4. Agency and multilingualism in public health care: how practitioners draw on local experiences and encounters

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INTRODUCTION

In this contribution we show how practitioners in the health care sector draw on experiences and encounters with local multilingualism. The health care sector is particularly intriguing, as here language 'needs' can have far-reaching consequences if they are not identified or responded to appropriately. Despite being a sector in which effective accommodation of language needs has long been identified as vital for ensuring accessibility and quality of treatment (cf. Phillimore, 2015; Zeeb et al., 2015), it is one in which practitioners can often be under immense pressure to produce ad hoc solutions and take decisions as they go along, based on their experience and knowledge.

Our contribution focuses on the role of individual agency in understanding the complexities and dynamics of responding to perceived language 'needs'. We show that there are many opportunities for a range of participants to assume agency roles in the process and to co-manage or shape the organisation of individual encounters. We discuss how they enact practical solutions that have the potential to transform into habitual practice through iteration, and how they forge what Liddicoat and Taylor-Leech (2020) define as 'projectivity' or future-oriented policy. We show how practitioners' ability to make decisions relies on their personal experiences and encounters with population groups gained in the local multilingual urban setting. Actors' experience of the multilingual city thus constitutes a resource that informs and empowers them in institutional contexts.

The discussion is set against developments in interlingual and intercultural communication research in public services in what has been termed 'super-diverse' settings (cf. Vertovec, 2007). Various interpreting modes, including on-site face to face (bilateral) interpreting, telephone interpreting,

video interpreting, and translation of signs (Tipton and Furmanek, 2016) are seen not just as a way of ensuring equal access (and social justice in general, cf. Piller, 2016, 134ff.) but also as a way of managing risk (Schenker et al., 2011) and avoiding unnecessary reliance on emergency services (Ngai et al., 2016). The health care sector in England and Wales requires the use of professional language services rather than relying on staff language skills (NHS, 2018). Nevertheless, staff attitudes towards, and awareness of their multilingual environment have been shown to play a role in the delivery of professional services (Cadier and Mar-Molinero, 2012).

Research on health care interpreting has tended to focus on the nature of provisions and their relevance to the quality of care (Flores, 2005; Bischoff and Hudelson, 2010; Schuster et al., 2016) as well as the collaborative dimension of interpreter-mediated events (Angelelli, 2003; Bührig et al., 2012) with some consideration given to the health care sector in the wider context of responses to urban language diversity (e.g. Matras and Robertson, 2015; Gaiser and Matras 2016). This contribution explores the interpreting encounter in the wider context, embedded in and shaped by the diverse setting, its actors (defined as those whose behaviour is rule-governed) and their forms of agency and skills and knowledge. In this sense we move away from traditional understandings of policy development and enactment, and show the relevance of local decision-making processes and practices in the field of Interpreting and Translation. In so doing, we foreground the micro-level dynamics and practicalities around meeting language 'needs', building on other research that has shown how, in activating their own multilingual resources, practitioners assume agency, which contributes in effect to policy enactment within the institution (cf. Johnson and Johnson, 2015; Hornberger et al., 2018; Gaibrois, 2019; Keshet and Popper-Giveon, 2019).

AGENCY AND PRACTICE-BASED POLICY ENACTMENT

Research into language policy increasingly emphasises the role of local practice as opposed to the study of policy documents (cf. Bonacina-Pugh 2012, 2020; Pennycook, 2013). More attention is also being given to the concept of agency as the enactment of policy through discourse and individual initiative. Liddicoat and Taylor-Leech (2020) define agency in language policy as a process of social engagement that is impacted by iteration (drawing on past experience), projectivity (future oriented action) and practical evaluation. Iteration refers to the continuation of established practice routines. Liddicoat and Taylor-Leech argue that agency is not found only in the reproduction of past experiences, but also involves a creative reconstruction of the world that gives shape and direction to it. They regard projectivity as a future-oriented

component of agency that involves a process of imagining possible future trajectories of action that are relevant to the actor's hopes, fears, and desires for the future (Liddicoat and Taylor-Leech, 2020, 5–6).

