

# Takeaway



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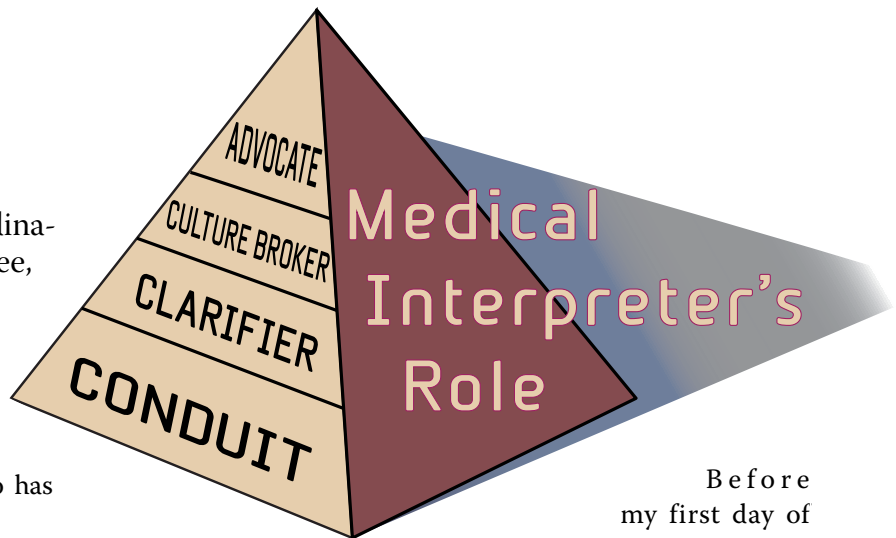
## Taking ego out of volunteer interpreting

When I first met with the volunteer coordinator at a community health clinic in Milwaukee, I was careful not to oversell my abilities.

“I’m fluent in Spanish, but I’m not a native speaker,” I said, stressing those last words *native speaker*. Yes, I know the language. Yes, I’m comfortable in conversation. But no, I’m not going to be as good as someone who has spoken Spanish since before they could walk.

The coordinator was unfazed. After I finished explaining where I picked up the language — started studying it as a kid, Spanish major in college, studied abroad, worked abroad, still use Spanish occasionally for work — her face relaxed into a smile. “You’ll be fine! I’ve had interpreters here who only minored in Spanish and maybe spent, like, a week in Mexico once on vacation.” I was reassured, but also concerned — if I was anxious about my own qualifications, how did any of the volunteers before me get by on only a Spanish minor and a week in Mexico ordering *cervezas*?

I am as fluent in Spanish as I’ll ever be. And yet, the bar still seemed too low for me to start as a volunteer interpreter. For all my skills, I didn’t come to the role with an arsenal of medical vocabulary. Sure, I’d gone to the doctor a few times when I lived in Spain, but before each visit I pored over ailment-specific vocabulary so I could confidently describe my symptoms in the exam room (in doing so, I learned that the Spanish *seno* is a false cognate for *sinus*; do not confuse the two).



Before my first day of volunteering, I bought a laminated cheat sheet with Spanish medical vocabulary and a diagram of the respiratory system, the skeletal system, the muscles. I studied it in the car on a road trip with my in-laws. I found a playlist on Spotify intended for children (“Learn Body Parts in Spanish!”) and listened to a man with a Midwestern accent run through words I already knew, in case I encountered a patient who had a concern about her eyelashes or fingernails or earlobes. All of the vocabulary — every organ and every piece of medical equipment

— needed to be fresh in my mind before my first day.

Of course, on my first day, nobody showed up to talk about eyelashes or fingernails or earlobes. They mostly came to talk about diabetes, which was fine until the vocabulary turned technical and I froze.

PROVIDER TO PATIENT: Next time, please bring your glucometer.

ME TO PATIENT: La próxima vez, favor de traer su... um... glu... co...

PATIENT: ¿Glucómetro?

Oh. That was easy.

Despite my best efforts, I had to accept that there would be words I could never anticipate and scenarios for which I could never fully prepare. As I've continued to accompany patients in the exam room, I've realized that live interpreting is a collaborative process, not a one-woman show. I have the benefit of being in the room with both the doctor and the patient, where the patient can occasionally assure me that they understood the doctor, rescuing me as I fumble with my cheat sheet in the hopes of finding the name of a blood pressure medication.

Even though I'm not a native speaker, for the patients I meet, I am a welcome aid. No one has turned up their nose at me, even when I've needed a minute to verify a word or ask the provider to explain something in a different way (it works just as well to talk about "gum disease," which is easier to interpret, as it does to discuss "gingivitis," which also happens to be the same word in both Spanish and English).

I'm letting go of my pursuit of perfection. It was a quest that only served my own vanity: I wanted to impress my patients with my flawless Spanish. I wanted them to wonder if I'd spoken it all my life. But their needs have nothing to do with my insecurities. Patients want a voice in the exam room, and that's what I am — a conduit helping to keep communication flowing smoothly, even when I can't clear every bump out of the road. [M]

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