in frame.

When ████ responds rapidly with the date of birth of Melina's first child, the unique closeness of their relationship causes a little discomfort, indicated by staggered, and stilted, laughter. The interpreter suggests they are related, which is later confirmed when ████ refers to himself as ████ brother-in-law. At one point he notes "I tell you really know everything".

After the consultation, I check to see whether MW1 has worked with the interpreter before and remark that this appointment was very unusual: MW1 agrees that it was fun and that she doesn't have too many like that (the implication being that there are others!).

Gosha

A Polish patient requires an anti-D injection. MW2 explains and the patient is okay with me sitting in on the appointment. She explains that she hasn't had much sleep – has a 2yr old and 13 yr old – and appears a little anxious. MW2 reassures her that she has been doing job for 30 years approx. and has never had to use adrenaline. However, when she administers the drug, the patient has a reaction- colour drains from her face, her eyes go glassy, she can't breathe and panics. MW2 sends me to find another m/w as she also wasn't expecting a reaction. This is a scary experience!!

I return to room and ask her if the patient if wants me to leave – no she's fine with me staying. The on-call doctor is bleeped

and comes in to check her, although she talks too fast, using extensive medical terminology and idioms: does the patient understand or is she in shock? As she sits in recovery, she is wringing her hands – are they cold? – and fidgeting, I wonder whether her symptoms could be a reaction to adrenaline as well.

<u>Unrecorded observation</u>

This consultation features a young woman who needs additional tests run to check for Downs' Syndrome and other abnormalities. She is now 16 weeks: as she registered late for antenatal care, she has missed the routine checks, usually taken earlier in pregnancy. MW2, HCA1 and I try to explain my research and offer her the option of not taking part: she is happy to participate but does not want the consultation recorded. This is understandable, given the possibility of a problematic pregnancy. However, as she looks anxious, I repeatedly ask if she wants me to leave but she says no, just no recording.

MW2 explains the potential concerns to JW, who is acting as an interpreter.
MW2 begins…..'what we're lookin at is a baby's DNA in your blood…..because it tells us about Down's Syndrome or any other problems". As she finishes talking to the woman, JW takes over and interprets – the patient nods and says very little.

The women sit in a triangle having a triadic conversation. MW tries to reassure patient and tells her that the test is 99.9% accurate, but if it reveals a potential difficulty the patient will be offered amniocentesis. When the midwife also says that the rest of the bloods looked okay, the patient begins to relax. There is 57 day wait for results. MJ shows the patient how she puts them on the database and explains how it is sent over by

courier. When M asks, 'how do you feel about having the test?', the patient just nods.

<u>Interpreter</u>

Prior to one of the observations, I have time to chat to a Bengali interpreter, born in the UK. She started interpreting by working informally for neighbours, parents and then her husband, before he died. Over the years, the work evolved into formal interpreting, which gives her a flexible working life that fitted around childcare responsibilities. However, she is disappointed not to have more work at ███████ hospital, as it is nearer to home: there is an implication that interpreting work is competitive and having to pay for travel is a disincentive to work further afield.

<u>Student midwives</u>

Visiting the clinics in ███████, with the hope of interviewing midwives before they begin community visits – very clear no one expecting me. Sit around as they ready themselves for the day and try to elicit experiences from m/w – very interesting conv with two trainees who seem to rely on Google "if the language is really bad I call up the information on Google and then translate the page and then they can read it because they have to give their consent", but also draw on their own personal resources:

"I speak a few languages Urdu Punjabi and a little bit of Arabic ….in one of the consultations the patient ….brought a relative and she was translating but I don't think they realised I could understand everything she was saying and some of the stuff she was saying wasn't exactly what the midwife was telling her to say to her so it was useful to know where you can step in

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and you're not translating properly or you missed this out and I've actually….. funnily enough I've used my language with doctors on the ward so when I'm speaking to them or they quickly want to tell something they'll use it outside the room or not in front of the patient but generally it's nice to know that there are people there who speak my language."

Appendix E: Consent forms – E1

Institute of Education

ᴹ UCL

Dear Participant,

I am studying at UCL Institute of Education and I am conducting research for a doctoral thesis (PhD).

The purpose of my research is to provide a better understanding of health communication in multicultural communities. I am interested in languages and would like to observe your conversation with your midwife and/or interpreter. I am not interested in medical information.

This research will assist ███████████████ in improving patient experience and contribute to the academic research on health communication.

All information will be anonymized: names will be changed and all information will be kept confidential.

I would be very grateful if you could help me with this research. If you would like to participate, please read, complete and sign below.

Title of project: an analysis of communicative practices in a superdiverse consulting room.

