International Journal of Interpreter Education

Volume 7 | Issue 1 Article 8

2015

Interview with a Trailblazer: Jessica Dunkley, MD

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Abstract

Jessica Dunkley is a Deaf medical doctor currently in her second year of residency with the University of Alberta in Canada. In this interview she describes her experiences of accessing medical school with interpreting services. She discusses the skills, knowledge and attributes she seeks in the interpreting team working with her in this complex medical context, and she describes her needs and preferences for the working norms that the designated team must adopt. Her experiences offer interpreters and educators opportunities to examine their own interpreting assumptions and to learn about the ways in which Deaf doctors and medical practitioners perform their work in order to produce effective interpreting services.

Keywords: interpreters and interpreter education; Deaf doctors; medical discourse; decision making; team interpreting; American Sign Language (ASL); power and privilege.

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Russell and Dunkley

Interview with a Trailblazer: Jessica Dunkley, MD

Dr. Jessica Dunkley is a Medical Doctor from Vancouver, Canada. She is also a Registered Physiotherapist and holds a master's degree in Clinical Epidemiology. Jessica is Deaf and grew up with deaf parents. Her resiliency is demonstrated in her passion to reach out to everyone to reframe their perspective in their journey to success. She enjoys working with diverse populations, from indigenous peoples to people with disabilities. She has a passion for giving motivational speeches to youth across the country and strives for equal access for deaf people in higher education. After graduating from medical school, Jessica began a 5-year residency program in Public Health and Preventive Medicine at the University of Alberta in 2013. Aside from academia and medicine, she enjoys road cycling along the Sea to Sky Highway.

Debra Russell is an ASL–English interpreter and interpreter educator from Calgary, Canada. Her interpreting practice spans 30 years, and is community based in a range of medical, legal, mental health and employment settings. As the previous Peikoff Chair of Deaf Studies and the Director of the Western Canadian Centre for Deaf Studies at the University of Alberta, her teaching has also taken her to six continents. In addition to her teaching, she maintains an active research program, with current projects that focus on Deaf interpreters, legal interpreting, and mediated education settings for Deaf children. In 2011 she was elected President of WASLI (World Association of Sign Language Interpreters). Deb is also a dedicated student of yoga and loves to travel.

Deb: Share a bit about your background with us.

Jessica: My experience using interpreters began when I was 5 and entered kindergarten and used them throughout Grades 1–12 (elementary and secondary education system). I used interpreters as a child, and then I used interpreters in my undergraduate degree and my postgraduate training. I think it's interesting that my preferences for interpreters have changed over the years. I have a medical degree, and I'm about to do a 5-year internship in family medicine and public health, which is the path one takes in Canada to practice medicine—complete medical school and then a residency. For those unfamiliar with "public health," it refers to programs that address the social, economic, and environmental factors that affect health. There are four major aspects to public health, such as health surveillance, health protection, disease and injury prevention and health promotion.

I think my interest in medicine came from when I was doing physical therapy in my undergrad year. Until then I hadn't thought about medicine, because I had the experience of being raised in a family where my parents were both deaf; and I had looked at their lives, which were rather limited, and assumed that as a deaf adult my opportunities might be similarly limited. However when I attended university and began my physical therapy course, I realized then that there were greater educational opportunities for me in the health care field, and that my options were really wide open. For example, technology is available that can support me in health care, such as a visible stethoscope, which substitutes for the actual hearing of the sound. So there are all kinds of electronic solutions that are available to me, and that attracted me to medicine.

In terms of the internship I am about to start, the first 2 years will require a lot of medical interpreting. That will include hospital, family medicine clinic time, and also many academic meetings during the day, medical conferences, and so on, so I'll use a regular designated interpreter for that work.

The third year, which is an academic year, will be more like graduate school. And then in the fourth and fifth years, I'll be focusing on public health, so that could be working for a provincial Health Authority, working for the Federal Government in some of their areas. This will be at a managing and operational level, so more administrative rather than a strong clinical focus. The work will look at health care at the population level, and could be outreach work, or it could be operating preventative programs, or it could be mother–infant health programs, fetal alcohol syndrome programs, obesity, and so on. The clinical medicine will really focus on medical issues at the individual level, and so public health will be much more looking at the long-term solutions and the long-term effects of health solutions. So, for example, looking at antismoking programs and at legislation and finding out whether or not those are successful as a determiner in increasing public health.

Deb: And what was it like going to medical school in Canada—you were the first Deaf person here to blaze that trail—and how did interpreting services fit into that training?

