The interpreting team with one of the surgeons. From left: Sebastiana Pale, Ofelia Pérez (Spanish-Tzotzil interpreters), Julie Burns, Katharine Allen (English-Spanish interpreters), and Fru Bahirael, M.D.

The Connected Interpreter: Integrating Interpreting and Translation into Medical Missions

The story of how professional interpreters were integrated into the planning and execution of a medical mission to Chiapas, Mexico, serves as a budding language access model that is adaptable to missions and disaster response efforts.

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It's 5:30 a.m. as a sleepy crew of volunteer medical providers and interpreters assemble in a Los Angeles hotel lobby, coffee in hand, toting 25 huge duffel bags of medical equipment and supplies. Destination: the remote village of San Andrés Larraínzar, nestled in the highlands of Chiapas, Mexico—home to one of the poorest and most vulnerable indigenous populations in the area.

In May 2015, Mammoth Medical Missions, in partnership with Rotary International, Rotary Club of Bishop Sunrise, and Club Rotario de Oriente de Tuxtla, Mexico, embarked on its fourth mission to provide medical training and free surgeries to this remote area. For the first time, professional medical interpreters were integrated into the mission's planning, execution, and evaluation from the project's inception.

Our story, shared here, points to a preliminary template for a working language access model that can be adapted to missions and disaster response efforts.

THE PROBLEM

Billions of dollars are spent annually around the world to address global health, disaster relief, and humanitarian aid. Providers who speak English, French, German, or Swedish hop on planes to treat people who speak indigenous and tribal languages in Asia, Africa, and South America. For all their diversity, however, such efforts have one thing in common: unsolved language barriers.

With few exceptions, reality on the ground points to a mish mash of ad hoc and "we get by" solutions to multilingual communication barriers.[1] Partially bilingual providers work with untrained volunteer interpreters to cobble together a shaky communication chain that is easily broken. Despite all the money being spent to design and implement sophisticated relief programs, usually little thought is given to addressing the inevitable challenges to be faced when trying to communicate important information to non-English-speaking individuals. When it comes time to actually provide services to those in need, many top-notch medical volunteers find themselves at a disadvantage—engaging in toddler-level exchanges involving hand signals with critically ill patients. The probability of life-threatening mistakes is unreasonably high.

OUR MISSION

The overall purpose of the medical mission chronicled here was to provide critical medical training and hands-on care to providers and patients who see too little of either. So, what was our goal as the interpreting team brought in to assist with this project? We wanted to model a viable and realistic process for ensuring that language access is provided by professional and supported ad hoc interpreters in a medical mission setting.

In short, we didn't want the planning, funding, and onsite implementation to fail by hitting the language barrier brick wall once the project went live. And we certainly didn't want any catastrophic medical mistakes because doctors and patients couldn't communicate.

THE PROCESS

This was an ambitious, multi-focus service mission project. It included a week of intensive skills training for local medical providers and a half-day disaster seminar at the Escuela de Protección Civil in Tuxtla, Gutierrez. After the training, medical

