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Julie Wechsler April 13, 2021

Motivations of Student Medical Interpreters: Personal, Professional, or Altruistic?

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Abstract

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This study presents an interdisciplinary examination of the role, training, and motivation of undergraduate student medical interpreters. Interpretation is an essential part of an accessible healthcare system; when patients do not speak the same language as their doctors, they face poorer medical outcomes, decreased doctor-patient trust, and a diminished desire to seek medical care. When professional interpreters are not available, patients may rely on *ad hoc* interpreters, but their lack of training can be as detrimental as having no interpreter at all. Student volunteers, however, offer a solution to this problem. While not full-time interpreters, they receive official training, and thus can help fill the need for language services. Despite this particular capacity to help lower language barriers, and though much work has been done in linguistics and medical sociology on the purpose and role of professional interpreters, student volunteer interpreting has not been widely studied. In this work, semi-structured individual interviews with student interpreters were conducted to determine both how and why they volunteer their time to interpret. Using a thematic analysis framework, their motivations were found to fall under three general categories: (1) personal identity, as students often grew up speaking the language they interpret; (2) community engagement, because of the opportunity to make a direct impact on patients; and (3) pre-professional experience, since many of these students aspire to careers in healthcare. A greater understanding of these motivations adds to knowledge about language mediation and validates the utility of students in this role. Beyond the academic implications in linguistics, psychology, and medical sociology, this research also has direct applications for encouraging the development of student interpreter programs. Particularly in communities with high proportions of immigrants, and especially in fields such as healthcare, these students can contribute to making medical care as inclusive and accessible as possible.

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Table of Contents

CHAPTER ONE: INTRODUCTION **1**

CHAPTER TWO: A REVIEW OF THE LITERATURE ON MEDICAL INTERPRETATION **6**

SECTION 2.1: HOW DOES GOOD COMMUNICATION LEAD TO BETTER HEALTH OUTCOMES? 6
SECTION 2.2: WHAT HAPPENS WHEN A PATIENT AND A PROVIDER DO NOT SPEAK THE SAME LANGUAGE? 9
SECTION 2.3: WHO CAN BE AN INTERPRETER? 13
Subsection 2.3.1 Ad hoc interpreters *13*
Subsection 2.3.2 Professional interpreters *14*
SECTION 2.4: THE ROLE OF THE INTERPRETER 17
SECTION 2.5: CURRENT USE OF INTERPRETER SERVICES 19
SECTION 2.6: STUDENTS AS A POTENTIAL SOLUTION 21
SECTION 2.7: UNCOVERING MOTIVATION: BENEFITS AND BARRIERS 24
SECTION 2.8: THE PRESENT STUDY 27

CHAPTER THREE: METHODS **28**

SECTION 3.1: PARTICIPANTS 28
SECTION 3.2: INTERVIEWS 30
SECTION 3.3: DATA ANALYSIS 31

CHAPTER FOUR: PRESENTATION AND DISCUSSION OF RESULTS **34**

SECTION 4.1: THE ROLE OF THE INTERPRETER 34
Subsection 4.1.1 A functional but personally uninvolved intermediary *35*
Subsection 4.1.2 Characteristics of a good interpreter *38*
Subsection 4.1.3 Perceptions of the student role, as compared to professionals *41*
SECTION 4.2: POTENTIAL BARRIERS TO INTERPRETATION 45
Subsection 4.2.1 Training and preparing to interpret *45*
Subsection 4.2.2 Interpreting *47*
SECTION 4.3: MOTIVATIONS AND BENEFITS FOR INTERPRETING 51
Subsection 4.3.1 Identity: Personal background *52*
Subsection 4.3.2 Identity: Aspiring to a career in healthcare *54*
Subsection 4.3.3 Community: Interpreting both for others and with others *60*
SECTION 4.4: GRATIFICATION OF HELPING OTHERS 62
SECTION 4.5: INTERPRETING IS DIFFICULT, BUT DOABLE 66
SECTION 4.6: CONNECTING INTERPRETER MOTIVATIONS TO PSYCHOLOGICAL THEORIES OF MOTIVATION 67

CHAPTER FIVE: IMPLICATIONS AND CONCLUSIONS **71**

SECTION 5.1: HOW MIGHT INTERPRETING AFFECT THE STUDENTS LONG-TERM? 71
SECTION 5.2: HOW MIGHT STUDENTS INTERPRETING AFFECT THE MEDICAL PROFESSION LONG-TERM? 74
SECTION 5.3: HOW MIGHT STUDENTS INTERPRETING INFLUENCE OTHER STUDENTS? 75
SECTION 5.4: STUDY LIMITATIONS 77
SECTION 5.5: FUTURE DIRECTIONS 79
SECTION 5.6: CONCLUSIONS 81

REFERENCES **84**

APPENDIX A: INTERVIEW GUIDE **93**

APPENDIX B: CODEBOOK **94**

APPENDIX C: ADDITIONAL REPRESENTATIVE QUOTATIONS **95**

CHAPTER 1. Introduction

Translation and interpretation are essential tools to help bridge the gaps that language diversity creates. Both are ways to convert one language into another—translation for written language, and interpretation for spoken. Both connect people and communities, increase communication, and foster cross-cultural interaction. These services are useful in a variety of contexts, from personal conversations to court proceedings to commercial advertisements. Translation helps transform entertainment and news into multiple languages, making the world ever more connected, and interpretation changes the words spoken by leaders in one language into others that are more easily understood by people across the world.

In smaller-scale individual settings such as education, the justice system, and healthcare, language barriers may have significant, life-altering consequences. As such, in these settings, both forms of language mediation—translation and interpretation—are not only helpful but indispensable. For healthcare in particular, language barriers are an important issue to target because good clinical communication is critical for ensuring high-quality care (Flores, 2005; Karliner et al., 2007). Since the goal of medical interpreters is to diminish those barriers and help providers better care for patients who speak other languages, in this thesis I present an interdisciplinary study of medical interpretation. The main aim of this work is to identify the motivations of undergraduates who volunteer to be medical interpreters. In uncovering why they are interested in interpretation, why they persevere through the lengthy training, and what they gain from it overall, I bring awareness to a group which may be able to help fill gaps in communication in healthcare.

To address these issues, I examined an undergraduate group at a major Southeastern research university as an example of a successful student interpretation program. To protect the

group's privacy, I will refer to the organization as Student Volunteer Interpreters, or SVI. SVI accepts around ten new students each year and partially subsidizes their participation in an official 40-hour training course led by professional interpreters. They then coordinate volunteer interpreting sessions at a local clinic for Spanish- and Portuguese-speaking patients. With several years of history interpreting in a sizeable metropolitan area and continued recruitment each year of new interpreters, they have shown a sustained commitment to helping Spanish and Portuguese speakers in their community.

Not many groups like SVI exist across the United States, and to my knowledge, very few have been documented in the literature on health communication. On the other hand, much has been written about professional interpreters, especially as they compare to untrained interpreters or to situations without an interpreter at all; such research has revealed the serious gaps in communication that can occur without a qualified language mediator (Flores, 2005). While it is certainly important to know how professional interpreters work and affect healthcare, they are not the only group of trained interpreters that exists. Students like those in SVI, though they may have less interpreting experience than an adult with a multi-year professional career, do receive training from an independent language services agency on how to become an interpreter and thus are much more prepared to help than on-demand untrained interpreters. More work focusing on student interpreters, such as this thesis, is pivotal for understanding differences and similarities between the categories of trained interpreters. While a robust comparison with professionals is beyond the scope of my project, I hope that my focus on students can contribute to increased visibility of student volunteers in the literature and encourage further study of this niche group of interpreters.

With all its complexity and utility, interpretation itself is a rich field of study. In the cognitive sense, it is a fascinating example of the power of the human brain to take in, mold, and produce language in real-time and often high-stress situations. In the social sense, it is a key resource to have—particularly in communities with high proportions of immigrants, and especially in fields such as healthcare—to ensure that adequate communication is possible. This topic has ties to a range of fields, such as linguistics, psychology, and healthcare, each of which informs the background, methodology, and analyses that I employed in my research.

The question of what counts as adequate communication in a medical setting falls squarely in the realm of health communication. Since interpretation is a resource which helps improve spoken interactions in a healthcare setting, assessing the medical interpreter's perspective on their work can provide important insight into not only who is offering that resource, but also how, why, and to what extent it is effective. To accomplish this, it is first necessary to understand the dynamics of an interpreted conversation: how both the interpreter and the interpreted parties interact with each other, and how specific linguistic decisions are made. Asking and answering questions about interpreters targets the underlying theme of learning how language mediation affects communication.

Medical interpretation also relates directly to the sociology of medicine. Language barriers are an example of a social determinant of health; the study of the need for interpretation is thus also a lesson in how healthcare can be exclusionary and difficult to navigate. In the next chapter, I will explore the serious negative consequences of *not* having an interpreter, consequences which are not a risk for those patients who speak the same language as their physicians.

In addition to medical sociology, research in medical (and pre-medical) education informs this work because the interpreters in SVI are students. Most of the volunteer interpreters in this group are on track to become health professionals. This includes anyone with the intent to matriculate into a program of medicine, dentistry, podiatry, optometry, public health, nursing, physician assistantship, or other sects of healthcare. While the specific admission requirements for each of these professions vary, they have in common a strong academic record, leadership, clinical experience, volunteering, regard for others, and observation of those practicing the student's intended career (because of this similarity, I refer to all such students with the label "pre-health"). Volunteering as a student medical interpreter could logically be described as a "super-pre-health extracurricular activity" because it encompasses nearly all of those competencies. As interpreters, students work directly with patients in a clinical setting, which gives them exposure to actual delivery of care; they interact with doctors in the workplace, which is an example of shadowing and can give students an idea of what fields interest them; they learn cultural competency, an essential skill for an aspiring compassionate provider to develop; and they directly serve their community, helping others in a way that is meaningful for them. Learning these skills as an undergraduate interpreter might have important implications for a student's future career.

While interpretation is certainly a worthwhile task because it has the power to make healthcare more inclusive and accessible, it is far from easy. What is it that motivates people to overcome the difficulties associated with interpreting? I ask this question about students in particular because they are uniquely situated along the spectrum of interpreters. More like untrained interpreters in terms of experience, but closer to professionals in terms of official preparation, they interpret neither for a career nor on a whim. They can therefore offer an

interesting perspective into the inherent value of interpreting. The purpose of this research is thus to answer the following question: *How and why do students choose to become trained volunteer medical interpreters?*

Learning more about the costs and benefits of interpretation for the students themselves is useful to determine what most motivates them. While specific motivations will surely vary between individuals, I hypothesize that there will be common themes. Psychology research methods are useful analytic tools to uncover these themes for two main reasons. First, psychology has established the study of general motivation (cf. Carver & Scheier, 1982; Deci & Ryan, 1985; Maslow, 1943), which provides guidance for what may qualify as a good reason for a certain behavior. Theories of motivation can be applied to the particular case of medical interpretation to uncover students' drives. Second, social psychologists have conducted significant work to understand the motivations behind helping and altruism (Jhangiani & Tarry, 2014). Helping others via interpretation requires a great deal of preparation, focus, and skill, and it does not provide interpreters with any tangible compensation; previous work can be useful for explaining why students choose to exhibit this behavior anyway.

A greater understanding of students' motivations adds to knowledge about language mediation and validates the utility of students in this role. Furthermore, beyond the academic implications for linguistics, psychology, medical sociology, and pre-health education, this research also has direct applications for encouraging the development of student interpreter programs at other universities to help fill the need for language services. Before presenting the specifics of this study's methods and findings, I will introduce previous work to more thoroughly explain why it is critical to recognize interpreters as a necessary resource in healthcare.

CHAPTER 2. A review of the literature on medical interpretation

2.1 How does good communication lead to better health outcomes?

In order to understand why interpreters are necessary in healthcare, it is important to recognize both what good communication looks like in a medical encounter and the ways that communication can break down when a language barrier is present.

Though medical encounters range widely in content, the basic components of their structure tend to be consistent. These are an introduction to the patient, a history and description of their current problem(s), a physical exam, discussion of recommendations, and a final wrap-up of the visit (Anspach, 1988; Harvey & Koteyko, 2013; Roter & Hall, 2006). Since the topic at hand is the patient's health, each aspect of the interaction is usually more focused than a casual conversation. The general purpose of these visits is four-fold: to obtain information, to advise and educate the patient, to address the patient's emotional state, and to encourage them to be involved in the interaction (Roter & Hall, 2006). To accomplish this, each participant—both the doctor and the patient—is essential, as is their connection through the conversation. Roter and Hall argue that both physician and patient are "experts" in their own way. The doctor, having undergone medical training, knows a great deal about medical issues and solutions. The patient, knowing their own history and being the one who actually experiences those medical issues, knows the most about their exact physical situations and any life details relevant to their health.

A classical view of medicine tends to place more emphasis on the doctor's expertise than on the patient's, thereby granting the doctor the greatest power in the interaction. Since providers know what sort of information is important, they construct the interaction in a way that will achieve their ends: not only are they deliberate with their own questions, but they also direct how the patient should respond, even if that neglects the importance of the patient's natural

contributions (Mishler, 1984). Though the motive for this is clear to the doctor, it may make the conversation feel unnatural or disconnected from the patient's point of view (Harvey & Koteyko, 2013). Doctors guide the conversation to such an extent that their speech has even been described as "repressive" of the patients' views (Anspach, 1988). It is true that without the doctor's knowledge and experience, there could be no treatment solutions, but it must also be acknowledged that without the patient's perspective, the doctor would be at a loss for what to even treat. As such, a hallmark of good communication in a medical interaction is valuation of both the patient's and the doctor's input, with active listening and participation from both sides.

Along with information gathering, medical visits involve doctor explanations and patient questions. An effective interaction should ensure that the doctor has sufficiently explained the patient's condition and treatment, and it should also allow space for patients to clarify anything that they are unsure about. Better understanding on the part of the patient as a result of that enhanced information sharing is associated with improved compliance (Roter & Hall, 2006). In addition to the specific topics of conversation involved in good health communication, nonverbal cues also play a role in medical encounters. Friendly or positive gestures, facial expressions, body language, and tone can all contribute to a patient's sense that the doctor cares about them, which in turn is reflected in higher satisfaction ratings (Roter & Hall, 2006).

It makes sense that if a patient feels heard and valued, as well as confident that they comprehend their medical circumstances, they would also feel more positively about their medical care. Indeed, when these factors of good communication are present, patients tend to report greater satisfaction with their physician visits (Roter & Hall, 2006). When patients are satisfied, doctor satisfaction increases too, as do positive outcomes such as compliance with the treatment plan and likelihood of returning to seek care (Roter & Hall, 2006). It has even been

shown that better doctor-patient communication is associated not only with improved perception of the visit and more positive emotions toward the healthcare system, but also with actual physical health improvements, such as mitigated symptoms and better-controlled clinical correlates of conditions like diabetes and hypertension (Stewart, 1995, as cited in Roter & Hall, 2006, p. 159). Simply put, better communication leads to better outcomes. This reinforces the notion that strong communication relies on a true *interaction* between doctor and patient, not just one or the other. Furthermore, it reveals that positive, effective communication has a real impact on the patient experience and can have striking effects on a patient's future care.

All of the aforementioned positive consequences that result from good communication presume that doctors and patients speak the same language. A review of work on language concordance by Diamond et al. (2019) confirms that in situations where patients and doctors do share a language, patients' perception and outcomes—understanding of their medical condition, adherence, and satisfaction overall—are improved. In an ideal world, this would apply to all patients, irrespective of language; if doctors could speak all languages with native-level proficiency, they could draw on their professional training to inform the medical side of the conversation while also dialing into the cultural and social factors associated with other languages to create a comfortable, trusted environment. Unfortunately, considering the sheer number of languages that exist in the world—more than 7,000, according to the Ethnologue (Eberhard et al., 2020)—it is impossible for one doctor to know every language that patients may speak. This being the case, interpreters are the next-best solution after language-concordant providers for solving language barriers.

2.2 What happens when a patient and a provider do not speak the same language?

Although most individual medical schools and even the Association of American Medical Colleges (AAMC) do not explicitly require English proficiency, one must have strong proficiency in English to become a doctor in the United States. Most institutions have English coursework as a prerequisite for admission; the Medical College Admissions Test (MCAT) and United States Medical Licensing Examinations (USMLE) are only offered in English; communication and writing skills are often explicitly required competencies for medical schools, with the implication that those assets are English-based; and schools generally only conduct their curricula in English. This trend continues beyond medical school, too, since to be eligible to take the U.S. board certifying exams, doctors who did their medical training abroad must prove their English proficiency (Educational Commission for Foreign Medical Graduates, n.d.). Because it is difficult for someone who does not speak English well to become a doctor in this country, English-speaking patients generally do not have to strain to find a language-concordant provider.

However, not all patients speak English—far from it. The United States Census Bureau has found that 350 languages are spoken in this country (U.S. Census Bureau, 2015). According to a recent American Community Survey's (ACS) 5-year estimate, 21.6% of the U.S. population speaks one of these languages other than English at home (U.S. Census Bureau, 2019). The census's data collection methods identify those who are Limited English Proficient, or LEP, as "the population 5 years or older who self-identify as speaking English less than 'very well'" (U.S. Department of Justice, 2020). At the time of this ACS estimate, 8.4% of the population older than 5 years qualified as LEP, amounting to more than 25 million people who may have trouble navigating the English-speaking healthcare system (U.S. Census Bureau, 2019).

In addition to the difficulties that come with language differences generally, parsing all the forms of communication in healthcare can be challenging even if patients do speak the same language as their doctors. *Health literacy* is defined as “the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others” (Office of Disease Prevention and Health Promotion, 2020). Whether patients have difficulty reading health information, have little access to it, or are otherwise prevented from understanding it—as is the case for LEP patients—their resulting decrease in health literacy can hinder their participation in the healthcare system. For example, untranslated signs, pamphlets, infographics, and intake forms can interfere with patients’ ability to navigate hospitals and clinics, understand their care, and provide accurate information (Karwacka, 2014). In fact, studies have found that lower health literacy is often associated with more negative health outcomes, as has been observed in diabetes (Schillinger et al., 2002) and heart failure (Peterson et al., 2011). (See Berkman et al. [2011] for a review). With measures in place to increase health literacy, such as translation for LEP patients, patients can become more informed about their care.

