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# MULTILINGUAL AND MULTICULTURAL HEALTH COMMUNICATION: INSIGHTS FROM MEDICAL ANTHROPOLOGY AND LINGUISTICS

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**Abstract**: The increasing cultural and linguistic diversity of contemporary societies poses critical reflection on language as a culturally embedded framework that shapes and interprets the world. In the context of migration to Italy, this perspective highlights the intertwined nature of linguistic and cultural mediation, challenging health communication, particularly in multilingual medical interactions. This study integrates medical anthropology and linguistics, and focuses on the intersection between professional roles, cultural mediation, and the fluid identities of healthcare providers. Drawing on ethnographic fieldwork conducted in three clinics of the third sector, two in Cosenza and one in Florence (Italy), the research combines participant observation with discourse analysis (Gee 2014) to investigate the interactional asymmetries between non-Italian-speaking patients and healthcare professionals. In these specific contexts, data collection involved recorded medical consultations and ethnographic fieldnotes. The latter became one of the primary methods of documentation, and shaped the content of the analysis, thus based on practitioners' medical consultations given in two of the clinics, and psychological/psychiatric consultations given in the third. Active involvement with the care team provided additional insights into how cultural and linguistic mediation shapes patient access to healthcare services. The study also highlights the complexities of the interpreter's dual role as both a cultural mediator and an observer, revealing tensions and challenges that might arise in these kinds of multilingual interactions. The preliminary findings underscore the need for a context-sensitive approach that adapts medical anthropology and linguistic analysis to the challenges of multilingual healthcare. Using a mixed-methods approach, this contribution examines qualitative data and critical reflections from the field, seeking innovative strategies for improving healthcare communication. The research reflects on professional identity's fluidity and its implications for fostering more culturally sensitive healthcare practices. It aims to contribute to the development of integrated methodologies enhancing the quality of care for patients from diverse backgrounds.

**Keywords**: healthcare communication; multilingualism; cultural mediation; medical anthropology; discourse analysis.

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## *1. Introduction*

Health communication in multicultural societies is increasingly shaped by intersecting structural inequalities, linguistic barriers, and professional gatekeeping. In multilingual healthcare settings, precariousness and diversity co-exist, bringing to the fore new forms of interaction where the construction of knowledge and legitimacy is neither linear nor stable. As widely shown in academic literature (Wadensjö 2014[1998]; Gavioli and Baraldi 2011; Scibetta and Ardizzoni this issue; Quaranta 2017; Giordano 2014; Mizori 2025), communication in healthcare is rarely a mere transfer of clinical information. Rather, it is a negotiation between knowledge systems, institutional hierarchies, and sociocultural identities (Sarangi and Roberts 1999).

In Italian third-sector clinics serving people with migratory backgrounds, these dynamics become especially evident, revealing the hybrid and fluid nature of professional roles. Encounters depend not only on medical issues but also on language availability, intercultural positioning, and institutional expectations. Where institutional resources are limited, cultural mediators fill crucial gaps, not merely translating words but recontextualizing meanings and social nuances. Yet their work is often undervalued and reduced to a functionalist view. Ethnographic accounts show that access to healthcare frequently depends on whether patients are accompanied, bureaucratically or socially, by someone adept at navigating the system on their behalf, creating asymmetries with deep consequences (Sen 2007; Marmot 2016). Health systems in migration contexts thus become arenas not only mirroring but also reinforcing or challenging inequalities. In this light, communication is more than a technical matter: it is the medium through which authority, trust, and narratives are enacted, or denied (Sayad 2002: 207).

This article focuses on multilingual medical encounters involving vulnerable migrant populations, aiming to reveal how agency and authority are co-produced through everyday acts of negotiation, within strict institutional protocols and shifting epistemic alignments. Building on frameworks from critical medical anthropology and discourse analysis, we examine how linguistic mediation, repair sequences, and code-switching become more than support tools: they constitute the very locus where care is enacted, professional roles redefined, and epistemic asymmetries challenged.

