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# Teaming in Translation: training interpreting, medical, and midwifery students in simulated birth settings / Teaming in Translation: formación de estudiantes de interpretación, medicina y enfermería obstétrico-ginecológica en entornos simulados de parto

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**Abstract:** This paper reports on the *TeamTra – Teaming in Translation* project, conceived in response to calls for improved training of both professional interpreters and healthcare providers. TeamTra is a cooperation among the Medical Faculty, the University Hospital, the Institute for Applied Linguistics and Translation Studies (IALT), and the Oriental Institute (OIL) at Leipzig University. The program is aimed at medical, midwifery, and interpreting students and draws upon interprofessional and simulation education models to provide students with hands-on experience for different professions using simulated patient-physician/midwife encounters in maternal health. Special attention is devoted to cultural differences, varying degrees of health literacy and challenges of triadic communication. The course was carried out for approximately 80 students in the 2022/2023 winter semester and in the 2023 summer semester. This paper reports on the first year of the project, which included a pre-kick-off survey, a satisfaction survey, and feedback sessions.

**Keywords:** Healthcare interpreting; Interprofessional training; Public service interpreting

**Resumen:** Este artículo informa sobre el proyecto *TeamTra – Teaming in Translation*, que se concibió para mejorar la formación de intérpretes y profesionales de la salud. Es una cooperación entre la Facultad de Medicina, el Hospital Universitario, el Instituto de Lingüística Aplicada y Estudios de Traducción (IALT) y el Instituto Oriental (OIL) de la Universidad de Leipzig. Este programa está dirigido a estudiantes de medicina, enfermería obstétrico-ginecológica (matrona) e interpretación y se basa en modelos de educación interprofesional y de simulación para ofrecer a los estudiantes una experiencia práctica, reuniendo a las distintas profesiones para simular encuentros entre paciente-médico/matrona en el contexto de la salud materna. Se presta especial atención a las diferencias culturales, los distintos grados de educación sanitaria y los retos de la comunicación triádica. El curso se llevó a cabo para aproximadamente 80 estudiantes en el semestre de invierno 2022/2023 y en el semestre de verano 2023. Este artículo informa sobre el primer año del proyecto, que incluyó una encuesta previa al inicio, una encuesta de satisfacción y sesiones de retroalimentación.

**Palabras clave:** Interpretación en el ámbito sanitario; Educación interprofesional, Interpretación en los servicios públicos

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## 1. Introduction

According to the World Migration Report of 2022, the number of migrants worldwide has increased considerably over the last 50 years. If in 1970 the number of people living outside their country of origin was 93 million and in 1990 it reached 153 million people, today, 281 million people are migrants (3.6% of the world's population). In this 50-year timeframe, Germany has become the second major destination for migrants worldwide. In 2021, there were nearly 16 million international migrants in this country (McAuliffe & Triandafyllidou, 2021, p.24). Moreover, according to the German Federal Statistical Office, this figure is brought up to 20 million when it includes the population with a migration background, that is, the foreign-born and the population born to migrant parents in the country (DESTATIS, 2022; Strelow et al., 2021).

Studies taking a closer look at the realities of migrants in Germany have shown that people with limited German proficiency do not tend to access certain services. As a result, their health outcomes are generally worse. For instance, the foreign population in Germany presents lower vaccination rates and is more affected by mental illnesses than German nationals; foreigners also have a higher maternal mortality rate (Mösko et al. 2016; Razum et al., 2008).

Migration and health disparities go hand in hand, with language and culture playing a central role in and having a disproportionately adverse effect on foreign-language speakers. This issue came to the attention of the scientific community as early as the 1980s, and studies have consistently shown that working with interpreters is essential to reducing health disparities (Brisset, Leanza and Laforest, 2013). According to abundant literature on the field, so-called linguistic gaps are responsible for "inappropriate diagnosis, poorer adherence to treatment and follow-up, more medication complication, longer hospitalizations and decreased patient satisfaction" (Brisset, Leanza and Laforest, 2013, p. 131).More specifically, in the case of migrant women, various studies in healthcare show that language barriers prevent women from attempting to access as well as receive the healthcare they need (Hoang, Le and Kilpatrick, 2009). Moreover, migrant mothers in high-income countries are reported to experience considerable inequalities in healthcare provision (Hughson et al., 2018) and more perinatal complications (Sami et al., 2019).

In this context, the Teaming in Translation (TeamTra) project was conceived in response to calls for improved training of both professional interpreters and healthcare providers (Fukui et al., 2024). The project involved approximately 80 students in the 2022/2023 winter semester and in the 2023 summer semester. It resulted from a cooperation between the Medical Faculty, the University Hospital, the Institute for Applied Linguistics and Translation Studies (IALT), and the Oriental Institute (OIL) at Leipzig University. The aim of this paper is to report on the first year of the project, including surveys and feedback from students. A partial report on TeamTra was previously given in Reichmann et al. (2023). The project has recently been granted an extension, also running in the winter semester 2023/2024.

To this end, section 2, below, provides an overview of the interrelations between translation and health. Next, section 3 will describe the entire program aimed at medical, midwifery, and interpreting students, drawing upon interprofessional and simulation education models (cf. St.Pierre and Breuer, 2018) to provide students with hands-on experience in simulated patient-physician/midwife encounters in the context of maternal health. Section 4 shares student feedback, in addition to addressing some of the challenges faced during the project. Lastly, section 5 contains a discussion of the results and our final remarks.

## 2. Translation and health

Translation and interpreting are two of the main pillars for integrating migrants into national healthcare systems (Hlavac, 2021). Moreover, implementing a working system for interpreting services in healthcare is a task for policymakers that depends on political will. Antonini et al. (2017) underline that policy approaches vary greatly among countries and draw attention to the fact that many countries aim at assimilation[1] rather than promoting integration and/or pluriculturalism. Thus, there is little political will to establish and/or support (existing) translation and interpreting systems and solutions.

Often, foreign-born patients and patients born to migrant parents experience difficulties accessing the national healthcare system, and the lack of interpreters is one main reason. This, however, does not mean interpreters are not available, but that they are only very rarely hired for work since there is usually no agreement on who should bear the costs of their services. As in other geographies, many non-German-speaking patients resort to bringing friends, family members or volunteers to medical appointments, while clinics and hospitals will oftentimes have untrained bilingual staff to act as makeshift interpreters. Accordingly, public service interpreting in Germany, and elsewhere, is primarily carried out by non-professional interpreters (Baraldi and Gavioli, 2016; Kalina, 2001; Sauerwein, 2006; Ticca, 2017). This comes with significant challenges for both healthcare professionals and patients since strained or flawed communication can lead to misunderstandings or, in the worst case, inadequate care (see Glenn et al., 2003, Krystallidou et al., 2018).

