Translanguaging outside the Academy

Negotiating Rhetoric and Healthcare in the Spanish Caribbean

Rachel Bloom-Pojar

SWR STUDIES IN WRITING AND RHETORIC

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tive that is socially and culturally embedded. This perspective often promotes a hierarchical view of speech and writing habits based on perceived notions of standard language use and variance from that standard. The vignettes just presented demonstrate only a few of the moments when I became self-aware of how others perceived my languaging. Why was it that this woman figured the most reasonable explanation for my (a white woman's) ability to speak Spanish was that my husband might be from México? How many other white women in the United States had she met who either did not speak Spanish or attributed their fluency to a relationship? As I told the man in Mérida, the Spanish that I have developed over the years has been influenced by my time spent in El Salvador and the Dominican Republic (DR). I knew that I had developed certain ways of speaking that would be marked as Dominican Spanish, but this was further confirmed when I was in a different Spanish-speaking country and this man was curious about why I spoke Spanish como una dominicana. What were the dialectal features that made him comment on that? And what is it that made my sobrina exclaim that I could speak well?

At its core, this book aims to examine these questions and challenge linguistic inequalities regarding the uptake of "translanguaging" as a rhetorical act. Ricardo Otheguy, Ofelia García, and Wallis Reid "define translanguaging as the deployment of a speaker's full linguistic repertoire without regard for watchful adherence to the socially and politically defined boundaries of named (and usually national and state) languages" (283). Any rhetorical discussion of dialects, or varieties, of language brings into question how they are perceived across contexts. In addition to politically and socially defined boundaries of language, race, class, and gender are just a few of the other facets that influence how individuals perceive each other's languaging. These perceptions may interfere with an individual's ability to truly translanguage and feel free to draw from his or her full linguistic repertoire in certain contexts.

While others have responded with curiosity and enlightened surprise at my Spanish languaging, their perceptions are largely based on the contexts we were in (nonacademic) and my position of privi-

lege as a white, North American woman who could travel to various countries. Many others do not have the luxury of being perceived as novel or intelligent for these types of languaging skills (Flores and Rosa), and many institutional contexts are not accepting of the community discourse of Spanish that I have learned so much from in my time abroad. Although I have worked in institutions of higher education since graduating from college, I rarely speak Spanish within the walls of my workplace for fear of judgment from language studies professors who remind me of those who once graded me on my ability to master "standard" Spanish. Although those classes laid an important foundation for me to build on outside of the classroom, my confidence in speaking Spanish evolved outside of an academic context. This difference in how my languaging is perceived, how certain types of languaging are privileged in our classrooms, and how some individuals are constrained in their ability to draw from their full linguistic repertoires drives me to explore the rhetorical potential of translanguaging. In the pages that follow, I begin by discussing concerns in the classroom, but only as a point of reference and departure. Understanding how I came to explore the rhetoric of translanguaging begins with how I learned about language variance in the dissonant spaces between my classroom learning and my professional development as a rhetorician and medical interpreter.

MEDICAL SPANISH

During my undergraduate studies, I took an elective medical Spanish class as part of my major curriculum. "You're not pre-med? Then, why are you in this class?" I remember my peers asking, shocked that anyone would sign up for the class without an interest in pursuing a health profession. I responded with some version of "who knows if I might volunteer or work as a medical translator someday." The class was difficult for me. Based mostly on vocabulary and a bit of translation theory, much of our work involved memorizing words and phrases, and then articulating them within an imagined medical context (through written tests, oral exams, and so on). The most difficult part about studying the content was

that I did not know the meaning of many of the words in English. Some words looked almost identical, with an accent or change in spelling here or there, so I was not any closer to understanding the meaning of electrocardiograma by seeing the translation, *electrocardiogram*. I constantly needed to look up words in English or ask others to explain them to me. I was aware of varying dialects of English, but this was a whole new language that made the class feel like I was trying to absorb two words from two "named languages" (English and Spanish) that appeared almost identical to me in my nonprofessional understanding of medical conditions and procedures. I was not only negotiating two languages but also struggling with unfamiliar disciplinary discourses. Needless to say, I did not retain much of the information I learned; this was probably also due to the fact that I would not be called on to translate in a medical setting for several years. I kept my medical Spanish textbook for future reference, por si acaso (*just in case*).

ENCOUNTERING SPANISHES OUTSIDE THE CLASSROOM

A couple of years later, I traveled to the DR for the first time. I was working as a teaching assistant with a theology study abroad course, and I acted as an interpreter and general aid to help the professor with students on the trip. I had worked in this position the previous year, on my second trip to El Salvador, and I was interested in learning more about the DR, this country en el Caribe (*in the Caribbean*). I quickly realized that many students who learned Spanish as a second language in the United States had difficulty understanding the Spanish spoken in the DR. Being the curious language lover that I am, I was more intrigued and eager to learn the local dialect of Spanish than I was upset about the dissonance between what I heard there and what I had learned in my classes. This first trip to the DR would end up serving as a crash course in language variation, since much of my classroom instruction had been based on Central American and "standard" Spanish. This was the first time I learned that rubia did not just refer to a *blonde* woman, for some of the boys were tirando coquetas (*flirting/catcalling*) and called me

this word. I stopped them and asked, "Pero no soy rubia . . . eso significa que tengo pelo blanco, no?" (*But I'm not rubia . . . that means that I have blonde hair, right?*) They quickly explained that no, I definitely was a rubia, and pointed to my skin to explain why. I also learned the word cabello for *hair* on one's head, and the meaning of ahorita, which did not translate as I thought it would to *right now*, but rather meant *a little later*. Then there was one of my favorites: un chin (pronounced oo-n ch-een), which meant *just a little bit of something*.