Rather than treating patients as passive recipients of biomedical decisions, the approach foregrounds the interactional work required to navigate identity, power, and access to rights, both within and beyond the clinic. Through micro-ethnographic investigation, we address three research questions: how does communication in multilingual clinics reflect and reshape power asymmetries and forms of social inclusion/exclusion? What mechanisms of repair, mediation, and joint action emerge in response to breakdowns or failures in the interaction? How do ethnographic and conversational data reveal the iterative negotiation of legitimacy, knowledge, and care in institutional settings?

A key aim is to reflect on how communication is shaped by broader structural inequalities, especially those produced and sustained by language. Language mediates not just information but power, vulnerability, and belonging.

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Multilingualism in healthcare is therefore "deeply political" (Gavioli and Baraldi 2011), and in fragmented systems such as Italy's third sector, the clinic becomes a microcosm of wider tensions around migration, care, and institutional responsibility.

## *2. Theoretical framework*

This study integrates insights from critical medical anthropology and discourse analysis (Gee 2014) to investigate health communication in multilingual clinical settings. Drawing on Kleinman's (1980) explanatory models and Farmer's (2003) theorization of structural violence, medical encounters are understood as arenas where power and knowledge are continually renegotiated. Positioning Theory (Harré and van Langenhove 1999) frames the relational dynamics of agency, legitimacy, and epistemic stance within institutional interaction, while Interactional Sociolinguistics (Gumperz 1982; Roberts 2009) illuminates how participants' talk indexes alignment, authority, and social identity.

Communication in healthcare is both interactional and institutional: a socially situated practice shaped by cultural assumptions, power relations, and linguistic inequalities. Language functions as symbolic capital (Bourdieu 1991: 43), unequally distributed and closely tied to power, legitimacy, and access. What counts as "competent" or "appropriate" speech in institutional contexts is socially conditioned, and in multilingual encounters, these asymmetries are often exacerbated. Patients who do not share the dominant language may find themselves marginalized not only linguistically but also epistemically and institutionally.

The performative dimension of institutional talk shows how categories such as *doctor*, *patient*, and *interpreter* are not pre-given but emerge through repeated interactional practices (Sarangi and Roberts 1999; Goodwin 2000; Cicourel 1987; Spotti 2019). Professional identity thus appears as an emergent, relational feature of interaction, contingent and sensitive to local dynamics (Arnaut *et al.* 2015). In multilingual contexts, where communicative resources are unevenly distributed, these roles are frequently reconfigured through improvisation.

Triadic interactions involving interpreters or mediators add further complexity. Interpreters act as co-participants rather than neutral conduits: they manage turn-taking, clarify ambiguities, modulate directives, and attend to the affective texture of the encounter (Wadensjö 2014[1998]: 22). Their epistemic stance and institutional familiarity shape how meanings are conveyed, reframed, or selectively omitted (Gavioli and Baraldi 2011: 218). Within such dynamics, roles and information are continuously co-constructed, challenging rigid distinctions between "mediated" and "non-mediated" communication.

A flexible understanding of multilingualism as situated and negotiated thus becomes essential. Migration changes not only access to care but also the ways illness is lived and communicated (Young 1995). Social determinants – legal status, housing, income, networks – mediate people's ability to use health services (Marmot and Wilkinson 2006; Labonté and Schrecker 2007). These

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structural forces also shape what Bourdieu (1972: 64) calls *habitus*: "structured structures" that guide practices and perceptions. The *habitus* of health practitioners can reproduce hierarchies and exclusions if cultural and linguistic asymmetries remain unacknowledged.

Finally, ethnographic engagement in clinical settings is inherently participatory and reflexive. The researcher's subjectivity plays a constitutive role throughout the research process. Rather than claiming detached objectivity, ethnography relies on systematic field strategies and analytic accountability, recognising that interpretive capacities are key to understanding situated practices (Arnaut *et al.* 2015; Emerson *et al.* 1995). This stance resonates with the notion of cultural humility (Tervalon and Murray-García 1998): instead of claiming mastery, the researcher cultivates critical awareness of power differentials, institutional constraints, and the partiality of their own lens (Quaranta 2017).