This understanding of agency draws on the notion that agency entails the capacity of individuals to influence a pre-existing state of affairs or course of events and that such capacity may be enacted as part of an exercise of choice or as an act of resistance, variously constrained by context and circumstance (cf. McNamara, 2019, 16–20). Agency is often understood as the capacity to introduce variation on repetitive processes thereby subverting them and the identities that they produce (Butler, 1990, 198–199) and as breaking away from a given frame of action in order to transform it (Lipponen and Kumpulainen, 2011, 816). It is thus also a temporally embedded social process, one that incorporates past practices as well as undertaking future-oriented actions (Emirbayer and Mische, 1998). Ahearn (2001, 112ff.) therefore views agency as a 'socio-culturally-mediated capacity to act': While an 'actor' might be somebody whose action is rule governed, the 'agent' according to Ahearn (2001) exercises own power in the sense of an ability to bring about effects. The process of claiming agency involves conscious reflection and deliberation as well as having motivation, skills and ability (in terms of social positioning) to act. In order to capture the fluidity of the process we maintain our reference to the health care practitioners whom we interviewed as 'actors' rather than try to introduce what would risk being a somewhat random distinction between 'actors' and 'agents'. Instead, we assess how actors may at times assume a greater sense of agency: Common to these various positions is an understanding of agency as deviation from script or non-conformity; it does not follow an expected routine as prescribed by an institution but takes on some form of autonomy, though often with the pragmatic goal of achieving an end result in a way that is simpler and more practical rather than with the explicit goal of resisting power.

If the above description of agency is accepted, policy can be seen as something that is constantly re-practised and hence contested. However, the outcomes are nevertheless bound up in various power asymmetries that are manifest in the institutional encounter. This explains the level of variability in practised policies of language: An institutional service provider with multilingual competence may be more open than a colleague who speaks only the majority language to a service user's desire for autonomy over the translation process; however, as our examples later show, the multilingual service provider may overestimate their own and others' capacities and repertoires, leading to questions about whether institutional imperatives of risk management and patient choice are always effectively addressed.

Investigation of individual agency in institutions has relied on participant observation as well as analysis of discourse practices and testimonials.

Hornberger et al. (2018) introduce an ethnographic approach that relies on observation and long-term immersion to derive insights into actors' patterns of behaviour and engagement in policies and practices. Special attention is given to tension between ideologically driven formulations of policy or ideological spaces that are monoglossic and implementation spaces that support the sustainability of actual heteroglossic (multilingual) practices. Investigating school programmes in the US state of Washington, Johnson and Johnson (2015) show how nominally identical models harbour different practices. They conclude that local actors have power over decision-making processes, which they describe as processes of appropriating policy to local contexts. They take a multi-site approach to examine how local power constellations affect policy appropriation and implementation in multiple centres. Wodak and Savski (2018) present a critical ethnographic approach to examining the inner workings of organisations and their role in policy implementation arguing that an examination of discursive practices, interactions and contextual knowledge should allow researchers to go beyond observation and explicitly evoke a normative stance. Gaibrois (2019) also adopts a discursive approach to practice suggesting that speaking about multilingual practices in the work environment can affect relations within an organisation. Basing her analysis on interviews she examines where and how employees feel empowered to seize opportunities, take responsibility and decisions and create new possibilities. She interprets such instances of empowerment as the creation of agency through resistance toward established practice, requests for adaptation, offers of support and legitimising practice diversity ('bricolage').

METHODS AND SETTING

We position our analysis in the context of these studies. We focus on interviews with actors who represent different roles in the health care sector in the same city. We show how testimonials provide insights into the knowledge that actors rely on when navigating the institutional setting. We are interested in particular in elements of knowledge that equip actors to take decisions and enact a course of action to structure the encounter between service user and professional practitioner. We show how personal experience in the multilingual city is an important resource from which actors derive empowerment and agency.

Our research draws on nearly a decade of observations on language practices in the local health care sector with a focus on Central Manchester Universities Hospitals NHS Foundation Trust (CMFT) and surrounding General Practitioner (GP) practices. This included semi-structured interviews and focus group conversations with health care professionals and with interpreters and translators.

In the present contribution we focus on testimonials extracted from interviews with altogether seven health care professionals: four GPs, a dentist, a pharmacist, and a GP practice manager. We consider as 'testimonials' statements that are embedded into narration or conversation that contain evaluations of provisions, and descriptions through which participants reconstruct their own actions and the considerations that led them to take these actions.