Jessica: In terms of my previous study experience at medical school, the first 2 years certainly had an academic focus, and the last 2 years were hospital focused. In the first 2 years, I think it was very similar to any academic program in the ways that I used interpreters, and I looked for interpreters who demonstrated fluency in American Sign Language. I also looked for interpreters who could convey highly technical information at a very high rate. That information came quickly, and I needed interpreters to be very organized to be able to respond to new vocabulary (such as the 5,000 new words needed for medical school). Sometimes interpreters needed to understand and convey the content; other times they just needed to provide it to me in the English format, and I could adapt because I had a very solid understanding of the information. This situation required the interpreters to be flexible and willing to proceed when they didn't always understand. I had the skills to filter through the information and determine how I would understand that information and then apply it, and so they could give that information to me in pieces, and I could link that together. That was challenging for the interpreters to get used to as opposed to maybe working with other students who don't use similar strategies.

I've also noticed that interpreters who have a postsecondary education seem better able to handle the volume and the rigor of medical school. I'm not speaking about interpreter education specifically, but rather interpreters who are well read, who are very familiar with world events, and who have a large global knowledge. I think that this gives interpreters the maturity to do the work: maturity regarding their own self-control skills, their ability to deal with stress, self-management skills, their ability to function in a health care setting, and to recognize the importance of the work. It can be very stressful working in a hospital environment, and it requires a great deal of speed; not all interpreters can do that. Also, for interpreters who would like a standardized schedule, things being stable and very predictable, and who would like to know what they're doing day-to-day—this is not the environment for you. In a medical environment, the work is always unpredictable. I needed interpreters who had a thirst for knowledge and were thrilled to be able to learn new things. Those types of interpreters did very, very well in this environment.

As a consumer, I'm very assertive about what my needs are in terms of interpreting. I like to be able to set up the relationship with the interpreter. I like to be very clear with them about what my needs are as a deaf physician. For example, I don't need them to sign every single thing that's going on in an environment, because I can manage this just as well as my non-deaf physician colleagues can. When I'm approached, I don't need to wait for the interpreter to be present. I can deal with it; I've got strategies. If I look over at the interpreter, however, it means that I'm looking for some interpreting services. I want to be treated as an equal deaf physician, and that requires me to be assertive these interactions with my medical colleagues. It can take an interpreter a little bit of time to get used to that style, especially if they have worked with deaf consumers who depend more fully on interpreting services to interact with others.

Deb: What is the bottom line for you when you think about the traits you want the interpreters working with you to have?

Jessica: I think if interpreters are open-minded and open to feedback, that's great. But there are other interpreters who don't like my particular approach. They're very used to their own traditional way of viewing interpreters and deaf clients, and it affects how they interact with them. I don't like that. I make it very clear that it's inappropriate for the situation that I'm in, and whether the interpreter likes feedback or not, that's how it needs to be. For example, if I'm dealing with a patient and there's something that arises and the way the interpreter is working doesn't suit me, then I want them to be open to the feedback, and I want them to be able to modify their behaviour immediately in regard to what I need in the clinical sense. And so it's really important to me that the interpreter understands his or her own weaknesses and is open to adapting their style.

I'm very firm on that particular principle because an unwillingness to discuss feedback doesn't reflect well on either myself as the deaf physician or the interpreter. There have been times where I really want to be able to get along with the interpreters I'm working with, and so I can sometimes take advantage of that, you know, like as a teenager I could take advantage of interpreters that I really liked and who liked me.

Deb: Can you describe what you mean by taking advantage of the interpreters?

Jessica: I could take advantage of those interpreters who were willing to negotiate with me when I was in high school. For example, there were a few interpreters who sort of went outside of their role (gave me hints on tests, took notes for me, etc.), but it benefitted me, and when it benefitted me, I embraced it. I was a teenager. I didn't do this in my undergrad, but that wasn't a particularly career-oriented program either because in sciences, you can take courses and not be really sure what you're doing. Medical school was a very career-focused program, however, and medicine is the same thing, and so my requirements of interpreters are different than they might be for other deaf consumers.

Deb: The next question is, given that you've seen so many interpreters, how would you like to offer some advice to interpreter educators? What would you like those programs to do differently and/or what would you like them to do more of as they educate the next generation of interpreters?