I enjoyed learning from the communities in the rural towns we visited, so I asked the professor how I might travel back in the future. He told me that there were many doctors and dentists who travel to the DR every year but do not know any Spanish, and they were always looking for interpreters. I was appalled at the thought of anyone traveling to a country to perform medical or dental procedures without speaking the same language as the patients. How could the doctor or dentist know what the patients needed? How many errors might occur because of language barriers? This was the first time that I recognized the desire to interpret as being in an advocacy role for patients—to ensure that their words and needs were understood, and that they also understood all that was being said about their health and medical care. This led to my spending the next two summers working with a nonprofit organization called El Centro para la Salud Rural (CSR) (*The Center for Rural Health*)[3] and serving as a guide and interpreter for one high school group and two teams that were assisting the center's summer health program. By alternating graduate coursework in rhetoric and composition during the academic year and this summer work abroad, I began to dive deeper into questions about language and rhetoric in an attempt to bridge what I was learning in the classroom and experiencing in the clinics abroad.

While working with these programs in the DR, I saw myself as an advocate, interpreter, and facilitator between host communities and US visitors. I knew that these programs were fraught with issues (Van Engen; Lasker), and yet it was because of those issues that I felt called to work in the liminal spaces of these transcultural in-

teractions. I wanted to strive to communicate in a way that helped to care for all individuals involved, while ultimately challenging the visitors to empathize with their hosts and understand their way of life as not just drastically different from their own, but also as equally human and deserving of respect. I was especially aware of the potentially negative implications of miscommunication and error within the medical program. We were dealing with people's lives and health, and it was important to me that the clinics were run with as much professionalism, respect, and quality of care as one might expect under similar material circumstances (that is, without x-rays) in the United States.

In my first year with the health program, in 2011, many interesting moments surfaced around differences in language and culture. I was intrigued with how instances of translation were negotiated by visiting practitioners and Dominican volunteers on the health team. I also began to notice my own speech developing into a more localized accent and my ability to comprehend the phrasing of this dialect improving every day. I saw this as important progress if I was going to succeed at working with and interpreting for the community members of this program. There were many moments when I remembered the difficulty of my medical Spanish class, and realized how much easier learning a language seemed within a context of repetition and tangible application. I became intimately familiar with ways of talking about dental procedures and types of pain to determine the best course of action. I would ask if the pain was like a pinch or if it got worse with hot and cold foods or beverages. I'd instruct patients what to do: escupe (*spit*) or muerde (*bite*). I learned to talk about diabetes and what blood pressure medicine they were taking (thus learning what Metformin and Atenolol were). I also interpreted instructions in the pharmacy many times: toma una tableta cada cuatro horas sin comida . . . (*take one tablet every four hours without food . . .*) and helped the pharmacists field questions from patients about their prescriptions. I was developing medical knowledge, but within a very specific context with very specific forms of Spanish to discuss health and illness. But that was what made sense—to learn to communicate and understand discourses

of health that the community members used in their daily lives. If we could not do this, then what were we there for?

As US participants adjusted their Spanish to "sound more Dominican" and rephrased medical terms to reflect their patients' language use, the entire team began to privilege the local dialect and community discourses of health. This was, in my opinion, the best rhetorical move the health providers could make to be intentional and ethical with their languaging and healthcare. Following my first year with the program, I developed a qualitative study to examine these rhetorical moves among languages, and to learn from local residents and visiting practitioners about how they responded to cultural and linguistic differences in their work together.

It is with deep gratitude to the health practitioners and local volunteers with whom I have worked that I present their stories as part of this book. They taught me about translanguaging before I even knew the terms "translingual" or "translanguaging" existed. Entonce(s), no(s) vamo(s) pa'lante. (*So, let's go forward.*)

Rachel Bloom-Pojar's book articulates a much needed shift in how the field imagines translanguaging. Far more than a classroom pedagogy, this kind of language work is ubiquitous—and vital to the literal health and well-being of communities whose language practices are undervalued or stigmatized.

—Jay Jordan, University of Utah

Moving outside of classroom-based and English-dominant contexts, Rachel Bloom-Pojar draws from an ethnographic study of a summer health program in the Dominican Republic to examine what exactly rhetorical translanguaging might look like, arguing for a rhetorical approach that accounts for stigma, race, and institutional constraints. Within a context where the variety of Spanish spoken by the local community is stigmatized, Bloom-Pojar examines how raciolinguistic ideologies inform notions of stigma in this region of the Dominican Republic, and then demonstrates how participants and patients in this study "flip the script" to view "professional" or formal Spanish as language in need of translation, privileging patients' discourses of Spanish and health.

This framework for the rhetoric of translanguaging (1) complicates language ideologies to challenge linguistic inequality; (2) cultivates translation spaces across modes, languages, and discourses; (3) draws from collective resources through relationship building; and (4) critically reinvents discourse between institutions and communities. Ultimately, the study emphasizes how a focus on collective linguistic resources can enhance translanguaging practices between institutional and community contexts.

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