Health literacy certainly pertains to written information, but inasmuch as its definition also includes the use of health services, it applies to spoken interactions, as well. When conversations between doctors and patients who do not speak the same language are left uninterpreted, it is much more difficult to obtain the previously mentioned positive outcomes and markers of good communication. There is a large body of research on the issues that arise when interpreter services are not used for LEP patients. If a patient does not speak the doctor’s language at all, or only speaks very little of it, they may be less able or more hesitant to provide important medical details. An inability to accurately explain or understand the situation can have

consequences ranging from missing small facts about a patient's history, to failing to obtain informed consent, to misidentifying and incorrectly treating specific symptoms (Flores et al., 2000). One of the most striking examples mentioned in the literature is the story of a young man whose expression of feeling "intoxicado" (dizzy) was misunderstood as "intoxicated." This led to his being treated for a drug overdose instead of the actual problem, a brain aneurysm, tragically resulting in complete paralysis (Harsham, 1984, as cited in Ku and Flores, 2005, p. 437, and Flores et al., 2000, p. 847). In another case, an error in understanding a mother's speech led to an incorrect suspicion of child abuse and a subsequent decision about custody of the child without the mother's informed consent, when the injury had really been an accident, a fact made clear when an interpreter was finally involved (Flores et al., 2000). In addition to physical health complications that can arise from a lack of language support, mental health encounters are also impacted by language barriers; without an interpreter, diagnoses may be less accurate and more severe in some situations (Flores, 2005). While these cases are extreme, they underscore the importance of interpreters, since even small details being misunderstood can lead to significantly deficient medical care.

The fact that there is a third party in a two-person conversation necessarily interrupts normal conversational flow, so interpreted visits may not be perfectly equivalent to language-concordant ones. Nevertheless, substantial previous research has shown that having an interpreter markedly increases the caliber of communication between language-discordant doctors and patients. For instance, Karliner et al. (2007) found that accuracy of diagnosis, patient understanding of their conditions and treatment, and adherence to treatment recommendations all improve with an interpreter. Patient satisfaction, too, increases when an interpreter is present (Flores, 2005; Karliner et al., 2007; Schenker et al., 2012). Interpretation also appears to

encourage improved follow-up care, as indicated by increases in later trips to the doctor, obtainment of medication, and employment of preventive health measures such as screenings (Flores, 2005; Jacobs et al., 2001; Karliner et al., 2007). Further work has found that when they had an interpreter, LEP patients' clinical markers, such as diabetes metrics, were more similar to those of English-speaking patients with the same condition (Tocher & Larson, 1998, as cited in Karliner et al., 2007, p. 737). Therefore, interpretation is useful both subjectively in the sense that the interaction feels more comfortable for the patient, and objectively in that it improves concrete medical outcomes.

In addition to bringing LEP patients much closer to the level of English-speaking ones in these realms, interpretation also reduces the cognitive load on both patients and providers. While patients may be grateful for the doctor's attempt to speak their language (or vice versa), the burden of trying to speak another language can exacerbate the language barrier and lower the overall quality of care (Hsieh, 2006; Prince & Nelson, 1995; Schenker et al., 2012). Though bilingual physicians, nurses, and other medical staff may be asked to step in to interpret, that draws them away from their own work, which is not ideal (Chen, 2006; Hsieh, 2015). Along with the accuracy and knowledge that an interpreter can provide, therefore, having a separate party to focus on the language allows providers to attend to their main responsibilities and patients to their chief complaints (Aitken, 2019; Schenker et al., 2012).

Since LEP patients constitute a measurable proportion of the population, institutional language support is warranted. Good healthcare should be a given, and to provide it only to patients who have a grasp of the dominant language (or to provide markedly better care to those patients) is to exclude a diverse and sizeable subset of the population. Medical interpreters offer a solution to this problem; by being knowledgeable in medical topics in both languages, they can

enhance the quality of communication to the extent that it approaches that of a language-concordant interaction.

2.3 Who can be an interpreter?

Technically, the term "interpreter" can include anyone who attempts to interconvert spoken languages between two people. Although the label can be applied to a variety of people, not all interpreters are equivalent. They tend to fall into two categories: *ad hoc* and *professional*. I will first explain the difference between an *ad hoc* and a professional interpreter, and then argue that trained student interpreters should be seen as a category distinct from either of these.

2.3.1 Ad hoc *interpreters*

An *ad hoc* interpreter is anyone who steps in for a particular circumstance to interpret (Hsieh, 2006). This could be a friend or family member who accompanies the patient to an appointment, another medical provider or hospital employee whose main function is not as an interpreter (e.g., a nurse or staff member), or a bilingual stranger who is called in unexpectedly to interpret. *Ad hoc* interpreters' services can often be sought much more quickly and conveniently than those of a professional, which is one of the main reasons they are used (Diamond et al., 2008).

In spite of their accessibility, *ad hoc* interpreters' lack of training means that they cannot reliably provide the same quality of care that a patient deserves. There are some arguments in support of *ad hoc* interpreters as being "better than nothing," but non-professionals have been shown to be no different from not having an interpreter at all, at least in terms of the number of serious errors made (Flores et al., 2012). Even if the patient is able to deduce the meaning of a

mistaken phrase, or the error in question is not very significant to the visit as a whole, small inaccuracies add up to lower quality communication. Whether they are marginally better than no interpreter or tantamount to having no interpreter at all, *ad hoc* interpreters certainly cannot guide the interaction to the extent necessary.

Even worse, they can actually negatively impact the interaction in several ways. The most common problem seen with *ad hoc* interpreters is that they often leave out important information and make mistakes that could have serious consequences, more so than a professional interpreter (Flores, 2005). Familiarity with the patient, an advantage that professional interpreters do not have, could make the patient more comfortable. But that, too, can have dangerous implications: children may not want to give bad news to their parents, family members may not want to cross privacy barriers with other relatives, and someone familiar with the patient may forget to convey information that is obvious to them but not the doctor, such as allergies or previous conditions (Haffner, 1992; Schenker et al., 2012). The interpreter is left to judge what information is important, and without proper training, there is no guarantee they will remain faithful to the speaker's original utterance. Interpreting in this way is thus problematic because of a lack of training and, if the *ad hoc* interpreter is close to the patient, a concomitant lack of emotional objectivity. These deficits, combined with the potential decrease in quality of care, are reasons to avoid using untrained *ad hoc* interpreters.

2.3.2 Professional interpreters

The label "professional interpreter" may be applied to anyone who interprets on a full-time, paid basis, whether they are employed by a hospital or clinic or their work is a freelance job (Davidson, 2000). In contrast to *ad hoc* interpreters, professionals undergo direct education

about the theories behind interpretation and why it is important, as well as practical instruction to ensure that they effectively convey the patient's and doctor's messages. Concrete interpreting skills build on existing linguistic competence to convert someone from a bilingual person to a true interpreter, and the accompanying theoretical material provides context and a "why."

The National Council on Interpreting in Health Care (NCIHC) is an organization which sets U.S.-wide guidelines for medical interpreting, including standards for interpreter training programs (2011), as well as a code of ethics (2004) and a set of standards of practice (2005). Having such recommendations ensures that all trained interpreters are equipped with certain knowledge and practices.

The first important aspect of training is that it teaches prospective interpreters how to interpret, which is an exceptionally complex ability. Conversations with an interpreter are not like casual, everyday conversations. With three people in a two-person interaction, the interpreter's job is not to add new information as a conversational participant, but to convey what has already been said in another language. Rather than simply using a language they grew up speaking, interpreters essentially have to learn a new way of communicating: new concepts, new conversational pacing, attention to every detail, and an awareness of the responsibilities that come with the role of the interpreter. The interpreter must make quick decisions—selecting specific words, adjusting grammatical structures, being as accurate as possible, and addressing cultural differences—so they must be familiar with every level of both languages, from individual word meanings to culture-specific slang to different styles of speech. In teaching interpreters how to make these decisions, the training emphasizes confidentiality, accuracy, and patient advocacy. Interpreters are taught how to position themselves in the medical environment,

both literally (learning where the interpreter should stand relative to the patient and the provider) and figuratively (identifying their role in the medical interaction).

To effectively interpret, an interpreter has to know not just *a* language, but the language of the setting in which they interpret (Kelly & Zetzsche, 2012). Conversations in medical settings have such specific (and often complex) content that basic language proficiency is a necessary but not sufficient qualification; learning the specific medical concepts and terminology they will be speaking about distinguishes them from *ad hoc* interpreters, who lack such specialized knowledge.

Training also makes interpreters aware of more abstract issues, such as the importance of interpretation, the inner workings of the U.S. healthcare system, and cultural sensitivity (NCIHC, 2011). The latter issue is particularly important for creating a mutually understanding environment; while the cultural context that a patient brings to a visit can play a role even when patients and providers speak the same language, speaking a different language comes with even greater likelihood of cultural differences. A variety of practices and beliefs can influence the interaction, such as ideas about where illness comes from, discomfort with asking personal questions, potentially offensive gestures and phrases, varying styles of speech, and stigmata around mental health or other conditions (Hudelson, 2005). Varying styles of communication, too, can affect the interaction, such as differences in patient autonomy and decision-making, perceptions of the doctor's personality, and the flow of the interaction (Flores et al., 2000). Through deliberate training, interpreters learn to carefully navigate potentially delicate situations.

In accordance with the NCIHC recommendations, interpreters can receive their official credentials after passing both a written exam and an oral exam from one of two national certifying organizations, the National Board of Certification for Medical Interpreters and the

Certification Commission for Healthcare Interpreters (NCIHC, n.d.). To be eligible to take these exams, one must prove their language proficiency and have completed at least 40 hours of dedicated interpreter training beforehand (Certification Commission for Healthcare Interpreters, n.d.; National Board of Certification for Medical Interpreters, n.d.). There is some disagreement on the extent of preparation required to get an interpreting job (some employers require one of the national certifications while others accept smaller-scale certificates such as the 40-hour course SVI students take), but considering the importance of successful interpretation, some type of official certification attesting to an interpreter's preparation is critical for providing the best language support (Aitken, 2019). Because training furnishes interpreters with tools to grapple with the various aspects of interpretive communication, it sets professionals several steps above *ad hoc* interpreters in terms of their capacity to render a close interpretation of doctors' and patients' speech. It is thus critical to call upon not *ad hoc* interpreters, but those who have actually undergone official certification when seeking help for a patient.

2.4 The role of the interpreter

Although interpreter training curricula intend to teach prospective interpreters the role of the interpreter (Angelleli, 2014), this position is complex and its exact nature is still a topic of debate. Some definitions employ the broad terms "communication facilitator" (NCIHC, 2004) or "bridge" (Hudelson, 2005), both of which refer to fact that this position links people who do not share a language. Some suggest that an interpreter is a "conduit" (Sleptsova et al., 2014), a completely neutral party whose singular role is to interpret every word exactly as it was originally said. Others emphasize the "cultural [broker]" aspect of the role (Monroe & Shirazian, 2004), which spotlights the interpreter's bicultural identity as an asset to narrow possible cultural

lacunae between provider and patient. Still others include "message clarifier" and "patient advocate" (Hasbún Avalos et al., 2013), painting the interpreter as a more active party who notices when a patient or doctor does not understand (or is in some other way at a disadvantage), then intentionally uses their platform to resolve confusion or advocate for the patient. As the diversity in definition shows, interpretation is multifaceted; it requires excellent facility with both languages, strong knowledge of specific vocabulary, a grasp of both cultures, and a certain degree of agency. Although interpreters are meant to operate with the goals of "impartiality and invisibility" (Sleptsova et al., 2014), fulfilling their duty fully means that they are not simply an auxiliary part of the interaction who can just be ignored. Instead, they are an integral part of the conversation; without them, good communication would not be possible.

Previous work on health communication indicates that because of their status as care providers, doctors are perceived as more knowledgeable and as sources of authority, thus claiming the most power in a medical conversation (Anspach, 1988; Harvey & Koteyko, 2013). The added language disparity present in a language-discordant interaction might imply that providers hold even more of the agency in that situation, since patients are less able to convey their situations. However, in an interpreted conversation, perhaps surprisingly, the power dynamic shifts not to the provider but to the interpreter. Hsieh (2006) maintains that

> The nature of bilingual health communication implicitly guarantees that an interpreter will be the most powerful person in a medical conversation because the interpreter is the only person who understands the two languages, determines what should be said or heard, and is vested with rights to interrupt others' utterances. (p. 184)

Equipped with this power, it is the interpreter's responsibility to leverage all of their assets—knowledge of language, culture, and the medical setting, plus their training—to facilitate effective communication for all those involved (Davidson, 2000).

2.5 Current use of interpreter services

The Civil Rights Act of 1964 contains a section, Title VI, which "prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance" (U.S. Department of Justice [DOJ], 1964). A subsection of this legislation, Executive Order 13166, was enacted in 2000 to specifically address limited English proficiency services and states the following:

> The Executive Order requires Federal agencies to examine the services they provide, identify any need for services to those with limited English proficiency (LEP), and develop and implement a system to provide those services so LEP persons can have meaningful access to them. (U.S. DOJ, 2000)

As a consequence of this legislation, any group that is funded by the government must ensure that language services, including both written translations and spoken interpretation, are available for those who need them.

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care, last updated in 2013, provide concrete suggestions for implementing linguistic supports in healthcare. With suggestions like providing language services at no cost, encouraging diversity in different health sectors, and working with communities to best serve their needs, their aim is for organizations "to advance health equity, improve quality, and help eliminate health care disparities" (Office of Minority Health, 2013). National recognition of

language as a barrier, as well as specific guidance for how to address this issue in healthcare systems, is a good way to encourage support for LEP Americans.

Despite the precedent that legislation sets, linguistic resources remain inadequate in some cases. Certain healthcare institutions may not have the financial means to support robust language services; they may not be able to afford to pay full-time staff interpreters or independent interpreting agencies, or they may lack the technology to support audio or video remote interpreting, a common alternative to in-person interpretation (Laur, 2016). If this problem is to be solved, discussions between providers, institutions, and insurance companies must take place to assess how sufficient resources can be allocated to interpretation services (Chen, 2006).

Depending on a particular institution's circumstances, financial concerns may be legitimate, but a recent review of the costs of interpreting found that in general, interpreting did not increase an institution's expenses dramatically (Brandl et al., 2020). The benefit—that interpreters can bring LEP patients up to the communicative level of a language-concordant patient—outweighs the slight costs. Furthermore, considering that lack of an interpreter could lead to excess spending on measures like unnecessary testing, longer hospital stays, or medical malpractice suits, paying for interpreter services would save those additional costs and contribute to better financial health in the long term (Ku & Flores, 2005).

Even in cases where the cost of interpreter services is less of an issue and a hospital system has some staff interpreters, their immediate assistance is not guaranteed. Doctors may not anticipate the need enough in advance to request an interpreter, or it may be difficult to find one, because the patient's language is not covered or because there are not enough interpreters available at once (Hsieh, 2015; Karliner et al., 2004; Schenker et al., 2011). Having to wait for

an interpreter can lead to inadequate care; for example, if a doctor has to wait a while for an interpreter before asking about level of pain, patients may be provided with insufficient pain medication (Hsieh, 2015). Limited accessibility to interpreters is therefore one reason why they may not be called upon.

Despite these potential issues, physicians report feeling better about the care that they give when they use an interpreter and that they can still connect with patients in these interactions (Karliner et al., 2004). If the problem is that there are not enough people around to interpret—such as in rural communities or smaller clinics—increased presence of interpreters can help alleviate the pressure on current interpreters to work faster. Although phone or video remote interpreting can be useful, it may not be ideal; Hsieh (2015) notes that “There are situations where a provider may prefer an untrained on-site interpreter over a professional telephone interpreter, who is unable to provide the emotional support needed” (p. 79). If on-site interpreters were more easily accessible, doctors would not have to decide whether to sacrifice professionalism or in-person empathy. In that sense, increasing the presence of interpreters at these facilities may help increase good communication and the positive outcomes associated with interpreter use.

2.6 Students as a potential solution

Undergraduates who interpret through a university student organization offer a solution: they are trained, they are volunteers, and they are interested in aiding the community in a way related to healthcare. Each of these characteristics makes them well suited to fill the need for language services at local hospitals and clinics.

Though not full-time professionals, trained student interpreters do receive official instruction in the terminology, ethics, and logistics of interpreting. Teaching young people what it takes to interpret not only makes them more effective language mediators, it also increases the visibility, awareness, and appreciation of interpreters, which may help increase language services in the future. However, only a handful of programs that train students to be medical interpreters have been documented in the literature (Loyola University Chicago Stritch School of Medicine [Aitken, 2019], Icahn School of Medicine at Mount Sinai [Aitken, 2019; Diaz et al., 2016], Penn State College of Medicine [Vargas Pelaez et al., 2018], and Brown University [Monroe & Shirazian, 2004]). Of these, most are for medical students, and only one (Monroe & Shirazian, 2004) includes both medical and undergraduate students. Programs do exist for college students to interpret, but these are mostly in other, non-healthcare settings (e.g., Schuster, 2014). Studying SVI, the group on which this thesis focuses, thus adds to the dearth of scholarship regarding undergraduate students interpreting in healthcare.

These extant student interpreting groups have implemented their own individual training programs, ranging from courses designed specifically for those schools, to abridged existing training programs, to more informal training sessions. Although they range in duration (from a few hours to 80 or more), most programs include live practice and some form of assessment at the end, a quality measure assuring that the students are prepared to begin interpreting on their own. As a result of having participated in the training, students in some of these other programs felt more comfortable interpreting, more easily grasped the purpose of an interpreter, and improved their medical vocabulary (Diaz et al., 2016; Vargas Pelaez et al., 2018).