Name of researcher: Emma Brooks

Please tick box

1. I read and understood the information sheet for the study. ☐

2. I understand that I can ask questions at any time. ☐

2. I understand that my participation is voluntary and that I can leave at any time. ☐

3. I agree to take part in the above study. ☐

4. I agree that Emma can record my voice. ☐

5. I agree that Emma can use my words, without using my real name. ☐

6. I agree that the information can be kept safely and may be used for future research. ☐

7. I understand that all information is private and that Emma will not tell anyone my name. ☐
Name _____ Signature _____

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If you have any questions please contact me: e.brooks.14@ucl.ac.uk or my supervisor john.gray@ucl.ac.uk.

Appendix E: Consent form E2

UCL

Dear Participant,

I am a student at the Institute of Education, University College London.

I am interested in the different languages used in ██████.
I am interested in midwife and patient communication in ██████

I would like to listen to you and your midwife during the antenatal appointment.
All information will be anonymous and confidential.

I would be very grateful if you could help me with this research.

Title of project: an analysis of communicative practices in a superdiverse consulting room.

Name of researcher: Emma Brook   Please tick box

1. I understand the information sheet for the study.   ☐

2. I understand that I can ask questions at any time.   ☐

2. My participation is voluntary and I can leave at any time.   ☐
                                                                      ☐
3. I want to take part in the above study.

4. I agree that the researcher can record my voice.   ☐

5. Emma can use my words and will not use my real name.   ☐

6. I agree that the information is kept safely and may be used for future research.
                                                                      ☐
7. I understand that all information is private and that Emma will not tell anyone
my name.   ☐
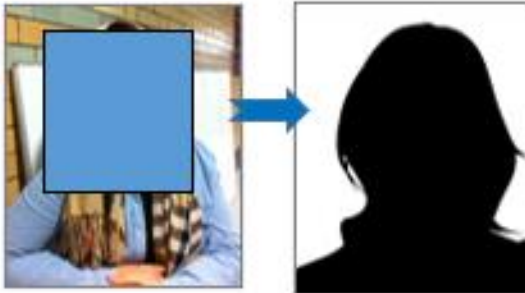Name _____   Signature _____

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If you have questions please contact me: e.brooks.14@ucl.ac.uk or my
tutorjohn.gray@ucl.ac.uk.

Appendix E: Consent forms E3

Institute of Education

My name is Emma.
I am a student at university.

I am doing some research at the hospital.

I am interested in the different languages

I would like to listen to your conversation

Appendix A3

I am only interested in language not medicine.	
Soraya ?	
I will change your name so you cannot be identified.	Information is confidential. No one knows your name.
Information is confidential. No one can read it.	Information will be on a locked computer. No one can read it.

If you would like to help, please read and sign the paper.

1. I understand the information.

2. I agree to help with the research.

3. I understand that I can ask questions.

4. I understand that all information is private and that Emma will not tell anyone my name.

5. I agree that Emma can record my voice.

6. I agree that Emma can use my words. She will change my name.

7. I agree that the information can be kept safe.

8. I understand that my participation is voluntary and that I can leave when I want.

Name _____   Signature _____

If you have any questions please contact me: e.brooks.14@ucl.ac.uk or my professor john.gray@ucl.ac.uk.

Appendix A3

Appendix E: Midwives' Consent Form E4

Institute of Education

UCL

Dear Colleague,

My name is Emma and I am currently conducting a research project exploring the role of language in antenatal consultations within ▮▮▮ University Hospital.

The purpose of the research is to provide a better understanding of communication practices in health settings based in diverse communities. The data collected will be anonymised and used to inform a doctoral study on health communication.

I would like to invite community midwives to take part in a focus group interview to collect information about perceptions, attitudes and experiences of carrying out these responsibilities in the community and at ▮▮▮ University Hospital. Information given in the interviews will be presented anonymously so that you cannot be identified.

I would also like to request permission to observe health consultations with antenatal patients. While it is not appropriate for patients considered to be 'at risk' to be included in this study, I am especially interested in migrant patients for whom English is spoken as an additional language. For the purposes of this research project, migrants are defined as those members of the community who were not born in the UK, and for whom English is not their first language. An additional project information sheet and consent form has also been drafted to obtain consent from patients and/or interpreters

I have obtained ethics permission from both ▮▮▮ and UCL Institute of Education. I will adhere to the British Association for Applied Linguistics (BAAL) code of ethics, ensuring confidentiality, anonymity and sensitivity at all times.

Please note that my interest is only in linguistic interaction and not medical practice.

It is hoped that this research will assist ▮▮▮ in strengthening and developing its patients' experiences and contribute to the academic research on health communication.