Conversely, the legal framework in Germany is surprisingly clear regarding equal rights. In fact, article 1(3) of the Basic Law states “No person shall be favoured or disfavoured because of sex, parentage, race, language, homeland and origin, faith or religious or political opinions” (Basic Law for the Federal Republic of Germany, 1949). Furthermore, enshrined in the German Civil Code, is the duty of healthcare professionals to provide information and obtain informed consent (BGB, Sections 630c, 630e), which are crucial to patient human rights. However, no specific law regulates interpreting in healthcare.

As a result, healthcare interpreting in Germany is characterised by a high degree of heterogeneity. A small number of clinics have taken on the responsibility of providing interpreting services, relying on interpreters recruited internally among staff and/or externally among freelance interpreters (Universitätsklinikum Hamburg-Eppendorf, n.d.). Yet, in most cases, patients have no in-house interpreters on which to rely. For certain groups (e.g., asylum-seekers who are waiting for a response to their application), local governments provide interpreters to a limited degree (Stadt Leipzig, 2020). In light of this complex context, the TeamTra project attempts to fill a crucial gap regarding the right of the non-German-speaking population to healthcare.

## 3. Project TeamTra – Teaming in translation

After embedding the project in the simulation teaching (Rotzoll, 2016) at the LernKlinik Leipzig, the medical school’s skills and simulation lab, and considering different perspectives, scholars and practitioners in Medicine, Midwifery, and Interpreting began the project. The field of maternal health was chosen because the bachelor’s programme in midwifery had only recently been established at the referred university and has curricular flexibility, which was ideal for the introduction of this new teaching module. Moreover, maternal health is a field where successful communication and positive experiences not only impact the parties in question but also society as a whole. In fact, according to Susam-Saraeva and Fonseca (2021, p. 348), “conception, pregnancy, birth, labour and postpartum periods are crucial life events which have

[1] See Dahinden and Bischoff (2010) for a more detailed look at different integration policies.

a bearing on the future health of individuals, as well as the collective health of families and societies".

The next step that our team took was the selection of the foreign languages to be used for the training among the four languages offered in the two Master's programmes in Conference Interpreting at Leipzig University, namely, Arabic, English, French, and Spanish. Arabic and Spanish were chosen because they were most likely not to be understood by the medical and midwifery students, thus ensuring healthcare professionals would rely on the rendering of the interpreters.

### *3.1 Project aims*

TeamTra brought together three groups of students – interpreting, medical, and midwifery to create awareness about the complexities of triadic collaboration, considering three perspectives: cultural, linguistic, and medical. The objective of the training was to improve the interpreters' knowledge of institutionalized healthcare settings, on the one hand, and the healthcare professionals' knowledge of interpreting practices, on the other hand.

### 3.2 *Pre-Kick-off survey*

Before the project's kick-off and before the medical and the midwifery students could be enrolled, the interpreting team designed a survey using LimeSurvey®2 to learn about the expectations of interpreting students and those enrolled in studies in Interpreting, Medical settings, and Midwifery at Leipzig University (Appendix 1). Our survey replicated Pöchhacker's (2000), who surveyed healthcare service providers and untrained interpreters in Vienna to investigate the nature and limits of the interpreter's task. The results of the survey matched those of Pöchhacker's study carried out almost 25 years ago. For instance, regarding interpreters' potential simplification of technical language, most health professionals agreed, although the percentages varied depending on the groups. Thus, while in Pöchhacker's study most nurses (90%) agreed with the need to simplify language in our case, the highest percentages were obtained by the midwifery staff and interpreting students who participated (100%). Doctors followed, with 75% (Pöchhacker, 2020) and 50%, respectively (our study), and interpreting students, with 75% (Pöchhacker, 2020) and 63%. Other parallels were also found, particularly considering the rates for explaining terms, summarizing, and omitting to save time, with doctors having the lowest agreeing rates, except for filling in forms in German. Additionally, the mismatch in terms of the expectations of healthcare professionals and interpreters' self-awareness was confirmed in both surveys. Therefore, the pre-kick-off survey came to confirm what we, as interpreter trainers, are already aware of: that the role of the interpreter has not yet been adequately defined and should include much more than oral translation based on the providers' perception (Pöchhacker, 2000). Moreover, the expectations of these two groups (interpreters and providers) are not always aligned (See the complete survey in Appendix 1).

### 3.3 *Infrastructure*

The LernKlinik, where the project that we focused on takes place, is a skills and simulation lab for dentistry, pharmacy, medical, and midwifery students. It has 23 training rooms for students to develop practical skills and learn from hands-on experience. They receive training not only in medical procedures and the handling of medical devices (e.g., ultrasound machines), but

[2] LimeSurvey® is a free software that helps design online written surveys in PHP.

also in patient interaction and communication (Miller, 1990; Rotzoll, 2016). For the latter, the LernKlinik recruits both amateur and professional actors to play the role of patients to make training situations as realistic as possible. In this context, communication skills are considered one of the crucial elements for a successful treatment outcome.

The focus on practice is not only an approach adopted by the Medical School but also by the Philological Faculty, which offers a hands-on master's programme in conference interpreting, during which students also benefit from simulation teaching (cf. Okuda et al., 2009).

### *3.4 Project design*

The project ran over the course of twelve months, coinciding with the two semesters of the academic year. The course was designed and implemented in each semester, as shown in Figure 1.

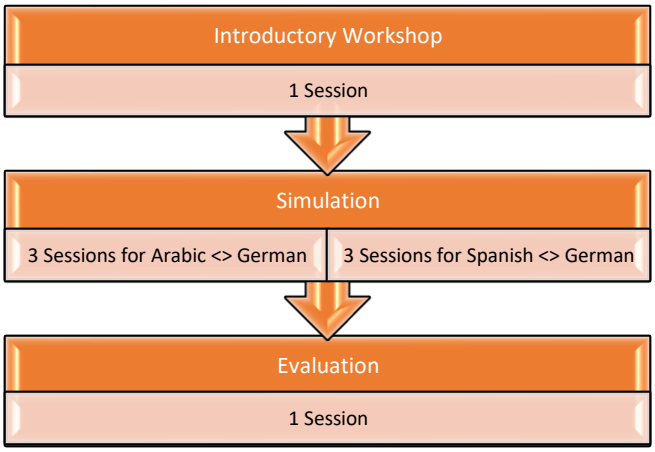


*Figure 1: Design of a project round.*

Each semester consisted of one eight-week round, and every round consisted of three segments (see Figure 1). The first session was an introductory workshop. Then, six simulated interpreting sessions took place, three in each language (Arabic and Spanish). Finally, there was an evaluation session. Each session lasted 90 minutes. Below, we provide an overview of the three segments.

#### *3.4.1 Introductory workshop*

The introductory workshop has several aims. First, to introduce students from all the groups to the work setting: on the one hand, to familiarize medical and midwifery students with interpreting, and, on the other hand, to introduce interpreting students to the medical profession. Second, to define the roles of participants. Third, to set specific learning goals for each student group and fourth, to discuss positive outcomes and possible pitfalls. A fifth goal was to also bring attention to cultural aspects (e.g., varying degrees of health literacy) and to local customs regarding the interaction between patients and healthcare professionals (e.g., the gender of the attending physician and the social status of doctors). The last goal of the introductory workshop was for students to get to know each other, thus laying the ground for future interprofessional collaboration.