SVI is unique in that its students undergo a 40-hour official training course administered by an independent provider called ALTA Language Services. After passing SVI's internal

application and interview stages, selected students spend their first semester in SVI completing the course, which normally is spread over five eight-hour learning days with the rest of their SVI cohort (about ten people). Because of the COVID-19 pandemic, in-person training in 2020 was suspended, so the most recent class of interpreters went through the ALTA training in an online format. While the modality of instruction changed and the online version of the course included people not in SVI, the content was the same as if it had been in person.

Like the professional programs mentioned previously, the ALTA course includes lessons on a variety of topics, such as the role of the interpreter, medical terminology and concepts, ethical considerations, access to language services, and preparation for certifying exams (ALTA Language Services, 2020). ALTA's course, offered in 42 languages, is not aimed specifically at students; rather, anyone who speaks English and one of the available languages can participate. At the conclusion of the program, interpreters are awarded their official certification, which fulfills the requirement of 40 hours of training mentioned earlier as being required for the national examination. Therefore, although SVI student volunteers are not nationally certified, they have completed the same preparation expected of a nationally certified interpreter. Having formally learned to interpret, students work in a manner much closer to a professional than an *ad hoc* interpreter can. Furthermore, as a corps of trained interpreters who have all received the same instruction, these students can contribute to providing a similar level of care to all patients, even across interpreters.

Offering their services without expectation of payment, students augment the trained interpreter workforce without also adding to the expenses associated with hiring professionals. In addition to interpreting out of a desire to volunteer, students who already have an interest in healthcare may be more likely to have a genuine interest in medical interpreting; it is an

opportunity to provide linguistic support while also being exposed to a field they would like to pursue as a career. Learning the medical material in training early on may help them with pre-health classes, standardized tests throughout medical education, and professional school courses (or, conversely, entering the medical concepts section of the training with an existing knowledge of biological systems from their health-related coursework may make that portion of the course more familiar). College student interpreters also have a slight advantage over medical student interpreters in that the latter may experience role confusion between their duties as interpreters versus as medical trainees; if they focus on eliciting specific information from a patient, which they know is useful as a result of their medical education, they may fail to interpret as accurately (Aitken, 2019). Thus, recruiting students who have similar interests and motivations to a medical student but who do not yet have that conflict (such as undergraduates) may be an effective way to increase interpreter presence without compromising the quality of the interpretation.

2.7 Uncovering motivation: Benefits and barriers

One reason why there is little existing work on student medical interpreters is perhaps that for many students, costs such as time and effort outweigh the benefits such that they do not find it worthwhile to start interpreting. Since organizations like SVI do exist, however, through this thesis I aim to learn what pushes students in these groups to interpret, taking a psychological view of their motivations. Like emotion, personality, and other topics in psychology, researchers have tried to explain motivation through a variety of theories. With such a breadth of work and little consensus, it is useful to provide a brief overview of the theoretical and methodological background of studying motivation before attempting to analyze the specific case of student interpreters.

According to the American Psychological Association (APA), one definition of motivation is “the impetus that gives purpose or direction to behavior and operates in humans at a conscious or unconscious level” (APA, n.d.). Often, motivation is explained evolutionarily, with behaviors linking to biological needs and propagating one’s genes. Such drives are termed *primary needs* (Cofer & Petri, 2020), but motivation is not limited to these life-sustaining activities. *Secondary needs*, in contrast, are unrelated to basic physiological drives; they are learned and more socially inclined (APA, n.d.; Cofer & Petri, 2020). Since providing medical interpretation obviously does not determine a person’s biological fitness, it is best classified in this latter category.

The drive to interpret also fits better with the following alternative APA definition of motivation: “a person’s willingness to exert physical or mental effort in pursuit of a goal or outcome” (APA, n.d.). In addition to factors that encourage behavior, this definition raises the idea of what might *discourage* it. Since interpretation involves training and a sizeable time commitment, it clearly requires effort, and that could theoretically prevent someone from interpreting. I aim to understand where the “willingness to exert” such effort comes from, or in other words, what the students’ ultimate goals of interpretation are.

Motivation can be studied through a number of research methods, both quantitative and qualitative. While quantitative data can help answer specific questions more definitively, a strength of qualitative methods (like interviews, which were employed in this study) is that they provide more robust information about personal experiences (Price et al., 2013). In this way, qualitative research can account for the variety of motivations that may exist for individuals.

A few key investigators have contributed to the development of motivational theories. Maslow’s idea of a hierarchy of needs (1943) states that humans experience a range of

motivational factors, but that basic physiological needs must be fulfilled before shifting to higher-order ones. Deci and Ryan's work on Self-Determination Theory (1985, 2020) focuses mainly on such higher-order needs, arguing that humans strive for autonomy, competence, and relatedness. Freud's psychoanalytic theories (1922) take a different route, positing that it is unconscious urges that determine behavior, rather than primary or secondary needs. Because interpretation has both benefits (such as helping others or getting clinical experience) and barriers (such as training and time commitment), another theory of motivation, initiated by Harlow (1949, as cited in Pink, 2011) and later continued by Deci (1971) is relevant: intrinsic and extrinsic motivation.

Intrinsically motivated activities are genuinely enjoyable and continued because of one's inherent interest in them (Harlow, 1949, as cited in Pink, 2011, p. 3; Ryan & Deci, 2020). Extrinsically motivated behaviors, on the other hand, are completed for other reasons, rather than just for their intrinsic value (Ryan and Deci, 2020). This type of motivation is often associated with monetary rewards, but feelings of obligation or even positive verbal feedback are also considered extrinsic motivators (Deci, 1971). I hypothesize that if a student is *intrinsically* motivated to interpret, she might find it fulfilling, exciting, or satisfying to be providing her language services. If a student is *extrinsically* motivated to interpret, she might instead be doing so because she can put the activity on her résumé, or because she is required to participate in a certain number of service hours, or even because her supervisor congratulates her every time she finishes an interpreting session. In studying student motivation, one could explore whether an *internal* desire to interpret or an intent to gain the *external* rewards associated with interpreting is the stronger impetus; but in reality, intrinsic and extrinsic motivation are not mutually exclusive, so I expect to find a blend of these factors, rather than a strict dichotomy. While this qualitative

study of motivation does not pretend to reveal universal truths about motivation, it does contribute to the larger questions of why and how people choose to overcome effort and perform a behavior such as volunteering.

2.8 The present study

There are several challenges that come with interpreting which may discourage students, but as evidenced by the fact that groups like SVI exist, these challenges are not insurmountable. This study aims to understand the balance between the positive and negative factors explained above and how they contribute to a student's decision to become an interpreter. Exploring the students' motivations about all of these considerations will provide valuable insight into what drives them to keep going, despite the arduous preparation and potentially trying scenarios involved in interpretation.

Because previous research shows that interpretation is worth the effort in terms of patient outcomes, finding out why current interpreters choose to interpret is a way to learn more about the interpreter role overall. In speaking with SVI interpreters, I expected to see motivations similar to those outlined above, such as a desire to help others and to gain pre-health experience. Purposefully examining student volunteers brings them to the forefront of the conversation on interpretation, which has so far only touched upon this demographic in a few cases.

Although the role of the interpreter is to be relatively invisible, failing to notice them does a disservice to the amount of effort and dedication that goes into interpreting. Since interpreters give voice to patients, I hope through this thesis to uplift their voices and place due value on their work.

CHAPTER 3. Methods

To study the motivations of student interpreters, I conducted interviews with SVI members. This study was evaluated by the Emory Institutional Review Board and determined to be exempt from further review. Informed verbal consent was obtained at the start of each interview, which all took place between September and December 2020. The qualitative interview data was coded and analyzed for themes following the process of thematic analysis (Braun & Clarke, 2006), with a focus on the students' motivations and perceptions of the role.

3.1 Participants

As I am an outsider to this group, I obtained a list of current Student Volunteer Interpreters members from the SVI Executive Board and contacted those students individually via email about participating in the study. Out of the relatively small group of interpreters (approximately thirty), seventeen responded with interest and participated in interviews. Each was compensated with a $10 gift card emailed to them after the conclusion of data collection. Two spoke Portuguese and the rest spoke Spanish, and all self-described as having a very strong grasp of the language ("fluent," "native," "proficient," or the like). Some were born and currently reside in the U.S., others were born abroad and moved to the U.S., and the rest were international students who still currently live elsewhere but come to the U.S. to attend college. All asserted that they have spoken the language at home throughout their lives. Places where students live or have lived include Mexico, Cuba, Ecuador, Venezuela, El Salvador, Honduras, and Brazil. Twelve of the seventeen were female, and the average age was 19 years old. Table 1 lists these demographic characteristics.

Table 1. Demographic characteristics of SVI interviewees.

Demographic characteristics	**Number of students (%)**
Age	Avg. = 19.4 (range: 18-21)
Gender	Female: 12 (70.5%) Male: 5 (29.4%)
Ethnicity*	Hispanic: 4 (23.5%) Hispanic/Latinx: 7 (41.2%) Latinx: 4 (23.5%) Mexican: 1 (5.9%) Did not respond: 1 (5.9%)
Year in school	First-year: 2 (11.8%) Sophomore: 6 (35.2%) Junior: 5 (29.4%) Senior: 3 (17.6%) Post-graduate: 1 (5.9%)
Career interests	Medicine: 8 (47.1%) Medicine + other (business, public health): 4 (23.5%) Nursing: 2 (11.8%) Dentistry: 1 (5.9%) Undecided healthcare: 2 (11.8%)

*Students were asked about their ethnicity in an open-ended fashion, which is why there is some variability in their responses.

Because the yearly application process for SVI occurs early in the fall semester, seven participants were new interpreters completing the training at the time of the interviews; none of these new interpreters had yet had the opportunity to interpret in clinics. The remaining ten were at least second-year students who had completed the fall training course in the past and had interpreted with SVI for at least one full semester. These students ranged in experience, as some had interpreted several times over the course of their time in SVI, while others were new interpreters during the 2019-2020 school year and so had fewer exposures. The latter group may have only interpreted once in person (or not at all) before the COVID-19 pandemic caused all in-person interpretation sessions to be canceled in Spring and Fall 2020. The resulting shift to on-call remote interpretation meant that interpretation sessions were more intermittent for all members of the group. Despite the potential differences in amount of experience, I refer to these

ten students in this thesis as a single group of "more experienced" interpreters because they have more interpreting exposure than the students going through training. Importantly, all the interviewees were committed members of SVI at the time of the interviews and either had completed or were in the process of completing the required 40-hour training course.

According to the SVI Executive Board, there is no preference for class year during the selection of new interpreters, so each new group can include students of any year. The distribution of class year for this sample was skewed to the middle: two first-years, six sophomores, five juniors, three seniors, and one past member who graduated recently.

3.2 Interviews

The interviews were conducted in English and followed a semi-structured format, starting with an introduction to the study and informed verbal consent. The interview then proceeded with obtaining the participant's demographic information and Spanish or Portuguese language background followed by interview questions. These focused on participants' initial reasons for joining and a description of that process (e.g., *When did you first get involved in SVI?*); how the interpretation sessions typically proceed, including specific memorable examples (e.g., *Describe a typical encounter with a patient and doctor.*); a discussion of the benefits and challenges they face while interpreting; what their role entails (e.g., *How do you see yourself in comparison to professional interpreters?*); information about being a member of SVI (*Please describe your interactions with the other student members of SVI.*); as well as a request for their advice for other student interpreters. The interview guide was adjusted slightly for newer interpreters to accommodate for differences between the groups (see Appendix A for the full interview guides for both groups).

Interview questions were designed based on themes that were identified from the existing literature, as well as the goals of this project; they were meant to cover the personal experience and motivation of the interpreters, as well as their perception of their role. Participants were encouraged to give examples and share details as they saw fit, and the order of the questions was loosely followed. Each interview was conducted and recorded over Zoom and lasted 30-60 minutes (average: 36 minutes). *Otter.ai* software, integrated into Zoom, was used to auto-transcribe the recordings, and those raw transcripts were checked against the video recordings to correct minor errors and ensure accuracy of the transcriptions.

3.3 Data Analysis

After the interviews were completed, I began to analyze the qualitative data through a thematic analysis approach, as laid out originally by Braun and Clarke (2006) and later described by Kiger and Varpio (2020). Thematic analysis is a flexible method for analyzing qualitative data that focuses on finding salient themes from a set of qualitative data; because my data was in the form of individual interviews, with students giving many rich examples and explanations, it was an ideal framework for going about my analysis, as trends and commonalities could be more clearly pulled out of the corpus. First, I examined the data several times so as to engage deeply with what the students said: I took notes during the interviews, then manually checked the transcriptions, then reviewed all transcripts looking for codes and themes. As I reviewed the data, I created codes by noticing commonalities and recurring concepts, such as type of motivation, experiences while interpreting, and perceptions of the interpreter role.

The codebook (see Appendix B) was split into four main sections: *Demographics*, covering age, gender, ethnicity, major, career interests, and language background; *Specifics*

about interpretation, including the logistics of interpreting, the benefits to patients and doctors, the difficulties, the role of the interpreter, the role of language in the interaction, and personal experiences interpreting; *Motivations and benefits*, focusing on the reasons SVI members express for interpreting and what they get out of it; and *SVI specifics*, involving details relevant to the students' experience as a SVI member, such as descriptions of the application and interview process, their thoughts about SVI in particular, and interactions with other members.

Reliability of this set of codes was checked by having two researchers independently code a portion of the data based on the established codebook and check for agreement, then repeat that process such that a total of approximately 10% (by number of words) of the overall interview data was examined. The final round of coding showed strong agreement (defined as a consensus in the selection and location of codes for nearly all of the data by the second round).

After the codebook was established and reliability was verified, the next step was to study the codes and look for themes. This work took a more realistic approach as opposed to a constructionist approach, focusing on the individual experiences of the interpreters rather than the societal reasons for those motivations (Braun & Clarke, 2006). After having conducted a literature review, I formed initial themes by reading and re-reading the coded data, looking at individual codes across the dataset and observing trends, and comparing answers to the same question from different interpreters (Braun & Clarke, 2006; Kiger & Varpio, 2020). The themes that stood out were those which appeared across several students' responses or were repeated in different ways, even in responses to different questions.

Although I asked separate questions about the reasons why students started interpreting (motivations) and what they gain from it (benefits), in exploring the data, I found that these

categories are actually not as distinct as I initially expected them to be. It is important to explain why I chose not to distinguish too strictly between benefits and motivations in my analysis.

Students may initially choose to interpret for a particular reason, which would by definition serve as a motivation. They could also arrive at that reason after having started to interpret, thereby seeing it as a benefit. Alternatively, they may have expected a particular positive consequence of interpreting and appreciated that consequence after experiencing it, seeing it as both a motivation and a benefit. It could be informative to distinguish between early motivations and developed ones, especially looking at the same group of interpreters before and after they start, because that could assess awareness of and prior knowledge concerning interpretation. For this project, however, students often spoke about the same concepts in terms of both reasons for and outcomes of interpreting, showing that benefits and motivations overlap. Whether a certain concept was a perk they knew about beforehand or something they found out about afterward, the end result was the same: a commitment to bettering other people's lives through language mediation. As such, apart from select noticeable themes, I have discussed all of these factors under the umbrella of "motivations" because together, they form a more complete picture of what it is that makes these students want to interpret. A full explanation of the results of this analysis is presented in the following section.

CHAPTER 4. Presentation and discussion of results

My interviews with SVI students revealed a variety of motivations of student medical interpreters. I have grouped the findings into themes, presented below, which come from my informed assessment of the interview data. These fall into three broad categories:

- the role of the interpreter
- potential barriers to interpretation
- motivations for interpretation

Below, I explore each of these categories more deeply, providing sub-themes within each, along with selected quotations that demonstrate the theme. To protect interviewees' privacy, they are referred to by an assigned code (such as I1 or I2 to represent Interpreter 1, Interpreter 2, and so on). Filler words were removed from some of the excerpts for clarity. A longer list of related quotations can be found in Tables C1-C4 in Appendix C.

4.1 The role of the interpreter

To understand how interpreting actually works, it was useful to hear about students' typical experiences. Their accounts mirrored the current literature about interpreting, such as how turn-taking works, where an interpreter should stand, and the health consequences of language barriers. Much of that description was impersonal and consistent across interpreters, so I will not focus on that here. Instead, I aim to understand not simply the technical details of the position but how students conceptualize the role as a whole. The explanations herein of what they feel the purpose of interpretation is set the scene for what they need to be motivated *for*. The chief themes of this section are (1) the purpose of the interpreter, (2) the characteristics of a good interpreter, and (3) the student role in comparison to that of a professional.

4.1.1 A functional but personally uninvolved intermediary

Interpreters are both very involved and completely uninvolved in interpreted conversations; they participate directly by converting phrases between languages for patients and doctors, but they are uninvolved personally, in that they must do their best to eliminate personal opinions, information, or biases. This slightly paradoxical view, along with the students' use of terms like "bridge," "conduit," "clarifier," "cultural broker," and "connect[or]," aligns with how previous research and the NCIHC National Code of Ethics (2004) describe the interpreter role (Hasbún Avalos et al., 2013; Hudelson, 2005; Monroe & Shirazian, 2004; Sleptsova et al., 2014).

While these terms reinforce the idea that interpreters play an important communicative role, students also described themselves as being removed from the interaction: one should act "invisible," "not… involved," or "like you're not in the room." The common thread is that they are there only as the interpreter, not as themselves; this echoes the idea of "Role Boundaries" outlined in the NCIHC Standards of Practice for interpreting, which states that interpreters must not be personally involved (2005, p. 8). Some interpreters employed metaphors to portray the role, saying the interpreter is only part of a person (emphases mine):

> "The goal is to be like *barely a person*, like *just a voice* for the other two people to communicate." (I1)
>
> "I'm just like the *little whisper in your ear*, saying, 'Okay, this is what she's saying in the language that I'm speaking.'" (I2)
>
> "I like to think of it […] *as like a speaker*, you know, in the room, like if you were not there." (I5)

Such phrasing emphasizes that only an interpreter's spoken ability is involved. This last quote, where I5 describes the interpreter as a speaker, evokes a mechanical view of the role, which others echoed. Some went so far as to say that their goal is to act not just like part of a person, but as something automated and inhuman (emphases mine):

> "The most important thing is to be completely just *like a tool, like if you were a machine*. […] You serve as a very *direct and involved tool*." (I4)

> "You're trying to be *like a machine*, right, you're trying to be [like] a Google interpreter, let's say, that takes it perfectly." (I5)

> "[You're] kind of *like an input/output type of system* where you hear something and just repeat it in the different language." (I17)

Describing the role with metaphorical language defines it more clearly than would a simple statement about translating between languages. Terms like "bridge" emphasize that the role is meant to provide a route between doctors and patients; allusions to being only a voice indicate that interpreters should provide their linguistic capacity and little else; and comparisons to "tool[s]" and "machine[s]" further stress the utility of the role, painting the interpreter more as an impersonal, practical figure than as an involved interlocutor. In highlighting such characteristics, the interpreters stress the importance of being objective, unbiased, accurate, and anonymous.