Ethnographic analysis proceeds through *sensitising concepts* (Blumer 1969: 148): ideas that "suggest directions along which to look" rather than prescribe what to see. Linguistic and discourse-analytic tools are embedded within this ethnographic epistemology (Arnaut *et al.* 2015), deployed reflexively to account for the researcher's positionality within circuits of power and knowledge.

## *3. Methodology*

Fieldwork was conducted between October 2023 and July 2024 in three third-sector healthcare clinics in Italy – two in Cosenza (Calabria) and one in Florence (Tuscany). These clinics offer free medical and psychological services to adults in fragile conditions, operating through volunteer or semi-voluntary staff in contexts marked by linguistic diversity and structural precarity.

The study employs a micro-ethnographic approach (Sarangi and Roberts 1999) combining participant observation, ethnographic interviews, fieldnotes, and audio-recorded consultations. Where recording consent was not granted, detailed fieldnotes were kept. Conversation-analytic techniques were applied to map repair sequences, code-switching, alignment, and interactional framing (Sarangi and Roberts 1999; Cicourel 1987). Particular attention was given to communicative breakdowns – when linguistic, cultural, or institutional mismatches emerged. Rather than anomalies, these were read as sites where institutional authority, professional boundaries, and patient agency are actively constructed and contested.

During fieldwork, I participated in the clinics' routines – attending meetings, engaging in informal conversations, and occasionally assisting with translation or communication. This dual positionality offered privileged access to the communicative ecology while raising ethical and methodological tensions. Reflexivity was embedded throughout, acknowledging how the researcher's presence shaped both data production and interpretation.

Interactional data were contextualised through documentary materials and fieldnotes, ensuring that micro-level analysis remained connected to macro-level issues of inclusion/exclusion and institutional policy. Consequently, linguistic

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mediation is approached not as a neutral tool but as an ambiguous, situated practice with tangible consequences for rights, care, and recognition.

The following analysis presents three illustrative cases corresponding to distinct interactional configurations: shared language, mediated consultation, and researcher-led facilitation, highlighting how language, identity, and role are negotiated in real time under conditions of institutional precarity and communicative improvisation.

## *4. Three configurations of interaction*

The following section presents three illustrative episodes from the fieldwork, each corresponding to a distinct configuration of multilingual clinical communication. Across them, recurring forms of interactional asymmetries emerge: between clinical reasoning and existential precarity, linguistic proximity and institutional misalignment, formal protocol and informal brokerage, and finally, the blurred boundaries of research participation.

### 4.1. Doctor and patient share a language

#### *4.1.1. Between bureaucracy and chronic illness*

In some clinical encounters, healthcare providers are able to communicate directly with patients using a shared second language. These cases, although relatively uncommon, provide a useful contrast to mediated or improvisational forms of communication. They show how linguistic alignment can foster relational proximity, while also revealing the limits of shared language when broader institutional misalignment persists.

One such case took place in a general medicine clinic in Florence between a Latin American patient and an Italian doctor who happened to be fluent in Spanish. The patient, recently diagnosed with Type 2 diabetes, expressed uncertainty about how to use the insulin prescribed during a hospital visit. The doctor effortlessly alternated between registers, explained the treatment plan in accessible terms, and answered questions with clarity. Their turn-taking was smooth, misunderstandings were minimal, and rapport was established quickly.

> **Patient:** Fui al médico ayer. Al hospital, al socorro.
> *I went to the doctor yesterday. To the hospital, to the aid*
> **Doctor:** ¿Estuviste al socorro aquí en Careggi?
> *Were you at the hospital here in Careggi?*
> **Patient:** Sí. El doctor de ahí dice que se necesita urgente la residencia.
> *Yes, the doctor there says a residency is urgently needed.*
> **Doctor:** La cita es para empezar… Esta doctora es una diabetóloga, entonces ya te dio un tratamiento.
> *The appointment is to start... This doctor is a diabetologist, so she has already given you a treatment.*
> **Patient:** Con inyecciones. Pero yo vengo para que me digan cómo, porque no me lo explicaron.