### *3.4.2 Simulation*

Three staggered scenarios were developed:

(1) Admission interview to labour and delivery room.
(2) Informed consent discussion on pain relief during delivery.
(3) Informed consent discussion on surgical delivery.

After the introductory workshop, the three scenarios were played out in Arabic and Spanish, totalling six ninety-minute sessions. Students varied every time a scenario was played out. The simulation sessions were structured in three parts, (a) introduction, (b) simulation, and (c) feedback.

During the introduction, students received information about the scenario and the aims of the simulation session. Each group of students also received specific learning goals. They also completed a short, online questionnaire about their impressions of aboutan interpreted conversation between a healthcare professional and a patient. Furthermore, both the role-playing participants and the observers were instructed on how to give and receive feedback according to the 3W3 method (Lubienetzki and Schüler-Lubienetzki, 2020).

The simulations involved one student from each of the three groups (interpreting, medicine, and midwifery) and, depending on the scenario, one or two simulation patients and/or birth companions. The actors were trained and thoroughly briefed by Lernklinik personnel. Their role-playing scripts included information about aspects such as name, language, age, appearance, personality, education, occupation, social status, family situation, living conditions, social network, background information on family and upbringing, reason for the medical consultation, pre-existing conditions, lifestyle, emotional conditions (including fears and worries), attitude toward the situation, place/room of consultation, birth companion status, main concern of birthing person and/or companion, opening the scene, body language, behaviour during the role-play, communication challenges, and overall information on pregnancy (weight, height, medication intake, eating habits, bowel movement, immunization, etc.). Actors were also directed by one of the LernKlinik simulation support staff via microphone and earpiece when needed. In scenarios (2) and (3), the birthing person was accompanied by a partner, adding complexity to the situation.

Scenario (1), in turn, revolved around a pregnant woman who was under the impression that her water broke while she was doing yoga. She arrived at the hospital by ambulance. Upon arrival, the interprofessional team's task was to work together to provide a diagnosis, require further tests, and/or decide to admit the patient to the labour and delivery room. Similar role-playing scripts were devised for scenarios (2) and (3).

The simulation segment (b) of each session lasted 30 minutes. It is important to underline that there was a high degree of immersion since simulations take place in a realistic hospital room with a CTG and ultrasound machine, a hospital bed, a fake pregnant belly, healthcare participants in scrubs etc. (Figure 2). The midwife, the physician, and the interpreter had to talk to the patient and try to obtain important information, such as patient history, risk factors, etc., which the actors provided based on the script. The interpreter's role was essential in this setting since without him/her, communication with this patient would be very limited (e.g. through

[3] The 3W method is a structured feedback tool that involves three elements: perception (*Wahrnehmung*), effect (*Wirkung*), and recommendation (*Wunsch*). It guides students in feedback-giving by making them follow a simple scheme that streamlines feedback. An example would be: "I noticed that you were making good eye contact with the patient" (perception); "I felt like that helped establish good rapport with the patient" (effect); and "We should keep this up in future sessions" (recommendation).

gestures).

*Figure 2: Simulation with a patient, a physician, an interpreter, and a midwife (right to left). Photo by Bodo Tiedemann*

The observers – teachers and students – watched what took place inside the hospital room in an adjacent observation room behind a one-way mirror. After the simulation, participants and observers met for discussion and feedback (c). Participants shared their thoughts on their own role, goals, and how they felt during the simulation. Observers also provided feedback on what they saw and on the learning goals. At the end of each session, students filled in a second online survey containing questions about their participation and their satisfaction with the sessions.

### *3.4.3 Evaluation*

In addition to the feedback, at the end of each simulation session, the last session of each of the rounds was dedicated to evaluating the simulation sessions to identify areas for improvement (with formative goals). Different aspects, such as the positioning of the hospital bed in the room, the timing of the elements of the simulation, the method used for giving feedback, etc. were discussed and modifications were subsequently applied to the following sessions. The feedback obtained from the surveys was also shared with the project team to incorporate changes to the second or following rounds.

## 4. Feedback from students

### *4.1 General findings*

The findings in this section are a compilation of students' responses to the EvaSys®4 surveys and their oral feedback given during the discussions immediately after the simulation sessions. Generally, the student feedback was split into four categories:

(1) Satisfaction with course.
(2) Suggestions for improvement of scenario.

[4] EvaSys® is a tried-and-tested tool for online questionnaires.

(3) Feedback sessions.
(4) Individual feedback.

In (1), students indicated they were satisfied or very satisfied with the simulation sessions, rating it with an average of 1.8 on a scale from 1 (very good) to 6 (unsatisfactory) (Figure 3).

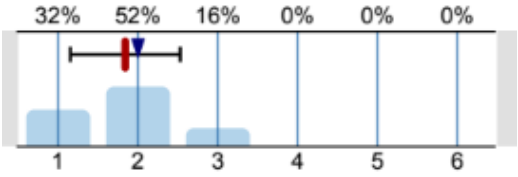


*Figure 3: Student assessment of round one.*

In the satisfaction survey, students were asked to specify 1-3 learning outcomes from the scenario and given the opportunity to leave general comments. Among the learning outcomes, students stated: "I feel I am now better prepared to work in an interprofessional team in a multicultural setting.", "The woman should always be the centre of attention.", "Interpreted consultations take much longer.", and "It would be great if it were possible to always work with [professional] interpreters in the clinic." From these, it was evident that the simulation scenarios helped create awareness among students for the challenges and opportunities of medical interpreting.

Students also made suggestions to improve scenarios (2). A small number of comments referred to time constraints, expressing their wish to have more time for the simulation. As the entire session only lasted 90 minutes due to university timetables and the capacity of the LernKlinik, the simulation itself only lasted 30 minutes. In addition, the number of observers, especially considering teachers, during the feedback sessions, was perceived as intimidating by some students. This was immediately considered for the second scenario. The number of teachers in the room was reduced, and focus turned to a peer-to-peer approach to feedback, more in line with the LernKlinik's Peer-Assisted Learning approach (cf. Blohm et al. 2015). This coincided with another comment students made, that they received too much feedback and were not able to process all of it. Accordingly, the amount of feedback was reduced in the third and subsequent sessions of round one.

One of the challenges faced during the first round was finding medical students willing to participate. As one of the decisions taken at the beginning of the project was to work only with medical students in their final practical year,5 the pool of students in the maternal health ward of the Leipzig University Clinic was rather small. This made the recruiting process cumbersome. Therefore, for the second and third rounds, the project team changed the eligibility criteria to first year obstetrics students as well as paediatrics and/or anaesthesiology students. This second group of students reported having felt slightly overwhelmed with the maternal health setting, considering that they did not have any prior experience in this field or lacked sufficient knowledge about this field. Thus, to this group, the simulation had one more layer of complexity, with the potential of taking the focus off the project's communication goals.