To that end, interpreters acknowledged that they are not authorized to make decisions in the interaction, manipulate the information in any way, or offer their thoughts. These students were clear that although they speak for both doctors and the patients, they are neither:

> "You're not there as a doctor, you're not there as someone to give advice, you're there as someone to directly translate every single word that they're saying." (I2)

> "We don't know how to assess [what is significant] because I mean we're not medical, we're not physicians, so we don't know that aspect of diagnosing and all of that." (I8)

> "You don't really want to put any personal input of what you think because you're not really qualified to have an input about someone else." (I17)

While interpreters do not have the same type of power as the doctors and patients, students agreed with Hsieh (2006) that their language skills equip them with a different sort of power:

> "When you're interpreting, you feel like you're the most important person in the room because you're the only person that's understanding 100% of what's going on. And you carry so much responsibility with that." (I10)

> "[While you're interpreting] you also feel this big responsibility on your shoulders and with that […] you feel more into what you're doing, a pressure to get everything right." (I9)

> "It's such an important task for us to do. It's a lot of responsibility communicating about someone's health situation to a health care provider. So I think you just have to be really responsible with it and know that what you're doing is important and every word counts." (I15)

Though they recognize that their personal selves are not to be brought up during the interaction, the students do thus acknowledge the importance of (and responsibility that comes with) their presence. It is they who allow the interaction to happen, so they have some agency in the interaction, but this must be handled carefully (Angelelli, 2014). Further confirming that they know they play a vital role in the care of LEP patients, students reported some of the same patient benefits of interpreting as described in Chapter 2, such as positive medical outcomes, increased patient comfort, and better communication for both patients and doctors (Flores, 2005; Karliner et al., 2007; Schenker et al., 2012). One stated that having been an interpreter, she recognizes that interpreters should always be sought to best serve patients:

> "We've gotten that patient experience of […] if we know that this person comes speaking a whole nother language that we don't know, our automatic thought is, I need an interpreter in here, like it should not be a question, it should not be a doubt, it's 'I need one, now.'" (I2)

While their goal is to be unbiased and unobtrusive, SVI students agree that interpreters should not be seen as just an auxiliary, optional tool, but as an essential component of medical care. Existing research on interpretation similarly concludes that interpreters should be treated as an integral member of the medical team (Clarridge et al., 2008; Krystallidou et al., 2020; NCIHC, 2004; Schenker et al., 2012; Weaver et al., 2020). Although the interpreter is meant to be a functional but personally uninvolved intermediary, this supports the idea that interpreters should

recognize their own work as a crucial component of an inclusive clinical environment, and that doctors, nurses, and other providers for whom they interpret should do so, as well.

4.1.2 Characteristics of a good interpreter

One interpreter said, "It's not the same thing to be bilingual as to be a certified medical interpreter. It's really different" (I11). What is it that turns a student into an interpreter? And what makes an interpreter a *good* interpreter? Out of all the characteristics that my interviewees expressed, three that stood out were language proficiency, professionalism, and passion.

Six out of the ten more experienced interpreters referenced strong language skills as an essential characteristic, and several of the seven newer interpreters also said that a high level of language is required. The focus was on Spanish or Portuguese proficiency and none mentioned competence in English outright, but since the interviews were conducted in English (and they interpret between English and either Spanish or Portuguese), this was assumed.

Some of the interviewees were members of the SVI Executive Board and are thus involved in choosing the new interpreters; they confirmed that strong language skills are imperative, even citing this as one of the most important characteristics sought in prospective interpreters:

> "Sometimes we get really good applicants who… it's tough, and they're really passionate, but their Spanish is just not that great. […] Your Spanish needs to be good because if you mess up, you can kind of mess up the patient too, right? […] So if your Spanish is not good, even if you're an incredibly passionate person, then it's, you know, you have to be objective in that aspect. So it kind of sucks, but unfortunately those two things need to go together." (I5)

> "It depends on their level of the language, so if the person was not too good at the language, I'd be like, 'Actually, give up, it's harder than you think'. […] It breaks our hearts to, you know, not allow people to do it because it's tough, but you can see the difference between people." (I10)

As I5 and I10 suggest, a student may have a strong desire to help out, but that is not sufficient if they do not also have a strong language capacity. Already having a grasp of the language—as someone who is bilingual or at least a long-time speaker of that language—makes interpreting easier and increases a student's chance of success.

Assuming that an interpreter is fully bilingual and has an advanced enough level of both languages to interpret, students also emphasized several other characteristics, listed in Table 2 below, that were related to being committed to interpreting.

Table 2. Important characteristics for an interpreter.

Professional characteristics	***Interpersonal characteristics***
Be professional (I1, I3, I5, I15)	Be attentive/a good listener (I3, I6, I8, I9, I10, I13, I16)
Take it seriously (I1, I5, I11, I15)	Be empathetic (I6, I7, I8, I9, I10, I14)
Have confidence in your abilities (I3, I6, I14, I16)	Be culturally competent (I1, I11, I15)
Have strong language skills (I2, I5, I9)	Have a nice manner (I7, I9)
Be humble/willing to admit mistakes or limitations (I3, I5, I13)	Be patient (I14, I17)
Be efficient (I5, I14)	Know how to interact with others (I3)

In terms of professionalism, students must be dedicated to the role and to truly hearing what others have to say; they must be efficient and take the position seriously; and they must be willing to acknowledge their mistakes. If they can acquire these characteristics, they can create a positive, professional communicative atmosphere. These skills can apply to most careers, but they are particularly useful considering that most of these students intend to go on to medical school; a sense of professionalism, humility, efficiency, and commitment parallels what Vinson (n.d.) describes as important characteristics for a medical student to have.

So-called "soft skills" that have to do with interpersonal interaction are important, as well. Interpreters should be not only efficient and professional, but also culturally competent, patient, and good at listening. Six interpreters specifically mentioned empathy, and several

others, through their descriptions of how they interacted with patients, showed a similar emphasis on visualizing themselves in the patient's situation. Through the use of language like "imagine how difficult it is" or "I know how hard it is" to be in that situation, interpreters picture themselves in the position of not being able to speak English in an important context like the medical setting, even if they have not experienced it personally:

> "These patients are going through [a] moment of vulnerability, right, they're going to the doctor for something that's bothering them, something that might be really personal to them, or just going through a difficult moment, and [they] can't speak the language – imagine how difficult that is." (I5)

> "I could only imagine how hard it would be if my parents [who only speak Spanish] decided to come here [to the U.S.] and get healthcare, and [if] my family [were] moving […] to countries that they don't speak the language perfectly […] I can only imagine what that kind of struggle would be." (I9)

> "I can't imagine how frustrating or how difficult it would be […] for example if I was, I don't know, in like India or something, and I was speaking English and nobody spoke English and I needed […] a procedure, and I didn't know what was going on." (I14)

By stepping into the shoes of the patients and imagining their perspective, students realize how frustrating it must feel for a patient to not be able to communicate effectively. Because of this, they aim to create a comfortable environment for both patients and doctors, demonstrating genuine care for others' well-being. In contrast to the view of a machine presented earlier, the following quotes exemplify kindness, being pleasant, and making the patient feel comfortable:

> "I think there should also be a certain level of a nice personality […] not being an intimidating character […] expressing a smile when you see the patient, not having a mean face or an annoyed face. […] Expressing a smile, having a voice that's more uplifting, certain qualities like that are definitely very necessary." I7)

> "I think more than just the skills that you have to have in order to interpret, you have to be very understanding. […] I think what makes an interpreter a good interpreter is the ability to transition between different people." (I10)

These interpreters agree that interpreting requires much more than language proficiency. Their comments emphasize the interpersonal nature of the role and stress that it is important to treat their fellow conversation-participants with respect and understanding.

Interpersonal skills and advanced language proficiency are both necessary assets for an interpreter, but they must also be accompanied by an actual desire to serve in this role. Such a passion came up frequently in my interviews, such as in I5's quote above. Passion is difficult to define, but in the sense that it is a deep desire to participate in a task, it is a fitting descriptor of these interpreters. Unlike language proficiency, which was mentioned outright several times, passion for interpreting was conveyed more subtly through the interviewees' demeanor and other answers. Whether it was that they themselves felt passionate about SVI's mission, that they liked being in a group with others who had a similar goal, that they looked for new interpreters who would also be committed and interested, or that they stressed how important interpretation is for patients, it was clear that SVI students have a strong desire to interpret, and that a student's dedication to interpreting is key.

Taking these characteristics together forms an image of the ideal interpreter: someone who is able to speak both languages very well, who truly wants to be there helping the patients, and who will do so in a caring but professional manner.

4.1.3 Perceptions of the student role, as compared to professionals

Up to this point, the SVI interpreters have described the role in a way that fits with previous literature on adult professional interpreters. This is noteworthy; the fact that their reports are largely unrelated to their student status suggests that at least in the eyes of the students themselves, the student interpreter role approaches that of a professional.

The clearest difference between a trained student and a trained adult who has interpreted for several years is that the college-aged interpreter necessarily has less life and work experience compared to the older adult (Schuster, 2014). When I asked students about this, and how they perceive their role compared to a professional's, I expected to hear concerns about it; perhaps it would make them nervous to be less experienced, or restrict their ability to interpret because they know less. As it turned out, only a few students brought up their lack of experience at all. When they did, they maintained that it does not greatly affect their ability to carry out the task:

> "We go through the same training as the professionals do, so […] we have the same certification. But that is something that really kind of was worrying to me at the beginning because […] when I started, I was like, 'I'm just 18 years old, these people need adults who do this all the time. I don't know how helpful I'm going to be able to be.' But at the same time, I'm fully trained, I got the same training as those adults, and if I weren't there, no one would be." (I1)

> "I think the biggest thing, like yeah we're not professionals, like yeah we make mistakes and we're more prone to making mistakes. […] But for my understanding, I think we are as qualified as the people who are serving for five, six years. […] Experience is obviously a big factor. […] But I think that a lot of people who are motivated enough like a lot of us are in [SVI] have the ability of circumventing maybe the super technical stuff and being able to express it in a more easy way for both the patient and the doctor." (I3)

While students' skills may not be equivalent to those of someone with a great deal of experience, they are perceived as being "close enough" to a professional that they can still be of assistance. It seems that students include themselves in the same category as professionals, with some even referring to SVI as "professional interpreters" or "quasi-professional[s]." Aligning themselves with professionals in this way is further evidence that students do not perceive themselves as significantly different.

SVI members did identify some key differences owing to their position as students, but these were relatively minor. One is that there could be an odd dynamic with patients or doctors because of their age, which is less likely to happen with a professional interpreter. Though

interactions could not go on as smoothly without the interpreters, they are also often the youngest person in that interaction, with the least life experience and expertise. The patients tend to be older than the students, and the providers—even those who are medical or physician assistant students, as some are at the clinic where SVI interprets—are not only older, but also have more medical experience. Several students mentioned feeling intimidated, or that this created a strange situation:

> "I think all the patients that I have encountered have always been older than me. So it's definitely a little weird at the beginning. […] It's weird because they're older than you, so there's this type of seniority there, but you're the one providing the service. But then you just realize how […] you as a human being are capable of helping other people, no matter how young or how anything you are, you're still useful." (I6)

> "I think it can also be kind of shocking for the patients and even for the health care providers because, you know, it's such a professional setting and then a 19 year old walks in and is just interpreting all this information and you're like, 'Okay, is this reliable? Is this person well-trained? She seems young, she doesn't seem like she knows what she's doing.' So I think it could also make an impression on whoever's in the room, and of course with time, during the consult or the procedure, the person will probably realize, 'Okay, she knows what she's doing. She's interpreting, everything's working out fine.' But at first, I think it can be quite an impression." (I15)

> "That's definitely going to [make me] nervous walking into a patient's room with [a doctor] where they have these years of experience and I have a 40 hour training course. It's going to be a little bit of an impostor syndrome, maybe. But […] I do think that's going to go away after a couple weeks of doing it." (I17)

While students may feel awkward at first because of their position, any age-related discomfort appears to dissipate once they start interpreting. SVI members also guessed that patients probably do not even know they are student volunteers and tend to be grateful for the help even if the interpreter seems young, so their age does not seem to impact patient perceptions, either.

Other differences noted were that professionals are more confident, more capable of dealing with difficult situations, more knowledgeable about language variation, involved in more complex cases (and more cases overall), and under more pressure. Though these attributes, along with more experience, may equip professionals with more interpreting tools, students said that

with practice and over time, they are able to improve and can still provide good language support.

The consensus among the interpreters that there is little difference between students and professionals is in large part due to their training. The only distinction between students and full-time professionals is an additional national certifying exam; otherwise, students go through the same course that professionals must take initially. The fact that SVI students have an official certification means that their services are likely to be more effective than those of an *ad hoc* interpreter, and they realize how that prepares them well:

> “There were some terms I didn't know how to interpret and now I feel more confident. The training is so important […] you wouldn’t realize how important is to be certified.” (I11)

> “I've always interpreted and translated for my mom when I was younger, so I just felt excited about being able to actually learn about interpretation and not just do it at the doctor's office randomly. I wanted to actually learn it and then also be able to do it at clinics near my house or something. I wanted to be proficient in it and not just say that I've interpreted before, but I wanted to have that experience with it.” (I13)

The training helps students feel more confident interpreting by providing them with the resources and knowledge for how to interpret effectively. Even though they are less experienced, being formally trained makes them feel that they can provide adequate help.

To confirm whether there really are significant differences between students and professionals, one would have to compare their work objectively, which this study did not do. It would also be informative to view the two groups from the opposite perspective, assessing how professional interpreters perceive student volunteers. Nevertheless, it is encouraging to hear from the students that they feel useful because that opens up a wider range of people who may be able to step in and help diminish the pressing problem of language barriers in healthcare.

4.2 Potential barriers to interpretation

It is clear from the themes described above that SVI students feel interpretation is important and worthwhile; however, it is also evident that there are challenges that come with it. I raise the idea of barriers to interpretation in the context of motivation because it is useful to learn what could—but in reality does not—prevent students from interpreting. Knowing both how they conceptualize the role and what could discourage students from fulfilling it reveals what students' motivations help them overcome.

4.2.1 Training and preparing to interpret

Even before starting to interpret, certain aspects of the training have the potential to deter students. Normally, SVI members spend five Saturdays in a row completing the 40-hour training course. Students must find room in their schedules to attend the course, practice their vocabulary, study for their oral and written exams, and do homework assignments outside of class time. The most recent class of interpreters took the course as a self-paced online class, with asynchronous recorded videos and live Zoom coaching sessions. While the material was the same and the workload was presumably also substantial, one newer interpreter said that it was "much more easier and feasible now" (I12) that they can do it on their own time. The online nature of the course therefore may help mitigate time as a barrier, but it is still a considerable commitment.

Once interpretation starts, the in-person clinic visits on weekend mornings may also present an issue:

> "Another challenge is just getting people to be free and available to help, honestly. […] It's hard to find time to actually go help on Saturdays, because it's Saturday at 8 in the morning, like I'm not gonna lie to you, Saturday at 8 in the morning, I want to be in bed, with my pillows chilling. But at the same time, you have to get out and you have to do it if you get assigned, but a lot of people struggle with that." (I3)

A few other students echoed the sentiment that it takes some effort to fit SVI participation into their already-busy lives. The idea that college students may not have the time or the bandwidth to volunteer is substantiated by findings from recent Current Population Survey data from the U.S. Census and Bureau of Labor Statistics, which report that college-aged students (20-24 years old) show the lowest proportions of people who volunteer compared to groups of other ages (Grimm & Dietz, 2018). There are a few possible explanations for this trend; for example, students may have to juggle a heavy course load, extracurricular activities, their social lives, a job, or any of the multitude of other activities that occupy a college student's time and are associated with becoming a self-sufficient adult (Grimm & Dietz, 2018). For those who do volunteer, then, as SVI students do, there must be relatively strong motivation to get past the time barrier.

In addition to the time cost of the training and volunteering sessions, there is also a significant financial cost: $650 per interpreter, for the course SVI uses (ALTA Language Services, 2020). SVI partially subsidizes this amount (and therefore must limit the number of students they accept in each class of interpreters), but even with a portion of it covered, students must be willing and able to pay the remaining balance. As one member said, this is certainly not a given and can even be a major deterrent:

> "One of the boxes that you have to check when you're applying is, *Will you be able to pay like $300 for the course*? And that's not an easy box to check. That's something that, you know, for me, I remember I had to call my parents […] and be like, 'Mom, is this okay […] I know it's $300 and it's for a course, but I really want to do this.' So I know that it's hard for a lot of people. So […] I feel like the people that apply, they want to do this. […] It is a barrier, but it shows a lot of, you know, what we do and the fact that what we're doing is a serious thing, but it also shows that when they apply, people actually want to do it." (I10)

After learning of the cost, I expected more students to echo this sentiment vis-à-vis the price, but few did more than note that there was an expense. While it may be a deterrent, the cost does legitimize the course and assert the validity of the certification. It is important to note that since I

only interviewed current members, my data do not reflect the opinions of students for whom the cost was prohibitively expensive, which is certainly possible; nonetheless, for those who choose to interpret, it must be seen as a positive investment.