TESTIMONIALS AND FINDINGS

Engagement with Scripted Practice

The first two testimonials show how participants understand, accept and engage in institutionally scripted practice routines around the provision of interpreting services:

Example 1: GP 1

> By and large, they always have the language we need. I think we're delivering here a world-class service, we can deal with anybody from the world now, irrespective of their language skills. And I think, having telephone translators specifically is a good option, because it's versatile. It doesn't disrupt the consultation. It provides intimacy for the patients.

Example 1 is from a GP based at a practice in South Manchester and concerns interpreter services that the practice has access to through an external interpreting agency. The comments show pride in the service and awareness of its importance to the health care system. They also show an implicit level of trust in the provisions and an assumption that they generally resolve communication barriers. Drawing on his past experience to assess available language provisions, the GP highlights the advantages of telephone interpreting both from the viewpoint of the practitioner (non-disruptive) and the patient (provides intimacy). This shows an awareness of the way different interpreting modes that are among his "repertoire of routine actions" (Liddicoat and Taylor Leech, 2020, 5) can be used strategically. It is noteworthy, however, that the potential disruption deriving from telephone-based provisions (due to the logistics of handling a phone, lack of a clear connection, and fragmented narratives) is underplayed, suggesting an uneven understanding of the risk of different modes of interpreting in this setting.

Example 2: Dentist

> It was a case of she had come to her first appointment and didn't understand a word so it was picked up that she needed an interpreter so then we arranged another appointment and we had an interpreter brought out for that visit.

Example 2 shows practitioners as decision-makers in the use of language provisions, a role accepted by the patient. It also suggests that ensuring effective communication is perceived as a priority, as practitioner and patient accept a delay of the treatment so that an interpreter can be present. The example indicates an absence of pre-registration of interpreter needs. The practitioner, in what should have been the central encounter in the action chain, had to mitigate an issue that should have been addressed at an earlier point. The lack of specificity in regard to identifying the patient's needs ("it was picked up") suggests that the chain of communication extends beyond the practice team; the emphasis on the collective 'we' suggests a service-level response and cross-team knowledge of appropriate provisions that are not reflected across the wider action chain.

Actors' Personal Initiative and Decision-Making

In the next example, a general practitioner based at a hospital comments on a personal strategy that appears to be driven by convenience, as the personal choice of provision from outside the system is not foreseen by regulations and guidelines:

Example 3: GP 2

> And the best option, which works for me, and which sounds really silly, is Google translate. I just type it in, and it works great, yeah. Really easy.

The statement (especially the meta-comment "sounds really silly") expresses the perception that this ad hoc solution may not be recognised officially or more widely as a way of facilitating communication during consultation. However, based on his own experience of using this strategy successfully he deems it as a legitimate practice for the everyday encounter with patients. The GP's evaluation of the strategy to use Google translate as "best option" is in itself a dimension of agency (Emirbayer and Mische, 1998) as it responds to emerging needs. The comment shows the efficiency of the software tool but highlights a compromise in the principle of patient-centred care: Reliance on phrases of limited length to construct a medical encounter is risky and is likely to mean that much of the patient-centred phraseology used by practitioners (medical scripts) is likely to be dropped, calling into question the principle of equal access.

The next three examples show the relevance of individual decision-making in shaping practice. Individual actors take initiative to deal with communication difficulties in a way that they perceive as effective. They make use of a multiplicity of multi-modal support tools, sometimes in an improvised manner and otherwise as a matter of routine. Decisions on the choice of tools and modes

are often based on prior experience and driven by actor initiative rather than institutional regulations or recommendations. Actors assume agency when they identify gaps in scripted language provisions, which is a way of negotiating power relations and implicitly contesting decisions and recommendations that are pre-formulated by institutional arbiters (cf. Hornberger et al., 2018). This may result in an imbalance in power, where macro-level actors and their policy decisions are overridden by micro-level actors, who can assume power positions in practice.

Example 4: GP 3

> On one occasion, when a patient needed to speak to staff and the staff were unable to identify which language they spoke (to get the appropriate interpreter) … The only thing we could do was to use their mobile phones to their friend [*sic*], which was really uncomfortable.

The GP in example 4 works in a practice in a small town around 20 miles from Manchester, where two thirds of patients were asylum seekers or refugees. The decision to use a patient's mobile phone and talk to their friend to overcome communication difficulties is an ad hoc response to an unusual situation, one that is not directly anchored either in scripted or in past practices. The unease at the involvement of an unknown third party reflects awareness of risks and ethical implications. These reflections had led the interviewee to create several support resources: printed leaflets in various languages, and a YouTube video with voice overs in ten different languages with information about the health care system, registration, and appointments, which discouraged patients from using family members and friends as informal interpreters. Deviation from the scripted routine thus led to projectivity in the form of the design of pre-emptive or educating measures.