In a similar vein, some of the midwifery students, with none to hardly any prior experience with interpreters, also reported, during the group feedback session (3), having felt out of their depth and sometimes unsure of what was expected of them. Therefore, for round two, adjustments were also made to address these issues, with modifications to the

[5] This corresponds to medical residency and the last year of medical school.

introductory workshop and the introduction to the simulation session (part a) to include midwifery students more effectively. Nevertheless, the feedback (4) given by the midwifery in the anonymous EvaSys® tool still carried the lowest ratings (Appendix 2) for the three scenarios considering goals, clarity of task, development of communication skills, and professional development. These aspects will be addressed again in the Discussion section.

In later sessions, we experimented with assigning interpreting and translation students simulated patients' roles. As they spoke both working languages this may have impacted the 'authenticity' of the scenario to a small extent since omissions or mistakes that the interpreter made did not lead to as much miscommunication as they would have in a setting with a simulated patient who did not speak any German. On the other hand, this limitation was deemed acceptable because it facilitated the recruiting of simulated patients and offered interpreting students the opportunity to play a different role.

The feedback sessions (3) were led by a young midwifery graduate student and were held immediately after the simulations. Feedback was compiled by one of the project team members, a young translation scholar in a strictly observational capacity. Next, the collected data was organized in an Excel spreadsheet for analysis.

As mentioned above, due to the formative nature of the sessions, the feedback questions were adjusted throughout. Thus, not all of them were asked questions during every single feedback session. Considering the objectives of our study, the following sections include a report on our findings for the following questions: (4.1) "What went well?", which became "What did I do well?" in later sessions; (4.2) "What would I do differently next time?"; (4.3) "How did I feel?"; and (4.4) "How was team work?", and (4.5) "What did I learn/take away from this experience?", which was merged with "Are there any general comments about the course?" in the final sessions.

### *4.2 What went well? / What did I do well?*

Regarding the positive aspects that they had observed, interpreting students reported that the working environment was adequate, that everyone worked well together, and that the simulations were a good practicing experience. The same applied to the midwifery students, who stated that the team communication had worked well. In fact, everyone had been considerate and on equal terms with the actor couple. Medical students also indicated that the working environment was adequate. On the other hand, these students also reported that there was room for concerns and questions from parents.

When this question was changed to "What did I do well?" in later sessions, more specific answers were obtained from the three groups of students. Interpreting students listed the following aspects: introducing themselves well, rendering the full interpreting, handling unfamiliar terms well and finding strategic solutions, maintaining eye contact, communicating on an equal level with other participants, remaining calm with formulation difficulties, and toning negative comments down (e.g., "When a negative comment came, I toned it down a bit because it didn't help the situation").

In turn, midwifery students reported the following aspects as positive: supporting the birthing mother with her breathing, offering positioning techniques, asking about intensity of contractions, developing a good bond with the woman, being empathic and understanding the situation despite language difference, always being at the woman's eye level and sometimes squatting to do so, responding well to the woman in labour, offering the woman water or the ball, and encouraging the woman to take a break when overwhelmed by the situation (e.g., "I supported the woman well and addressed contractions and back pain. We found a good

position together; I offered her water and the ball. I advocated for her to take a break when the contraction started").

Lastly, when asked about what they had done well, medical students reported the following aspects: including the midwife adequately in the conversation, trying to reduce his/her own talking time, speaking slowly, calmly and pausing, speaking in a structured way, involving and addressing both parents, speaking directly to the patient (the whole situation was surprisingly pleasant), and making adequate eye contact. (e.g., "I spoke slowly and calmly and made good eye contact").

### *4.3 What would I do differently next time?*

When asked about what they would do differently in the future, interpreting students stated they would: prepare better lexically, check with the people in the room whether his/her positioning was adequate for everyone involved, discuss the length of the segment with the doctor beforehand, be more sure about whether he/she should interpret everything the birthing person and their companion discussed among themselves (e.g., "I wasn't sure whether I should interpret everything the couple discussed among themselves. Next time I could perhaps summarise these statements for the doctor and midwife"). Other aspects mentioned were making sure that everyone was involved in the communication, waiting for a contraction to pass before continuing to interpret (e.g., "I would wait during the contraction and wouldn't continue interpreting"), explaining technical terms more, and interpreting consistently in a formal/informal you (Sie/du)6.

On the other hand, midwifery students underlined they would improve by involving their partner more, positioning themselves in the room, playing a more active role during the medical consultation, explaining the role of midwives more clearly (because in one scenario patient and companion asked several times whether the midwife was a doctor), and mentioning less invasive methods (e.g., "When the doctor explained the epidural, I would have liked to have mentioned that there are other, less invasive methods of pain treatment, but I didn't want to interfere with the explanation").

As for the medical students, they stated they would try to: read the information sheet beforehand since they were overwhelmed with information (this statement came from non-OBGYN students included in the project to increase the pool of medical students, as mentioned previously), improve communication with the midwife (e.g.,"Communication with the midwife didn't go well"), be more structured, maybe sit down to be on the same level as the birthing woman, and better assess the amount of information provided to the patient (e.g., "I would maybe sit down. I wasn't on the same level as the woman. I listed all the risks, that might have been a bit much").

### *4.4 How did I feel and how was teamwork?*

Interpreters reported feeling more uncomfortable at the beginning but became increasingly comfortable as the scenario developed. They felt chaotic at times and were also taken by surprise when they forgot to interpret a certain segment and were asked to do so (e.g., "When I forgot to interpret in one situation it felt like a bit of a shock when the father asked me to").

[6] This distinction is important in German, and in other languages also since patients and healthcare professionals usually address each other formally (Sie). Being able to address someone informally in German usually depends on the person higher in status authorizing others to do so. Conversely, couples will address each other informally (*du*). This difference in pronouns requires the interpreter to be constantly alert, resulting in an additional cognitive load.

Regarding feelings, midwives reported feeling insecure and helpless at the beginning because they could not communicate with parents even when resorting to gestures or English. On a positive note, one student stated that when there was no interpreter on the scene, she felt uncomfortable, but that this happens in real-life, too (e.g., “When the interpreter wasn't there yet, the situation was very awkward, but also realistic. That’s often how it is in everyday hospital life”) Students reported that the negative feelings of insecurity changed when the interpreter arrived. Doctors also reported feeling insecure at the beginning but feeling better later in the simulation; non-OBGYN students reported feeling out of their depth. Time pressure was also reported (e.g., “How am I supposed to discuss the entire information sheet in such a short time?”).

Regarding teamwork, one midwife, complementing the medical student, said: “The teamwork worked well. The doctor passed on the authority to me as a midwife when he didn’t know the answer himself. That was very pleasant”. Moreover, an interpreting student reported that “The teamwork was very good. The language was spoken slowly and clearly, and I always had enough time to interpret”. Furthermore, a medical student complimented the work of the interpreting student: “Very good. The interpreter kept track even in more complex situations and didn’t leave anything out, for example, when the midwife suggested the bathtub”. The overall positivity of feedback can be attributed to the success of the project and the attitude of participants but also to the fact that all feedback sessions had been conducted in person, and students and actors were very careful not to lose or cause other participants to lose face. To balance this out, students also answered the EvaSys® survey mentioned above. We will bring both forms of feedback together in the Discussion section (section 5).