4.2.2 Interpreting

Even if students can spend time and money on the training, there are still additional barriers to interpreting inherent in the difficulty of the task. None of these interviewees hesitated to present examples when I asked about the challenges of interpreting; it is not just an easy, thoughtless conversation. Being an interpreter requires real effort to keep up with the pace of the conversation, to convey things accurately, and to do so in as unobtrusive a manner as possible. Students must be willing to put in the effort to meet such demands.

The NCIHC Interpreter Code of Ethics emphasizes being faithful to what is said (NCIHC, 2004). Matching that aim, accuracy was commonly described as paramount to this work, as the majority of interpreters (14/17) mentioned the importance of not straying from what the speaker said. Changing an utterance could introduce problems; for example, misrepresenting symptoms could lead to misdiagnosis, or poor explanation of medical directions could lead to poor treatment plan adherence. Several noted the importance of accuracy by contrasting what they learned in the course with how they used to interpret on an ad hoc basis for family:

> “With training you learn […] that everything is super important to be said. As a little kid, I was like, ‘Oh, gosh. Mom, you're telling them this super long story,’ and I'm like, ‘Yeah, she just said she's sick,’ and the doctor’s like, ‘Um, she just talked for like 30 minutes, I'm pretty sure she said more than she's just sick.’” (I2)

> “I would always interpret for my mom, but I would definitely kind of chop it up or I would try and keep the meaning, although I wouldn't really fully translate word by word, and something that I've taken away [from the course] is that that is definitely not the right thing to do, especially in a medical setting.” (I13)

> "You're supposed to repeat exactly what they say. […] I used to interpret for my mother because she didn't understand. And obviously, I wouldn't interpret 100% of what they were saying just because some of the stuff I thought was fluff and it didn't really need to be said, because it wasn't that important." (I16)

A chief issue with untrained interpreters—which these students describe here and which has been described in the literature (cf. Flores, 2005)—is that aspects of communication can be lost when *ad hoc* interpreters do not know certain terms or choose inconsistently what to interpret. By learning the "right thing to do," as I13 says, students reflect on their experiences as child *ad hoc* interpreters and see the value of training for accurate interpretation.

In order for the interpreter to render messages as close to the originals as possible, it is easier if the conversation proceeds with relatively short phrases and at a slower pace. Many interpreters explained that because the conversation feels unnatural to patients and doctors, they often slip into casual, non-clinical speaking habits: speaking quickly, using long sentences, going on tangents, or looking at the person who is speaking (the interpreter) rather than at each other. In cases where the conversation veers too far off track to maintain accuracy, interpreters must momentarily insert themselves into the conversation to ask speakers to slow down, pause, explain, or repeat (NCIHC, 2005). Part of the interpreter role is thus to know when to step *out* of it to advocate for themselves. The California Healthcare Interpreting Association (described by Angelelli, 2014, p. 577) states that interpreters must signal when they are speaking; in keeping with that idea, several SVI students say "This is the interpreter speaking," whenever they interject (see Table C2 in Appendix C). Assuming control like this can be difficult because of the power dynamic that exists in the consultation, as patients and doctors are contributors and experts in ways that the interpreter is not (Roter & Hall, 2006). Nevertheless, being trained about the importance of accuracy, interpreters return to the gravity of their role to dispel possible discomfort about interrupting.

To maintain awareness of the conversation, to be accurate, and to make decisions such as whether to interrupt, interpretation requires an excellent memory and that close attention be paid to every bit of the conversation (Nour et al., 2019, 2020). Brain imaging studies (e.g., Hervais-Adelman et al., 2015) confirm that interpreting is a taxing cognitive task involving high levels of executive control and language ability. Adding cognitive effort to the other difficulties already noted, SVI interpreters stated that it can be tiring:

> "It's hard from a social perspective, it's hard from a mental perspective, because you have to be very focused. And it's physically demanding because you have to be in a specific spot and you have to be very verbal and you have to be very interactive. And it's like, if you are someone who is uncomfortable with […] having your voice heard, it's really hard to be an interpreter." (I3)

The idea of "having your voice heard" harkens back to descriptions of the role. As the interpreter, it both is (in the literal sense) and is not (in the figurative sense) *their* voice. With that paradoxical position, it makes sense that there might be some discomfort with that feeling of being in-between.

While I3 does not clarify what it means to be "hard from a social perspective," it could be a reference to interpreting as emotionally draining, which has been described previously as a negative effect of interpreting (Novotney, 2020; Schuster, 2014). Though an interpreter's goal is to be an unbiased intermediary who is not personally involved in the case, they are people too, with empathy and full knowledge of the situation. Having to interpret medical content including mental health, sexual health, terminal diagnoses, end-of-life care, and other difficult or sensitive topics can be high-stress and even traumatic. Although the emotional impact of interpreting seems to be a legitimate concern, only three SVI students raised it as an issue:

> "This patient […] [was] just so relieved that they finally were able to get help, and she just was crying. And for me it was hard, because […] I'm a very sentimental person. And I'm like, I should not be crying, but it definitely got to me." (I8)

> "I feel like I'm a very sensitive person, and I'm very emotional. So I didn't really think about this when I applied, but now that I'm going through the course and they're talking about, like, okay, what if a patient died? Or what about if a patient […] has to get an abortion, or a delicate situation? Then you still have to interpret. There's no excuse for you not to interpret in that situation. So I don't know, I might get a little bit emotional at first, but I'll learn with time to try to control the emotions." (I15)

> "If you hear some bad story, and this goes for any medical profession, like if […] something terrible happens to a child or a family, that's definitely going to weigh on you. […] If you hear someone struggling with […] not being able to get the right healthcare coverage or something along those lines because of their nationality, that makes you think, like, 'Oh, this guy could be like me.' So then I think that might weigh on you a little bit." (I17)

These students do agree that serious situations could naturally have a (primarily negative) emotional effect on the interpreter. However, it is noteworthy that both I15 and I17 are in the newer cohort; they are only speculating here, not providing their own experiences, and may only have suggested these scenarios because such potential difficulties were posed in the training course (which is still fresh in their minds). I8 was the only student who has already interpreted with SVI who reported the emotional dimension of an actual interpreting encounter, and even this instance was about someone actually getting healthcare (a positive situation), not a sensitive scenario. Most likely, the lack of focus on the emotional difficulty of interpreting is a product of the fact that SVI interprets only in primary care clinics. Like other existing student interpreter programs, limiting the types of encounters for which students are allowed to interpret somewhat protects them from such challenges (Monroe & Shirazian, 2004; Schuster, 2014). Because of this lower-stakes setting, SVI students do not often witness harrowing situations and would thus have little reason to emphasize the emotional effect of interpreting. As such, potential emotional considerations may be less of a barrier for student groups, compared to professionals.

4.3 Motivations and benefits for interpreting

As shown, some aspects of interpretation are potentially discouraging to students. In addition to the time, financial, and effort costs, the seriousness of the situation—that the patient's level of healthcare is partly in the hands of the interpreter—creates a sense of duty and even stress for students. It would thus not be all that surprising if students choose not to interpret to avoid the strain. However, although there was little hesitation to recognize the challenges they face, SVI students interpret anyway, signaling that they must value this activity quite highly. With an understanding of what the role of the interpreter entails and some of its possible downsides, it is now possible to answer the question, *Why do student volunteers interpret?* My goal is to uncover what it is that pushes students to see the obstacles and dissuading factors in their way as manageable, rather than insurmountable.

Based on students' responses, it is not that interpreting is a lifelong dream. Only one described specifically hoping to interpret in college, which is a stark contrast to several others who explained that growing up, they did not even realize that professional interpreters existed. Many happened upon interpreting from the university student activities fair, SVI marketing materials, or from a friend who was already in SVI. After learning what interpretation involves, they must have thought about downsides they might encounter and rewards they might gain. To determine how they see such factors, I asked students directly what their motivations are for interpreting and what benefits they receive from it. I expected to observe a desire to help people, as well as some reference to the fact that interpreting is a clinical experience. They did articulate these, both as benefits and motivations, but they also expressed much more. The answer to why students interpret consists of two main themes: *identity* and *community*.

4.3.1 Identity: Personal background

In psychology, identities are defined as “descriptors […] personal traits […] and social roles […] and the content that goes with these” (Oyserman, 2015, p. 1). In other words, identity is how we see and describe ourselves, and as such it can be an influencing factor in motivation and decision-making (Eccles, 2009). Interpretation combines two major aspects of identity in that it connects to students’ personal histories as well as their future professional goals. In SVI, students are primarily motivated to interpret because of their personal backgrounds. I consider *personal background* here to mean any characteristic related to a person’s sense of who they are, so in this case, language background, family history, and ethnicity were most relevant.

Language is what draws most students in at the start. Five of the interpreters recalled seeing a sign at the SVI’s Student Activities Fair table that said *“¿Hablas español?”* (“Do you speak Spanish?”). Able to answer “yes,” they were immediately interested. Beyond the club fair, 6/17 cited the ability to use their language skills for something positive as a motivator:

> “I had never really used […] being bilingual in any way, only with my own life and my family, but I had never really used it to impact anything. So I thought [SVI] was really interesting and I wanted to get involved. […] It felt so liberating to be able to use it and, you know, make an impact.” (I10)

> “If you're capable to dedicate your time to helping and are lucky enough to have grown up with another language, I think it's really important to use it for […] something bigger than yourself and contribute back to […] your community. […] If you can help with the language barrier, that's one thing out of so many disparities that you can contribute towards easing.” (I14)

> “What […] attracted me the most was probably having something that I could do within the […] community that was related to my language and my culture.” (I15)

Students were interested in SVI because it is an opportunity to use their bilingualism—an asset they already have and do not have to work at—to connect with patients who need help. Interpreting thus allows them to see the linguistic aspect of their identity not as simply a

demographic characteristic, but as a tool that uniquely equips them to tackle the issue of language barriers.

For nearly all of the interpreters (12/17), being bilingual meant having personally seen a need for interpretation in the past. Some experienced a language barrier personally, though none had used an interpreter for themselves. A few others knew of family members or friends who needed an interpreter but did not necessarily fill that role themselves. About half (9/17), however, served as ad hoc interpreters for relatives (parents, most commonly) in various settings. Having seen what it is like to experience a language barrier in or around their families—whether they were able to help in the past or not—these interpreters are motivated to step in and help others overcome those hurdles, providing help as though the patients were related to them:

> "I would just be helping back my community […] as if they were like my family." (I8)

> "I just imagine everyone as like my family and sort of how […] my family […] they needed this help and if they would have received someone like me or someone like this, that it would have definitely made their transition easier." (I16)

This notion of family ties creates a direct connection between interpreters and patients that anchors the students into the community quite deeply and motivates them to help. This could be explained by the fact that people are often more willing to help people who are related to them, or if not directly related, at least perceived to be similar to themselves (Jhangiani & Tarry, 2014). When asked their ethnicity, all the interpreters who chose to answer self-identified as Hispanic, Latinx, and/or Mexican; they also described the population for whom they interpret in the same way. Because of this shared ethnic identity, students are not helping just any community, but *their own* community, a distinction represented in the way they spoke about the people whom they assist:

> "[Interpreting] would be […] having an actual impact in my community, you know, the Hispanic community." (I5)

> "And so just knowing that through this organization that I can help out in these clinics, starting, you know, at home, with similar clinics that my mom's been going to, similar communities. And I thought me having the capability to be able to help out […] I was immediately interested in helping out." (I7)

> "Some of these people live in my neighborhood and they go to these clinics. So just knowing that like I could have that impact on them and sort of do for them what I wish somebody would have done for my mom when I went to those clinics. That's what […] really motivated me, just, you know, knowing that I could help them." (I13)

The difference between "my community" or "the Hispanic community" compared to simply "the community" is significant; noticing that they have this shared aspect of identity with patients allows interpreters to visualize themselves in the patient's position more clearly, which makes them feel more strongly about helping.

Language and family background as well as ethnicity are clear factors motivating these students. Their descriptions of being part of the same identity group echo the concept of "oneness" that Cialdini, Brown, Lewis, Luce, and Neuberg (1997) describe: a "sense of shared, merged, or interconnected personal identities," which is a driving force of helping behavior (p. 483). The fact that SVI students brought up helping a group proximate to themselves in language and family characteristics seems to fit with that idea.

4.3.2 Identity: Aspiring to a career in healthcare

In addition to feeling connected to patients because of similar ethnic and linguistic backgrounds, student interpreters have a second dimension of connection to the role of a medical interpreter: they intend to pursue careers in healthcare. The students in this sample were all on pre-health tracks—in this case most commonly pre-medicine or pre-nursing, with some interest in public health and business. Being a medical interpreter, rather than any other type of interpreter, gives them experience that is personally relevant and interesting:

> "I'm a little more comfortable with [interpreting in a medical setting than at home] because I'm like 'Okay, I really want to learn this,' versus doing all these taxes […] and legal paperwork and all this, I'm just like, 'I just do not understand anything.'" (I8)

Through interpreting, students get clinical experience, which allows them to visualize themselves in the role of a healthcare provider; volunteer experience, which places them in the community and demonstrates their compassion; and general professional experience, which prepares them for the working world. Previous psychological research has examined how a person's view of their "future self" influences what they choose to do in the present (Oyserman, 2015, p. 4). The choice to interpret in college, therefore, can be seen as a way to attain the professional future self a student has previously imagined.

Shadowing providers helps students learn more about what careers they may be best suited for, make network connections, and gain mentorship from people already involved in their area of interest (Wang et al., 2015). Because students work directly with physicians, interpreting provides them with insight into, skills for, and connections to their futures in this field. SVI students greatly value such a chance to familiarize themselves with the medical setting:

> "It's really fun to just go to the clinics and it really attracted me this knowing that I was going to be interacting with patients when if I were not in this club, I wouldn't probably be interacting with patients until I got into med school." (I4)

> "I'm getting a lot of exposure to environment in a clinic, talking to patients, talking to medical students, talking to physicians […] some good tips about how to get to medical school, how's life in medical school, you know, MCAT, […] all these little things in the medical student life that kind of give you a little bit more perspective." (I5)

> "I refer to it as a free sample, kind of, of the career I'm interested in. […] It made me aware of how this whole process actually works, and not just looking at it from the outside." (I7)

> "I think it was really great to be exposed to medicine like that, to be a player in that interaction, not just observing. I think that was a big difference in other types of exposures to health care that I had had before." (I9)

Students' desire to work in a medical setting thus influences their decision to volunteer in one. Unique access to the medical setting is a powerful draw of interpreting; this was one of the strongest motivators I observed, as all but two interpreters described the health experience as a drive for them.

Students' pre-health identities propel them to interpret for the intrinsic value of witnessing the inner workings of a setting that genuinely interests them. But in order to maintain this identity (and eventually advance to the identity of a healthcare professional), students must take steps toward their intended career paths. Interpreting provides that extrinsic opportunity in the form of clinical and volunteer experience, as well as a head start on the process of professionalization.

Clinical experience allows undergraduate students to show that they have considered the career path they aspire to in a certain amount of depth. Volunteering (in any setting, not just in healthcare) allows them to display commitment to others, also critical for aspiring medical students. The competencies set forth by the Association of American Medical Colleges (AAMC) place "service orientation" first on their list, defined as one who "Demonstrates a desire to help others and sensitivity to others' needs and feelings; demonstrates a desire to alleviate others' distress; recognizes and acts on his/her responsibilities to society, locally, nationally, and globally" (AAMC, n.d.). If serving others is strongly valued in the eyes of the AAMC, a medical school governing body, it must be an important characteristic of future medical professionals (Koenig et al., 2013). Volunteer interpreting is a strong indicator of a student's dedication to service because it demonstrates sustained commitment, a desire to decrease the distress associated with a language barrier, and a wish to improve lives within the interpreters' own

community. Interpreting is thus useful when students apply to medical school, which is a major step toward becoming a medical provider.

Interpreters also garner valuable professional skills which will aid them in their futures, chief of which is effective communication. On a macroscopic scale, student interpreters observe firsthand how important that is, so they understand better how to facilitate communicative interactions. On a smaller scale, they learn specific skills to help do so:

> "[Interpretation] works on so many different professional skills […] like learning how to look at someone in the eye, and learning how to give […] hard truths that you have to say sometimes, and just learning how to say it in a way that doesn't come off with any bias or doesn't come off incorrectly." (I3)

> "For me, I think [the benefit of interpretation is] definitely developing better communication skills and getting rid of my shy side, and just [being] able to also develop professional ethics and… yeah, you know, a professional side." (I13)

Here, I3 and I13 refer to a few different communication skills—eye contact, giving difficult news, professional confidence, and ethics—that are certainly relevant to patient interactions, but which can also apply to plenty of other professional scenarios, such as interacting with senior colleagues, receiving feedback from a supervisor, giving presentations, or speaking with people outside of one's normal working group. Other interpreters mentioned improvement in leadership and in their language abilities, which are also transferable qualities that can apply more widely than just healthcare. Learning skills such as these early on will presumably help these students deal with both everyday interactions and difficulties in their professional lives, which contributes to the future fulfillment of their identities as health professionals.

As part of their career aspirations, pre-health students often aim to accumulate experiences that will prepare them to be in a healthcare setting and demonstrate their commitment to the field. Some may be truly intrinsic, while others are valued more for their

utility in getting into professional school (Lin et al., 2014). Although interpreting can be seen as an activity that bolsters one's résumé, only a few SVI students even mentioned their résumés:

> "Me personally, I get a lot of experience from it. Especially for volunteering hours, I know it's a résumé booster, but it's also just a really good way to see what a clinic setting is like, what a hospital setting is like." (I2)

> "For me, yeah, it's definitely helping people, one of the biggest benefits. You know, reinforcing my language skills in general and interpreting skills as well. Putting that on my résumé for nursing and them being able to use me in those settings where I would be useful for that interaction between either the physician, me and them, or just me and them one-on-one." (I16)

I2 mentions a résumé briefly, but not as a main motivation, indicating that she values the health experience more than simply holding the position. I16, too, emphasizes helping others first, and then mentions her résumé only as a signal to others that she can provide her linguistic services. Neither wants to put it on her résumé to get into a more prestigious health professions program or to boast; rather, the primary intent is to help people and to be useful, a more intrinsic drive.