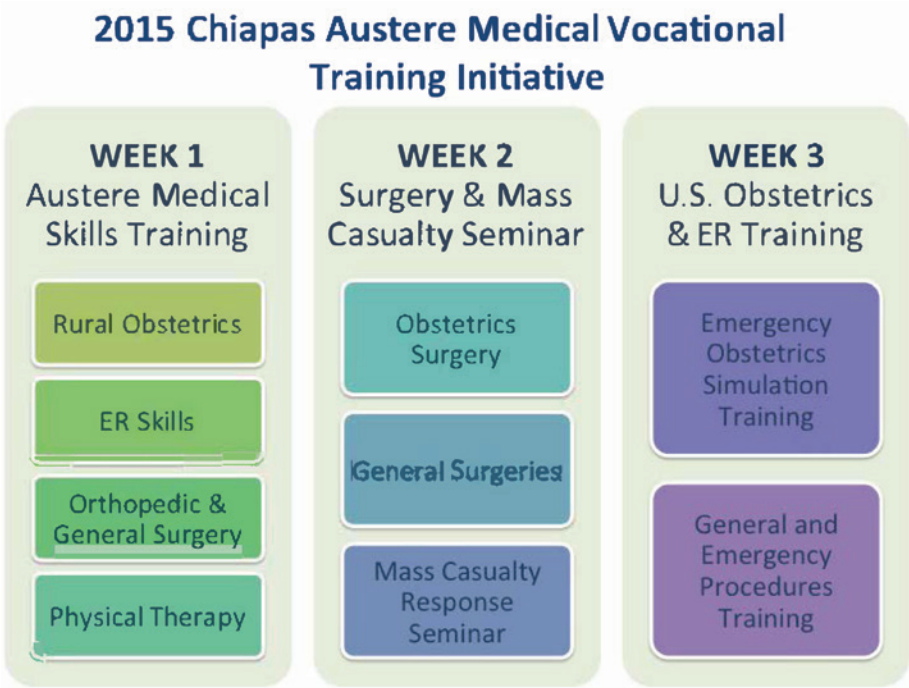

Figure 1: 2015 Chiapas Austere Medical Vocational Training Initiative

volunteers would spend a week in Chiapas providing no-cost elective surgeries for the indigenous population. Eight months later, several providers were brought to the U.S. for continued training. (See Figure 1 for a detailed breakdown of the mission's training schedule.)

The three-stage process described below provides an overview of how we incorporated language access into the Chiapas part of the project. (See Figure 2 on page 14 for a breakdown of the three-stage language services integration process.)

Stage 1—Access to the Planning Team: We had a vision. We didn't just want to volunteer to interpret for a medical mission. Instead, we wanted the mission to have full, professional language access baked into it. We figured the only way to make that happen was to start at the top and work our way to the core planning team.

How did we do that? We called the planning team and offered our expertise. Having already experienced the results of ad hoc, unplanned, and inadequate interpreting services during three previous missions, the planning team jumped at the offer.

We became part of the lead team eight months before the mission, during its initial planning and grant writing phases. As the mission's scope, team, location, and services came together, we were there throughout the process to make sure language access was considered during each stage of the mission's execution.

The provision of translation and interpreting services was written into the funding grant. Plans were made to create a mixed team of professional and ad hoc interpreters who could provide a broad range of interpreting services. In addition, the translation of key documents would also be provided. As professional English-Spanish interpreters, Julie and Katharine would team up with two Spanish-Tzotzil interpreters (Sebastiana Pale and Ofelia Pérez) and several bilingual members of the mission's core team.

Stage 2: Translation of Critical Documents: The demand for document translation for the project was substantive and essential. Everything from formal memorandums of understanding between U.S. and Mexican organizations, physical performance tests for the training week, and informed consent and post-surgery instructions for the patients were needed.

We advocated for including money in the grant funding to pay for professional translation services. The value of having access to translated documents to ensure smooth project operation and correct recordkeeping is incalculable.

Stage 3: Implementation: We had done the planning, envisioning as many possible scenarios as we could. Now it was time to jump from the frying pan into the fire and

A Day in the Life of a Medical Mission Interpreter

Picture this. A hot afternoon. One operating room. Two U.S. surgeons. Two Mexican surgeons in training. Two anesthesiologists (one U.S.-based, one a Mexican volunteer). An interpreting team comprised of two English-Spanish interpreters (Julie and Katharine) and one Spanish-Tzotzil interpreter. Two mixed-language scrub and recording teams. Two patients: the first one undergoing a total hysterectomy for painful fibroids, and the second, a young woman, with an incapacitating inguinal hernia that has caused her so much pain that she has only been able to eat two tortillas a day for the past two months.

As if on cue, the room is silent for a moment before springing to life again after the first incision is made. At this moment, our interpreting team is thrust into a complex multilingual communications dance. Instructions are given, surgical maneuvers are explained, instruments are requested, and questions are asked and answered back and forth between the surgeons and the anesthesiologists. Then there is another round of questions and answers between the patient and the doctor, between the patient and the anesthesiologists, and between the surgeons and the scrub team.

A head pops in the doorway—an interpreter is needed in pre-op. After a quick check-in and an assessment of the status of each surgery, a member of our interpreting team steps out. Then one of the surgeons cracks a joke to lighten the mood, so we attempt to convey the subtlety of humor across three languages. The clock ticks on … feet shift, one of us comes back in, the other steps out. The formerly silent young Tzotzil woman with the hernia wakes up from conscious sedation, crying tears of relief and gushing words of gratitude until we are all teary-eyed.

Averting Disaster

A middle-aged Tzotzil woman lines up with her husband, patiently awaiting her turn. She is scheduled for a full hysterectomy. Earlier in the week, the anesthesiologist conducted a preliminary assessment, speaking in broken Spanish, which the husband speaks a little and the patient not at all.

The woman passed the preliminary assessment, but now a Spanish and a Tzotzil interpreter are there with the anesthesiologist, working through the final assessment and consent process. This time, the pace is slower and the questions more thorough.

Anesthesiologist: "Do you have any symptoms of pain or fatigue?"