### 4.5 *What did I learn from this experience? / Are there any general comments about the course?*

Students reported having learned how to work with professional interpreters as compared to working with ad hoc interpreters (“It’s nice to see how well this can work with professional interpreters. In practice, we either have no one or relatives, which doesn’t work nearly as well”, said a midwifery student). Another student mentioned the importance of starting the scenario with no interpreter present, so healthcare students tried to communicate without speaking the patient’s language (“It was also a good experience to initially have to communicate with the parents without an interpreter,” said a midwifery student). Students also reported achieving better positioning in the birthing room (“Good positioning is possible, I doubted that before,” said an observer). One final aspect learned mentioned was the importance of active listening (“Active listening is important for things to work,” said an observer).

Regarding general comments, students mentioned that the introductory workshop was not as helpful as expected for the scenario preparation, that the goal of successful communication should be stated even more clearly, and that switching roles among observers and role players had been useful (e.g. “Preparation by participating as an observer last week was very helpful and useful. I knew that it wasn’t about the technical information, but about the communication situation”). On the other hand, observers also stated that the observation assignments had been very helpful; otherwise, they would have been overwhelmed. Similarly, they noted the importance of the midwife in birth settings and one student observer underlined it more specifically: “The midwife is the most important point of reference for the woman. I realised that today”.

Three other aspects were highlighted by the same instrument. The first one was the time constraint, which was mentioned by students of all profiles. In fact, one midwifery student said: “I would have liked more time for preliminary discussions within the team”. Two other elements

raised since the first scenario were eye contact and positioning in the birthing room. The latter became an increasingly important issue, and the many sessions and scenarios enabled participants to experiment it ("I was behind the woman at the beginning. The position was not optimal," said a midwifery student). Therefore, according to the feedback, both eye contact and positioning were much improved when comparing the first simulations with the final ones.

## 5. Discussion and final remarks

Based on the reports on the in-person feedback sessions in the previous section, participants reported overall feelings of well-being, as detailed in section 4. Some of the not-so-positive feelings resulted from project constraints, namely, feelings of pressure resulting from time constraints and participation constraints (increasing the medical student pool to non-OBGYN students) created feelings of insecurity or overwhelmingness. Regarding teamwork, no negative feedback was given during the in-person sessions. As stated above, this probably resulted from the fact that not only was the overall experience positive, but also because feedback was given face to face, and participants and observers were extremely careful in responding while taking part in a multi-student group.

Students realised the benefits of taking part in more than one simulation in the same role and/or in that of observer, albeit not many had the chance to do so. These students reported that, although they had not obtained good results the first time, they improved in the subsequent simulation ("[This time] I introduced myself as an interpreter. I didn't succeed the first time"). The feedback sessions also enabled self-reflection on the nature of the communication involving interpreters since an interpreter-mediated interaction can present more challenges to turn-taking ("I would have said something that I did not say [because I didn't want to interrupt]", reported a midwifery student), on top of the existing challenges in terms of hospital hierarchies in this particular case. Students also realised it was possible to establish good rapport with patients despite the language difference ("I developed a good bond with the woman, was empathetic and understood and commented on the situation despite language barriers," reported a midwifery student).

For the interpreters, uncertainty existed on whether to interpret utterances not directly aimed at the party being interpreted or that could be overheard in the background. Although the communication is described as triadic, there were often more than three people involved (for instance, the birth companion, another midwife, a doctor, etc.). The higher the number of people, the more challenging it was for the interpreter. In line with this, an interpreter reported: "Once the midwife said something during the doctor's consultation and I didn't think to interpret it. I only noticed it when the father asked". Moreover, another interpreting student said they were unsure whether to translate everything the couple discussed among themselves ("Next time I could perhaps summarize these statements for the doctor and midwife"). This shows that the possibility of taking part in more than one scenario enabled interpreting students to learn how to deal with this. However, many people talking at the same time or in different constellations can also be a potential stressor. One of the midwifery students expressed this by saying: "I would have liked a second interpreter to talk to the partner while the doctor and the first interpreter talked to the mother". Albeit an unrealistic expectation due to the current context of healthcare interpreting in many countries, this corroborates the complexity of the challenges that interpreting students identified in their feedback and the challenges they are likely to face –but hopefully now in a better-prepared way– in their future professional settings.

The EvaSys® surveys confirmed the overall satisfaction with the course (Appendix 2). However, on one hand, midwifery students provided the lowest rates for clarity of communication goals and learning goals as well as for improvement of communication skills

in teamwork, development of profession-specific, technical skills; usefulness of course structure, overall assessment of course, and benefits of sharing a course with other professions in terms of future practice. It should be noted that, according to the literature on healthcare communication, the interface between midwifery and medical groups in obstetrics has been found to be hierarchically marked, thus conflict and tension-prone (Schmiedhofer, 2021), and unclear role perceptions have also been found to lead to interprofessional conflicts (Meffe et al., 2020). During the simulation, such conflicts were not explicit (for reasons mentioned in section 4.3 and at the beginning of this section), but were likely to be underlying in feedback statements such as “Communication with the midwife didn’t go well”, and “When the doctor explained the epidural, I would have liked to have mentioned that there are other, less invasive methods of pain treatment, but I didn’t want to interfere with the explanation”.

On the other hand, interpreting students were the ones who assigned the highest rates of positive feedback in the EvaSys® surveys. For instance, course materials were considered more useful to the interpreters; this made sense since this group had no or very little prior knowledge of obstetrics and hospital settings. As a result, certain sections of the materials may have been redundant to the healthcare professions. In several accounts, interpreter feedback indicated how the experience had made them reflect on the ethics of interactions. In fact, as shown in section 4.2, one interpreting student stated that he/she toned town when dealing with negative comments. This reflection is in line with ethical dilemmas commonly faced by healthcare interpreters who work in women’s health settings (Susam-Saraeva et al., 2023; Bartłomiejczyk et al., 2024), and shows a certain degree alignment and sensitivity to patient needs. This could be expanded on in the future together with the ethical issues involving other statements such as: “I wasn’t sure whether I should interpret everything the couple discussed among themselves” and “I would wait during the contraction and wouldn’t continue interpreting”. As a result, these and several of the other statements mentioned above would make good points of entry for context-specific interpreter ethics discussions, which could be expanded on in future feedback and/or in course-specific situations in interpreter education, for instance.

In general, the results of TeamTra have shown that the course contributed to the development of interprofessional skills, which have the potential of being applied to an overall improved access to healthcare for migrants. From this point of view, it is important to highlight that funding for this project at Leipzig University was initially established for a 12-month period, but the project was extended to run in the winter semester 2023/2024.

Lastly, due to the successful outcomes, the project team is considering incorporating this training to the curriculum of the courses involved. By so doing, in light of the complex healthcare interpreting context in Germany, and of a potential change in language policy in healthcare (Berg, 2023), this would be another step towards filling a crucial gap in the right to healthcare of the non-German-speaking population.