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*With injections. But I came here to be told how, because they didn't explain it to me.*
**Doctor:** No es tan difícil. Mira…
*It's not that difficult. Look...*

Despite the apparent fluency and coordination, the interaction revealed underlying mismatches. The doctor focuses on biomedical management – glucose monitoring, dosage, timing – while the patient repeatedly signals concern about bureaucratic vulnerability and the absence of reliable follow-up. The phrase "la residencia" recurs, indexing not just legal uncertainty but a sense of being outside the system.

The consultation proceeds through collaborative clarification:

**Doctor:** Debes medirlo al menos tres veces al día: en ayunas, antes de comer, y en la tarde.
*You should measure it at least three times a day: on an empty stomach, before eating, and in the evening.*
**Patient:** Dos horas antes… Dos horas…
*Two hours before... Two hours...*
**Doctor:** No, antes justo de empezar la comida… Sí, con la comida lista vas a medir, y luego comes.
*No, just before the meal starts... Yes, with the meal ready you go to measure, and then you eat.*

At one point, the patient affirmed:

**Patient**: Capito, capito.
*Understood, understood.*
**Doctor**: Es importante escribir. Si no, lo olvidas todo.
*It is important to write. Otherwise, you forget it all.*
**Patient**: Lo anotaré.
*I will.*

The doctor mitigates directives through inclusive forms ("vamos a ver", "tenemos que ver"), avoids imperatives, and repeats key instructions to facilitate retention. However, the shared language does not resolve deeper structural asymmetries: the patient's uncertainty was shaped not only by biomedical novelty but by precarious housing, interrupted care, and limited institutional literacy. The doctor's multilingualism was instrumental in creating trust, yet this capacity remains contingent and unequally distributed across healthcare personnel. In the absence of formalized language support services, shared language becomes a precarious and unpredictable resource – helpful when available, but unreliable as a systemic solution.

### *4.1.2. Infection, side effects and trust*

A similar pattern emerged in a case involving a young French-speaking patient and the general practitioner following treatment for bacterial infection. The patient had been prescribed antibiotics and was returning for follow-up. Although the consultation was linguistically aligned, with both patient and

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doctor speaking French, the interaction revealed several layers of asymmetry – between institutional logic and bodily experience, between protocol and empathy.

The patient began by recounting his treatment:

> **Patient:** Le docteur ici m'a donné un autre paquet d'antibiotiques, et elle m'a dit de revenir vendredi.
> *The doctor here gave me another packet of antibiotics, and she said to come back on Friday.*
> **Doctor:** Donc vous prenez cet antibiotique depuis samedi?
> *So, you've been taking this antibiotic since Saturday?*
> **Patient:** Oui, presque 7 jours.
> *Yes, almost 7 days.*

However, he soon admitted to interrupting the treatment due to side effects:

> **Patient:** Le deuxième paquet, j'ai arrêté parce que j'ai eu un problème après l'antibiotique. Il m'a donné la diarrhée, tout le temps.
> *I stopped the second packet because I had a problem after the antibiotic. It gave me diarrhoea all the time.*

The doctor responded not with admonishment, but with a shift in tone:

> **Doctor:** Je pense que c'est très bien. Vous pouvez arrêter ici.
> *I think that's fine. You can stop here.*

This moment marks a turning point. Rather than enforcing biomedical adherence, the doctor recognised the patient's experiential knowledge and chose a strategy of validation. The structure "Je pense que... Vous pouvez…" softens the directive and rebalances the epistemic asymmetry.