Patient: "Well, yes, sometimes when I do housework, it hurts here" (the woman points to her chest).

The anesthesiologist's head jerks up from her questionnaire, fully alert. "How does it hurt?"

Patient: "Oh, it's no big deal. It goes away after awhile when I stop."

Anesthesiologist: "Do you ever get short of breath?"

Patient: "Well, sure, sometimes, but I just stop till it passes."

The anesthesiologist huddles with the obstetrician and interpreters. These are clear symptoms of a possible heart condition. There is no way to run the necessary diagnostic tests before surgery. Reluctantly, but firmly, the anesthesiologist decides the patient cannot have surgery this year. "She could die on the table if she has an underlying heart condition."

The interpreters help to relay the bad news. The woman and her husband are upset. They say they are willing to take the risk, but the decision stands.

Our hearts hurt for this woman, who is so clearly suffering. But as interpreters, we are proud. The work we have done to convince doctors to stop "getting by" with their Spanish and work with the interpreters instead has potentially saved a life.

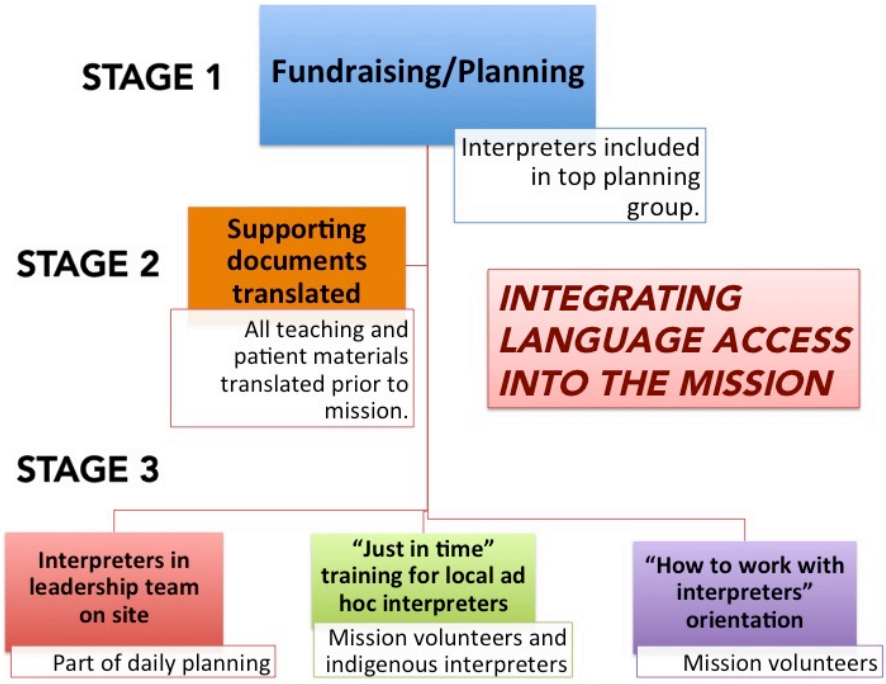

Figure 2: Three-stage language services integration process.

see if our proposed system would work. Overall, our vision for baked-in language access was a big success, thanks primarily to three key factors.

1. **Integration of interpreters into the onsite leadership team:** This factor cannot be overvalued. We had *equal* standing in the planning and leadership team. Our concerns and requests were taken seriously and implemented. (The sidebar on page 13—"A Day in the Life of a Medical Mission Interpreter"—describes a scenario that underscores the importance of our concerns being taken seriously to avoid potentially disastrous outcomes.) The mission leader backed up our requests with the medical providers and made adjustments to the daily logistics to ensure that we could cover key language needs.
2. **"Just in time" training for our mixed professional/ad hoc interpreting team on basic protocols and ethics:** This factor goes to the heart of our vision and efforts. Two professional interpreters provided onsite training of all ad hoc interpreters involved in the mission. Our "just in time" training included, among other elements, accuracy and completeness, asking for repetitions and explanations of unknown concepts, and pointing out potential communication train wrecks due to misunderstandings. Though brief, the training really paid off. Many key moments of successful communication pivoted on our ability to transfer ideas correctly from an English-speaking provider through an English-Spanish interpreter, then through a Spanish-Tzotzil interpreter to the patient and then back again. Our ability to work effectively as a team helped us navigate innumerable moments of disconnect, confusion, and "otherness." (The sidebar at left—"Averting Disaster"—describes a scenario in which the mixed professional and ad-hoc interpreting team successfully navigated the complexities of a surgical intervention across multiple languages and cultures.)
3. **"How to work with interpreters" orientation:** The training process wasn't complete without a parallel orientation session with members of the mission team on how to work effectively with their interpreters. We originally envisioned a sit-down

training meeting with everyone present at the same time. That never happened. We then shifted to Plan B, providing one-on-one orientation to team members whenever we could catch them.