I would be very grateful for your contribution and participation in this research. If you would like to take part, please read, complete and sign the attached information.

Title of project: an analysis of communicative practices in a superdiverse consulting room
Name of researcher: Emma Brooks
Institution: UCL Institute of Education, London

Please initial box

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason why.

☐

3. I agree to take part in the above study.

☐

4. I agree to the interview being audio recorded.

☐

5. I agree to the use of anonymized quotes in the reporting of the data.

☐

6. I agree that my data gathered in this study may be anonymized and may be stored securely on an encrypted computer.

☐

7. I understand that the anonymized data gathered in this study may be used for future research.

☐

Name: _____

Department/team: _____

Date: _____

If you have any concerns about the planned research or the way the research is conducted, you may contact me: e.brooks.14@ucl.ac.uk or my supervisor in the Department of Culture, Communication and Media: John.Gray@ucl.ac.uk

Appendix E: Interpreters' Consent Form E5

Institute of Education

⁙UCL

I would be very grateful for your contribution and participation in this research. If you would like to take part, please read, complete and sign the attached information.

Title of project: an analysis of communicative practices in a superdiverse consulting room

Name of researcher: Emma Brooks

Institution: UCL Institute of Education, London

Please initial box

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason why.

3. I agree to take part in the above study.

4. I agree to the interview being audio recorded.

5. I agree to the use of anonymized quotes in the reporting of the data.

6. I agree that my data gathered in this study may be anonymized and may be stored securely on an encrypted computer.

7. I understand that the data gathered in this study may be used for future research.

Name: _____

Company (if appropriate): _____

Date: _____

If you have any concerns about the planned research or the way the research is conducted, you may contact me: e.brooks.14@ucl.ac.uk or my supervisor in the Department of Culture, Communication and Media: **John.Gray@ucl.ac.uk**

Appendix E: Translators' Consent Form E6

Institute of Education

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Appendix A6

A research project conducted by UCL Institute of Education will explore the role of language in antenatal consultations within ███ University Hospital.

The purpose of the research is to provide a better understanding of communication practices in health settings based in diverse communities. The data collected will be anonymised and used to inform a doctoral study on health communication.

I have obtained permission to observe health consultations with migrant patients/staff for whom English is spoken as an additional language. For the purposes of this research project, migrants are defined as those members of the community who were not born in the UK, and for whom English is not their first language. An additional project information sheet and consent form has also been drafted to obtain consent from patients, health professionals and interpreters.

Although the names of the participants can be heard on the audio recording, information given in the interviews will be presented anonymously so that people cannot be identified. I have obtained ethics permission from ███ and UCL Institute of Education. I will adhere to the British Association for Applied Linguistics (BAAL) code of ethics, ensuring sensitivity, confidentiality and anonymization at all times.

I would be very grateful for your contribution and participation in this research. If you are able to translate conversations held between participants during health consultations and, would like to take part, please read, complete and sign the attached information.

Title of project: an analysis of communicative practices in a superdiverse consulting room

Name of researcher: Emma Brooks

Institution: UCL Institute of Education, London

Please initial box

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions. ☐

2. I understand that I am free to withdraw at any time, without giving reason why. ☐

3. I agree to take part in the above study and accept the remittance of £30 p/h ☐

4. I agree to keep information confidential and anonymous, and will not share the content with others. ☐

5. I understand that the data gathered in this study may be stored securely (after it has been anonymised) and may be used for future research. ☐

Name: _____

Company (if appropriate): _____

Date: _____

If you have any concerns about the planned research or the way the research is conducted, you may contact my supervisor, Dr. John Gray, in the Department of Culture, Communication and Media: john.gray@ucl.ac.uk

Appendix F:Transcription conventions

(adapted from Jefferson, 2004)

// Double obliques indicate overlapping talk

= indicate no break or gap a pair of equal signs, one at the end

of one line and the next at the beginning of the next turn,

indicate continuing talk with no break

(1) number within parentheses indicates the pause in number of seconds

(.) very brief interval between utterances

(   ) empty parentheses indicates inaudible text

((she frowns)) double parentheses indicates

transcriber's notes **e:** Colons indicate an elongation

of sound

CAPITAL letters indicate a loud emphasis on a word(s)

◦**word**◦ surrounded by small circles, indicates a softly spoken, or whispered, word

↑↓Arrows indicate a rise or fall in pitch

>word< carets either side of word(s) indicates fast paced speech, in comparison to surrounding text

<word> carets either side of word(s) indicates a slowing of speech, in comparison to surrounding text

£word£ pound signs indicate text spoken with a smiling

voice **under<u>lined</u>** text indicates a stress on a specific

syllable