Throughout the exchange, the patient attempted to quantify doses and justify his decisions:

> **Patient:** J'ai déjà fini un… J'ai apporté le deuxième, j'en suis à la moitié maintenant.
> *I've already finished one... I brought the second one, I'm halfway through it now.*
> **Doctor:** Deux paquets, c'est trop.
> *Two packs are too many.*
> **Patient:** Alors j'ai presque fini le deuxième paquet.
> *So, I've almost finished the second pack.*

The final phase of the consultation was marked by relational closure and mutual appreciation:

> **Patient:** J'ai tout dit en français, je suis obligé.
> *I've said it all in French, I'm very thankful.*
> **Doctor:** Vous êtes obligé?
> *Are you?*
> **Patient:** Vous avez la communication. Vous avez déjà un bagage. Merci

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> beaucoup. *You have communication skills. You already have experience. Thank you very much.*

This last remark shifted the focus from the clinical outcome to the communicative experience. The patient explicitly thanks the doctor not for the prescription or diagnosis, but for "*la communication*" – a recognition of effort, presence, and linguistic accommodation.

The encounter featured cooperative turn-taking, mitigated speech acts, and empathic alignment. Despite moments of lexical uncertainty and narrative fragmentation, the interaction sustained a sense of mutual respect.

This vignette underscores how linguistic alignment facilitates more than just message transmission – it supports dignity, attentiveness, and trust. Yet it also reminds us that such alignment depended on contingent resources: a doctor's multilingual competence, the availability of time, and a willingness to co-construct meaning in a non-standard idiom. In the absence of structural supports for language access, these moments remain valuable but vulnerable.

### 4.2. Mediated consultation

Although a shared language may foster trust and a sense of immediacy, it cannot always be assumed. The following case shifts the focus to interpreter-mediated interaction, where communication is triadic and meanings are actively negotiated across linguistic and institutional boundaries. Interpreter-mediated encounters make up a substantial proportion of multilingual clinical communication. One such consultation, observed at a clinic in Cosenza, involved a non-Italian-speaking male patient from North Africa, a general practitioner, and a male cultural mediator. The encounter, conducted in Arabic and Italian with intermittent code-switching, centred on the patient's chronic hypertension, gastrointestinal symptoms, and hemorrhoidal discomfort.

The interaction opens with the physician struggling to recall the patient:

> **Doctor**: Non mi ricordo…
> *I don't remember…*
> [The patient repeats his name.]
> **Doctor**: Chiedo scusa ma io…
> *I apologize, but I…*

The mediator steps in to contextualize:

> **Mediator**: Te l'ho portato il primo giorno… Quello che aveva il… Tumore…
> *I brought him to you the first day… The one who had the… Tumor…*

The dialogue continued with the mediator navigating between translation, contextual cues, and directives. The physician invited me to participate:

> **Doctor [to me]**: Allora poi l'anamnesi del viaggio se ti interessa la puoi fare tu, non ci sono problemi… Anche perché tu parli in inglese, così poi mi dici tu.

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> *Well, if you're interested, you can take the travel history, no problem...*
> *Especially since you speak English, then you tell me.*

Throughout the consultation, the mediator provided real-time translation and support, sometimes with embodied gestures or elaborations. At times, the doctor gave instructions directly to the patient in Italian, relying on the mediator's discretion for translation:

> **Doctor**: Respira... Brucia o hai dolore?...
> *Breathe... Is it burning or is it pain?*
> [The mediator translates each query into Arabic, albeit slowly; Arabic is not the patient's first language.]
> **Mediator**: Alcune volte brucia e alcune volte dolore.
> *Sometimes it burns and sometimes it hurts.*
> **Doctor**: Allora questo è un fatto di "*stomach*".
> *So, this is a stomach-related issue.*

After the first diagnosis, simplified as "stomach issue", humour entered the exchange at various points:

> **Doctor** [joking and with a friendly tone]: Gli devi dire che non deve bere birra!
> *You have to tell him he shouldn't drink beer!*

The mediator responds not only by translating but by managing the tone:

> **Mediator**: Eh appunto, glielo sto dicendo per questo! Sul serio! Vuoi dirgli che non deve bere più alcol?
> *Exactly, that's what I'm telling him! Seriously! Do you want to tell him he shouldn't drink alcohol anymore?*

In these moments, the mediator performs more than linguistic transfer. His response, showing that he had already been warning the patient about his alcohol use, subtly asserted a longitudinal relationship with the patient and signalled to the physician his ongoing engagement with the patient's behaviour. This positioning echoes Wadensjö's (2014[1998]) conceptualisation of the interpreter as co-participant, rather than a conduit.