## References

Antonini, R., Cirillo, L., Rossato, L., & Torresi, I. (2017). Introducing NPIT studies. In R. Antonini, L. Cirillo, L. Rossato, & I. Torresi (Eds.), Non-professional interpreting and translation. State of the art and future of an emerging field of research (pp. 1-26). John Benjamins.

Baraldi, C., & Gavioli, L. (2016). On professional and non-professional interpreting in healthcare services: the case of intercultural mediators*. European Journal of Applied Linguistics, 4*(1), 33-55.

Federal Republic of Germany. (1949). Basic Law for the Federal Republic of Germany. https://www.btg-bestellservice.de/pdf/80201000.pdf

Bartłomiejczyk, M., Pöllabauer, S., & Straczek-Helios, V. (2024) Ethical issues in activist interpreting – the case of Ciocia Wienia. [Online-first] *Interpreting, 26*(2), 1-27.

Berg, C. (2023). Schneller Arzttermine, Dolmetscher, Gesundheitskioske: So will Lauterbauch eure Medizinversorgung verbessern. Business Insider. https://www.businessinsider.de/politik/schnellere-arzttermine-lauterbach-will-arztbesuche-verbessern/

Blohm, M., Lauter, J., Branchereau, S., Krautter, M., Köhl-Hackert, N., Jünger, J., Herzog, W., & Nikendel, C. (2015). Peer-Assisted Learning (PAL) in the Skills-Lab – an inventory at the medical faculties of the Federal Republic of Germany. *GMS Zeitschrift für Medizinische Ausbildung, 32*(1). https://doi.org/10.3205/zma000952

Brisset, C., Leanza, Y., & Laforest, K. (2013). Working with interpreters in health care: A systematic review and meta-ethnography of qualitative studies. *Patient Education and Counseling, 91,* 131–140. https://doi.org/10.1016/j.pec.2012.11.008

Dahinden, J., & Bischoff, A. (2010). Integration unter den Bedingungen gesellschaftlicher Vielfalt und Transnationalität – einige Reflexionen. Dolmetschen, Vermitteln, Schlichten – Integration oder Diversität? Seismo.

DESTATIS (Statistisches Bundesamt) (2022). Gut jede vierte Person in Deutschland hatte 2021 einen Migrationshintergrund. Pressemitteilung. https://www.destatis.de/DE/Presse/Pressemitteilungen/2022/04/PD22_162_125.html

German Civil Code BGB. January 2, 2002. https://www.gesetze-im-internet.de/englisch_bgb/index.html

Fukui, N., Partain, D. K., Yeow, M., Farfour, H. N., Prokop, L., & Barwise, A. (2024). Learning to collaborate with medical interpreters in health professions education: A systematic review of training programs. *Medical Teacher, 46*(2), 258-272. https://doi.org/10.1080/0142159X.2023.2249211

Glenn, F., Laws, M. B., Mayo, S. J., Zuckerman, B., Abreu, M., Medina, L., & Hardt, E. J. (2003): Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics, Official Journal of the American Academy of Pediatrics, 111*(1), 6-14. https://doi.org/10.1542/peds.111.1.6

Hlavac, J. (2021) The development of community translation and interpreting in Australia: A critical overview. In J. Wakabayashi, & M. O'Hagan, *Translating and interpreting in Australia and New Zealand* (pp. 65-85). Routledge.

Hoang, H., Le, Q., & Kilpatrick, S. (2009) Having a baby in the new land: A qualitative exploration of the experiences of Asian migrants in rural Tasmania. *Rural and Remote Health, 9*(1), 1-11. https://doi.org/10.22605/RRH1084

Hughson, J.-A., Marshall, F., Daly, J. O., Woodward-Kron, R., Hajek, J., & Story, D. (2018). Health professionals' views on health literacy issues for culturally and linguistically diverse women in maternity care: Barriers, enablers and the need for an integrated approach. *Australian Health Review, 42*(1), 10–20. https://doi.org/10.1071/AH17067

Kalina, S. (2001). Zur Professionalisierung beim Dolmetschen. Vorschläge für Forschung und Lehre. In A. Kelletat (Ed.), *Dolmetschen. Beiträge aus Forschung, Lehre und Praxis*. (pp. 51-64). Peter Lang.

Krystallidou, D., Van De Walle, C., Deveugele, M., Dougali, E., Mertens, F., Truwant, A., Van Praet, E., & Pype, P. (2018). Training 'doctor-minded' interpreters and 'interpreter-minded' doctors. The benefits of collaborative practice in interpreter training. *Interpreting, 20*(1), 126-144.

Lubienetzki, U., & Schüler-Lubienetzki, H. (2020). *Lass uns miteinander sprechen. Psychologie für Studium und Beruf.* Springer. https://doi.org/10.1007/978-3-662-61829-5_1

Meffe F., Ng S., Nemoy L., Campbell D., Moscovitch L., Bishop C., Franziska S., & Chandrasekaran R.B. (2020). Calling all maternity care teams to the table! Exploring the driving forces contributing to interprofessional tensions in intrapartum care. *Journal of Obstetrics and Gynaecology Canada, 42,* 682–683. https://doi.org/10.1016/j.jogc.2020.02.069

Miller, G.E. (1990). The assessment of clinical skills/competence/performance. *Academic Medicine, 65*(9), 63-67.

Mösko, M., Dingoyan, D., Penka, S., Vardar, A., Schulz, H., Koch, U., Heinz, A., & Kluge, U. (2016). Prevalence of mental disorders and health service utilization among individuals with Turkish migration backgrounds in Germany: A study protocol for an epidemiological investigation. *Open Journal of Psychiatry, 6*(3), 237-252.

McAuliffe, M. & Triandafyllidou, A. (2021). World migration report 2022.International Organization for Migration (IOM). United Nations.

Okuda, Y., Bryson, E. O., DeMaria, S., Jacobson, L., Quinones, J., Shen, B., & Levine, A. I. (2009). The utility of simulation in medical education: What is the evidence? *Mount Sinai Journal of Medicine, 76*(4), 330-343. https://doi.org/10.002/msj.20127

Pöchhacker, F. (2000). The community interpreter's task: Self-perception and provider views. In R. P. Roberts, S. E. Carr, D. Abraham, & A. Dufour (Eds.), *The Critical Link 2: Interpreters in the community* (pp. 49–69). John Benjamins.

Razum, O., Zeeb, H., Meesmann, U., Schenk, L., Bredehorst, M., Brzoska, P., Dercks, T., Glodny, S., Menkhaus, B., & Salman, R.; Saß, A. and Ulrich, R. (2008). *Schwerpunktbericht der Gesundheitsberichterstattung des Bundes. Migration und Gesundheit*. Robert Koch-Institut.