Only one interpreter explicitly stated that having interpretation on their résumé was something that made them want to be involved:

> "I also thought [interpreting] would be […] a good experience to have personally, and I also think it's going to be a good thing to have on a résumé […] I can speak Spanish perfectly, but having the certification to actually be able to use it is a whole other thing that gives you an extra boost to be able to use it." (I17)

Even though this interpreter does mention specifically that interpreting looks good on a résumé, he explains that he wants to use his language faculty in a professional setting, which would be reinforced by this official certification; the underlying goal is still to help others, not just tout his skills. Furthermore, as with I2 and I16, this was paired with other reasons (e.g., medical experience), so this student is not solely interpreting for the extrinsic benefit. One SVI interpreter explained that it is easy to tell the difference between people who interpret because they really want to and people who do it for a résumé boost:

> "The people [who] want to help end up doing it and do it with pleasure and you can tell. But the others who are just trying to fill the requirement complain about it much more. […] A lot of people just try to join medical services in general just to fulfill requirements, sometimes. You can tell the people that don't. And at the end of the day, that's what makes a professional, what makes an amateur, you know, that's kind of what it comes down to." (I3)

This echoes the idea presented earlier that true commitment makes a good interpreter. None of the students in this sample described their motivations as only stemming from a desire to fulfill a requirement, as I3 says. Perhaps the interpreters did not want to make such an admission for fear of seeming shallow, or perhaps they only see the résumé benefits as marginal. Either way, the fact that other motivations were more clearly stated and consistent across interpreters shows that students focus on the others-oriented nature of the role rather than the advantages for themselves. This aligns with work done on college student volunteering by Trudeau and Devlin, whose study found that "students recognize and appreciate community service more as a way of giving back to the community than as a way of gaining the benefits of personal satisfaction and practical experience" (1996, p. 1886). Like those students, SVI interpreters see the positive regard they may get for being an interpreter as a positive perk, but not the main reason why they do it.

In essence, pre-health identity drives students to interpret partly because of their inherent interest in the task, as interpretation matches with their interests, and partly because it will be useful for achieving that identity goal. This and the personal background aspect of identity fit with the Expectancy Value Model of Motivated Behavioral Choice (Eccles, 2009). This psychological model of motivation suggests that identity factors have an important effect on what people choose to do: "individuals place more value on those tasks that either provide the opportunity to fulfill their identities or are consistent with their identities and long-range goals" (Eccles, 2009, p. 83). Interpretation both confirms the students' bilingual identities (allowing them to be "fulfilled") and aligns with their pre-health identity (which is a significant "long-

range goal”). Students are thus motivated to interpret because it draws together both an existing aspect of themselves and a conception of their future.

4.3.3 Community: Interpreting both for others and with others

One interpreter stated “I thought that was really cool that it was kind of a local impact that you could kind of feel a sort of personal attachment to” (I9). In combining both “personal attachment” and a “local impact,” this interpreter touches on identity and how it relates to community. Community is defined as “a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings” (MacQueen et al., 2001). Interpretation connects interpreters to two kinds of communities: first, the people whom they help, which emphasizes the geographical location aspect of community; and second, the other students with whom they interpret, which links to the ideas of social ties and joint action.

Personal connections to the community may be the reason why these students chose to work with SVI as opposed to another volunteer position, but the motivation to serve is contingent upon a more general, baseline desire to help others. This evokes the idea of the *social responsibility norm*, which is defined as “a sense of duty and obligation, in which people are expected to respond to others by giving help to those in need of assistance” (Jhangiani & Tarry, 2014, ch. 8). Eleven out of the seventeen interpreters mentioned “giving back” or “helping others” generally (and some interpreters spoke of being community-motivated both generally and specifically). Expressing a desire to help others, as these students did, is thus an indication that they are aware of the needs of those around them and interpret as a way to remedy them.

In addition to helping an existing community, student interpreters also create one within the group. Words used to describe the other interpreters and interactions with club members included "brilliant," "amazing," "awesome," "cool," "lovely," "great," "nice," "friendly," "competent," "helpful," "role models," and "welcoming". It is clear from these descriptions that these students respect and admire each other and that the atmosphere is a supportive one. Although the actual act of interpretation is done alone, the interpreters can interact with one another between patient encounters, as well as in club meetings and events. Each class of interpreters goes through the training course together, too, which makes the long hours of the class more bearable. All of these experiences make for a very close-knit group. The interpreters emphasized this closeness, explaining that they can always go to each other for questions, they lift each other up, and they create lasting relationships as a result of SVI. Considering how these students have similar language backgrounds, family histories, self-identified ethnicities, pre-professional tracks, and passions for interpreting, it is no wonder that they get along well. This idea was confirmed through what some of the interpreters said:

> "It might just be, you know, a lot of cultural similarities, a lot of people in [SVI] are, you know, a lot of first generation, you know, Hispanic– or, there's Portuguese speakers as well. But it's kind of like a very similar cultural background. […] We kind of have developed a friendship as well, just because of all the cultural similarities." (I7)

> "I also haven't really been that connected with other Hispanic students at [my university], so I feel like joining [SVI] really helped me to meet students that are Latino or Spanish-speaking, and I think that's really been great, as well." (I14)

> "I actually hang out with people at [my university] because I knew they were from [SVI]. So I got to know people, and we have general body meetings and then everyone just talks and everyone just gets along." (I15)

For some of the same reasons that interpreters feel connected to patients, such as language and ethnicity, they also find it easy to relate to one another. Especially when difficulties come up, it is helpful to be with students who are going through the same thing and who also have those

shared aspects of identity. This echoes the definition of community that MacQueen et al. (2001) present: SVI fosters an environment with shared interests, similar backgrounds, a common location, and joint goals of working together.

Interestingly, this dynamic of community-building appears to be more of a benefit than a motivation: only 4/17 interpreters reported that they had been looking to be involved in a campus community before joining SVI, but 17/17 talked about how positive they have found this group to be. Also, I heard praise for fellow interpreters in every interviewee's assessment of the group, but the degree varied depending on the interpreter. Some were concise in their positive assessments of the group while others were much more profuse in their compliments.

Because the most recent class had to complete their training online (instead of in person, as the course is usually administered), the relationship-building strengths of SVI were more muted for the less experienced interpreters than with the more experienced ones. Nevertheless, despite the COVID-19 pandemic, interpreters have still felt the supportive and welcoming nature of the club thanks to SVI's virtual events. I predict that if the newer interpreters were interviewed again once they have had more in-person group interactions, they would reflect on their experiences nearly as positively as the more experienced interpreters did here.

4.4 Gratification of helping others

Another strongly expressed result of interpreting was a feeling of gratification. When I asked about most memorable experiences interpreting, students replied with anecdotes that fell into two categories. First, for three out of the ten more experienced interpreters, their first time was most notable:

> "Once I went and interpreted for the first time, I was like, 'Okay, now I totally know why I'm doing this,' because it felt amazing. […] The first time I interpreted was just kind of

> like a realization, oh okay, this is what it is, and it's really important, and I'm able to help both people here." (I10)

After the drawn-out training process, it is unsurprising that the first chance to see how interpretation actually works would be particularly prominent in their memories.

In the second half of this quotation, I10 notes that there was a moment when she realized the importance of what she was doing. This exemplifies the second and more predominantly expressed type of memorable experience: students see the effect they have on patients, such as when patients who have not been able to get good care before are able to once SVI steps in to interpret. Often, the moments in which they really feel that their work is making an impact are also moments that made them feel good about what they were doing. I10's comment, that "it felt amazing," gets at that important dimension of not just memorable experiences, but of interpreting in general: that it feels good to help others. Thirteen out of the seventeen interpreters talked about the gratifying nature of the role, both mentioning how patients and doctors thank them for their help and describing the happy, satisfied, gratified, great, or other positive-valence feelings that come as a result of interpreting. In some cases they did not expand beyond these terms, but in other cases, they gave examples of reasons why they felt gratified:

> "I finished the interpretation and afterwards [the patient] thanked me. And she was like, 'Thank you so much, I've been trying to communicate, I've been trying to tell them exactly what I'm feeling, and I've never been able to […] and thanks to you, you helped.' And I mean, I was almost in tears because […] it was truly not this whole thing that took like an hour, it was literally a few minutes and from there they were able to truly help her and kind of give her assurance that it's okay, it's normal." (I2)

> "It's very satisfying to see how [the patients] chill out […] you see how they open up, and they tell you the whole story of how they got X or Y injury, or what happened and […] you see that […] they definitely get better care because they can communicate." (I4)

It is satisfying to know that their efforts, even though they might seem small in the moment, make a difference to the patients.

When I looked at each instance in my dataset of an interpreter feeling gratified, the most common themes in the surrounding text were benefits to the patients, the interpreter's ability to use their language skills, the provision of a necessary service, and the chance to facilitate communication. What all of these things have in common is the direct involvement and visible impact that the interpreters have: *because of the student interpreters*, patients can have better communication with their doctors. In the excerpts above and in others not shown here, the interpreters explained the visible effects their interpretation has on patients; they feel more relaxed, so they can communicate better, and they receive better care as a result. This theme was one of the most important. Six of the ten more experienced interpreters' most memorable interpreting sessions had to do with noticing their direct impact, and the majority (13/17) of all the interpreters described the same idea in other aspects of their responses. They emphasized both the impacts themselves—that the patients get relief, comfort, and assurance—as well as the fact that it is they who facilitate those positive impacts:

> "It's nice to know that […] I'm actually stepping in. I'm doing something, I'm trying to change this situation [of a language barrier]." (I1)
>
> "You are the reason why a person […] got health care that day." (I4)
>
> "I was like, 'Wow, I'm actually doing something good.' […] That's just really gratifying to see that I'm able to provide such a service to something so basic and so necessary." (I6)

These phrases feature the interpreters as active subjects, once again showing the agency they display in lowering language barriers in healthcare. Through their deliberate action, they feel "helpful" (I9) and "needed" (I10) and like they are "making [patients'] lives easier" (I11). Earlier, I explored how interpretation requires effort; realizing that they are instrumental in providing good care to patients is what makes interpretation meaningful to them and makes those efforts worthwhile.

Aside from the inherent satisfaction of being helpful, students are also often thanked directly for their work. Hearing “thank you” is a reward that can reinforce students’ internal desire to interpret:

> “In the end it's definitely worth every single minute that you put into it because you see the smile on their faces, and the thank yous that they tell you, they genuinely mean it.” (I2)

The finding that students are motivated to continue interpreting after getting positive feedback aligns with past work on motivation, as Deci (1971) found that positive verbal comments (an external, intangible social reward) increased intrinsic motivation. Despite the difficulties, despite the effort, even a simple “thank you” provides a further sense of gratification to the interpreters. While it is the patients who receive the most direct benefits of interpretation and students are ostensibly not compensated, students do profit from interpreting in more abstract ways, such as being told “thank you” or feeling good from having helped another person.

In descriptions of why it feels good to interpret, I observed a fascinating theme of reciprocal gratitude: the patients are grateful to the interpreters for their help, but the interpreters also feel grateful themselves for being in the position that they occupy:

> “I was thinking, I'm so glad that I was able to be here today and provide that help for her that she needed so she can be able to talk to the doctor. So I was really grateful for being there.” (I8)

> “I'm […] very grateful to be able to help out these communities, you know, seeing patients from backgrounds similar to mine and being able to help out, make them comfortable, is still always there, that motivation.” (I7)

As bilingual people, they do not have to struggle with a language barrier; even the students who mentioned facing this challenge themselves as children are now in the position of speaking both languages. Since they have an easier time navigating multilingual spaces, it is gratifying when they can help others do so, as well:

> "It's just such a wonderful thing to be able to help if you're bilingual. […] Using your second language to help others is really gratifying." (I8)

> "I think most interpreters in [SVI] are people that grew up with two languages, you know, so it's kind of just circumstantial, it's like, 'Oh, I'm just lucky to be in this situation,' but it's so hard to attain two languages that it makes me happy to be able to help other people with that. […] So it makes me very, very happy. It's just very gratifying for me, I would say." (I10)

> "[What drew me in was that] I could help people do my language, which I think is pretty interesting because it's not a skill that you have to work towards to help people. You just naturally have it and […] you can contribute with something that simple, it's awesome." (I15)

These comments demonstrate an awareness of how lucky they are to be the bilingual ones and to be able to interpret, rather than to be in the position of not being able to communicate. So in addition to feel *gratified* when they help others, the fact that they can help others in this way makes them feel *grateful* for being bilingual.

4.5 Interpreting is difficult, but doable

No matter how motivated students are, interpretation can still be nerve-wracking. The balance between being fully present but not inserting their own selves into the interaction; the investment of time, money, and effort; and the specific challenges of the role all make interpreting difficult. Students reported various worries, too, such as not knowing a word or concept, having to remember all the course material, trying not to make mistakes, and interacting with experienced healthcare professionals. Many of their comments relating to these difficulties, however, were hedged with phrases that somewhat assuaged their fears:

> "You're going to be […] the main person there to truly make sure that everything is being communicated efficiently, which can be kind of intimidating, but […] with practice definitely comes perfection. And I understand that can be kind of scary, but after doing training, you're kind of used to it." (I2)

> "[I'm nervous] that I don't do it correctly or that I don't interpret exactly as it is. I just don't want to make any mistakes and ruin their lives. [*laughs*] But […] I will do the best I can." (I11)

> "I knew that interpreting in a wrong way could have some consequences, but I guess just hearing that the person's life is in your hands […] I was like, "Okay, oh my gosh, I'm overwhelmed a little bit." […] I think it will be overwhelming, but at the same time, it's a great experience and I'll be able to deal with it." (I15)

The interpreters' accounts thus intersect on the idea that interpreting is difficult but not impossible. Though it seems hard, practice and the training course help; though it feels intimidating, it is easier to settle into the role after some time; and though it takes effort, it is worthwhile in the end. Eccles's Expectancy Value Model of Motivated Behavioral Choice (2009) explains this, as it suggests that a task's perceived difficulty and perceptions of one's own capabilities will influence whether it seems achievable. These interpreters acknowledge that their task is not easy, but with their language backgrounds, practice, and the group's support, they can overcome the challenges and have a real effect in their communities. Knowing that what they are doing is important, believing that they can do it, and eventually succeeding (which, according to Eccles, makes the task seem more valuable) helps encourage them to keep going.

4.6 Connecting interpreter motivations to psychological theories of motivation

From the findings presented thus far, it is evident that the interpreters are multiply motivated. Interpreting is driven by the interplay of personal identity and experiences, inward-facing career benefits, and outward-facing community motivation. Some were explicit about how interpretation combines such factors (emphases mine):

> "I saw this as a great opportunity because it *aligns* my […] pre-health path with also volunteering and helping others. And it's also a big part of being Latino." (I4)

> "Through [SVI] you're making an impact to your community and *at the same time* getting like an experience that's so impactful, so beneficial to you as a pre-health student." (I7)

> "So I think it was *a mix of many different factors*: me wanting to help out after having experienced that, the fact that it was a medical setting, everything felt very perfect." (I10)

I4 emphasizes health experience, volunteering, and her Latino identity; I7 focuses on health experience, making an impact, and his community; and I10 spotlights health experience and her own experience. What is interesting here is that individuals tended not to have only one motivation, but multiple. My findings suggest more specifically that effort notwithstanding, students' identity- and community-oriented motivations dovetail to encourage them to interpret. They also reveal that although students have many of the reasons they interpret in common, no two interpreters expressed them in exactly the same way. Because of that, the decision to interpret appears to be a conscious and personal one.

While individual theories about motivation have merit—and I have noted several places in this thesis where their positions apply—Carver and Scheier's seminal work on control theory (1982) subsumes most of the other existing ideas about motivation. It can be applied to a wide range of scenarios, and as such is a useful lens through which to analyze students' motivation to interpret. *Control theory* is the idea that perceived discrepancies, or differences between a current state and an ideal one, propel behavior (Carver & Scheier, 1982). For example, if a person feels hungry, they are perceiving a difference between an empty stomach (the undesired state) and a full one (the desired state). As a result, they will be motivated to perform a behavior (i.e., to eat) to reduce the discrepancy.

In the case of interpretation, identity and community motivations are well-illustrated by this model. In terms of identity, SVI interpreters perceive a difference between their current stage in life (college students) and their future careers. Insofar as all of these students intend to become healthcare providers, they must be aware of the qualities and activities that will help them

achieve their future goals. In other words, they must determine what behaviors will diminish the discrepancy: for example, to be knowledgeable about the medical field, they will take certain classes; to be aware of what the medical setting is like, they will garner clinical experiences; and to care for others, they will show their commitment to volunteering. Within each of these objectives, there are multiple possible routes to completion. To volunteer, for instance, they could plant trees or tutor children, or for clinical experience, they could work as a medical scribe or volunteer in hospital. The singular act of interpretation encompasses volunteering, healthcare experience, and community involvement, so it diminishes three avenues of discrepancy on the route to the student's future self.

Discrepancies can be internal processes, as in the preceding explanation, but they can also be external, existing between oneself and others (Carver & Scheier, 1982). For student interpreters, such a contrast is perceived between them and the patients whom they serve; the former do not need language assistance, but the latter do. While there is obviously a dissimilarity in language skill, the discrepancy rather emerges from the implications of the language barrier: there is a difference between how LEP patients *should* receive healthcare and how they actually do with no interpreter present. Observing this, students are pushed to step in and lessen the discrepancy.

Control theory is thus useful for explaining both the identity and community aspects that motivate students to interpret. They see something that does not match with the ideal—whether that is their ideal future self, or an ideal healthcare encounter—and take action to diminish the discrepancy. Because there is no concrete compensation for doing so, it is tempting to describe interpreting as an altruistic activity, defined as an act done for others at cost to oneself (Batson et al., 1981; Elster, 2006). Since students expressed feeling empathy for the person in need (another

foundational aspect of an altruistic act), this notion is further supported (Batson & Shaw, 1991). Considering the difficulties I have so far emphasized, as well as the genuine desire to eliminate the challenge of a language barrier, "altruistic" seems an appropriate descriptor of interpreting.