The mediator's actions reflected a nuanced alignment with both institutional and interpersonal registers. When the patient expresses dietary habits, the mediator selectively foregrounds medically relevant details while omitting others (e.g., jokes about alcohol), thereby filtering content for pragmatic coherence. This is not merely a linguistic act but a discursive positioning, balancing rapport and authority.

This observation reinforces the view that mediators in such contexts carry emotional and interpersonal labour often overlooked in institutional descriptions of interpreter roles (see Ardizzoni, this issue). In this encounter, the mediator oscillates between multiple, sometimes competing, accountabilities: fidelity to

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medical instruction, relational continuity with the patient, and awareness of the interactional frame.

The patient later recounts his migration route – from Pakistan to Dubai, Egypt, and Libya, followed by a 7-day sea crossing to Calabria:

> **Mediator**: Era una più grande perché erano 700 persone… È bella dura questa… No acqua, no mangiare.
> *It was a big one [the ship] because there were 700 people… It was really tough… No water, no food.*

This narrative, prompted by the physician and scaffolded by the mediator, reveals a shared ethnographic space within the clinical frame.

Such sequences illustrate that the interpreter-mediator is not a neutral intermediary but a relational node. His utterances, gestures, and omissions shape the emotional temperature of the interaction, co-constructing meaning beyond strict semantic equivalence.

As Gavioli and Baraldi (2011) argue, interpreters in healthcare are emergent figures in the interaction, whose presence cannot be reduced to translation. The mediator in this case filters institutional directives through culturally legible channels, sometimes modifying register, sometimes strategically withholding. The asymmetry this created was not necessarily a failure of translation, but rather a site of interpretive labour – both social and linguistic.

In sum, this encounter reflects the layered realities of interpreter-mediated care in under-resourced, multicultural clinical settings. The mediator performed an indispensable role involving not only language transfer but also interpersonal navigation, cultural brokering, and emotional regulation. These aspects remain largely invisible in formal policy or protocol but are central to how care is experienced on the ground.

### 4.3. Researcher as intermediary: Reflexivity and ambiguity

In contrast to the structured presence of a cultural mediator, the third case illustrates a more improvised form of language brokering – where the boundaries between observation and participation collapse, and the researcher is drawn into the communicative infrastructure. This case involves the field notes taken on a clinical consultation between a psychiatrist and a French-speaking patient undergoing treatment for trauma related to migration.

The patient had been prescribed psychiatric medication and reported experiencing persistent tingling sensations (formication) in his limbs. The psychiatrist's primary concern was to determine whether these symptoms might be side effects of the pharmacological treatment. If the symptoms were indeed attributable to the medication, clinical protocol would require an adjustment to the dosage or a change in prescription. However, the temporal relationship between the onset of symptoms and the start of the medication was unclear, and considerable time was spent trying to establish this chronology during the consultation.

The patient's limited Italian, combined with the absence of a professional interpreter, contributed to communication challenges, making it difficult to

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pinpoint when the symptom had begun. The psychiatrist persisted with various formulations and clarifications in an effort to elicit a precise answer, but the lack of shared language resources hindered mutual understanding. It was in this context that, at one point, the doctor turned to me and asked:

> **Doctor [to me]:** Senti fa' 'na cosa, parli francese spedita tu?
> Hey, tell you what, do you speak French fluently?

Caught off guard, I asked the patient to speak slowly in French. I reached for Google Translate. What followed was a laboured and uncertain mediation:

> **Doctor:** Puoi chiedergli se prende ancora le medicine?
> *Can you ask him if he's still taking the medication?*
> **Researcher (in hesitant French):** Vous prenez encore… Les médicaments?
> *Do you still take the medicines?*
> **Patient:** Oui, mais parfois j'oublie. C'est pas facile.
> *Yes, but I forget sometimes. It is not easy.*
> **Researcher (to the doctor):** Dice di sì, ma che ogni tanto si dimentica.
> *He says yes, but sometimes he forgets.*
> **Doctor:** E chiedigli se ci sono degli effetti collaterali…
> *Ask him if he has any side effects…*
> **Researcher:** Est-ce qu'il y a… Effets secondaires?