Reichmann, T., Fonseca, L.C., & Brückner, D. (2023). TeamTra: Joint training of interpreting, medical and midwifery students at Leipzig University. In C. Valero-Garcés (Ed.), *Traducción e interpretación en los servicios públicos (TISP) en transición / Public service interpreting and translation (PSIT) in transition* (pp. 157-170). Servicios de publicaciones de la Universidad de Alcalá.

Rotzoll, D. (Ed.) (2016). *Das Skillslab ABC. Praktischer Einsatz von Simulatorentraining im Medizinstudium*. De Gruyter.

Sami, J., Quack Lötscher, K. C., Eperon, I., Gonik, L., Martinez de Tejada, B., Epiney, M., & Schmidt, N. C. (2019). Giving birth in Switzerland: A qualitative study exploring migrant women's experiences during pregnancy and childbirth in Geneva and Zurich using focus groups. *Reproductive Health, 16*(112), 1-19. https://doi.org/10.1186/s12978-019-0771-0

Sauerwein, F. S. (2006). *Dolmetschen bei polizeilichen Vernehmungen und grenzpolizeilichen Einreisebefragungen*. Peter Lang.

Schmiedhofer, M., Derksen, C., Keller, F.M., Dietl, J.E., Häussler, F., Strametz, R., Koester-Steinebach, I., & Lippke, S. (2021). Barriers and facilitators of safe communication in

obstetrics: Results from qualitative interviews with physicians, midwives, and nurses. *International Journal of Environmental Research and Public Health, 18*(3), 1-16. https://doi.org/10.3390/ijerph18030915

Stadt Leipzig (2020). Vielfalt leben. Gesamtkonzept zur Integration von Migrantinnen und Migranten. https://static.leipzig.de/fileadmin/mediendatenbank/leipzig-de/Stadt/02.1_Dez1_Allgemeine_Verwaltung/18_Ref_Migration_und_Integration/Gesamtkonzept_zur_Integration/Broschure_VIELFALT_LEBEN.pdf

St.Pierre, M., & Breuer, G. (Eds.) (2018). *Simulation in der Medizin. Grundlegende Konzepte – Klinische Anwendung.* Springer.

Strelow, K. R., Bahadır, S., Stollhof, B., Heeb, R. M., & Buggenhagen, H. (2021). Patientengespräche im interprofessionellen und interkulturellen Kontext (PinKo*). GMS Journal for Medical Education, 38*(3), 1-19. https://dx.doi.org/10.3205/zma001463

Susam-Saraeva, Ş. & Fonseca, L. C. (2021). Translation in maternal and neonatal health. In Ş. Susam-Saraeva, & E. Spišiaková (Eds.), *The Routledge handbook of translation and health* (pp. 348-368). Routledge.

Susam-Saraeva, Ş., Acosta Vicente, C., Carvalho Fonseca, L., García-Caro, O., Martínez-Pagán, B., Montero, F., & Yañez, G. (2023). Roundtable: Feminist interpreting (studies) – the story so far. *Translation Studies, 16*(1), 134–159. https://doi.org/10.1080/14781700.2022.2147989

Ticca, A. C. (2017). More than mere translators. The identities of lay interpreters in medical consultations. In R. Antonini, L. Cirillo, L. Rossato, & I. Torresi (Eds.), *Non-professional interpreting and translation. State of the art and future of an emerging field of research*. (pp. 107-130). John Benjamins.

Universitätsklinikum Hamburg-Eppendorf n.d. Aufenthalt. https://www.uke-io.de/de/ablauf-kosten/aufenthalt.html

## Appendix 1

Pre-kick-off survey on the self-perception of interpreters and providers.

| | The role of interpreters include… | Interpreting students | | Interpreting Faculty | | Medical Faculty | | Midwifery Faculty | |
|---|---|---|---|---|---|---|---|---|---|
| | | Agree | Disagree | Agree | Disagree | Agree | Disagree | Agree | Disagree |
| 1 | simplifying technical language for the clients | 63% | 27%* | 100% | - | 50% | 50% | 100 % | - |
| 2 | adding information to explain technical terms to patients. | 64% | 36% | 80% | 20% | - | 100% | 80% | - |
| 3 | summarizing clumsy long utterances of patients. | 72% | 18% | 40% | 20% | 50% | 25% | 80% | 20% |
| 4 | summarizing clumsy long utterances of healthcare providers. | 54% | 27% | 20% | 60% | 25% | 75% | 60% | 20% |
| 5 | omitting utterances which are not to the point to avoid wasting time. | 54% | 18% | 60% | 20% | 100 % | - | 40% | 20% |
| 6 | omitting utterances which are inopportune or harmful to the client. | 91% | 9% | 20% | 40% | 75% | - | 60% | 40% |
| 7 | omitting utterances which are inopportune or harmful to provider. | 100 % | - | 40% | 40% | - | 75% | 40% | 60% |
| 8 | explaining foreign cultural references and meaning to patient. | 100 % | - | 100% | - | - | 100% | 60% | - |
| 9 | explaining foreign cultural references and meaning to provider. | 100 % | - | 100% | - | - | 100% | 60% | - |
| 10 | clarifying the meaning indeterminate statements by immediate follow-up questions to patient. | 90% | - | 80% | - | 50% | 25% | 80% | - |
| 11 | clarifying the meaning of indeterminate statements by immediate follow-up questions to provider. | 91% | - | 80% | - | 100 % | - | 80% | - |
| 12 | alerting parties to any misunderstanding in the conversation. | 100 % | - | 80% | 20% | 100 % | - | 80% | - |
| 13 | asking questions and giving information at the request of the provider in the absence of provider. | 9% | 82% | - | 100% | 25% | 75% | 20% | 60% |
| 14 | assisting patient in the absence of provider. | - | 91% | - | 100% | 25% | 50% | - | 100% |
| 15 | orally translating forms for patient when forms are not in the patient's language. | 82% | - | 100% | - | 75% | - | 60% | 20% |
| 16 | filling in forms with the patient when forms are NOT in patient's language. | 73% | 18% | 80% | 20% | 100 % | - | 100 % | - |
| 17 | filling in forms with the patient when forms ARE in the patient's language. | 27% | 64% | 20% | 80% | - | 100% | - | 80% |
| 18 | ensuring patient consent in cases of informed consent. | 82% | 18% | 80% | 20% | 100 % | - | 60% | 40% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 19 | asking patient to briefly provide contextual information before the consultation/encounter with provider. | 18% | 72% | 20% | 60% | 25% | 25% | 40% | 40% |
| 20 | asking provider to briefly provide contextual information before the consultation/encounter with patient. | 54% | 27% | 80% | 20% | 50% | 25% | 40% | 20% |
| 21 | positioning themselves close to or in the sight of the patient. | 100 % | - | 80% | 20% | 75% | - | 80% | 20% |
| 22 | positioning themselves close to or in the sight of the provider. | 100 % | - | 80% | 20% | 75% | - | 80% | - |
| 23 | touching or having physical contact with the patient. | - | 81% | - | 100% | - | 100% | - | 100% |
| 24 | making eye contact with provider. | 82% | 18% | 100% | - | 100 % | - | 80 | - |
| 25 | making eye contact with patient. | 91% | 9% | 100% | - | 75% | - | 80% | - |
| 26 | asking for repetition if interpreter does not understand patient very well. | 100 % | - | 100% | - | 100 % | - | 100 % | - |
| 27 | asking for repetition if interpreter does not understand provider very well. | 100 % | - | 100% | - | 100 % | - | 100 % | - |
| 28 | being respectful of patient's cultural background. | 100 % | - | 80% | - | 100 % | - | 100 % | - |
| 29 | ensuring efficient flow of interaction. | 100 % | - | 100% | - | 75% | 25% | 100 % | - |
| 30 | following providers instructions when they clearly have a positive effect on patient. | 91% | - | 80% | - | 75% | - | 40% | 60% |
| 31 | following providers instructions when they clearly do NOT have a positive effect on patient. | 9% | 45% | 20% | 60% | 25% | 25% | 20% | 60% |
| 32 | includes translating everyone that is speaking around patient. | 18% | 64% | 40% | 60% | 25% | 50% | 40% | 40% |
| 33 | translating only what is directly addressed to patient. | 60% | - | 18% | 73% | 100 % | - | 20% | 60% |
| 34 | includes briefing patient on how interpreting works. | 73% | 9% | 60% | 20% | 75% | 25% | 25% | 60% |
| 35 | briefing provider on how interpreting works. | 82% | 18% | 80% | - | 75% | 25% | 40% | 20% |
| 36 | asking for a break or for an interpreter replacement when working for longer than the standard time practice. | 91% | 9% | 60% | 20% | 75% | 20% | 60% | - |