However, there was also significant discussion among interpreters of how it feels good to help others. While intangible, the satisfied feeling associated with having helped someone—termed a "warm glow" in the altruism literature (Andreoni, 1990, as cited in Elster, 2006, p. 202)—is still a reward in the sense that it is a positive aftereffect of the action. Rather than altruistic, then, interpreting could more realistically be described as egoistic, since the behavior would be motivated not just by the desire to help the other, but by the positive personal effect that arises (Batson et al., 1981). Whether the "warm glow" feeling is a motivation or a byproduct raises the question of whether altruism truly exists; if it is a benefit, the actor does not have a net loss, and the act is not actually altruistically motivated. This is a longstanding debate which is still ongoing, and to analyze it adequately would require much greater depth than I can provide here. Instead, I will simply affirm that whether or not interpretation is truly altruistic, it still provides aid to the community and is thus valuable (Unger, 1991).

CHAPTER 5. Implications and conclusions

In examining the SVI students' expressed motivations, I discovered that a blend of personal connection, personal contribution, and personal benefit draws them to interpreting and encourages them to continue. In this chapter, I aim to situate my findings further within the body of existing research and outline the implications of this work.

5.1 How might interpreting affect the students long-term?

None of the interviewed students have intentions to become full-time professional interpreters after their tenure in SVI ends with graduation. Rather than a direct introduction to the career they plan for, interpreting in college is instead an opportunity to learn skills for and familiarize themselves with the broad setting of careers in healthcare to which they do aspire.

Interpreting has a number of important parallels to being a healthcare provider. Early exposure to the field kickstarts the process of *professional socialization*, which is the way that one learns tools and strategies for success in a certain vocation (Anspach, 1988; Vinson, n.d.). SVI students observe how providers behave, learn what kinds of questions they ask and how they make treatment decisions, and generally witness interactions within a clinic setting. Spending time in the medical setting early in medical school has been found to prepare students in terms of knowledge, concrete skills, and emotional conduct (Dyrbye et al., 2007); presumably, access to this space even earlier may prime students for what they will later learn.

A large part of this process is learning the *occupational register* of a career, that is, the terms and styles of speech people in the field use with one another (Anspach, 1988). By the very nature of the interpreters' participation in the interaction, they are not just hearing what doctors say; they are saying it themselves. In that way, interpretation gives students a chance to be much

more involved in patient care than they would be in another type of clinical or volunteer activity. Compared to students who simply observe, interpreters may thus learn better how to communicate like a physician, an important step on the way to becoming an effective provider.

Since interpretation focuses on both doctors' and patients' speech, interpreters may also pay more attention to what patients have to say when they are providers. Previous work in medical sociology has suggested that trainees are implicitly taught to prioritize objective, measurable information, even if it is to the patient's detriment (Anspach, 1988). In contrast to that trend, perhaps serving in this patient-centered role might teach students to value the patient's contribution to the medical conversation more. Based on how SVI interpreters talked about their work, this seems likely, as would the notion that interpreting has increased their awareness of the importance of communication in healthcare.

In addition to facilitating good communication, interpreters serve as a positive presence, as noted earlier. By bringing a sense of care into the interaction, students practice empathy, a provider characteristic frequently emphasized in medicine (Betzler, 2018). When students learn empathy in health professional schools (an increasingly common topic in these curricula), they learn some of the same tools that interpretation fosters, like eye contact and active listening (Vinson & Underman, 2020). Having practiced these skills early on, students will be more prepared as providers to create a positive emotional environment.

Many of the aforementioned skills transfer directly to patient care regardless of language. Interpreting is unique in that it also gives students an early introduction to the care of LEP patients. Though there have been some efforts to teach providers medical terminology in Spanish (e.g., Prince & Nelson, 1995), a much greater mastery of the language is required for adequate health communication. Rather than teaching providers a whole new language, a better

option is to work with people who already have some Spanish capacity, building on that baseline level to allow them to communicate directly in the patients' language (Clarridge et al., 2008). Considering that SVI students have sufficient language proficiency to interpret, they will in all likelihood not need an interpreter for patients who speak their language once they are healthcare providers themselves (and several mentioned that they look forward to becoming bilingual providers; see Table C4 in Appendix C). Since it has been shown that when patients are more likely to be satisfied when they speak the same language as their providers (Dunlap et al., 2015), this may lead to improved perception of these students as providers, as well as smoother, more direct communication with their patients.

Furthermore, these students will certainly know how and why to work with interpreters when patients speak languages they do not speak. Early exposure to interpreting, as well as the communication skills that can be gained from it, can help ensure that the next generation of healthcare providers understands the importance of interpretation and lowering linguistic hurdles in healthcare for any patient who speaks a different language (Basu et al., 2017). Student interpreters may therefore eventually be part of a future generation of doctors who are more capable of communicating effectively with LEP patients (Diaz et al., 2016).

On the whole, the way people think, act, and make decisions as pre-health students has implications for how they will think, act, and make decisions later on in their medical education (Lin et al., 2014). Consequently, acquiring important traits such as effective communication, dedication to training, and respect; exercising cultural competence; and practicing community engagement prepares students to continue such work when they become physicians (Kayser, 2017). As such, interpretation may have an effect on students that extends far past their undergraduate careers.

5.2 How might students interpreting affect the medical profession long-term?

In Chapter 2, I outlined some logistical reasons why interpreters may not be used, such as cost of hiring interpreters or lack of available staff at a given time. Though increasing the number of interpreters can help when there are none, there are other reasons why interpreter services are not always called which have less to do with the availability of interpreters and more to do with provider attitudes. In spite of the fact that research has shown both the positive consequences of using interpreters and the dangers of failing to do so, use of this resource is still not a given (Flores, 2005; Karliner et al., 2007).

In some situations, doctors may try to push ahead without language help, even though using an untrained interpreter (or none at all) has known downsides (Diamond et al., 2008; Monroe & Shirazian, 2004; Parsons et al., 2014; Schenker et al., 2011). Some may be hesitant to call upon interpreters because they assume the visits are less efficient and that the extra back-and-forth from patient to interpreter to doctor to interpreter to patient hinders communication and rapport-building (Karliner et al., 2004). They might also be hesitant to call for someone if the matter is small or would only take a minute; especially for situations they see as "lower stakes," practitioners are less likely to call on an interpreter and more likely to use their own limited skills or an *ad hoc* interpreter (Diamond et al., 2008; Tang et al., 2014). Doctors might also see LEP patient encounters as opportunities to test out a language they are learning, despite the fact that sacrificing good communication for the sake of their language practice is unfair to the patient (Diamond et al., 2008).

If providers are reluctant to work with interpreters or LEP patients, those attitudes may trickle down to their trainees, implicitly teaching students that providing LEP patients a lower standard of care is acceptable. This phenomenon is part of the "hidden curriculum" of medical

education (Kenison et al., 2017). In order to improve care for these patients, interpreter use must not only increase but be normalized; to do that, there must be a shift in the medical culture that emphasizes the importance of serving LEP patients equitably. In the short term, this should come from current providers modeling the behavior. If they are familiar with particular interpreters or have used interpreters many times before, they are more likely to do so (Karliner et al., 2004); accordingly, it is likely that interpreter use may follow a positive feedback loop: the more a doctor calls interpreters, the more they will do so in the future.

In the long term, there should also be a restructuring of medical education to include training on the use and importance of interpreters. Many studies (e.g., Parsons et al., 2014; Schenker et al., 2011; Tang et al., 2014; Weaver et al., 2020) have suggested that teaching trainees how and why to work with interpreters can have a marked effect on the care of future LEP patients. Having been interpreters themselves, SVI students will have already learned that; as a result, I predict that they will be more aware and less tempted to use shortcuts in the care of LEP patients. Moreover, students may have an effect on others; for example, SVI students interpret in clinics where medical and physician assistant students train, and several of them spoke about how they help the trainees learn how to work with interpreters. In addition to having curricular space dedicated to working with interpreters, then, SVI students reinforce the message that interpretation is essential. In this way, both in their own practice and in their interactions with peers and senior colleagues, students can contribute to changing the existing culture concerning medical interpretation.

5.3 How might students interpreting influence other students?

One interpreter summarized the importance of students interpreting in this way:

> "The fact that the more people that apply to be interpreters or the more people that get trained to be interpreters, the more that we can help solve this issue of language barrier access and access to health care." (I2)

Although this interpreter was speaking about SVI, and although this thesis has focused on English-Spanish or English-Portuguese bilingual students, the same motivations presumably could apply with any other combination of languages in the U.S. If this endeavor has been successful for SVI, it is likely that bilingual pre-health students at other schools would be similarly motivated to interpret in their communities. It should be feasible to establish other student volunteer interpreting groups elsewhere; training agencies exist in multiple cities, and virtual course formats (like the newer SVI students experienced) would allow their reach to expand further. Also, all kinds of volunteer groups already exist for both undergraduate and graduate students at most universities, so interpreting could add an interesting new dimension to existing opportunities at other schools. Most importantly, more interpreting groups could contribute to solving language barriers in other places just as SVI has done in its community.

In addition to encouraging other students to interpret, SVI students' accounts of their experiences could establish a potential avenue for determining the efficacy of existing interpreter training programs. These students spoke a great deal about what they learned in the course, and they tended to be consistent in describing the main learning objectives: the interpreter's role, proceedings of an interpreted conversation, and ethics. With the knowledge of what interpreter training programs are meant to teach, an assessment of student outcomes in vocabulary, ethics, and other topics taught in the program (including how students conceptualize the role, as I have done here) could potentially be a measure of quality control of the teaching. It would thus be informative to compare this dataset to the training program's stated aims to see how successful

the teaching truly was. In this way, students could help make future versions of the training course more effective.

5.4 Study limitations

Although I was able to obtain a good deal of interview data, this sample of seventeen was relatively small. It would be best to look at other existing groups like SVI (or to interview more SVI members) to generalize my findings with more certainty. Additionally, because interpreters had to opt-in and give their time, there could have been some bias in the sample if those who were willing to interview were particularly motivated and enthusiastic about interpreting. This might skew my results to be more positive in a way that is not representative of the group as a whole.

The sample was nearly balanced between more experienced and less experienced interpreters, and aside from a handful of places where differences were more noticeable, both groups generally expressed similar reasoning for wanting to interpret. Considering the fact that some time has passed since the more experienced interpreters began, it is possible that they have blended their initial motivations with the benefits they have encountered. My findings about what truly motivates students could be made stronger if I could have obtained pre-interpreting and post-interpreting data from every interviewee, rather than this cross-sectional view. This could be an interesting topic for a future project, confirming whether students' initial professed motivations match up to why they continue to interpret.

Finally, it is important to recognize that this is self-reported data, with students presenting their own experiences and opinions to me as the researcher, without my being able to observe their practices or objectively verify what their actual motivations may be. Asking the reasons

they interpret might thus be a bit artificial; since I intended to study internal motivation, there was an added layer of reflection required for them to convey it, and then another layer of evaluation in my analysis of their responses. However, the fact that the interpreters had to decide how they presented their experiences is also a strength of this study. Since I was curious to know how they perceive the role, asking them directly—despite the fact that it is a subjective account—was the best way to achieve this aim. I acknowledge that there is some risk of social desirability playing a role, especially concerning the personal benefits. For example, volunteering just so it looks good on a résumé tends to be frowned upon, so that could be why few people cited professional benefits as their chief reasons for interpreting. In the same vein, the construction that interpreting is difficult but doable is encouraging on one hand, as it suggests that interpreters have a great deal of grit and dedication, but it is possible that that, too, is somewhat of an exaggeration. For example, I find it unlikely that an interviewee would admit to me (a researcher whom they do not know) that interpreting is completely impossible, for fear of seeming like a complainer or giving a less positive impression of them or the role. In that sense, a desire to look strong and positive in the face of difficulty could have influenced these results.

Nevertheless, I believe that there was little reason for the interpreters to lie or to overinflate themselves. They were ostensibly unmotivated by a need to present interpreting in a positive light, as they were not being interviewed for a job or professional school, nor were they speaking with an interpreting supervisor. Even if they did select the more socially desirable aspects of interpretation to articulate, this informs what parts of interpretation are seen as more valuable and admirable. No act is completely unbiased or completely positively motivated, but these interviews provide a relatively wide panorama of a student interpreter's place.

5.5 Future directions

This study presented valuable new insights about student interpreters, but there is much work left to be done before this niche of interpreters is fully understood. For example, it would be informative to talk to these interpreters when they have actually become healthcare professionals to see whether students who have served as volunteer interpreters differ in any dimensions from students who are also bilingual and became healthcare providers but did not interpret. This could clarify what effect interpreting has on students, determining empirically whether the former group would really be more culturally competent, more effective communicators, and more willing to use interpreter services for languages they do not speak, as I have suggested.

In addition to examining what effect interpretation might have on future providers, differences within the group could provide further information about the role. Due to the size of my study, it was not feasible to complete a robust comparison of gender differences, but this could be interesting in a future project with more interpreters. Trudeau and Devlin (1996) have found differences in volunteer motivation between men and women, and Eccles (2009) and Rhoads (1998) also note that there are differences in values and motivations between men and women in various settings. Examining whether those differences hold true in the context of interpretation could provide greater understanding of the dynamics of interpreters' motivations.

The combination of being an active, contributing community member and also reaping some personal benefits may not be unique to medical interpretation. It would be interesting to study other types of activities related to volunteering and language (such as tutoring, coaching, or interpreting in other settings, for example) to see if other students express a similar combination

of motivations to those observed here or if the fact that it takes place in a clinical setting makes volunteer medical interpreting distinctive.

This project was a holistic review of the feelings of the interpreters themselves, so I did not get the chance to observe interpreted interactions directly. Although students feel they can be helpful (and most likely do provide good support), it is possible that, owing to their lack of experience, their student status has an effect on their interpreting of which they are unaware. One study, for example, found that while students learning to interpret are faster in their attentional cognitive capacity, professionals make fewer mistakes (Nour et al., 2019). Conducting further research on how these two types of interpreters differ in terms of the actual interpreting would be the most effective and objective way to determine how student interpreters' work compares to that of professionals.

Lastly, it would also be interesting in a future study to speak with all members of the interpretation interaction (doctor, patient, and interpreter) so as to examine the role of the student interpreter from different perspectives. Conducting a similarly-structured study with doctors and patients who have worked with both student and professional interpreters could consist of questions like *Do doctors feel like they can give the same quality of care with a student as with a professional interpreter?* or *Do patients feel more or less comfortable with students compared to professionals?* Answering these questions could provide further insight into perceptions of different types of interpreters.

In addition to further academic investigation of student interpreters, this work may have the extended application of stimulating more students to become involved in medical interpreting, as suggested in Section 5.3. I have shown that SVI students are motivated by personal identity, pre-professional preparation, and community engagement; knowing that these

are the motivations of one group may generalize to other university students, and as a result, other campuses may be able to draw on students who are interested and able to start groups like SVI. The theme of community I have described—a personal connection between patients and student interpreters—is especially important here because it is bidirectional: the community aspect makes students more willing to be involved in this important aid effort, and their work in turn has the potential to fill gaps for communities in need of language services. Because student interpretation is thus fulfilling for everyone involved, it should be encouraged beyond this individual group.

5.6 Conclusions

In this thesis, I have analyzed the role, training, and motivations of one group of student volunteer medical interpreters. It is well-known from the health communication literature that having an interpreter is important and can help improve patient outcomes; my work focuses on the interpreters themselves in an effort to increase their visibility and appreciate how they help orchestrate those improved outcomes. The goal of this work was to study students specifically, an under-evaluated demographic of interpreter, in order to learn more about why they choose to interpret. Taking together all of their expressed motivations, I have presented the idea that students are motivated to interpret not chiefly by the benefits they get from interpreting (though they do benefit), but because they can create and maintain connections to their identities and communities through interpretation.

It is important to study interpreters because they see the disparities associated with language barriers firsthand and try to mitigate them. My focus on SVI in particular brings to light some of the common challenges and benefits of being an undergraduate interpreter, which

contributes to knowledge about how they compare to their professional counterparts. By presenting the motivations and experiences of one student organization, I hope to bring this type of group to the forefront of the study of interpretation and recognize students as valid interpreters, especially as a resource for smaller institutions and communities. In so doing, this work might encourage other qualified students to form new groups like SVI on college campuses around the country. An increase in student interpreting groups would not only lead to greater awareness of medical interpretation, it would also improve patient outcomes in more communities; in this way, students can contribute to addressing the significant issue of language barriers in healthcare.

Rather than being an extraneous issue, language barriers are a critical element of social justice (Clarridge et al., 2008). Medical interpretation can ease patients' minds and ensure that their care is comparable to their language-concordant counterparts. Because it helps more community members receive adequate medical attention, interpretation therefore also helps foster spaces that are welcoming and tolerant of linguistic diversity. It is thus imperative that language services are implemented in health systems everywhere (Green & Nze, 2017). Furthermore, although the interpreters' own voices should not come across during interpretation interactions, they should not be ignored in discussions of how to achieve equity in healthcare.

To truly achieve this equity, however, we must look beyond language barriers and examine more broadly how cultural backgrounds link to healthcare. This can be done from a sociological perspective, aiding understanding of intergroup experiences, but also from a public health perspective, ensuring that communities are as healthy as possible regardless of cultural differences. This study is only the beginning of that initiative, but I hope that it may serve as a catalyst for increased emphasis on the role of culture in healthcare. With more established

information about the various players in this field, culture and language included, it will become clearer how best to serve diverse (not only linguistically, but in all senses of the word) communities.

In offering their linguistic resources and helping providers learn to work with interpreters, student interpreters make a difference beyond the life of any one patient. Just as interpreters lift up the voices of people who face language barriers, I hope that this thesis does justice to the voices of one group of people who make that possible.

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Appendix A

Interview Guide

Major differences between the interviews for more and less experienced interpreters are noted.