Example 5: Pharmacist

> We had a family, actually an entire family, had TB, Tuberculosis. They had very poor English. So as opposed to getting it all translated, their reading and writing wasn't great either, so we did a pictorial step-by-step with the nurses.

Example 5 shows another example of ad hoc decision-making and improvised solutions by a team of practitioners during an interaction with service users. In the team's perception, conventional provisions were insufficient to resolve practical communication difficulties and this required a bespoke initiative, which the team felt able and empowered to take. The description is an example of how institutional policy may fail to effectively respond to patients' needs in a particular situation; staff make choices to override default procedures and develop strategies to overcome such challenges. It also shows awareness of the multi-modality of language use and the limitations, in some cases, of modes

that rely on literacy, testifying to practitioners' active reflection on service users' language repertoires.

Example 6: GP 4

> that was a patient, again in my old practice, who refused a translator but then when it actually came to the consultation struggled with some of the medical terms. And that's awkward. Because they feel they don't need an interpreter, you feel they do, but you don't want to be insulting to their English.

The GP based at a suburban South Manchester clinic comments on the way that power relations are negotiated and the extent to which language skills evaluation can be projected onto power and self-esteem. The comment testifies to an awareness of the need to share power and agency with the patient while still making optimal use of the institutional provision and managing risk in that way. The GP's comment that he did not want to "insult" the patient's English suggests that the use of interpreting services may be interpreted as disempowering service users, or at least emphasising a disadvantage. The patient's decision to go without an interpreter reflects their desire for autonomy and self-determination. The GP's reflections indicate an awareness of the complex factors that may affect an individual's decision regarding the use of interpreting services.

Local Knowledge and Personal Experience

The next three examples demonstrate how local knowledge and personal experience is presented in the testimonials as a legitimate reference point to justify and explain actors' decision-making processes. Personal experience can empower actors to override a course of action that is set by scripted procedure:

Example 7: GP 1

> We did a little survey not that long ago and what we found was that there is a certain group of patients, particularly ladies, actually preferred the telephone translators. Because then they could divulge details of say domestic abuse, domestic violence, or sensitive topics, which they found, if there was another person present, they may be less open. And also, they could talk more about intimate symptoms that they have, whereas having a translator physically set there was a little bit prohibited.

The group of patients described in this example show a perceived preference for disembodied interpreter mediation as a means to address culturally sensitive topics (while the technical challenges presented by telephone interpreting appear to be overlooked). The statement testifies again to an established routine of using certain strategies to address particular situations and circum-

stances, thus opting between available modes of encounter management – face to face and telephone interpreting.

Example 8: GP 2

> When it comes to Asian communities, again, I can cover all ground. When it comes to African, I cover the ground there, and parts of India, I can cover. […] I can have someone there from the interpreting service, saying they speak one language. And when they're actually speaking [it is] either very very slang, so it's not even formal. Or, it's a completely different language they claim is the language they're speaking. And in such situations I just say "Look, you may as well stop, because I speak the language myself".

This example shows the intertwining of professional with personal experience. What is at stake is the issue of epistemic authority, or which actor's knowledge about language has currency or is most trusted: The GP highlights perceived gaps in the professional interpreter's ability to offer a particular language combination while potentially over-estimating their own capacity to acquire and deploy language knowledge in the workplace. The GP is resistant to appropriating the dominant discourse of professional interpreter provisions. As someone with a degree of proficiency in several languages and a social background that suggests exposure to situations in which 'getting by' with partial communicative ability has worked, this GP intervenes with the interpreter's management of the event, departing from scripted procedure including the dominant NHS discourse of safeguarding and risk management.

Example 9: GP Practice Manager

> We overcome that [language barriers] by a lot of our doctors speak the languages spoken in our area, except for Bengali, 'cause we haven't got a Bengali speaking doctor, we have to get our own interpreter. Or usually they do manage to bring their families, they do manage to communicate that way. And if there isn't anybody that they can bring, we have to book someone. It's a huge cost to the NHS. In the mornings it becomes a huge problem because they're ringing to make an appointment at eight o'clock I'm struggling sometimes if a member of staff has not turned up who speaks the language it becomes a huge problem but then I don't speak Bengali but then the Bengali-speaking people will understand a little bit of Urdu so I can sort of/ I speak a few words of Bengali so, so I usually manage.