LESSONS LEARNED

There were so many lessons that were learned during the course of the mission—individually, as a team, professionally, and personally. But the following key elements for a language access model stick out:

Hierarchical planning models are a good fit for integrating language access. Full-scale integration of language access into the mission resulted in smoother overall operations, many fewer misunderstandings, the prevention of several potentially major medical problems, and, most importantly, greatly improved patient care and outcomes from previous years.

Creating effective, mixed professional/ad hoc interpreting teams is possible. Two professional interpreters (ideally cross-trained with conference and community interpreting skills) were able to provide coordination, training, and oversight to untrained ad hoc interpreter volunteers. With guidance, the untrained interpreters achieved a greater degree of accuracy, transparency, and professional behavior.

Portable simultaneous equipment can multiply a small team's reach: Even a small amount of portable interpreting equipment can work miracles in expanding the reach of limited numbers of interpreters (as long as at least two are trained in simultaneous). With creative configurations, one 25-piece kit served for lectures, planning meetings, hands-on workshops, and the large mass casualty seminar.

The proper role of the interpreter in global health and humanitarian aid settings is worthy of study. The role of the interpreter for this kind of project needs a great deal of exploration. In our case, our role went well beyond the transmission of words. We were a vital component in fostering relationships of shared understanding, caring, and interconnection. We leaned on all

Practice exercise—consecutive relay into Tzotzil for traditional midwives: Julie Burns (left), Martha Kim, M.D. (middle), and Ofelia Pérez (holding patient's head)

our training with medical, legal, and conference ethics and protocols to handle the sheer diversity of interactions appropriately and professionally, adapting and stretching them along the way.

DEMONSTRATING THE IMPORTANCE OF THE INTERPRETER'S ROLE

Medical missions can be mostly volunteer affairs, but the seriousness of the organization put into them is often highly professional. Doctors maintain professional standards and practices even when operating in austere conditions. Why should addressing the inevitable language barriers to be encountered on missions be any different? We set out to demonstrate to the support professionals what coordinated and competent interpreting and translation could bring to a mission's overall success. And we succeeded.

As interpreters, we're in a position of enormous influence. We help weave myriad diverse cultural fabrics around the world into one global tapestry. The Chiapas experience was a vivid testament to the power of this global interconnectedness, and to the unique role interpreters and translators can play in achieving it.

NOTE

1. There are pioneering organizations that are engaged in groundbreaking work to professionalize this area, such as InZone's Interpreting in Conflict Zones program, as well as the collaboration between the International Association of Conference Interpreters, International Federation of Translators, and RedT to create the *Conflict Zone Field Guide*.

LINKS

Mammoth Medical Missions
www.mammothmedicalmissions.org

Rotary International
www.rotary.org/en

Club Rotario de Oriente de Tuxtla
www.facebook.com/ClubRotarioOrientedeTuxtla

International Association of Conference Interpreters
http://bit.ly/Conflict-Zone-Field-Guide

International Federation of Translators
www.fit-ift.org/guide-pour-zones-de-conflit

Inzone Interpreting in Conflict Zones
http://inzone.unige.ch

Red T
http://red-t.org

Katharine Allen is a veteran health care and community interpreter with over 30 years of experience interpreting, training interpreters and trainers, and providing curriculum design and language access services. She is the founder and co-president of InterpretAmerica. She is the lead developer for the Indigenous Interpreting+ 60-hour training course for indigenous language interpreters and an instructor for the Glendon School of Translation Masters in Conference Interpreting. She is the co-author of *The Community Interpreter®: An International Textbook*, as well as a licensed trainer for The Community Interpreter® curriculum. She has an MA in translation and interpreting from the Middlebury Institute of International Studies at Monterey. Contact: sierraskyit@gmail.com.

Julie Burns is a veteran interpreter trainer, a certified Spanish interpreter (Certification Commission for Healthcare Interpreters), and an ATA-certified Spanish>English translator. She has a master's degree in adult education. A former director of the Bridging the Gap Interpreter Training Program and a licensed trainer for The Community Interpreter®, she has trained thousands of interpreters. She has 20 years of experience in health care interpreting and translation, as well as extensive experience in health education and training in the U.S. and Latin America. Contact: julie@julieburns.net.