Jessica: I think right now, the number of Deaf people in educational settings is rising dramatically. I think many of those programs that teach interpreters have trained interpreters to work with the community; that is, working with deaf people who are accessing services as clients, whether that be in a welfare context, or a human service context, that kind of thing. So interpreter programs are often training people to work with deaf people who are not in a position of power, but that's changing. The more we see deaf people acquire advanced education and enter and advance within a range of professions, the more of a challenge this provides for interpreters and interpreter educators.

Maybe the community views graduates from interpreter programs as very competent, but from an academic perspective, I would suggest that they're not so competent yet. I'm more interested in their ability to convey information accurately, rather than whether or not their fluency in American Sign Language looks native-like or not. As mentioned before, I'm also looking for somebody who can adjust to my preferences, even if this means essentially tossing out things they learnt in the interpreter program. That is just part of working as a designated interpreter, and I don't think all interpreters appreciate that they will need to adjust practice so dramatically in that role. For example, the whole practice of consecutive interpreting doesn't apply well to the context that I'm working in. Often interpreters want to slow the process down, really work until they've constantly

understood everything. That's not the model of interpreting that I need. The power dynamics can be challenging and more complicated when you have a Deaf person in the position of service provider, and when that person has much more expertise than the interpreter. The Deaf person is in a powerful position here based on knowledge, training, expertise, and professional role, which is very different than what most interpreters have been trained for or have experienced in their work in the community.

Deb: Is there anything else you'd like to say, Jessica? Questions I should have asked you but I didn't?

Jessica: I would just like to add that I recently attended a screening process used to take students in to interpreter education programs. I had attended one several years ago, and then I did it again last year. I have a couple of different observations based on these experiences. I think one of the weaknesses of the way that we screen interpreters in or out of education programs is that there's an assumption that fluency in ASL is enough to make them a successful interpreter. Yet what I'm looking for is interpersonal maturity, world knowledge, and the ability to manage academic discourse. It strikes me that interpreting programs perhaps are operating on instinctual levels about what they're looking for in an interpreting student, and I'm not sure that those students really meet the needs of deaf academics. It may be that there aren't enough people who apply to programs, so maybe programs need to be doing much more promotion about the changing face of interpreting and understanding more about the range of deaf people interpreters will work with. Just as the nature of interpreting is expanding, we need to expand on what we are looking for in applicants.

Deb: *It certainly is a debate that's occurring around the world in terms of what are the attributes that make one a successful interpreter, and can we predict any of those attributes prior to taking students in. Certainly some of our early studies are speaking to self-confidence, higher levels of self-esteem being correlated within the foundational skills of acquiring interpreter skills and being able to work effectively. It may be that many of our Canadian and perhaps some of our North American programs are not screening in the same ways that you're describing that you would like them to, Jessica; and we're not focussing on measures of self-esteem or self-confidence, world knowledge, maturity, interpersonal skills. So the traits that you've been talking about, I'm not sure that we're really looking for them. We seem to be very focused on their language proficiency but perhaps not some of those other skills that are really key to effective practice.*

Jessica: That's a good point. I can really see that.

Deb: Finally, do you have a preference for gender matching in the designated interpreters that work with you?

Jessica: I don't usually, although sometimes I would consider it important in terms of patient care. For example, if I'm working with a female patient in a very sensitive situation—let's say a labour and delivery—then we would want to respect that patient's right to have a female interpreter present during labour and delivery. Otherwise, they've not only got something different in having a deaf doctor; they've also got a male interpreter in the room. In situations like that, gender matching is key. But beyond the patient context, gender matching is not so critical for me.

Also, just going back to the need to better understand the role of designated interpreters, I wonder if there is a need for a forum for interpreters who are working with designated health practitioners. Interpreters could have almost an exchange program where they could see other models that work, and where they could see how other interpreters approach the role of a designated interpreter. I think that that would be a really powerful approach to mentorship that probably can't be handled in an interpreter education program. As you said, we maybe have to let

go of things that we've been traditionally teaching interpreters in terms of serving deaf people who are in lower positions of power. Discourse management is much more than interpreting the words; for myself as a deaf professional it's also very much about the flow of interaction and how I'm perceived. So the mentorship between interpreters might be a key way to increase the pool of interpreters available to professionals like me.

Deb: I want to thank you very much for your time, Jessica. I appreciate you doing the interview, and I think that many of our readers who are training interpreters will be very interested to hear some of your thoughts about the changing face of interpreters and the kinds of attributes that they should be screening for in terms of getting interpreters to work in a designated role. Thank you very much for your time.

Jessica: Thank you, Deb.