The Practice Manager, an Urdu speaker, notes a range of ad hoc solutions and overlapping language resources for distinct communicative functions: The experience of Bengali-speaking people understanding "a little bit of Urdu" licenses the booking of appointments through receptive multilingualism (communication across similar languages; cf. ten Thije and Zeevaert, 2007). The description of staff language skills illustrates the practice's embedding in the local area and its language composition. It also conveys the belief that

health care professionals support the NHS when using informal interpreters where possible, as this saves money. There is thus a subjective balancing of NHS interpreting guidelines against a more tacit commitment to contribute to economic efficiency, one that derives from the everyday experience in the work environment rather than scripted policy.

Narratives about Language

Our final pair of examples shows how practitioners explain and justify taking initiative by constructing narratives on language:

Example 10: GP 2

> And again, it depends what part of Romania they are from, Roma travellers speak slightly different. It's all slang, it's language bits from everywhere, bits of language from India, bits from there. But they're officially from Romania, and your language is slightly different there, as well.

Example 11: GP 1

> So, to give you an example, there is three Kurdish languages. There is Kurmanji, Sorani, and Badini. There is two Farsi languages, Afghani and Persian. There is two types of Chinese, Mandarin and Cantonese. Both, which are provided. Actually, there is no point of giving a Badini Kurdish translation for a Kurmanji, because they don't understand each other.

The construction of language narratives appears to draw on an accumulation of everyday experiences with a diverse population of service users in the multilingual city. It is then presented as part of the actors' portfolio of specialised knowledge as professionals working in this setting and in that way as knowledge that qualifies them to manage decision-making nodes when it comes to encounters with service users. We thus witness once again the intertwining of professional authority with everyday personal experience (for the context for these two testimonials see Examples 1, 7 and 3, 8 respectively).

DISCUSSION

Several themes emerge from the testimonials considered above. First we note actors' awareness of and, by and large, confidence in the institutional provisions to manage communication and overcome language barriers. At the same time they report on their own initiative in taking decisions, either by compartmentalising settings and types of encounter and selecting among different options to manage them, or by enriching provisions at their own initiative and sometimes by overriding scripted procedures at their own discretion.

Reported strategies include the use of receptive multilingualism (capitalising on similarities between languages), using family members as a resource and drawing on technological tools. In their testimonials actors indicate that their decisions are informed by established practice routines. They are also shaped by a comprehensive assessment of the multilingual environment and experience of cross-language communication as well as by specific knowledge about languages acquired through such experience. These are justifications and qualifications which actors provide in their testimonials to explain and assert their own sense of agency in negotiating decision-making nodes in encounters between practitioners and service users. Recall that, as we explain above, we identify the fluidity of reclaiming agency in this sense; for that reason, we choose not to introduce a hierarchical distinction between 'actors' and 'agents'. Instead, we view 'actors' as participants whose performance and practice routines are generally governed by rules, but who may in a particular context assume agency by taking their own decisions.

Contextualised testimonials thus serve as a way of reconstructing actors' own sense of agency and of mapping elements of knowledge on which actors rely at pivotal decision-making nodes. They allow us to access the level of policy enactment and implementation at a local level and assess how individuals contribute to shaping policy through practice. The testimonials reveal that encounters between service users and practitioners in the institutional setting of the health care sector are sites in which language policy is appropriated, enacted, and implemented by a range of actors in different roles. Power relations are derived not just from institutional roles; rather, in an environment that is highly de-regulated and where there are often different options to manage encounters, actors rely to a considerable degree on accumulated knowledge. This includes local knowledge, gained passively by virtue of being immersed in the everyday locale, as well as first-hand experience gained from accumulated interactions in the work environment of public service in a diverse city. The multilingual urban setting is thus a key source of knowledge about language practices, provisions, options for support in heteroglossic encounters and about language itself.