- Verbal consent
- Demographic questions:
    - What year in school are you?
    - What is your major?
    - What are your career interests?
    - What is your level of proficiency/experience with Spanish or Portuguese?
    - If you feel comfortable sharing, where did you grow up? What is your ethnicity? How old are you? What is your gender?
- Interview questions:
    - When did you first get involved in SVI? How did you hear about it? What was the application and recruitment part like?
    - [More experienced]: Why did you choose to participate in SVI initially? Why do you continue to participate?
      [Less experienced]: What made you want to be involved? How do you feel now that you are in SVI?
    - What do you (see as/predict will be) the most significant challenges you face while interpreting? What's the most difficult thing to translate/interpret?
    - What do you (see as/predict will be) the greatest benefits to you as an interpreter? To the patients and doctors?
    - How do you see yourself in comparison to professional interpreters? Do you feel more/less familiar with the language and cultural knowledge? Do you feel that you can relate better/worse to some patients than a professional interpreter? Do the patients and doctors know that you are students? If so, does that come up in the interaction?
    - How do you keep up with the interpretation as they are talking?
    - Please describe your interactions with the other members of SVI.
    - What do you think are the most important qualities for someone to have to be an interpreter?
    - For more experienced only:
        - Describe a typical encounter with a patient and doctor.
        - Tell me about your most memorable SVI encounter.
        - What advice would you give to someone who is interested in becoming a student medical interpreter?
    - For less experienced only:
        - What do you see as the role of the interpreter?
        - How do you think your age will affect your interpreting?
        - Are there any downsides to interpreting?
        - What are you most looking forward to about starting to interpret? What are you most scared of when it comes to interpreting?
    - Anything else you'd like to share with me that we haven't covered already or go back and expand on?

Appendix B

Codebook

Only select subcodes are presented for conciseness.

Section	Parent Code	Subcodes
Demographics	Year in School Age Gender Ethnicity Major Career interests Language background	 Pre-health career track Working as an interpreter Other career (non-healthcare)
Interpretation	Benefits to the patients (or goals of the interpreter) Benefits to the doctors Challenges Personal experience interpreting Role of the interpreter Language	Better communication with doctors Learn to work with interpreters Accuracy Most memorable session Professional interpreter Student volunteer interpreters Ad hoc interpreters Dialectal differences
Motivations & Benefits	Motivation to start Benefits to the interpreters	Language/culture/family Health-related experience Contribution to community Multifactor motivation Professional experience Personal gratification Direct impact
SVI-specific	Intro to SVI Training Interactions as a SVI member Barriers to interpreting	Where did you hear about it? Training description What they learn Feelings about SVI Interactions with members Time cost of interpreting Financial cost of training

Appendix C

Additional representative quotations

Table C1. The role of the interpreter.

Theme	Representative quotations
4.1.1 A functional but personally uninvolved intermediary	• "As interpreters, we're trained to be invisible." (I1) • "As an interpreter, you're always supposed to be kind of like letting the doctor and the patient interact and so they're looking at each other […] it's a way to make them feel like they're communicating with each other solely, like almost like I'm not there." (I2) • "Your mission is to not be involved. […] Like your mission is to be like 'invisible.'" (I4) • "They can't look at you as an interpreter, you have to kind of make it seem like you're not in the room." (I7) • "As an interpreter, the attention is not on you, it's quite the opposite. The attention is on the conversation, and 'Please don't even look at me' type of thing, that's kind of how you want to be as an interpreter… I shouldn't be involved in the conversation, I should be just kind of mediating it." (I10)
4.1.2 Characteristics of a good interpreter	• "You have to be comfortable with your own voice, and you have to be comfortable with your own judgment, because if you start doubting yourself in the middle of an interpretation, you're losing your professionalism." (I3) • "I think a certain level of language skill is definitely needed. At the beginning of the organization, like during their introductory meetings, you know, getting the word out, they kind of say that anybody with a certain level of experience would be capable of helping out. And that's true, you know, to a certain extent, it's true that any level will definitely help out as volunteers. But sometimes, I feel like if I didn't have like the skill […] I guess it's like comfort with the language, like if you're not comfortable speaking the language, then it might make the interpreting session, you know, very difficult." (I7) • "Being able to actually say things in the level of, you know, the language that people are saying is key because that's what makes your interpretation like, real. It's what makes like what you're saying real, is you being able to really try to say things as closely as possible to, you know, what the person said." (I10)
4.1.3 Perceptions of the student role, as compared to professionals	• "I think the student interpreter sometimes is more humble and more able to express the emotions of the patient because we are so worried about capturing every single part of it and not as a routine that we try to like capture the emotion as well." (I3) • "I'm not really sure of any differences between [students and professionals]. I just know that there's a lot more school required for that and definitely a lot more complicated terms. […] I believe there may be more of a like a financial aspect to it too, since we're volunteers, you know, maybe it might be like 'you get what you pay for' or something. And so with these, since these are more primary care visits, I guess it's not too risky […] but with more professional interpreters there's a lot more, you know, risk involved since you're getting down to the more specific

	aspects of things. So, you know, their, their job is definitely a lot more difficult in my opinion." (I7) • "I guess because they're like professionals, they understand better like how to do things and maybe find ways– like they can be a little more assertive. […] I think like if there were to be like a situation where something's wrong, then definitely like professionals have more experience with that, versus us would be like, 'What should we do right now?' Because it still, I guess, is a learning curve for us, like we're still learning how to deal with it." (I8) • "Us students lack the confidence, so like we would constantly be like, 'Can you repeat, please?' [Professionals are] so confident they don't even have to do that. They know all of the strategies possible, they're just really good. Um, I feel like with practice we're going to be able to be like them, or maybe like close to that." (I11) • "...professionalism. Because if you're an interpreter, and especially for us because we're so young, you know, like we're 18, we're 19, but it's, it's such an important task for us to do. It's a lot of responsibility communicating about someone's health situation to a health care provider. So I think you just have to be really responsible with it and know that what you're doing is important and every word counts." (I15)

Table C2. Potential barriers to interpretation.

Theme	Representative quotations
4.2.1 Training and preparing to interpret	• "I joined my sophomore year, not my freshman year, because like the cost of the course was really high, and like I wasn't expecting it freshman year." (I8) • "Because you have to pay for part of the course, that already kind of showed the level of the club, like I already knew that it was a real thing and that it was a big deal and I think all of that were things I realized once I was going through the process. So I was like, 'Okay, so I'm going through a training, I'm paying a lot of money,' so I could see that it was, you know, real." (I10)
4.2.2 Interpreting	Difficulties with interpreting: • "A lot of people aren't used to talking with an interpreter. So they're just going to talk like normal […] like sentences and sentences and sentences and you have to kind of like just be ready to interpret every single thing they said. Which is hard because people don't talk like someone's listening and having to remember every single thing they say. […] It's just like if two people are having a conversation and you had to sit down and remember the whole thing and repeat it." (I1) • "And everything that is said has to be interpreted because it, for– to be an interpreter, you cannot just decide… what's important, what's not. It's every single thing that the patient says must be like told to the doctor, and likewise, if the doctor says something, you have to interpret it for the patient, which I think is a crucial part. […] And if someone feels like what they're saying is important, you just have to say it out of respect and also out of respect for what you've been trained to do." (I2) • "When you're interpreting, you might be the only person who speaks both languages, so if you make a mistake, like the doctor's not going to know that you made a mistake translating into Spanish, and the patient's not going to know that you made a mistake, you know, translating to English or Spanish, right? [...] You just have to kind of like go in knowing that if you make a mistake, you have to correct yourself for what you did, because if you don't correct yourself, the outcome might be worse than you, you know, just admitting that you made a mistake." (I13) Interpreters advocating for themselves: • "Or you can say, like, 'Hi, like **this is the interpreter speaking**. I'm sorry to interrupt, but is there any way you could like try to say maybe like two sentences and then do a short pause so that I can like get the best grasp of what you're saying and interpret as accurately as possible?'" (I1) • "And so it's also super informative for you to just be like, stop the conversation, truly be like 'Hi, **this is the interpreter speaking**, like I need a moment to research how to say this because I'm– I don't–' You don't want to say the wrong thing, right, because it can be totally like misleading and so you truly just have to take the time to be like, okay, stand up for yourself and just be like, 'I don't know it, but I will in just a second.'" (I2)

	• "If there's any misunderstanding at some point, you kind of have to step out of your zone and be like, 'Hi, **this is an interpreter speaking**, like this person has this specific question,' or 'Could you elaborate a little more?'" (I2) • "You can say '**This is the interpreter speaking**, do you think you could please, if it's possible you can make– you know, pause more often so I can communicate more effectively. […] "**This is the interpreter speaking**, could you please refer directly to the patient so that I can, you know, I'll interpret as if, you know, as if I'm not here." (I5) • "There is occasionally that struggle where like the patient will still kind of talk to you instead of the physician…. Maybe it might just be that they feel a little more comfortable having like a Spanish speaker in the room and feel very uncomfortable speaking to the physician himself or herself. And sometimes that's a little difficult because it makes the process seem like– like it's not how you were taught to do it, you're supposed to be taught to speak every single word that's being said from them…. And sometimes it's a little difficult to let them understand, you know, how the process is supposed to work. (I7) • "I'm not used to interpreting so I might have some difficulty at first, have to [say], like, 'Okay, can you just like go a little bit slower, like take some pauses there so that I can interpret?'" (I15) • "I think it's going to be very challenging in the beginning, getting used to all the little details you don't know – like when to interrupt someone, asking them to repeat it, when to like, say "Alright hold on, say less," all those little details that just come with memorizing what someone says and then translating it without forgetting any words or adding anything." (I17)

Table C3. Motivations and benefits for interpreting.

Theme	Representative quotations
Personal background identity	• "One of the biggest things for me was, I've always done it with my mom and I can't imagine how many other like parents like sometimes don't even have that opportunity. […] So I just think about families like that […] and like I know that with my mom, I wouldn't want her to go through that alone. And so I always try to like think back, like, 'Okay, if you did this for your mom, you can do it for someone else, surely.'" (I3) • "Today, this is super easy for me, I can talk in Portuguese, I can talk in English, and it's, you know, automatic, but I recognize, you know, the ability that I gained because […] it was really difficult to actually master […] English. So I think when I saw the opportunity of helping other people, it just– I thought it would be very gratifying because it's so frustrating to be in that position. Especially, you know, in a medical setting, it's so hard, and I'm sure in a medical setting patients are– have so much going on." (I10)
Pre-health identity	• "I think being part of [SVI] helped me kind of like stay on the path as well, because I know a lot of people, it does get hard and everything, but just like being able to see the interaction and being a part of, like the team helping the patient is like, 'Wow, I want to do this.'" (I8) • "just kind of be open to the experience. Just know that if it's something you love and it makes you decide to go to medicine– because like all of, or almost all of our students were pre-med at the time. So it's just like if it makes you want to do medicine 1000 times more, then that is so cool. But if it also makes you not want to do it at all, then that's also super cool, you know. So just kind of be open minded, would be some good advice, I think." (I9) • "I also knew it would be a cool experience to be in a medical setting just being pre-med and maybe, you know, maybe it would be a good chance for me to see if that's what I wanted to do, or if it would be something different." (I10) • "Getting that experience, I think, is really helpful for when I'm a nurse practitioner, but for when like all these other interpreters are also, you know, going toward their careers. I think it's really helpful to just kind of already, you know, know some of that stuff and then you know, being able to like apply that. Like when I'm a nurse practitioner, I'll have that experience, not only, you know, from school about like what like these diseases are, like what the medical terminology is." (I13)
Helping a community	• "My first motivation was I mean first, like find a club that like is significant and you know like isn't just like 'Oh, I'm in the Spanish like whatever,' you know that's not gonna help. But like I was trying to find something where I could actually help someone. […] My biggest motivation is helping someone, and I think it's stayed that way." (I3)

	• "I've always been super involved with like volunteering […] so I knew that when I got to college and I definitely wanted to do some type of some type of volunteering. […] I feel like it's more of an obligation to help the community than anything else, at least I see it like that, like as a priority." (I4) • "I thought it would be a good way to, to really make a difference in the Atlanta community and you know be involved in a really cool organization that– you know, actually helping others…. In the end, the overall goal is to, you know, be passionate about helping others and help out in the community through, you know, our goal of interpretation for these patients." (I5) • "[SVI] was the one that caught my attention right away just because the concept of having college students be able to be certified interpreters and, you know, give back to the community was pretty cool to me, and it was just something personal to me that I wanted to do for my community." (I12) • "The reason that I joined [SVI] and that I started wanting to interpret, I guess, was to mostly get back to my community because I know how hard it is to not know the language." (I16)
Forming a community	• "I think it's also like the fact that we, we kind of make like a little network within our club. […] If we don't understand something, my first instinct is going to be ask someone around me. […] And so being able to […] actually have like a support system if you don't know what to do, or you feel like [you] did something wrong, is huge. […] [And at meetings] you get to see new faces every time because there's always a new class of interpreters and whether you know them or not, they are now like part of your family." (I3) • "I think that's a huge part of [SVI], is being, you know, a big family." (I10) • "Really, it doesn't feel like it's just some type of like coworker relationship […] we're all like really comfortable with each other. You know, after our first interpretation session, I remember other friends who had done interpreting sessions before were really invested in like how it went for you, and like really asking how it all went, just because you know they care for each other, like a friendship. So it's really good. We all feel really comfortable with each other, and you know, we hang out outside of like interpreting sessions as well." (I7) • "[For training] it's super fun to have a class and to, you know, take the quizzes together. We're like, 'Okay, we're all in this together.'" (I10)
Feelings of gratification/satisfaction	• "[It's] honestly just like super impactful in your life, like the changes you make, you can see during that specific time, like once you're done, you get already praise for everything that you're doing, which I think is a bonus. And we see the smile on their faces and the fact that an

	appointment with a doctor and patient was able to go well, the fact that you were helping out for just a few minutes.” (I2) • “You can really tell that you made a difference. And to me, I feel like that's what brings the most value when you're interpreting. I think […] it's a really cool, you know, feeling.” (I5) • ““It was really tough at times […]. But […] I felt like I was being really helpful and, you know, giving [the patients] some sort of voice to communicate what was going on with their life. […] It was really great to be part of [SVI] personally to be able to be something that I think should be essential.” (I9) • “For me it's just kind of very gratifying to be able to do that, you know. It feels– It feels good to be needed in that scenario, like you feel like you're needed.” (I10) • “So me making their lives easier is the best thing. There's a lot of satisfaction in our work.” (I11) • “By being able to help, then that also makes me happy, so that's something else that I would be getting out of it.” (I14) • “I always feel like you obviously feel so satisfied after helping a person, just even if it is the stupidest thing, like even if it is like a little, I don't know, problem in the knee, that you can just like– the doctor just says “take Advil,” but like that person probably has so much like relief.” (I4)
Having a direct impact	• “I think that’s the huge advantage of being an interpreter, that you can see the immediate impact.” (I2) • “When you see how they first start and then end, it’s very satisfying to be like ‘Okay, like at least I made them feel a little more comfortable.’” (I4) • “I thought it would be a good way to, to really make a difference in the Atlanta community and you know be involved in a really cool organization that– you know, actually helping others and I saw that there’s a, there was a lot of need and you can, you can have a really big impact in the life of these patients.” (I5) • “It’s literally like doing stuff, you’re not– you’re learning by doing, not by like from a textbook.” (I6) • “I'm just excited to be finally like inside that setting and having like an important role where I can actually contribute to like people's healthcare.” (I15)

Table C4. Future implications for student interpreters.

Theme	Representative quotations
Teaching providers to work with interpreters	• "This is something that a lot of doctors aren't aware of yet. I think like if they have experience in a hospital, they're a little more aware of it, but in clinics and just areas like that, especially with minorities, are not aware of the importance of an interpreter and what an interpreter is supposed to do, and so I guess that's also why we do it because we try to let like the upcoming doctors or physicians, like the PAs, to really know that, 'Hey, like an interpreter is not supposed to be someone you talk to directly, like this is someone who– you're still having an interaction with the patient, and in order to make the patient truly feel like this is important to you, you must look at them.'" (I2) • "[Using a lot of medical terminology is] definitely kind of a problem with the doctors, but that's why they're getting the experience, you know, like, once they have more experience with us, then they're able to be like, 'Okay, I have to stop myself. I have to speak slower to make sure that everything that is being said can actually be said correctly.'" (I2) • "I hope that it's– it acts like– it makes them reflect on how the language barrier is something very relevant in the medical field, especially in the US because, you know, the percentage of people of Latin communities in the US, like of course people try to learn English, but it's also important for those who don't speak Spanish or Portuguese to recognize that there's a lot of us and we can't just learn English like that. It's a hard process, especially when you're like an adult and you have to work, you have to do all this other stuff, sometimes you don't have time to learn English. So I really hope that they reflect on that and they notice how like it's a privilege to speak English in the US and how that makes life easier." (I15)
Becoming bilingual providers	• "I want to be the physician, be the provider and not have to have a medical interpreter with me, like I can have that interaction, not have that language barrier with the patients." (I8) • "Getting that experience working in a clinic […] [seeing] how a doctor-patient relationship is, or the information that the doctor knows […] you'll be translating it for the patient, but in that way you'll also kind of be retaining that for yourself. […] Like when I'm a nurse practitioner, I'll have that experience, not only, you know, from school about like what like these diseases are, like what the medical terminology is, but also I'll actually be able to talk to my patient, you know, one on one without the need of somebody there because I've already interpreted before, so I already know how to speak to them directly. Right, so I can actually like form that connection with them. And I think that's like very helpful when you actually, you know, you can speak to them in their language and you don't like need somebody else to come in and help you." (I13) • "I want to be a bilingual doctor. I want to be able to have a patient, and if they don't speak any English, I don't want them to need an interpreter. I want

	to be the person that's able to do it on my own and I think that this is really a big step towards reaching that goal because I'm like learning medical terminology and I'm only planning on like learning more from here. And also just like it would allow me to be a provider that has like a better connection, I feel like, with my patients. Just like being able to understand or relate or connect with them through like a cultural or like language, linguistic level other than English means a lot to patients. Especially growing up, I know my mom was like "Oh, I'm gonna go talk to– I like this doctor because like they speak Spanish." You know what I mean? So it like helps you build like a better connection with the people that you are serving" (I14)