Eventually, recognizing the clinical relevance of the issue and the limits of the interactional context, the clinic coordinator intervened. She contacted a staff member from the reception centre where the patient was residing to gather supplementary information. Through this external inquiry, it emerged that the tingling symptoms had preceded the psychiatric treatment and were therefore unlikely to be related to medication. Moreover, the patient was already scheduled to see a medical specialist in the following days to investigate the nature of the condition.

This episode illustrates how clinical sense-making in multilingual contexts often exceeds the spatial and interactional boundaries of the consultation room, requiring recourse to external actors and institutional networks. Diagnostic reasoning proves fragile when temporal and causal connections must be inferred through fragmented, delayed, and linguistically mediated communication. In such situations, the act of observation is destabilised: I was drawn, often without preamble, into the communicative infrastructure. These moments, while ethically and methodologically fraught, illuminate the blurred boundaries of ethnographic roles and the systemic precariousness of language access in healthcare.

In this instance, I assumed the role of an *ad hoc* language broker, relying on my limited linguistic competence and digital tools. The interaction was halting, fragmented, and marked by communicative asymmetry: neither clinician nor patient had full control over the exchange, and my improvised position introduced yet another layer of opacity. Positioned as simultaneously responsible

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and inadequate, visible and marginal, my involvement exemplifies the tensions inherent in multilingual clinical care under constrained conditions.

Such episodes foreground the ethical ambiguity of research-in-action and raise pressing questions about the limits of detachment, the responsibilities of intervention, and the risks of misrepresentation. The field does not always accommodate observational distance; instead, it demands forms of engagement that are partial, situated, and morally entangled. In this context, cultural humility becomes central – not as a posture of competence or neutrality, but as an ongoing, self-critical orientation that recognises the instability of one's interpretive authority (Tervalon and Murray-García 1998). Rather than constituting methodological failure, such ambivalence can be reframed as an epistemic resource.

Such moments destabilise methodological stances, highlighting how observation and participation blur, and how the clinical space becomes a terrain for epistemic co-production under conditions of urgency and institutional fragility. The researcher becomes a visible node in the communicative network, shaping the very conditions of knowledge production. The clinical space emerges not as a site of passive data extraction but as a terrain of epistemic co-production, where understanding is negotiated under conditions of urgency, fatigue, and infrastructural fragility (Quaranta 2017: 259). It is in such contexts that reconsideration of ethnographic responsibility is necessary: what does it mean to intervene? To mediate incompletely? To be relied upon, despite one's limitations? Reflexivity, in such contexts, is not an optional addendum but a foundational condition for ethical and analytic engagement.

## *5. Discussion*

The three configurations analysed – shared language, mediated consultation, and researcher-led facilitation – offer a comparative lens for understanding how multilingual healthcare encounters unfold under conditions of institutional precarity. Taken together, these vignettes reveal communication not as a neutral conduit but as a socially and institutionally situated practice, shaped by relational positioning, affective labour, and ongoing epistemic negotiation (Napier *et al.* 2014). Rather than identifying stable patterns, the analysis points to a set of fragile yet meaningful alignments through which care, authority, and understanding are collaboratively sustained.

Across the three contexts, mediation emerged as a form of epistemic work. Mediators and interpreters did not simply reproduce words; they reframed questions, repositioned participants, and, in doing so, reshaped the epistemic stance of both patient and professional (Harré and van Langenhove 1999). Their interventions illustrate that language brokering is not a transparent transfer of meaning but a situated co-production of medical knowledge (Kleinman 1980; Farmer 2003; Wadensjö 2014[1998]). These small adjustments – choices of pronoun, reformulations, hesitations – made visible the moral and cognitive labour that sustains communication in precarious settings.