Experience in the linguistically diverse city allows actors to gauge their knowledge and course of action against their own and others' expectations and aspirations and empowers them to take initiative and to narrate explanations and justifications for their own initiatives. In this respect the material illuminates a different perspective to those discussed by Cadier and Mar-Molinero (2012), who focus on practitioners' language skills, and by Keshet and Popper-Giveon (2019), who address practitioners and patients' language skills and the social values attached to them. We present a case where decisions, actions and initiatives draw on the kind of urban, super-diverse repertoire described by Busch (2012) and by Blommaert and Backus (2013). This approach problematises

the notion of 'language' as a pre-defined set of structures and replaces it with the view that language and communication experience constitute a dynamic pattern of practices, potentially detached from pre-defined groups or speech communities and placed instead within emerging and evolving networks of practice. Crucially, it views language repertoires not just as language skills in the conventional sense of fluency and lexical and grammatical competence but also as the sum of impressions and experiences gained through a variety of encounters within such networks of practice.

In the context of language support provisions in the hospital, Liddicoat and Taylor-Leech's (2020) assertion that policy development is an essentially dialogic process merits particular attention. This is because users of health care services are seldom likely to have been involved in the formation of policies that govern the commissioning, delivery and quality management of language support provisions (cf. Tipton, 2017). Inevitably they 'receive' policy as it has been interpreted institutionally, for example provision of a professional interpreter who will expect to participate in accordance with an established framework. Broadly speaking, this also applies to practitioners, who are 'actors' as described by Ahearn (2001). However, our observations show that policy is not just passively absorbed and accepted but rather frequently undergoes processes of negotiation, as interactants adjust their interpretations of policy (whether formal scripted policy or personal micro policies shaped by language repertoires) to the situation at hand.

In part, this may be due to a very practical reason that actors (service providers) within the health care system may not be fully aware that there exists an institutional set of guidance on working with service users with low English proficiency. The policy basis on which encounters are anchored may therefore vary considerably, operating along a spectrum between ad hoc micro-level policy innovations based on a speculative and intuitive understanding of what constitutes effective communication with service users, and service interventions that are framed by the overarching structures of the institutional policy document on commissioning translation and interpreting services (NHS, 2018). Following Ahearn (2001), we may be interested in investigating practices that reproduce or transform the very structures that require such policies to exist in the first place. However, in our case what we understand by 'structure' is multi-layered and unstable (both at the institutional level of policy-as-structure, and at the interactional level of participation framework-as-structure). The structures mutually constituted by language practices in the interpreter-mediated encounter are characterised by their temporality; traces of structure may be re-enacted in other settings by both parties but they cannot serve as clear predictors of outcomes in each case. We embrace Emirbayer and Mische's (1998, 971) view of projectivity as "the imaginative generation by actors of possible future trajectories of action". They argue

that social actors negotiate paths toward the future and that they receive their driving impetus to do so from the conflicts and challenges of social life. Agency arises, they suggest, "as actors attempt to reconfigure received schemas by generating alternative possible responses to the problematic situations they confront in their lives" (1998, 984).

Some of our testimonials suggest that individuals make conscious choices not to involve professional interpreters even though they are entitled to request support. Such decisions are indicative of projectivity, as defined above: future-oriented actions in which the individual actor construes the self as capable of employing even limited language resources to facilitate autonomy and determine a course of action without having to draw on an available script or established routine. However, as stated above, these decisions are not without risk and come up against the practical evaluation strategies of institutional representatives who may take several courses of action as the lead agent with overall accountability for risk management and mitigation: override the decision and request an interpreter to attend, tolerate the decision and muddle through, tolerate the decision and proactively support the interaction by pooling personal resources (e.g. employing own language knowledge and repertoires, collaborating by using technology-based solutions such as Google Translate).

Similar to the observations discussed by Hornberger et al. (2018) from educational settings, we identify in health care settings implementational spaces that are 'carved out' from the bottom up and can resist the pressure of top-down policies. Such 'carving out' of implementational spaces rests in our study on a broad range of accumulated knowledge, site-specific and conjectural contingencies, that is, unanticipated events that arise as a consequence of external factors that are specific to a particular time period. This shows what Gaibrois (2019) identifies as the 'productive power' of multilingualism in these settings. New spaces are opened up by the various actors in the action chain when scripted institutional provisions are renegotiated in various ways, resisted and even rejected. But the testimonials also point to a trend towards expediency as the driver of decision making as opposed to institutional values of patient safety and patient dignity. From a policy perspective, this pragmatism and flexibility afforded by the de-regulated Public Service Interpreting and Translation environment may therefore require further critical attention to ensure that the chosen intervention strategies do not compromise patient choice and patient experience.

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