*Where figures do not add up to 100%, it is because respondents answered, “neither agree nor disagree.”

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## Appendix 2

EvaSys® survey results for Session 1.

| Student Group | Medical | | Midwifery | | Interpreting | |
|---|---|---|---|---|---|---|
| | *M* | *SD* | *M* | *SD* | M | *SD* |
| The learning goals for group work clear to me. | 1.50 | 0.84 | 1.73 | 0.80 | 1.50 | 0.58 |
| The subject-specific learning goals for my profession are clear to me. | 1.50 | 0.84 | 1.67 | 0.82 | 1.25 | 0.50 |
| The materials used in the course (presentation, exercise sheets) were helpful for my learning process. | 1.50 | 0.84 | 2.67 | 0.98 | 1.50 | 0.58 |
| The actors were helpful in my learning process. | 1.17 | 0.41 | 1.67 | 0.90 | 1.25 | 0.50 |
| How well did the course build on my previous knowledge? | 2.33 | 1.03 | 2.33 | 0.72 | 1.50 | 1.00 |
| Attending the course was helpful in developing my communication skills in teamwork. | 1.50 | 0.55 | 2.13 | 1.06 | 1.25 | 0.50 |
| Attending the course was helpful in developing my profession-specific, technical skills. | 2.50 | 1.52 | 2.47 | 0.99 | 1.50 | 0.58 |
| I found the overall structure of the course to be useful. | 1.67 | 0.82 | 1.93 | 0.80 | 1.50 | 0.58 |
| How would you ultimately rate the course? | 1.50 | 0.55 | 2.07 | 0.70 | 1.50 | 0.58 |
| How do I rate the benefits of sharing a course with other professions in terms of my future practice? | 1.33 | 0.52 | 2.00 | 0.76 | 1.25 | 0.50 |

*N* = 22 Participants. n(Medical) = 3. n(Midwifery) = 15. n(Interpreting) = 4

EvaSys® survey results for Session 2.

| Student Group | Medical | | Midwifery | | Interpreting | |
|---|---|---|---|---|---|---|
| | *M* | *SD* | *M* | *SD* | M | *SD* |
| The learning goals for group work clear to me. | 1.57 | 0.54 | 1.76 | 1.03 | 1.36 | 0.50 |
| The subject-specific learning goals for my profession are clear to me. | 1.57 | 0.54 | 2.12 | 1.22 | 1.29 | 0.47 |
| The materials used in the course (presentation, exercise sheets) were helpful for my learning process. | 2.14 | 1.07 | 2.47 | 1.18 | 1.29 | 0.47 |
| The actors were helpful in my learning process. | 1.57 | 0.54 | 1.53 | 0.72 | 1.07 | 0.27 |
| How well did the course build on my previous knowledge? | 2.14 | 1.07 | 2.06 | 1.09 | 1.57 | 0.76 |
| Attending the course was helpful in developing my communication skills in teamwork. | 1.29 | 0.49 | 2.76 | 1.45 | 1.57 | 0.65 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Attending the course was helpful in developing my profession-specific, technical skills. | 1.86 | 0.69 | 3.24 | 1.52 | 1.57 | 0.51 |
| I found the overall structure of the course to be useful. | 1.57 | 0.54 | 2.76 | 1.03 | 1.31 | 048 |
| How would you ultimately rate the course? | 1.57 | 0.54 | 2.53 | 0.80 | 1.36 | 0.50 |
| How do I rate the benefits of sharing a course with other professions in terms of my future practice? | 1.57 | 0.54 | 2.53 | 1.18 | 1.50 | 0.52 |

*N* = 38 Participants. n(Medical) = 7. n(Midwifery) = 17. n(Interpreting) = 14

EvaSys® survey results for Session 3.

| Student Group | Medical | | Midwifery | | Interpreting | |
|---|---|---|---|---|---|---|
| | *M* | *SD* | *M* | *SD* | M | *SD* |
| The learning goals for group work clear to me. | 1.00 | 0.00 | 1.83 | 1.27 | 1.17 | 0.41 |
| The subject-specific learning goals for my profession are clear to me. | 2.00 | 0.00 | 2.17 | 1.47 | 1.00 | 0.00 |
| The materials used in the course (presentation, exercise sheets) were helpful for my learning process. | 1.00 | 0.00 | 2.25 | 1.42 | 1.33 | 0.52 |
| The actors were helpful in my learning process. | 2.00 | 0.00 | 1.92 | 0.90 | 1.00 | 0.00 |
| How well did the course build on my previous knowledge? | 5.00 | 0.00 | 2.00 | 1.35 | 1.50 | 0.84 |
| Attending the course was helpful in developing my communication skills in teamwork. | 2.00 | 0.00 | 2.58 | 0.79 | 1.33 | 0.82 |
| Attending the course was helpful in developing my profession-specific, technical skills. | 1.00 | 0.00 | 2.92 | 1.00 | 1.17 | 0.41 |
| I found the overall structure of the course to be useful. | 1.00 | 0.00 | 2.33 | 1.07 | 1.00 | 0.00 |
| How would you ultimately rate the course? | 1.00 | 0.00 | 2.83 | 1.11 | 2.17 | 1.94 |
| How do I rate the benefits of sharing a course with other professions in terms of my future practice? | 2.00 | 0.00 | 2.30 | 1.16 | 1.33 | 0.52 |

*N* = 19 Participants. n(Medical) = 1. n(Midwifery) = 12. n(Interpreting) = 6