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Moments of misunderstanding or lexical mismatch were equally instructive. Repair sequences, rather than signalling failure, often opened up interactional spaces where patients could clarify intentions, question diagnostic categories, or assert forms of agency otherwise constrained by institutional hierarchies (Sarangi and Roberts 1999). Seen from this angle, miscommunication itself became a generative event – an opportunity for participants to renegotiate meaning and participation within the limits of institutional authority.

Authority, in fact, appeared fluid and contingent, continuously performed through talk and relational alignment. Institutional rules were rarely applied mechanically; they were interpreted, suspended, or re-negotiated in response to local contingencies and moral reasoning (Cicourel 1987; Bourdieu 1991). Staff, mediators, and patients jointly navigated these boundaries, crafting a pragmatic ethics of care in which legitimacy was distributed and provisional.

Professional identities, too, proved to be dynamic and context dependent: clinicians, mediators, and I as a researcher frequently crossed the boundaries of their and my formal roles, responding to communicative breakdowns and institutional constraints (Roberts 2009; Arnaut *et al.* 2015). These shifts revealed both the flexibility and the fragility of the communicative order, as well as the symbolic capital each participant brought to the encounter (Bourdieu 1991).

The affective dimension of these interactions should not be underestimated. Emotional strain often accompanied linguistic friction, especially under bureaucratic pressure or clinical uncertainty. This unacknowledged emotional labour subtly shaped the atmosphere of encounters and the possibilities for care. My participation as researcher occasionally shifted between role – as translator, facilitator, or silent witness – added further layers of reflexivity and ethical tension (Emerson *et al.* 1995; Hammersley 1992). These moments, far from methodological noise, offered insight into how institutional structures determine who may speak, what counts as knowledge, and whose voices are heard.

The lack of formal interpreting systems did not produce silence but improvised ecologies of meaning: gestures, digital tools, fragments of shared language, and moral appeals. Such bricolage strategies highlighted how linguistic accommodation is individualised and unequally distributed, revealing how structural precariousness is absorbed into interpersonal responsibility.

Overall, the study does not claim to provide exhaustive explanations, but it seeks to contribute modestly to ongoing conversations in three directions. First, it shows that bringing together different methodological and analytical lenses can illuminate how identity and legitimacy are negotiated in interaction, extending work on “knowledge as co-produced” (Duranti 2001). Second, it suggests that combining micro-ethnographic observation with discourse-analytic detail helps situate language within broader social and institutional processes, an approach still under-represented in health communication research. Finally, although based on a limited set of cases, the findings indicate that recognising mediation and repair as forms of professional and moral practice could inform training and organisational strategies aimed at fostering equity in multilingual healthcare.

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## *6. Conclusion*

Clinical interaction in multicultural third-sector clinics emerges as a complex, negotiated process rather than a straightforward transfer of biomedical information. Multilingual mediation, repair mechanisms, and the flexible reframing of institutional roles all contribute to a dynamic construction of knowledge, legitimacy, and care.

Integrating critical medical anthropology and discourse analysis demonstrates that health communication is shaped by micropolitics and institutional precarity. Analysing repair and mediation reveals how frontline negotiation can mitigate – though not fully resolve – structural and epistemic inequalities. Recognising these interactional resources is essential for designing more equitable health policies and intervention strategies in precarious settings (Marmot 2016; Sen 2007).

Multilingualism in clinical contexts cannot be reduced to a technical issue. It intersects with broader dynamics of trust, authority, and access. Shared language does not guarantee understanding, and mediation does not always prevent breakdown. What matters are the shifting alignments and relational labour that sustain communication under constraint.

In sum, multilingual encounters should be seen not as obstacles but as crucial arenas where inclusion, rights, and care are continuously negotiated. They reveal the everyday micropolitics through which power, knowledge, and belonging are co-produced. Future research should extend these findings to other health systems and examine the long-term impact of communicative practices on patient satisfaction, equity, and health outcomes.

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